Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

East Lancashire Hospitals NHS Trust Board Meeting

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Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD MEETING (OPEN SESSION) AGENDA

20 NOVEMBER 2024, 12.00

BOARDROOM, BIRCH HOUSE

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

OPENING MATTERS				
TB/2024/143	**Chairman's Welcome**	Chairman	v	
TB/2024/144	**Apologies** To note apologies.	Chairman	v	
TB/2024/145	**Declarations of Interest** To note the directors register of interests and note any new declarations from Directors.	Chairman	d✓	Approval
TB/2024/146	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 11 September 2024.	Chairman	d✓	Approval
TB/2024/147	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2024/148	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2024/149	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2024/150	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information/ Approval
QUALITY AND SAFETY				
TB/2024/151	**Staff / Patient Story** To receive and consider the learning from a patient/Staff story.	Chief Nurse	p	Information/ Assurance
TB/2024/152	**Corporate Risk Register Report** To receive an update on the Corporate Risk Register and approve revisions based on the Executive Risk Assurance Group, Committees' and Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Executive Medical Director	d✓	Assurance/ Approval
TB/2024/153	**Board Assurance Framework** To receive an update on the annual review of the Board Assurance Framework and risk appetite and approve the revisions based on the Executive Risk Assurance Group, Committees' and the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Executive Director of Service Development and Improvement	d✓	Assurance/ Approval
TB/2024/154	**Patient Safety Incident Response Assurance Report** To receive the paper as a summary update on the incidents reported under the new Patient Safety Incident	Executive Medical Director	d✓	Information/ Assurance

	Response Plan (PSIRP). This report also includes information on maternity specific serious incidents reporting as required by Ockenden recommendations.			
STRATEGIC ISSUES				
TB/2024/155	**Maternity and Neonatal Services Update** *T Thompson to attend for this item.*	Chief Nurse / Divisional Director of Midwifery and Nursing	d✓	Information/ Assurance
ACCOUNTABILITY AND PERFORMANCE				
TB/2024/156	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed, with items being raised by exception: **15.15** a) Introduction (Chief Executive) **15.20** b) Safe (Executive Medical Director and Chief Nurse) **15.25** c) Caring (Chief Nurse) **15.30** d) Effective (Executive Medical Director) **15.35** e) Responsive (Chief Operating Officer) **15.40** f) Well-Led (Director of People and Culture and Executive Director of Finance)	Executive Directors	d✓	Information/ Assurance
GOVERNANCE				
TB/2024/157	**East Lancashire Hospitals NHS Trust Self-Assessment Report 2023-24 for Department of Education, Research and Innovation**	Executive Director of People and Culture	d✓	Ratification
TB/2024/158	**Emergency Preparedness, Resilience and Response (EPRR) Annual Statement**	Executive Director of Integrated Care, Partnerships and Resilience	d✓	Ratification
TB/2024/159	**Ratification of Board Sub-Committee Terms of Reference** a) Finance & Performance b) Trust Charitable Funds	Committee Chair Committee Chair	d✓ d✓	Approval Approval
FOR INFORMATION				
TB/2024/160	**Triple A Reports from People and Culture Committee** To note the matters considered by the Committee in discharging its duties. a) September 2024 b) October 2024 (Development Workshop)	Committee Chair	 d✓ d✓	Information
TB/2024/161	**Triple A Reports from Finance and Performance Committee** To note the matters considered by the Committee in discharging its duties.	Committee Chair		Information

	a) September 2024 b) October 2024		d✓ d✓	
TB/2024/162	**Triple A Reports from Quality Committee** To note the matters considered by the Committee in discharging its duties. c) September 2024 d) October 2024	Committee Chair	 d✓ d✓	Information
TB/2024/163	**Triple A Report from Audit Committee** To note the matters considered by the Committee in discharging its duties. a) October 2024	Committee Chair	 d✓	Information
TB/2024/164	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2024/165	**Trust Board (Closed Session) Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
CLOSING ITEMS				
TB/2024/166	**Any Other Business**	Chairman	v	
TB/2024/167	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2024/168	**Board Performance and Reflection** To consider the performance of the Trust Board, including asking: 1. Have we, as the Board, via the agenda and our discussions fulfilled our objective of supporting our: a. Communities b. Staff c. Stakeholders 2. Have we, as the Board fulfilled our statutory obligations.	Chairman	v	
TB/2024/169	**Date and Time of Next Meeting** Wednesday 15 January 2025, 12.30pm, Boardroom, Birch House	Chairman	v	

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **145**

20 November 2024 **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	08.07.2024
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	12.11.2024
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	15.05.2024
Professor Graham Baldwin Non-Executive Director	• Director of Centralan Holdings Limited • Director of UCLan Overseas Limited • Director CY IPS Ltd • Director UCLan Cyprus • Director UCLan Professional Services Ltd • Deputy Chair and Director of UCEA • Chair of Maritime Skills Commission • Member of Universities UK • Chair of MillionPlus • Chair of University Vocational Awards Council • Chair of Lancashire Innovation Board • Member Preston Regeneration Board	Awaiting confirmation Awaiting confirmation Awaiting confirmation Awaiting confirmation Awaiting confirmation Awaiting confirmation Awaiting confirmation Awaiting confirmation Awaiting confirmation Awaiting confirmation 04.04.2022 24.05.2022 Awaiting confirmation	23.05.2024

Name and Title	Interest Declared	Date Declared	Date last updated/ Confirmed
	• Member Burnley Town Board • Member Burnley Economic Recovery Board	Awaiting confirmation Awaiting confirmation	
Charlotte Henson Interim Executive Director of Finance (from 01.10.2024 to 31.10.2024)	• Positive nil declaration	02.10.2023	01.10.2024
Sharon Gilligan Chief Operating Officer and Deputy Chief Executive	• Positive nil declaration	12.09.2019	11.11.2024
Melissa Hatch Associate Non-Executive Director (01.12.2023)	• Business Development professional at Citizens Advice. Responsible for charitable income generation.	10.07.2024	11.11.2024

Name and Title	Interest Declared	Date Declared	Date last updated/ Confirmed
Jawad Husain Executive Medical Director and Deputy Chief Executive	• Spouse is a GP in Oldham	30.03.2020	23.04.2024
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	12.11.2024
Peter Murphy Chief Nurse	• Spouse works at Liverpool University Foundation Trust.	24.03.2023	15.05.2024
Kate Quinn Executive Director of People and Culture	• Director at Lancashire Institute of Technology	Awaiting confirmation	11.11.2024
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	13.09.2023 13.09.2023 11.11.2024	11.11.2024

Name and Title	Interest Declared	Date Declared	Date last updated/ Confirmed
	• Spouse is a GP in Blackburn with Darwen	11.11.2024	
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	11.11.2024

Name and Title	Interest Declared	Date Declared	Date last updated/ Confirmed
Richard Smyth Non-Executive Director	• Spouse is a Patient and Public Involvement and Engagement Lay Leader for the Yorkshire and Humber Patient Safety Translational Research Centre, based at Bradford Institute for Health Research, Bradford Royal Infirmary. • Spouse is a Non-Executive Director at Lancashire Teachings Hospitals Foundation Trust as from 04.02.2019. • Chair of Board of Governors at Bury Grammar School as of 27 March 2023.	11.09.2018 22.03.2019 11.01.2023	12.11.2024
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	24.04.2024

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TRUST BOARD REPORT **Item** **146**

20 November 2024 **Purpose** Approval

Title	Minutes of the Previous Meeting
Report Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mr S Sarwar, Chairman
Date Paper Approved by Executive Sponsor	13 November 2024

Summary: The minutes of the previous Trust Board meeting held on 11 September 2024 are presented for approval or amendment as appropriate.

Report linkages

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

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

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

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 12:00, 11 SEPTEMBER 2024

MINUTES

PRESENT

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

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

Mrs K Atkinson	Executive Director of Service Development and Improvement
Mrs M Hatch	Associate Non-Executive Director
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience
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
Ms C Henson	Operational Director of Finance	
Mrs H Hudson	Team Sister, Pendle East District Nurses	Item: TB/2024/123
Mr S Islam	Deputy Medical Director (Performance)	
Mrs L Fisher	Clinical Team Leader, Pendle East District Nurses	Item: TB/2024/123
Mr M Pugh	Corporate Governance Officer	
Mr A Razaq	Director of Public Health, Blackburn with Darwen Borough Council	

Miss T Thompson	Divisional Director of Midwifery and Nursing	Item: TB/2024/128

APOLOGIES

Professor G Baldwin	Non-Executive Director
Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary
Mrs M Brown	Executive Director of Finance
Mr J Husain	Executive Medical Director / Deputy Chief Executive

TB/2024/115 CHAIRMAN'S WELCOME

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

Mr Sarwar reminded directors that Mrs Brown would be departing the Trust later in the month and expressed his, and the Board's, sincere thanks to her for her many contributions to the organisation over her career.

Mr Sarwar went on to inform directors that the meeting would also be Mr Smyth's last in his role as a Non-Executive Director. He stated that Mr Smyth's legal and analytical skillsets had been invaluable to the Trust, particularly in relation to recent system work activity and extended his thanks to him for all that he had done for the organisation.

TB/2024/116 APOLOGIES

Apologies were received as recorded above.

TB/2024/117 DECLARATIONS OF INTEREST

There were no changes requested to the Directors Register of Interests, and no declarations of interest made in relation to any agenda items.

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

TB/2024/118 MINUTES OF THE PREVIOUS MEETING

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

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

TB/2024/119 MATTERS ARISING

There were no matters arising.

TB/2024/120 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/2024/098: Patient Safety Incident Response Assurance Report: Mrs Quinn reported that overall compliance for the level 1b training module had risen to 76.5% for Board members and to 77% for senior managers. She explained that a number of former Trust colleagues were still being included in the list of staff required to complete this training and confirmed that this was being addressed.

Mr Sarwar acknowledged that progress was being made and requested that the same target of 95% compliance was maintained, and a further update provided, at the next meeting of the Board in November 2024.

RESOLVED: Directors noted the position of the action matrix.

TB/2024/121 CHAIRMAN'S REPORT

Mr Sarwar provided a summary of his activities since the previous meeting of the Board. He advised that in addition to his day-to-day duties at the Trust, he had continued to attend meetings of the Provider Collaboration Board (PCB) and Strategic Leaders' Group alongside his fellow Chairs and Chief Executive Officers (CEOs) from across the system. Mr Sarwar indicated that he also continued to attend meetings of the Lancashire Place Partnership on behalf of providers and emphasised the importance of this group in shaping the relationship between providers and their place partners.

Mr Sarwar confirmed that he had also participated in a range of activities at Trust level, including attending several recent Safe, Personal and Effective Care (SPEC) panels. He commented that these had served as an invaluable insight into the Trust's staff, the work they did and the challenges that they continued to face.

Mr Sarwar went on to inform directors that a listening event had recently taken place following the recent nationwide unrest and rioting in the wake of the murders in Southport in July, as it had become clear that a number of staff from predominantly Black, Asian and Minority Ethnic

(BAME) had been adversely affected by these events. He stated that some of the experiences described by staff had been shocking and saddening to hear and confirmed that a range of support mechanisms had been put in place for any colleagues requiring it. Mr Sarwar highlighted that the situation had also made clear that the Trust had wider cultural issues that it would need to address and advised that he had been part of the launch of a formal anti-racism campaign the previous day alongside Mr Hodgson. He added that this campaign was primarily focused on listening to lesser heard voices and taking a zero-tolerance approach to any inappropriate behaviours going forward and emphasised the role of the Board in this process.

Mr Sarwar reported that he had been closely involved in a recent recruitment campaign for additional non-executive and associate non-executive directors and had spoken to over 40 individuals who had expressed an interest in joining the Trust. Directors noted that the associated shortlisting process had now been completed and that interviews were expected to take place in early October 2024. Mr Sarwar explained that a further recruitment exercise would be undertaken later in the year to source a non-executive director (NED) with specific legal expertise, as no suitable candidates had come forward through the first campaign.

Mr Sarwar concluded his update by acknowledging the intense pressure and demand being placed on the Trust and extended his thanks to all colleagues for everything that they continued to do for the organisation.

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

TB/2024/122 **CHIEF EXECUTIVE'S REPORT**

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

Mr Hodgson referred to a National Leadership event that had taken place the previous week with the Chief Executive of NHS England (NHSE), Amanda Pritchard, the rest of her Executive team and the newly appointed Secretary of State for Health and Social Care, Wes Streeting. He reported that the main theme at this event had been recognition of the changing landscape due to the recent change in Government, but also that a number of other areas remained the same, including the challenges with finances pressures on urgent and emergency care (UEC) pathways and the role of wider health determinants and societal cohesion in healthcare. Mr Hodgson explained that recent months had been seen as something of a 'reset' moment for

the NHS and that the imminent publication of the findings from the investigation into the Health Service by Lord Darzi were expected to play an important role in this and in the planning process to come. He clarified that the second element to this was a separate causal analysis piece around the current state of the NHS that would consider funding, the impact of the COVID-19 pandemic and the ongoing effect from increases in demand and societal issues. Mr Hodgson indicated that a significant amount of engagement work would also be taking place with the public and staff, alongside these pieces of work, in order to form a new 10-year plan for the NHS.

Mr Hodgson referred to the comments made by Mr Sarwar regarding the Trust's response to the recent national civil unrest and stressed that there had been a clear need for senior leaders to act. He reported that the responses to the Trust's formal launch of its anti-racism campaign had been very positive but acknowledged that there were still examples of inappropriate behaviours in the organisation that would need to be addressed if it was to meet its goal of becoming intentionally anti-racist.

Mr Hodgson went on to inform directors that there was national recognition of the ongoing pressures on UEC pathways and pointed out that the Trust continued to see particularly high numbers of patients. He noted that the organisation continued to perform well in regard to the four-hour waiting time target but acknowledged that this concealed a multitude of other issues, including the long waits still being experienced by many patients in the Trust's emergency department. Mr Hodgson added that the Trust had recently approved its winter plan for 2024-25 which was expected to significantly reduce the need for corridor care and its subsequent impacts on the patient experience.

Mr Hodgson informed directors that several developments had taken place at a Lancashire and South Cumbria (LSC) system level. He confirmed that LSC remained in formal financial intervention arrangements and that the Trust continued to work with colleagues from PA Consultancy. Directors noted that the first phase of this work had now been completed and that the Trust had established a dedicated 'cell' structure to manage further work. Mr Hodgson clarified that the second phase would consist of wider work across LSC to identify any further areas of opportunity and that it was likely that the de-escalation of UEC areas would feature heavily in this.

Mr Hodgson went on to provide a summary of other developments taking place at Trust level, including an upcoming Board session on information governance and cyber security following

the ‘ransomware’ attacks in London earlier in the year. He reminded directors that the Trust had taken on the running of physical health community services in Blackburn with Darwen (BwD) from Lancashire and South Cumbria NHS Foundation Trust (LSCFT), with it transferring its East Lancashire Child and Adolescent Services (ELCAS) in return and confirmed that everything was running well.

Mr Hodgson informed directors that the results from a patient survey conducted in November 2023 had recently been published and highlighted that the Trust had performed well in areas relating to kindness, compassion, and respect for dignity. He went on to explain that it had performed less positively in terms of the overall amalgamated patient experiences, particularly when compared to previous years and when compared to some surrounding organisations. Mr Hodgson acknowledged that some of these results were undoubtedly due to the relentless pressure on UEC areas but emphasised the need for the board to take these findings seriously. He added that these results would also need to be built into the Trusts recently developed patient experience strategy to ensure that it was able to give patients a more positive experience.

Mr Hodgson reported that there was a significant degree of concern around flu and COVID-19 vaccination uptake and noted that the Trust’s own performance in this area had fallen over recent years. He stressed the importance of encouraging colleagues to take up the offer of vaccinations to protect both them and patients.

Mr Hodgson went on to provide a summary of other positive developments at the Trust, including the recent undertaking of the 500th endovascular repair of an aortic aneurysm, a clerical worker at the Trust winning two bronze awards at the 2024 British Transplant Games, the naming of a room on the Central Birth Suite at Burnley General Teaching Hospital (BGTH) after a much loved midwife who had passed away the previous year and the airing of series three of the ‘Cause of Death’ documentary, which featured Trust colleagues alongside those from Lancashire Teaching Hospitals NHS Foundation Trust.

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 Ribblesdale, Hyndburn Rural, Hyndburn Central and Pendle East District Nursing teams, the Ambulatory Emergency Care Unit, the Lancashire Women and Newborn Centre, Antenatal Ward, wards C5, C5 and C10, Critical Care, Ward 15, Coronary Care, Ribblesdale and Marsden Ward. Mr Hodgson reported that three other areas had recently lost their SPEC

status and confirmed that a range of targeted support had been implemented to help them reattain this.

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

Mr Sarwar observed that the level of financial scrutiny on NHS provider organisations was only likely to increase over the coming months, particularly around run rates and waste reduction programmes. He also noted that the seemingly never-ending demand being placed on the Trust's services were due in the part to a lack of capacity in primary care areas and invited feedback from Mr Razaq on the types of conditions being seen in community areas and why more of them were ending up on UEC pathways.

Mr Razaq confirmed that a range of work was taking place with primary care colleagues on a range of programmes, including one around cardiovascular disease and other chronic conditions. He added that a BwD Flu Group had also been instigated for the winter season and that a separate Health Equity Group had been established with primary care leads.
Responding to a further query from Mr Sarwar on the concerns around vaccination uptake, Mr Razaq indicated that every effort had been made to be on the front foot with messaging in community areas in previous years and that this would continue. He advised that there would be a particular focus on flu vaccinations in the current year and that improvements in vaccination rates had already been seen in some key demographics. Mr Razaq added that door to door visits had been conducted for the spring booster campaign and confirmed that work would be taking place with Integrated Care Board (ICB) nursing and immunisation leads to reach out to communities that were typically more hesitant to come forward for vaccinations.

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

TB/2024/123 **STAFF STORY (PENDLE EAST DISTRICT NURSES)**

Mr Murphy provided a brief introduction to the patient story. He informed directors that the slides being presented were being provided by the newly SPEC accredited Pendle East District Nursing team and was intended to showcase the complexity of community-based services and the compassionate care that they provided to patients.

These slides can be viewed by clicking the link here.

Mr Husain extended his thanks to Mrs Fisher and Mrs Hudson and commented that the level of workload being managed by the Pendle East team and the importance of partnership working had come across clearly in their presentation. He added that it was a good example of place coming to life and what could be achieved when the integrated healthcare approach was done properly.

Mr Sarwar pointed out that the role of community teams would only become more important going forward and noted that this would likely take a huge amount of effort to accomplish. He enquired what else could be done to help district nursing and other community teams.
Mrs Fisher explained that workforce development was a key area that required further consideration, particularly in terms of training and additional support. She added that a significant number of staff continued to be lost to other more attractive roles and specialties and that teams such as hers and Mrs Hudson's would be unable to meaningfully progress without investment to develop in this area going forward.

Mrs Anderson advised that she had participated in a number of SPEC Panels in district nursing teams and agreed that more thought was needed around retention, career progression and being able to reward staff properly for developing their skills.

Mr Hodgson stated that the financial challenges facing the Trust would only increase the importance of how it would choose to spend the funding that it did have. He noted that around 60% of the NHS budget was currently spent in acute areas and that every effort would need to be made to turn the dial on this and ensure that community areas received the investment that they deserved over the coming years.

Mr Murphy thanked Mrs Fisher and Mrs Hudson for their time and for providing him and other board members with the opportunity to come and spend time with them and their teams as part of the Trust's SPEC process. He agreed that there was a clear need to give more strategic thought to community teams and to have more nuanced conversations around the associated funding arrangements going forward.

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

TB/2024/124 CORPORATE RISK REGISTER (CRR) AND RISK PERFORMANCE REPORT

Mr Islam referred Directors to the previously circulated report and provided a summary of key highlights. He reported that there were currently 20 risks on the CRR, one of which had been added since the previous meeting, this was:

- **9301** - **risk of avoidable patient falls with harm.**

Mr Islam confirmed that there had been no movement in the scores assigned to the other 19 risks and that risk **10082 - failure to meet internal and external financial targets for 2024-25** remained the highest scoring on the register at 25.

Mr Islam went on to highlight that the number of open risks had fallen by 6% since the previous meeting but reported that the total number of overdue risks had increased by 34% over the same period. Directors noted that the highest numbers of risks related to clinical management at 40%, following by health and safety at 18%.

Mr Islam concluded his update by referring to the challenges outlined in the report and the summary of next steps provided, including system improvements to the Trust's Datix system and further work around the profiling and mapping of risk types.

Mr Smyth referred to risk **7165 – failure to comply with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)** and noted that RIDDOR compliance had been an issue for the Trust for a number of years. He acknowledged that significant progress was now being made in this area but raised concerns that capacity and resource shortages within the Trust may lead to similar issues in the future.

Mr Hodgson agree that the capacity of the health and safety team was a potential risk but pointed out there had been consistent reductions in the number of risks and open risks over recent months. He added that the increase seen in the current month was likely a natural and unavoidable consequence of the general business of the Trust.

Mr Sarwar commented that the focus should remain on the Trust's delivery of its statutory responsibilities and noted that RIDDOR compliance was a good example of this. He requested that this continued to be monitored through the Audit Committee.

Mr Rehman made reference to risk **8216 - Poor records management due to sub-optimal**

implementation of new Electronic Patient Record (ePR) system and observed that there were now a significant number of mitigations and assurances in place around this. He requested clarification on when it was expected that the resource and bandwidth being taken up by management of the Trust's ePR system was expected to start to decrease so that it could be directed elsewhere.

Mrs Atkinson reminded directors that the ePR had now been in place for just over a year and emphasised the importance of the Trust continuing to work on better understanding the system and the data that it was now starting to produce. She added that it was not expected that the amount of focus on the ePR would reduce but that it would likely move from stabilisation through to securing more value from the system and that the associated risk profile would also change over time as a result.

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

TB/2024/125 BOARD ASSURANCE FRAMEWORK (BAF)

Mrs Atkinson referred directors to the previously circulated report and confirmed that the cover report provided a summary of the changes to each of the individual BAF risks. She highlighted that there had been a particularly noticeable series of updates to BAF Risk 1 (Integrated Care / Partnerships / System Working) that had shifted it from planning to more delivery and benefits realisation focused piece.

Mrs Sedgley observed that BAF Risk 5 (Financial Sustainability) was still scored at the maximum rating of 25. She acknowledged that the financial pressures on the Trust were clearly significant but proposed that a discussion around this took place at the next meeting of the Finance and Performance Committee to consider if any changes were required.

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

TB/2024/126 PATIENT SAFETY INCIDENT RESPONSE ASSURANCE (PSIRA) REPORT

Mr Islam provided a summary of key points from the PSIRA report. He confirmed that reporting levels remained under control but highlighted that there had been an increase in moderate harms primarily due to the reclassification for the grading of pressure ulcers. Mr Islam informed directors that all incidents would have now have an additional recorded

component of psychological harm, in addition to physical, as part of the wider shift to the Learning from Patient Safety Events (LFPSE) service.

Mr Islam went on to report that there had been no breaches of duty of candour and that compliance had improved around the reporting of IR2 incidents form June onwards. He advised that seven new Patient Safety Incident Investigations (PSIIs) were being investigated and that there had been a total of 23 open PSIIs as of the end of June 2024.

Mr Sarwar noted that the compliance for all levels of the national Patient Safety Training Modules were below the 95% target that the Trust had set for itself. He requested that the factors behind this were discussed in more detail at the next meeting of the Quality Committee.

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

TB/2024/127 **SUPPORTING UNPAID CARERS IN LANCASHIRE AND SOUTH CUMBRIA**

It was agreed prior to the meeting that this item would not be discussed.

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

TB/2024/128 **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 confirmed that the Trust continued to meet all compliance requirements for this action.

Safety Action 2 - Maternity Services Data Set (MSDS): Miss Thompson confirmed that the Trust continued to meet all compliance requirements for this action. She also advised that the Maternity Services Data Set had been completed and was due to be signed off by colleagues from the Local Maternity and Neonatal System (LMNS) later in the day.

Safety Action 3 - Transitional Care (TC): Miss Thompson confirmed that the Trust had successfully met all compliance requirements for this action.

Safety Action 4 - Clinical Workforce: Miss Thompson confirmed her colleagues were progressing with the audit for employment of short and long-term locums. She explained that the findings of a consultant attendance assurance audit, evidence of compliance to

Anaesthesia Clinical Services Accreditation (ACSA) standards and additional information regarding the neonatal nursing workforce action plan and compliance with British Association of Perinatal Medicine (BAPM) standards were included in appendices 4 to 7 in her report.

Safety Action 5 - Midwifery Workforce: Miss Thompson indicated that a significant amount of work had been done with Mr Murphy in relation to the safe staffing elements on this action. She also advised that further work would be taking place with finance colleagues to develop and finalise the associated business case report.

Safety Action 6 - Saving Babies Lives v3 Care Bundle (SBLv3): Miss Thompson confirmed that the Trust was now on track with all six elements relating to this action.

Safety Action 7 – Maternity Neonatal Voice Partnership (MNVP) User Feedback: Miss Thompson advised that a patient experience group for Maternity and Neonatology had been implemented to review Care Quality Commission (CQC) maternity survey results. She also informed directors that feedback gathered by the Trust's Maternity and Neonatal Voices Partnerships (MNVP) lead in a recent engagement session would be taken to the patient experience group for review and action planning.

Safety Action 8 – Training: Miss Thompson confirmed that the Trust was making good progress in achieving compliance with this action but highlighted that risk had been identified relating to falls in Practical Obstetric Multi-Professional Training (PROMPT) compliance for anaesthetists and obstetricians.

Safety Action 9 - Board Assurance: Miss Thompson confirmed that the Trust was compliant against this action and that a bespoke dashboard was now in place that would support better triangulation around any incidents.

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 was meeting all requirements for MNSI reporting. She informed directors that a senior independent advocate that had supported investigations at University Hospitals of Morecambe Bay NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust had been invited to do the same at the Trust.

In response to a request for clarification from Mr Rehman on neonatal deaths, Miss Thompson advised that all deaths were taken through the relevant avenues for further discussion. She went on to explain that there had been a recent rise in neonatal deaths and that this had been caused in large part by a change in BAPM guidance that meant that babies were now being

resuscitated from 22 weeks. Miss Thompson added that such cases were highly complex and had led to the resulting higher trend.

Mr Murphy reported that good progress was being made with the business case around midwifery staffing and that it was expected to be ready within the next two months. He confirmed that it would be taken through all due process and advised that this work was being done in conjunction with LMNS colleagues.

Mr Sarwar thanked Miss Thompson for her report and update and noted that clear progress was being made in key areas. He commented that there remained a tension between tighter finances and the need to continue to keep delivering on required standards and that this was especially true for maternity given the raised degree of scrutiny being placed on it over recent months. Mr Sarwar emphasised the need for the Trust to continue to live within its means whilst also making the right choices and investing in the right areas to maintain patient and staff safety.

Mrs Sedgley stated that further consideration would be needed in the future as to how the Trust could engage more with its local communities and encourage people to train to become midwives. She added that this tied into its role as an anchor institution.
Mr Murphy agreed that the Trust should endeavour to seek solutions to staffing within its own locality and advised that a range of good work was already taking place in terms of coaching and mentoring in this area.

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

TB/2024/129 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 July 2024. He noted that the key areas were the numbers of patients waiting 65 weeks for treatment, UEC performance, finances and the Trust's pay bill.

b) Safe

Mr Murphy highlighted that the Trust was expecting to be fully established for registered nurses over the coming months and that this would contribute to a continued reduction in bank and agency spend.

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

c) Caring

Mr Murphy referred Directors to the Caring section of the report. He highlighted that the scores for the Friends and Family Test (FFT) remained above threshold for inpatients, outpatients and community and that Trust performance for patient experience was above threshold for four out of four competencies.

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

d) Effective

Mr Islam advised that the previously reported issues with mortality data quality, and its effects on the Trust's Hospital Standardised Mortality Ratio (HSMR) and Summary-Hospital-level Mortality Indicator (SHMI), continued and that it was expected that these would not be properly addressed until July 2025 at the earliest. He highlighted that assurance could be taken from the Trust's crude mortality rates, as these had continued to decline over recent months.

Responding to a query from Mr Sarwar, Mr Murphy confirmed that mortality had been considered in detail by the Quality Committee and was due to be discussed again at its next meeting later in the month.

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

e) Responsive

Mrs Gilligan reported the Trust's performance against the four-hour A&E standard at 80.89% in July against the national target of 78%. She informed directors that the Trust had agreed to a more challenging target in relation to the 28-day faster diagnosis standard for cancer and had achieved performance above the national target of 75% in both July and August. Directors noted that the Trust was also on track to achieving the 95% trajectory target for the 31-day

cancer standard by March 2025. Mrs Gilligan reported that theatre utilisation remained a particularly strong area of performance for the Trust and highlighted that it had been ranked as second best in the country for a number of weeks.

Mrs Gilligan went on to advise that there were a series of other more challenging performance targets for the Trust, including Diagnostics Waiting Times and Activity (DM01) and 62-day cancer performance. She emphasised that the national target to reduce 65-week waiters down to zero had been the most challenging of her career thus far and reported that, as of the meeting, there were 311 patients still at risk. Mrs Gilligan provided assurances that the situation was being closely micromanaged and that every action was being taken to reduce this before the end of the month. She informed directors that one patient would breach the deadline and explained that this was out of the Trust's control due to their specific case being managed through national tiers. Mrs Gilligan added that the matter had been escalated and that confirmation had been given that the Trust would not be held to account for this patient as a result.

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 highlighted that sickness levels had stabilised at around 5% but pointed out that this was still above the national average. She indicated that a significant amount of activity would be taking place around ensuring better care and better value would start to focus in on this area more over the coming months. Mrs Quinn highlighted that there had been further reductions to agency spend over recent months but explained that this had been offset by an increase in bank spend over the same period. She confirmed that improvements had been made to the Trust's appraisal compliance and that a raft of changes would be implemented over the coming months to raise this further, including the introduction of team-based appraisal sessions. Directors noted that core skills training compliance had not moved to any significant degree and that the Trust's data and digital team had implemented additional notifications to non-compliant staff to address this.

Mr Sarwar commented that sickness and absence rates still being above the national average was unacceptable and that it still did not seem to be moving in the right direction. He observed that other absence was currently hovering at around 18% and requested a more in-depth discussion on this outside of the meeting. Mr Sarwar requested that the levels of sickness were clearly quantified in a dedicated report and circulated to all Board members on a monthly basis going forward. He also requested that a 'deep dive' into the issues with core skills training took place at a future meeting of the People and Culture Committee.

In response to a query from Mrs Hatch, Mrs Quinn confirmed that detail breakdowns around sickness were available and that the main contributing factors were mental health and musculoskeletal issues. She added that burnout was a very real risk for colleagues working in the Trust due to the previously mentioned workload and capacity issues and advised that the health and wellbeing team would be focusing on resilience going into the winter period.

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.**

A report, quantifying the levels of sickness and absence in the Trust, will be circulated to Board members on a monthly basis.

A 'deep dive' into core skills training compliance will take place at a future meeting of the People and Culture Committee.

TB/2024/130 SPE+ IMPROVEMENT PRACTICE UPDATE

Mrs Atkinson referred directors to the previously circulated report and confirmed that it would feature as part of the Board's regular reporting cycle going forward. She explained that it was intended to set out the progress of both the ongoing development of the Trust's improvement practice and highlight the breadth of improvement work taking place. Mrs Atkinson reminded directors that the Trust's improvement strategy had been developed alongside its quality strategy in 2022 and indicated that additional work had been done to map it against the NHSE Improvement Impact Framework. She added that work was also underway to build improvement capacity across the Trust, including an ongoing 'Year of Improvement' event. Mrs Atkinson highlighted that the improvement work being done across the organisation was starting to bear fruit, particularly in UEC areas and in relation to ambulance handover times.

Mr Sarwar emphasised the importance of the Trust being able to clearly demonstrate and better quantify the impact of its improvement practice going forward.

Mrs Atkinson confirmed that several improvement workstreams were linked to the Trust's spending plans and that any direct impacts could be seen through these. She added that additional work was taking place to better evidence other benefits across quality, costs and people.

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

TB/2024/131 **ANNUAL REPORT ON MEDICAL APPRAISAL, REVALIDATION AND GOVERNANCE**

Mr Islam reported that of the 727 doctors in the Trust, 716 had been appraised in the 2023-24 financial year. He explained that there were various reasons for the 11 missed appraisals but confirmed that these had been all been agreed and approved. Mr Islam informed directors that 141 or 148 revalidations had also taken place over the same period and that there had been no reports of non-engagement. He concluded by advising that there had been four referrals to the General Medical Council (GMC) and there were currently 58 trained case investigators in the Trust.

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

TB/2024/132 **EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL STATEMENT**

Mr McDonald referred directors to the previously circulated report and explained that it set out the arrangements for the annual EPRR Core Standards Assurance Process for 2024-25. He highlighted that the key ask for the Board was for delegated authority to be granted to Mr Hodgson and himself to submit the EPRR Assurance Framework on behalf of the Trust by the deadline of the 31 October 2024. Mr McDonald confirmed that the Trust's full statement would be presented at the next meeting of the Board in November for completeness.

Directors confirmed that they were content for delegated authority to be provided to Mr Hodgson and Mr McDonald as set out in the report.

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

TB/2024/133 **RATIFICATION OF BOARD SUB-COMMITTEE TERMS OF REFERENCE**

Directors confirmed that they were content to approve the revised terms of reference for the Quality Committee and Audit Committee.

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

TB/2024/134 **TRIPLE A REPORT FROM FINANCE AND PERFORMANCE COMMITTEE**

The report was presented to the Board for information.

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

TB/2024/135 **TRIPLE A REPORT FROM QUALITY COMMITTEE**

The report was presented to the Board for information.

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

TB/2024/136 **TRIPLE A REPORT FROM AUDIT COMMITTEE**

The report was presented to the Board for information.

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

TB/2024/137 **REMUNERATION COMMITTEE INFORMATION REPORT**

The report was presented to the Board for information.

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

TB/2024/138 **TRUST BOARD (CLOSED SESSION) INFORMATION REPORT**

The report was presented to the Board for information.

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

TB/2024/139 **ANY OTHER BUSINESS**

No additional items were raised for discussion.

TB/2024/140 **OPEN FORUM**

It was confirmed that no questions had been submitted by members of the public prior to the meeting.

TB/2024/141 BOARD PERFORMANCE AND REFLECTION

Mr Sarwar sought feedback from Directors as to whether they felt the Board had appropriately addressed and fulfilled its objectives in relation to its communities, staff, and stakeholders. He commented that he felt that the Board had recognised the pressure that staff remained under, the benefits of partnership working and that the challenges the Trust faced could only be addressed collaboratively.

Mr Hodgson stated that he felt that the point raised earlier in the meeting regarding the need for the Trust to ensure that it focused on its statutory obligations with the current capacity limitations in place was a good one. He added that he also felt that the Board had successfully struck the right balance between covering a good range of topics whilst also maintaining an appropriate level of scrutiny.

RESOLVED: Directors noted the feedback provided.

TB/2024/142 DATE AND TIME OF NEXT MEETING

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

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **148**

20 November 2024 **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, October 2024

(148) Action Matrix

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2023/040: Maternity and Neonatal Service Update	A full business case regarding the additional funding required to satisfy the Birth Rate+ nursing and midwifery staffing recommendations will be developed and presented to the Board for approval at a later date.	Chief Nurse/ Head of Midwifery	Q1 2024-25	Agenda Item: January 2025 (Closed Board Session)
TB/2024/066: Corporate Risk Register and Risk Performance Report	Discussions to take place regarding the addition of RIDDOR incidents to the Trust's internal audit plan for 2024-25.	Executive Director of Finance / Executive Director of Integrated Care, Partnerships and Resilience	November 2024	Update: a verbal update will be provided at the next meeting.
TB/2024/094: Patient Story	Updates will be provided six months after patient stories are initially presented to the Board regarding any actions taken and/or improvements made.	Chief Nurse	January 2025	Update: a paper will be presented to the Board capturing the feedback from previous patient stories at the required intervals. The first such paper will be presented at the Trust Board meeting in January 2025.

Item Number	Action	Assigned To	Deadline	Status
TB/2024/098: Patient Safety Incident Response Assurance Report	Training compliance with level 1b Patient Safety Training will reach 95% by the next meeting.	All Board Directors/ Executive Director of People and Culture	November 2024	Update: An update will be provided at the next meeting of the Trust Board.
TB/2024/129: Integrated Performance Report - Well-led	A report, quantifying the levels of sickness and absence in the Trust, will be circulated to Board members on a monthly basis. A 'deep dive' into core skills training compliance will take place at a future meeting of the People and Culture Committee.	Executive Director of People and Culture Executive Director of People and Culture	Ongoing November 2024	Update: work is ongoing with colleagues at PA Consulting to accurately quantify key workforce metrics, including sickness and absence levels. A slide will be circulated to Board members once these have been finalised. Agenda Item: People and Culture Committee, December 2024

Lancashire and South Cumbria Provider Collaborative

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **150**

20 November 2024 **Purpose** Information

Title	Chief Executive's Report
Report Author	Miss S Wright, Joint Director of Communications
Executive sponsor	Mr M Hodgson, Chief Executive
Date Paper Approved by Executive Sponsor	20 November 2024

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

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

Report linkages

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

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

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by:

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

1. Background

This report is divided into sections covering the following:

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

2. National Updates

Change NHS – a national consultation to support a 10 year health plan

The Department for Health and Social Care and NHS England has launched a national public consultation to inform a new 10-year health plan.

The intention is to create a truly modern health service designed to meet the changing needs of our changing population.

Over the next five months, there will be a series of colleague and public engagement events across England and people are also being asked to share their ideas and experiences online at Change.NHS.uk.

The public engagement exercise will help shape the government's 10 Year Health Plan which will be published in spring 2025 and will be underlined by 3 big shifts in healthcare:

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

Autumn budget includes additional funding for NHS

As part of the Autumn Budget 2024, the Government allocated an extra £22.7 billion to the NHS over this year and next.

It includes funding to reduce waiting times by supporting the NHS to deliver an extra 40,000 elective appointments a week in order to reduce waiting lists. This is part of the Government's plan to make sure patients wait no longer than 18 weeks from their referral to getting treatment.

The Budget also includes:

- £1.5 billion to fund new surgical hubs which will help build capacity for over 30,000 additional procedures, and more than 1.25 million additional diagnostic tests (which use CT or MRI scanners)
- £70 million to invest in new radiotherapy machines to improve cancer treatment
- Over £2 billion for NHS technology and digital improvements to increase productivity and save staff time
- Over £600 million increase in local government spending to support social care
- £26 million to open new mental health crisis centres

Pressure on A&E continues

NHS data published in October showed there had been 1.2 million more accident and emergency (A&E) attendances so far this year compared to the same period before the pandemic.

Between January and September, there were 20.4million A&E attendances, compared with 19.14million in 2019.

The continued surge in demand came after the NHS set out its winter plan which included around-the-clock system control centres, better reporting of long patient delays and more care in the community including falls services, virtual wards and same day emergency care.

NHS begins rollout of flu and COVID vaccines

The NHS made COVID and flu jabs available for older adults, care home residents and those with long-term health conditions in October as the drive to protect against a 'tripledemic' of viruses this winter continued.

Flu season usually peaks in December and January and recent figures from UKHSA showed that over the past two winters there were at least 18,000 deaths associated with flu and more than 19,500 with COVID.

As part of the campaign, 23 care homes across Lancashire and South Cumbria are rolling out vaccinations delivered by their own staff following a successful pilot last year. Flu vaccinations for children and pregnant women started on 1 September to help stop the virus spreading as schools returned.

The Respiratory Syncytial Virus (RSV) jab is also available to those aged 75-79 and pregnant women from 28 weeks to protect their child – there is evidence it could prevent thousands of A&E attendances, hospital admissions and serious cases this winter alone.

NHS 111 offers crisis mental health support for the first time

Millions of patients experiencing a mental health crisis can now access support through NHS 111.

People of all ages, including children, who are in crisis, or concerned family and loved ones can now call 111, select the mental health option and speak to a trained mental health professional.

Previously, local health systems had their own separate phone lines taking around 200,000 calls per month.

For people who need support at A&E, if there is a risk to life, every emergency department in England now has a liaison psychiatric team available to offer specialist care

Anonymous reporting for NHS staff to report sexual misconduct at work

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

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

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

England's NHS mental health services treat record 3.8 million people last year

Around 3.8 million people were in contact with NHS mental health, learning disability and autism services over the last year, up almost two fifths compared to before the pandemic.

New NHS figures published today show that 3,790,826 people were in contact with services during 2023-24, compared to 2,726,721 in 2018/19.

This includes more than one million children, with 16-year-olds most likely to be seeking NHS support.

Major crackdown on NHS waste

The government has launched a major crackdown on waste in the NHS to save millions of pounds a year.

A new strategy - the Design for Life roadmap - is being published to radically cut the number of single-use medical devices in the health service and reduce reliance on foreign imports.

Disposable medical devices substantially contribute to the 156,000 tonnes of clinical waste that the NHS produces every year in England alone. The roadmap paves the way to slashing this waste and maximising reuse, remanufacture and recycling in the NHS.

NHS England Chair to stand down at the end of March

The chair of NHS England Richard Meddings will stand down from his role at the end of March. He will have been in post for three years when he steps down in March 2025.

In a message to NHS England staff, he said that approaching three years in the role and having had discussions with the health secretary about what the NHS and social care will need over the next 10 years to make the shift to prevention, primary and community care a reality, he decided that now is the right time to step down.

The Department of Health and Social Care will shortly advertise the role of chair to allow for an open and competitive process to take place, as well as the necessary parliamentary approvals.

3. Regional Updates

Lancashire and South Cumbria ICB board meeting

Members of the Lancashire and South Cumbria Integrated Care Board (ICB) met on 11 September, 2024. More information and a recording of the meeting is available to watch online here.

Your health. Your future. Your say

NHS Lancashire and South Cumbria Integrated Care Board (ICB) is hosting a series of engagement events to discuss the future of local health and care services.

'Your health. Your future. Your say' is a proactive public engagement programme to inform and involve people in decisions that will help the NHS recover from the long-term impacts of the COVID-19 pandemic and transform to be fit for the future.

The event is open to everyone living or working in the area and events have been taking place across the System, including Blackburn and Burnley last month.

One LSC went live on Friday, 1 November.

One LSC has now gone live after each of the five Trust Boards approved the necessary final agreements to proceed.

One LSC has brought together around 4,000 colleagues working in corporate services in all the Trusts in Lancashire and South Cumbria who are now operating as one, in a more joined up way.

Each provider Trust has shared ownership and responsibility for running One LSC and for setting service standards, with ELHT acting as host.

The One LSC leadership team have been out and about around all Trusts since go live to meet teams and provide reassurance, a welcome pack has been provided to all colleagues impacted, and dedicated online resources have been created to ensure people have access to any new systems and policies.

Clinical Transformation

Work is ongoing to look at future delivery of clinical services.

Analytics and innovation agency, Strasys, has been working with Trusts on a proposal for a network clinical model, that could deliver services in a more cost effective and coherent way.

Following a series of workshops with clinical leaders, they have looked at activity data and patient outcomes from 2020 to 2022 along with existing configuration to assess economies of scale or opportunities for savings.

They have put forward recommendations that have been set out in a roadmap.

Strasys is now in the process of presenting its findings to the acute trusts for consideration.

Hundreds supported by new mental health teams

Almost 400 people with complex mental health needs have been supported by new multi-agency teams across Lancashire and South Cumbria over the last year.

Known as enhanced multi-disciplinary teams (EMDTs) they are made up of professionals from different NHS, local authority and voluntary sector organisations and were introduced as part of a programme of work known as community mental health integrated transformation.

The teams offer tailored support to people with mental health conditions such as psychosis, bipolar disorder, personality disorder, eating disorders, severe depression and mental health rehabilitation needs.

Dental access and oral health improvement programme launched

A new programme launched by NHS Lancashire and South Cumbria Integrated Care Board (ICB) is helping those with the greatest need to access NHS dentistry.

The dental access and oral health improvement programme will focus on areas including where investment should be prioritised, improving patient pathways and communications to the public and to staff.

One of the ways in which the ICB has supported an improvement in access to dental services is by guaranteeing funding for the Lancashire and South Cumbria dental helpline. This service was established to support people who don't have access to a regular NHS dentist and provides advice, support and an urgent appointment where required.

Community Diagnostic Centres helping speed up tests for patients

A new approach providing health tests in the community is helping speed up diagnostics for patients across the region.

People are now able to choose between attending a hospital or a new Community Diagnostic Centre (CDC) for a range of tests including x-rays, MRI scans, CT scans and ultrasound. Certain cardiac and respiratory tests, along with blood tests, are also offered.

Since the launch of the CDCs, more than 350,000 additional diagnostic tests have been completed in Lancashire and South Cumbria.

ELHT manages two CDCs in Burnley and Rossendale. Collectively they have provided an additional 73,059 tests to patients in East Lancashire and Blackburn with Darwen since opening in August 2021 for Rossendale and October 2022 for Burnley.

4. Local and Trust specific updates

Use of the Trust Seal

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

On the 25 September the seal was applied to an amendment to an indemnity letter for the conversion of the former Trust Headquarters to a ward on the Royal Blackburn Teaching Hospital site between ELHT and Consort. This was signed by Martin Hodgson, Chief Executive, and Michelle Brown, Executive Director of Finance (until 31 September 2024).

On the 25 September the seal was applied to a deed of variation of contract between ELHT and Lancashire teaching Hospitals NHS Foundation Trust for the sale of property/land on Old Bank Lane, Blackburn. This was signed by Martin Hodgson, Chief Executive, and Michelle Brown, Executive Director of Finance (until 31 September 2024).

On the 25 September the seal was applied to a lease between ELHT (on behalf of ELHT&Me) and Consort regarding retail units two and three at the Royal Blackburn Teaching Hospital site. This was signed by Martin Hodgson, Chief Executive, and Michelle Brown, Executive Director of Finance (until 31 September 2024).

On the 31 October the seal was applied to a replacement of managed equipment contract between ELHT, Consort Healthcare and Siemens Healthcare LLP. This was signed by Martin

Hodgson, Chief Executive, and Charlotte Henson, Interim Executive Director of Finance (until 31 October 2024).

Changes to the Executive Team and Trust Board

Since the last meeting of the Trust Board there have been a couple of changes to the Executive team.

Executive Director of Finance Michelle Brown retired in September after 17 years with ELHT. I would like to put on record my thanks to Michelle for everything she delivered during her tenure. Sam Simpson joined us in the role at the start of November. Sam joins us from NHS England North West regional team and brings a wealth of experience from within the NHS and from a number of other sectors and organisations, which I know will be a huge benefit to the Trust.

Executive Medical Director Jawad Husain has also indicated his intention to retire in March 2025 and the search for a new colleague in this role has begun with aspirations to manage a robust assessment centre before Christmas and enable a smooth and efficient handover in the spring.

Remembrance Events

As is customary at this time of the year, the Trust organised two poignant Remembrance ceremonies which were well attended and appreciated. One was held at Burnley General Teaching Hospital and another in the Garden of Memories at Royal Blackburn Teaching Hospital. Both were led by colleagues in the chaplaincy team and supported as ever by our amazing veteran support team, with input from the armed forces and a great attendance from the Trust.

Moving services out of Accrington Victoria

The Trust has announced it is to move services out of Accrington Victoria Community Hospital to ensure the historic and much-loved site is preserved for generations to come.

The building in Haywood Road is in a critical condition but a commitment has been made that clincal services will remain in the town for local people.

This includes the four main services currently provided at the hospital, which will be relocated just a short distance away at either Accrington PALS or Holly House in the town centre or Acorns in Blackburn Road. These services are the Minor Injuries Unit (MIU), X-Ray, Outpatients and GP services delivered by PWE Healthcare.

Following the announcement, the Trust has put extensive plans together and supported staff as they prepare to move.

A public meeting organised by local MP Sarah Smith was attended were around 50 local people attended to hear the plans, provide feedback and ask questions. Engagement sessions have also been organised by the Lancashire and South Cumbria ICB as part of the legislative requirements of moving GP services.

Once the moves are completed, the Trust has given a public commitment to working with local people including Hyndburn Borough Council, MP Sarah Smith and the wider community in the town to both celebrate Accrington Victoria's rich history and ensure investment is secured to protect its legacy for the future. It is expected that the 'what next for Accrington Victoria'

conversation will begin in the New Year and include an extensive communications campaign to ensure local people are able to have their say.

65-week wait target reached

The Trust managed to achieve a national target to eliminate 65-week wait for elective care.

An enormous amount of work was done by teams who put plans in place to meet the NHS England goal by 30 September.

This was done despite the operational pressures remaining consistently high throughout the year.

Anti-racism commitments

Following last month's Board meeting and the launch of an Anti Racist Campaign, the Trust has continued its work to become an intentionally anti-racist organisation, which is a strategic priority for 2024/25.

This included organising a two week programme of events including inspiring speakers, training opportunities and opportunities to raise awareness of the importance of being proactively focused on equality and inclusivity.

The ELHT Big Get Together provided opportunities to connect, learn and grow. Among the activities on offer were listening rooms where colleagues shared their lived experiences, anti-racism and allyship training and inclusive recruitment training, workshops on psychological safety and a special session on understanding Islamophobia providing insights into the challenges faced by Muslim colleagues and how we can be more mindful and supportive.

The fortnight also provided a great opportunity to launch the new Neurodiversity and Hidden Disabilities Staff Network and included the first ever Anti Racism Summit at Royal Blackburn Teaching Hospital.

During the summit, the Trust received a prestigious award presented for reaching the bronze standard of the anti-racism framework operated by the North West Black, Asian and Minority Ethnic (BAME) Assembly.

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

Further Faster 20 initiative to reduce waiting lists

The Trust is one of a number of Trusts to be part of a national initiative to reduce waiting lists.

Further Faster 20 brings together clinicians and operational teams with the challenge of collectively going 'further and faster' to transform patient pathways and working to reduce unnecessary appointments and improve access and waiting times for patients.

Clinical transformation groups have been established across 19 specialties, involving clinical leads from across the trusts as well as national speciality leads, and other key stakeholders.

The aim is that by learning from each other, harnessing the solutions that already exist in departments across the country, trusts can make a positive impact, for both the NHS workforce and for patients, on a national scale.

Working together to reduce spend

As part of ongoing work to reduce spend, an incident management team called Better Care Better Value has been established looking at all aspects of Trust activity.

They have identified areas where savings can be made and are tracking data to measure impact.

Every directorate has done a deep dive into their spend and introduced changes, including different approaches to temporary staffing and rostering.

Changes have also been made across the Trust, including:

- New authorisation process for taxi bookings
- Review of how all teams are logging and authorising hours and annual leave
- A reduction in the use of agencies for temporary staffing
- Launch of scheme to repurpose unused and unwanted stationery
- Recycling medicines initiative

In early November, Simon Worthington from NHS England's national finance team spent two days with colleagues at the Trust understanding the progress being made on this area of work as part of his role supporting the Lancashire and South Cumbria system as a whole on reducing spend and ensuring a common focus on operating within established budgets.

State-of-the-art chemotherapy unit opens at Blackburn Hospital

Local communities have come together to raise over £120,000 for a state-of-the-art chemotherapy unit at Royal Blackburn Teaching Hospital.

The newly refurbished "Bluebell Unit" will provide chemotherapy, immunotherapy and supportive treatments to cancer patients.

It was officially opened in September.

The unit is now home to the acute oncology team and systemic anti-cancer therapy team, who are based together for the first time, which will improve the support available for patients and team members. It also has dedicated private rooms for patients and their loved ones.

The investment has been made possible thanks to the support of a wide number of community organisations and local residents who raised the money through various fundraising events, including cave dives and tea dances.

New cancer diagnostic equipment to support patients

Patients at Royal Blackburn Teaching Hospital will benefit from state-of-the-art cancer diagnostics equipment, made possible thanks to a fundraising campaign by fashion designer outlet Labels for Cares.

The new addition to the endoscopy unit has been made possible thanks to a generous donation of £250,000 that was raised for the hospital's charity ELHT&Me by Labels for Cares.

In September the Endoscopy team hosted a special thank you event where they showcased the equipment and demonstrated how it supports cancer diagnostics.

This is not the first donation from Labels for Cares, which stands for Cancer Assessment Rapid Early Support. In 2020 their donations supported the introduction of two endoscopy machines at

Burnley General Hospital, which have already scanned thousands of patients, providing swift results and utilising the latest technology to improve patient outcomes.

The organisation was set up after one of its founding members successfully battled cancer. Their aim is to help improve cancer survival rates in East Lancashire by promoting access to early cancer screening.

First SPE+ Leadership Core Pathway cohort complete training

The first cohort of the SPE+ Leadership Core Pathway celebrated the completion of their programme at a special event.

The 14-month programme enabled colleagues from multi-professional roles to undertake a programme of compassionate and inclusive leadership development, focussing on developing an understanding of themselves as a leader, their impact on team performance and wellbeing, as well as their influence on change and continuous improvement.

At the final event, they presented their quality improvement projects to colleagues and members of the Executive team.

SPEC success for Trust colleagues

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

- Blackburn's Coronary Care Unit were presented with a gold SPEC
- Pendle East District Nurses have achieved their first silver SPEC
- Burnley Urgent Treatment Centre (BUTC) were awarded their first silver SPEC status
- Burnley West District Nurses were presented with a silver SPEC
- Colleagues on Ward C7 were awarded their first silver SPEC

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

Patient experience strategy launched

The Trust's new patient experience, engagement and involvement strategy was launched last month with two special virtual events.

More than 150 colleagues joined the sessions, where Chief Nurse Pete Murphy shared his thoughts on the new strategy and its ambitious targets.

The three-year strategy has been designed with colleagues and patients and their representatives, with emphasis put on supporting the needs of our most vulnerable patients, including those with learning disabilities, cognitive impairment (dementia) and children and young people.

Delivering excellent care requires the experience of our patients, carers and families to be considered at every opportunity. The Trust is committed to taking every opportunity to hear from people who use our services, their families, carers and visitors and encouraging them to get involved in shaping the way the Trust provides its services.

The strategy outlines plans to introduce patient safety partners, increase the influence of patients and the public as we develop plans and processes, help the Trust identify and minimise the impact of health inequalities, and widen the engagement of patients and public.

Olympics organised for stroke patients

Inspired by the achievements and resilience of those competing at the Paralympics, Marsden Unit at Pendle Community Hospital organised their own Olympics for patients recovering from a stroke.

The 'Marsden Olympics' were a creative way of supporting rehabilitation and included a selection of activities and games.

From discus using paper plates to help co-ordination and core-stability, through to bowls to develop visual scanning and balance, the event was enjoyed by everyone on the ward.

It was used as a way of reminding patients anything is possible and encouraging exercise to support their recovery.

And supporting that message was special guest, Paralympian Gregg Stevenson who won medals at this year's Paralympics rowing events. He dropped in to meet staff and patients and offer encouragement.

Local celebrity Ted Robbins officially opens Heart Care Unit

The new heart care unit at Royal Blackburn Teaching Hospital was officially opened by local comedian Ted Robbins.

The unit actually opened a few months ago, bringing the Coronary Care Unit and the Cardiology Ward together into a single location along with a new cardiac assessment unit and ambulatory area, but due to the General Election, plans to mark the milestone were postponed.

But last month it finally happened and the team were delighted that Ted was able to cut the ribbon.

Ted is a comedian, actor and broadcaster who has appeared on many shows including Coronation Street, Father Brown and Phoenix Nights. He suffered a cardiac arrest on stage in front of 30,000 people as he starred alongside Peter Kay in Phoenix Nights Live at the Manchester Arena in 2015.

Staff survey underway

This year's national NHS staff survey will close on 29 November.

Colleagues around the Trust have been encouraged to have their say to help shape future plans.

Case studies have been shared highlighting action taken following previous surveys and how that has improved day to day working in teams.

Targeted activity has also been taking place to encourage everyone to participate, with a particular emphasis on developing influencers who can help increase uptake.

The NHS Staff Survey is one of the largest workforce surveys in the world and has been taking place every year since 2003.

Everyone who works in the NHS in England is invited to take part, with anonymous feedback used to develop improvements and action plans local and nationally.

Vaccination campaign for colleagues

The COVID and flu vaccines are once again being offered free to all colleagues at the Trust.

Vaccinators have organised drop-in sessions and are roaming sites to provide every opportunity for staff to take up the winter protection.

This year, teams were offered the opportunity to book a vaccinator to attend their team meetings, audits or training events. These vaxathons were taken up by over 60 teams, potentially helping over 1,500 people receive their vaccine.

This followed feedback from staff last year who said they needed longer lead-in times for booking dates in their diary. Vaxathons could be booked up to two months in advance.

Winter wellness

A series of winter wellbeing events have taken place across the Trust to support colleagues with their health and wellbeing.

Colleagues were able to drop in for a wellbeing chat with the Well Team plus one-to-one financial support with an advisor from HSBC, Metro Moneywise, Library Services, Staff Guardians and the Hidden Disabilities Team.

There was also the opportunity to receive winter vaccinations

It is part of ongoing health and wellbeing support, providing guidance, resources, and support across all areas of wellbeing – physical, mental, and emotional.

Keeping patients steady on their feet

A self-referral service at the Trust is helping to keep patients safe on their feet, live independently and reduce hospital admissions.

Patients who have been admitted or attended hospital due to a fall or unsteadiness can be seen by the Steady On! Falls Prevention Team. The team of two carry out home assessments to identify what needs to be put in place to support patients with daily living and reduce future hospital admissions.

They look at a range of factors to create a falls prevention plan, including safe, supportive footwear and foot care and helping with medication support.

The team also assess the home environment and lighting, discuss activity and exercise to promote strength and balance and ask the question ‘do you fall?’ to identify any patterns to try and reduce risks.

It is part of a range of community services provided by the Trust to help people avoid unnecessary admissions to hospital and receive support in their usual place of residence.

Church on the Street Podiatry and Treatment Room Service celebrates first anniversary

Over 100 local residents in Burnley have been able to access podiatry services in the heart of their community as part of a drive by the Trust to improve treatment.

Nurses opened a new podiatry and treatment room service at Church on the Street in Burnley, as a number of scheduled appointments for routine wound and foot care at health centres were not being attended.

Church on the Street is already home to a number of community services, including health care, housing and mental health support so the podiatry team identified it would be a more comfortable and familiar environment for their patients.

They are now celebrating their first anniversary in the church and say the project has successfully increased the number of people now receiving treatment on a regular basis.

New free service will support expectant parents in East Lancashire

The NSPCC and East Lancashire Hospitals Trust (EHLT) have launched a new service to support the mental health of parents-to-be.

Pregnancy in Mind (PiM) is a free NSPCC service for expectant parents experiencing difficulties during 12 and 34 weeks of pregnancy.

The initiative helps parents develop coping skills which can help them mitigate the effects of parental worries and feel more confident about the arrival of a baby and help build strong relationships with their child.

Techniques to help participants include mindfulness meditation and active relaxation.

PiM is a virtual service, meaning participants can all attend from the comfort of their own homes while still engaging with other parents-to-be and practitioners.

Tree of life to support grieving families

Over 200 people gathered at the Lancashire Women and Newborn Centre (LWNC) at Burnley General Hospital to witness the unveiling of the 'Tree of Life' sculpture.

Standing at 4 meters tall, the creation by North West sculptor Ruth Moilliet is a stainless steel blossom tree adorned with over 130 blue, lilac, and silver blossoms.

It has been made possible thanks to a donation from the Friends of Serenity charity to support families who have lost a baby who are able to have their baby's name engraved on a personalised leaf.

The unveiling of the sculpture marked the conclusion of Baby Loss Awareness Week with the Wave of Light ceremony, an annual global observance honouring the lives of babies lost too soon.

Drop-in clinics for whooping cough and RSV vaccinations

Pregnant women across East Lancashire are now able to receive the flu, Pertussis (whooping cough) and Respiratory Syncytial Virus (RSV) vaccines at new antenatal drop-in clinics at the Trust.

These vaccinations are recommended to pregnant women as a preventative measure to reduce the risk of complications for infants, who are often vulnerable to respiratory illnesses.

The new drop-in clinics are held from 1.30pm to 5.30pm each Friday in the antenatal clinics at the Trust’s two acute hospital sites, Royal Blackburn Hospital and Burnley General Hospital.

These give every pregnant woman the opportunity to protect herself and her baby in a convenient and supportive environment.

New midwifery assessment gets underway

The Trust has welcomed its first cohort of registered midwife degree apprentices from University of Central Lancashire (UCLAN).

Helen Cookson, Janine Matthews and Nicole Perry will attend university two days a week and work the remaining 21.5 hours of their contract in clinical practice at the Trust.

They are part of a cohort from the four maternity provider Trusts in Lancashire and South Cumbria who are completing the three-year course.

During that time they will rotate through placements covering the whole of maternity services at both the Burnley and Blackburn sites, including Blackburn birth centre and in the community.

The programme is giving our existing maternity support workers an opportunity for career progression and is allowing the Trust to develop their teams.

Maternity Support Worker Keelie receives prestigious midwifery award

Keelie Barrett, a Maternity Support Worker (MSW) from Burnley, has been honoured with a Chief Midwifery Officer (CMidO) Award for her outstanding contributions to maternity care.

The CMidO Award recognises exceptional individuals within the maternity workforce who have made a significant impact on maternity care and services.

Keelie, who has worked at the Trust since 2009 as a maternity support worker prior to becoming an MSW Clinical Educator in November 2023, has excelled in her role, particularly through her leadership and training of other maternity support workers across the Trust.

This was recognised in Keelie’s nomination for the CMidO Award by her colleagues, along with her dedication to recruitment development and the Maternity Apprenticeship Programme where she has played a pivotal role in both recruiting and supporting new colleagues.

Henna, headscarves and helpful myth-busting at Visit My Mosque open day

150 colleagues tried henna and headscarves, learnt about Islam and enjoyed a slice of cake at a Visit My Mosque open day.

Royal Blackburn Teaching Hospital's prayer room opened its doors to non-Muslims who would not otherwise visit a mosque.

It was part of a national annual initiative, Visit My Mosque, which gives people the opportunity to learn about the faith.

Blackburn with Darwen Mayor Brian Taylor cut the cake as colleagues were given tours of the prayer rooms and took part in a myth-busting quiz about Islam.

Team effort helping to aid discharge

Colleagues from the Pharmacy team, clinical flow and the discharge lounge have been working together to help improve flow and discharge in the Trust.

A new pilot is helping to improve the time patients can go home from hospital with their medicines – and ultimately free up beds.

Thanks to a discharge dashboard, highlighting the patient journey in one easy place, Pharmacy Technicians are able to see live data and prepare take home medicines in advance for any patient identified as suitable for the discharge lounge.

They are able to identify patient safety issues relating to medications and making sure patients have all the information they need for their discharge home.

Medical Examiner's Office becomes a statutory service

The Medical Examiner's Office marked a milestone in September as it became a statutory service.

This means it is now a legal requirement for the Medical Examiner Service to review every death not directly referred to the Coroner.

The transition to a statutory service signifies the importance of ensuring accurate death certification and enhancing the overall quality of patient care.

Health day for people with learning disabilities or autism and their families

Colleagues from the Trust hosted an open day for people with learning disabilities or autism and their families.

The ‘Our Health Day’ event was a marketplace of stalls in the Learning Centre at Blackburn Hospital.

It highlighted specific services for people with learning disabilities or autism, but also included an area which demonstrated procedures such as endoscopy to explain the process and reduce any fear or anxiety.

New menu is a recipe for success

A taster day that was organised to launch and test the new patient menu at Burnley General Teaching Hospital received first class reviews.

The event was an opportunity to showcase the high-quality meals the catering team serves to patients at Burnley.

A selection of sample food included burgers in tomato sauce, fishcakes and vegetable gratin - with orange and ginger chicken and individual cakes being the firm favourites.

New menus were launched last month at both Pendle Community and Burnley General hospitals.

ENDS

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT | **Item** | **152**

20 November 2024 | **Purpose** | Approval / Assurance / Information

Title	Corporate Risk Register Report
Report Author	Mr J Houlihan, Assistant Director of Health, Safety and Risk
Executive sponsor	Mr J Husain, Executive Medical Director
Date paper approved by Executive sponsor	

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

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

Report linkages

Related Trust Goal	Deliver safe, high quality care 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 risks. One risk has an increased risk score 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 risks. One risk has an increased risk score. There has been no movement or change in any other risk scores.
   b) Highest areas of risk relate to financial sustainability, digital systems and storage of data, the management of medical devices, insufficient capacity to meet demand and sub optimisation of the electronic patient record system.
   c) A breakdown of risks by risk type shows eleven (55%) are clinical management risks, three (15%) are data and digital risks, two (10%) are finance risks, two (10%) are health and safety risks, one (5%) is a medical devices risk and one (5%) is a patient safety risk.
   d) A breakdown of risks by division shows eleven (55%) are Trust wide, four (20%) are corporate, two (10%) are within diagnostic and clinical services, two (10%) are within surgical and anaesthetic services and one (5%) is within medicines and emergency care services.
   e) A summary and detail of risks held on the CRR is included within the appendices.

Risk Management Performance Activity

5. A summary of key points to note since the last meeting.
   a) Numbers of open risks held on the risk register are down from 682 risks in Q4 2034-24 to 623 in Q3 2024-25, a decrease of 9%.
   b) Risks identified as being significant or moderate have increased, from 215 risks in Q4 2023-24 to 239 in Q3 2024-25, an increase of 11%..
   c) Risks remaining open over 3 years old are down from 400 risks in Q4 2023-24 to 338 in Q3 2024-25, a decrease of 16%.
   d) Overdue risks have increased from 107 in Q4 2023-24 to 168 in Q3 2024-25, an increase of 58%.
   e) 11% of tolerated risks have currently surpassed their review date.
   f) Highest numbers of risks held relate to clinical management i.e. medical, nursing or operational (40%) followed by health and safety (18%).
   g) A breakdown of clinical management risks shows the highest risk sub types are concerning capacity and demand (21%) followed by assessment / diagnosis (9%), standards of care (8%) and treatment or procedure (8%).

h) A breakdown of health and safety risks shows the highest risk sub types relate to buildings and infrastructure (29%) followed by security management (14%) and equipment management (non-clinical) (10%).

i) Highest numbers of risks are held within the diagnostic and clinical service division (26%) followed by surgical and anaesthetic services (22%).

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

Mitigations for risks and timelines

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

a) A comprehensive and detailed exercise to improve overall risk identification accuracy to ensure all risks are categorised appropriately has been completed. This includes:

i. The identification of strategic and operational risks benchmarked against strategy, legislation, set regulatory standards and practice.

ii. An extensive list of new risk type and sub type categories that provide a better 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. Continued reaffirmation of the risk management framework (RMF) and process of escalation.

ii. Control measures to drive improvements regarding numbers 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.

iv. More detailed assurance requirements within divisional reporting.
v. Specific inclusion, monitoring and achievement of KPI metrics.
vi. More intensive focus and scrutiny by the RAM and Executive Risk Assurance Group (ERAG).
vii. Targeted review of all live and tolerated risks whereby the current risk score has met its target score and of their subsequent closure.
viii. Engagement with relevant lead specialisms and subject matter experts to improve the management of clinical and corporate risk types.
ix. 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 presentation at the Core and Essential Skills Group for approval 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 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 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 and strengthening of the risk management strategy and framework.
d) Improving the BAF and links to the risk register.
e) Developing clearer risk appetite statements.

f) Strengthening risk governance including board reporting and senior management overview.
g) Better development, use and or completion of generic risk assessments.
h) Enhancements to risk management software for better tracking and performance.
i) Improved awareness, education, training and competence in risk management including risk assessment through development of training.
j) More effective use of the risk register.
k) Improve risk management audit outcomes.
l) More proactive response and focus on emerging risks.
m) Expanding stakeholder engagement initiatives to improve risk awareness and ownership.
n) The use of risk management KPI and target criteria remains a key area of focus and driver.
o) 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
08 November 2024

Summary of the Corporate Risk Register

	ID	Risk Type	BAF	Division	Title	Likelihood Score	Consequence Score	Risk Score	Exec Lead	Effectiveness of Controls	Risk Movement	Committee / Group
1	10082	Financial	5	Trust wide	Failure to meet internal and external financial targets for 2024-25	5	5	25	M Brown	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	M Brown	Inadequate	⟷	Data & Digital Senate
3	9545	Clinical	2	SAS	Potential interruption to surgical procedures due to equipment failure	5	4	20	M Brown	Limited	⟷	Medical Devices Steering Group
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	9746	Financial	5	Corporate	Inadequate funding model for research, development and innovation	4	4	16	K Quinn	Limited	⟷	People & Culture Committee / Finance & Performance Committee
8	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
9	8033	Clinical	2	Trust wide	Increased requirement for nutrition and hydration intervention in patients resulting in delays	4	4	16	P Murphy	Limited	⟷	Nutrition & Hydration Streeting Group
10	7165	H&S	2	Corporate	Failure to comply with RIDDOR	4	4	16	T McDonald	Limited	⟷	Health & Safety Committee
11	6190	Clinical	3	Trust wide	Insufficient capacity to accommodate patients in clinic within timescales	4	4	16	S Gilligan	Limited	⟷	Elective Productivity & Improvement Group
12	10065	Clinical	2	DCS	Pharmacy Technical Service refurbishment programme	3	5	15	J Husain	Inadequate	⟷	TWQG B / Quality Committee
13	10062	Clinical	2	Trust wide	Risk of harm and poor experience for patients with mental health concerns	3	5	15	P Murphy	Inadequate	⟷	TWQG A / Quality Committee
14	9900	NICE	2	Trust wide	Poor identification, management and prevention of delirium	5	3	15	J Husain	Limited	⟷	TWQG B / Quality Committee
15	9895	Clinical	3	SAS	Patients not receiving timely emergency procedures in theatres	5	3	15	J Husain	Limited	⟷	SAS DQSB
16	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
17	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
18	9301	H&S	2	Trust wide	Risk of avoidable patient falls with harm	3	5	15	P Murphy	Limited	⟷	Falls Strategy Group / TWQG A
19	8808	H&S	2	Corporate	Breaches to fire stopping and compartmentalisation at BGH	3	5	15	T McDonald	Adequate	⟷	Fire Safety Committee / TWQG B
20	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

Corporate Risk Register Detailed Information

No	ID	Title				
1	10082	**Failure to meet internal and external financial targets for 2024-25**				
Lead		Risk Lead: Akhlaq Hussain Exec Lead: Charlotte Henson	**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 17/10/2024** **Change of risk handler and risk lead. No change in risk score** The Trust is reporting a deficit of £6.8m for the 2024-25 financial year to date, £0.9m behind the revised breakeven plan. However, our current run rate is showing a £14m deficit pressure. The 2024-25 capital programme remains unchanged at £33.1m with year-to-date capital spend at £4.5m, £1.5m behind plan. The cash balance on 30th September was £1.5m, an increase of £0.8m compared to the previous month. This position continues to be supported by £18.2m of Provider Revenue Support Public Dividend Capital (PDC). Largely as a result of the continued effect of the Trust having to withhold payments to suppliers due to its cash position, Better Payment Practice Code (BPPC) performance has further deteriorated in September, as expected. While the Trust is now only meeting the target to pay 95% of invoices on time for the financial year to date by value for NHS invoices, performance for the value of non-NHS invoices paid on time is just below target at 94.0%. Year to date spend on agency staff represented 2.2% of total pay against the ceiling set by NHS England (NHSE) for 2024-25 of 3.1%. The Waste Reduction Programme for the 2024-25 financial year is £59.7m, of which £11.6m has been delivered in the year to date, in line with plan, including £10.5m of recurrent efficiencies. **Next Review Date 15/11/2024**		**Date last reviewed**	**17/10/2024**
				Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
					25	**25**	**25**	
				8-week score projection	**25**			
				Current issues	System wide external influences			

No	ID	Title				
2	10086	**Lack of adequate online storage for images may result in missed or delayed diagnosis**				
Lead		Risk Lead: Dan Hallen Exec Lead: Charlotte Henson	**Current score**	**20**	**Score Movement**	

Description	There is a risk that capacity for the storage and transfer of ECHO images from ultrasound machines used within Chronic Obstructive Pulmonary Disease (COPD) and Neonatal Intensive Care Units (NICU) services may result in missed or delayed diagnosis if no suitable clinical management or digital storage solution can be found. The ultrasound machines currently used have no option for storage and transfer of images currently being stored on scanning machines that have very limited memory availability. Once storage limits have reached, capacity and images cannot be offloaded and machines will stop functioning which may result in loss of images and the potential of patients having missed or delayed diagnosis of life saving cardiac abnormalities and pulmonary pathologies impacting on the management of care, patient safety and increased medicolegal implications if the risk is not suitably managed or controlled.	**Gaps and potential actions to further mitigate risk**
Controls and Assurances in place	**Controls** 1. The existing service contract has been extended. 2. Current ultrasound images stored on scanning machines and McKesson software installed on NICU computers. 3. Image transfer via desktop, through the PACS system, out of hours and via MS teams which have prevented transfer of a baby and safe overview of images. 4. Patient transfer to other Hospitals for echocardiology review. 5. Set standards on provision of an ultrasound service issued by the Royal College of Radiologists include key areas essential for delivery of high quality, effective ultrasound imaging services and examinations that services are expected to review and follow. 6. Organisational policy and procedural controls in place for the lifecycle management of medical devices. **Assurances** 1. Imaging incidents closely reviewed and monitored and linked to the management of risk. 2. Cerner e-PR has an imaging module, cloud storage and PAS patient list connection that capture, store, access and share imaging data and multimedia across the system providing a holistic patient view. 3. Current capacity levels regularly being monitored. Capacity within Childrens Observation and Admissions Unit is 117.2 GB (99.8% full) with 247.9 MB remaining. Capacity within COPD is approx. 250 GB and NICU is approx.. 800 GB with further capacity checks required. 4. The Technical Diagnostics Team within the Integrated Care Board (ICB) is exploring costs and solutions, with Bridgehead identified as a solution, along with cardio imagery. Planning parameters and vendor response in place for viability. 5. Work is underway with software providers for a temporary solution for the storage of images that does not add to current storage capacity. An approach has been considered for Siemens to partition VNA and assist with the holding of data and or for Sectra to provide a fully functional solution until a more permanent solution is found. 6. Regular meetings held between the Executive Medical Director, Chief Nurse, Director of Finance and Director of Operations for the Family Care Division to understand the risk and mitigations required. 7. Divisional Quality and Safety Meetings in place to review and support the management of this risk. 8. Medical Devices Management Group meetings in place to provide assurances of compliance regarding the lifecycle management of medical devices.	**Gaps / weaknesses in controls** 1. Additional cost implications for contract extension and a software storage solution. 2. Current ultrasound images stored on scanning machines have limited memory capacity. 3. Images transfers to desktop, through PACS and MS teams is ineffective. Attempted input of images onto PACS slows the entire system down, is too big to be sent via image exchange portal and has limited storage availability. Use of MS teams heavily reliant on availability of consultants to attend MS team meetings. 4. Patient transfers to other Hospitals may be unnecessary, unsafe and reliant on bed availability. 5. Limited assurance Royal College of Radiologists standards are being used to benchmark or measure performance or compliance. 6. Additional staff training in system use is required. 7. Development of a virtual private network (VPN) tunnel is under trial and not embedded as clinical management process. 8. Cranial ultrasound scans and echocardiogram images cannot be separated and stored with further exploration of how scans are stored required. 9. A planned strategy and system solution being brought in by the ICB to increase storage capacity is awaiting implementation. 10. Limited assurance policy and procedural controls regarding the lifecycle management of medical devices is robust, is being followed or suitably performance managed. **Gaps / weaknesses in assurances** 1. Common incident themes relate to equipment malfunction, delays in diagnosis, clinical symptoms warranting emergency transfer of patient to another Hospital and difficulties transferring images. 2. Cerner e-PR imaging module and set up requires further exploration to determine effectiveness. 3. Limited evidence of assurance current capacity levels are regularly checked and monitored. 4. Bridgehead solution remains fully dependent on the release of funding and approval by the ICB. 5. Solution offered by Siemens does not help image sharing with other Hospitals and effectiveness of direct image transfers still requires exploration. 6. Effectiveness of the Medical Devices Management Group to support management of this risk.
Update since the last report	**Update 16/10/2024** **Change of risk lead. No change in risk score.** Risk has been reviewed by the Chief X Information Officer. Assurance of compliance against national guidance for the storage of clinical images is being reviewed which will help support mitigation of this risk and a reduced risk score. **Next Review Date 15/11/2024**	**Date last reviewed**: **16/10/2024** **Risk by quarter 2024-25**: Q1: 20; Q2: 20; Q3: 20; Q4: **8-week score projection**: 12 **Current issues**: System wide external influences

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

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

Update since the last report	**Update 07/11/2024.** **Risk reviewed. No change in risk score** ED continue to see increased pressure on pathways with up to 940 attends on some days and subsequent overcrowding, with high number of decisions of admittance. Organisationally we have opened an additional medical ward to 25 beds, with another planned to open on 1st Dec-24. All clinical space at that point will be in use. There has been an increase in no's of patients on the main hospital corridor with support from NWAS colleagues. Nursing vacancies for establishment remain good, with an additional 10 registered nurses and 10 health care assistants per shift. No reports of any moderate incidents have been made within the last month, demonstrating the improvement plan is working **Next Review Date 06/12/2024**	**Date last reviewed**	**07/112024**			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			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: Dayle Squires / Victoria Bateman 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. Locum staff recruited 3. Additional senior BMS recruited. 4. MLA posts filled. 5. Triaging of cases to prioritise cancer cases. 6. Breast workload referred to neighbouring NHS Trusts across Lancashire and South Cumbria with increasing outsourcing to further reduce backlog. 7. Colposcopy screening cases referred to external provider. 8. Routine cases sent to external reporting services. 9. Additional dissection bench created to increase capacity. 10. Overtime being offered to existing staff to cover gaps and increase capacity. **Assurances** 1. Consultant staff supporting with dissection. 2. Work being triaged based on clinical urgency given the information provided upon the request form. 3. Weekly cancer performance meetings attended by the histology/performance manager. 4. Escalation process for priority cases is well established. 5. Pathology collaborative exploring support.			
Update since the last report		**Update 07/11/2024** **Increase in risk score to 20.** There has been a total of 24 unexpected results from the routine backlog. All cases are being currently reviewed. **Next Review Date 06/12/2024**	**Date last reviewed**	**07/11/2024**		
			Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
				16	**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: Daniel Hallen Exec Lead: Jawad Husain	Current score	20	Score Movement	⇔

Description	A lack of continuous optimisation and investment may lead to frustration and create disillusionment, leading to poor usage and productivity, unsafe workarounds, substandard data and ineffective clinical decision making.	**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** General - limited capital budget to invest in additional hardware or software as clinical requirements develop - the lack of sufficient administrative resource - lack of effective clinical management to support and maintain implementation may impact on service provision and delivery leading to a secondary impact on patient safety - inability to rapidly flex current system to respond to emerging demands from 'external' NHS bodies for additional information Clinical management - key control issues identified regards elective outpatient and inpatients i.e. clinic set up and bookings; flow and discharge i.e. admission, discharge and transfer processes and discharge workflows; encounters; radiology integration; equipment and prescribing - other issues identified relate to endoscopy booking issues; GP discharge summaries and reporting - clinical management policies, procedures, systems and processes may not be in place or updated to reflect system changes following go live - clinical management policies, procedures, systems and processes may not be followed by clinicians or are being effectively monitored by policy authors, committees and or groups - there is more than one method of recording the same piece of information - pharmacy medicines dispense system requires updating Emergency preparedness, response and resilience - limited assurance policy and or procedural requirements remain effective, are being monitored, reviewed or followed Governance - there is no robust document management solution currently in place e.g. imaging, documentation etc. Digital - local data and digital strategy in development to help drive successful implementation of e-PR system - network instability which may lead to intermittent crashes - extended contracts on existing digital systems that provide current cover causing unexpected, additional financial pressure - no functioning information governance service at present - impact on infrastructure if technology, clinical management and techniques are developed in isolation from main e-PR - not all digital and clinical management systems are registered or known about - current system contracts do not identify specific switch over dates and are being rolled over annually - community services system is not connected to acute setting - scanning solution not consistent across all specialties and case note groups - rolling replacement of hardware and regular audits of IT service desk issues to identify challenges around themes such as reliable Wi-Fi etc. - clinical incidents relating to system implementation and use to identify challenges - integration architecture skills set is not native to the trust Patient and staff safety - limited assurance staff related health and wellbeing support systems are being used, monitored or reviewed for Cerner related issues **Gaps / weaknesses in assurances** Clinical management - staff familiarisation and confidence with the new system to support safe clinical pathways e.g. admission, transfer, 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
Controls and Assurances in place	**Controls** General - significant resource in place to support improvement opportunities and deliverables - dedicated senior consultant identified by Cerner to undertake work to review issues identified and support further development and actions required - recruitment of e-PR champions, super users and floor walkers to support system implementation - development of e-PR SharePoint one stop shop site of readily available resources e.g. workflow sheets, 'hot sheets' outlining brief instruction on how to complete tasks on Cerner and FAQ's covering general, clinical, administrative, IT, pharmacy and discharge processes Clinical management - improvement plan in place with identified learning outcomes spread across the Trust - initial focus on outpatient areas i.e. head and neck, cardiology, urology, fracture clinical, gynaecology, respiratory and dermatology - completion of project to identify all policies, procedures and guidance affected by system implementation - prescribing is structured and follows a digital process with appropriate auditing capabilities - replacement of ICE with Order Entry Catalogue and Order Entry Form to place requests and ordering of all surgical procedures and medications Communication - regular updates using a variety of trust wide communication systems, digital and social media platforms - use of roadshows and walkabouts to raise awareness and demonstrate system use - issue of role specific posters, flyers and key contacts - use of displays across inpatient and staff areas Education, training and competency - registration process and extensive roll out of end user training and support - development and issue of staff handbooks - library of quick reference guides developed and available on SharePoint and e-Coach and organised by job role describing how to use particular tools or complete set workflows e.g. admission, transfer, discharge, prescribing etc. - series of patient journey demonstration and training videos have been created and available to view on the learning hub and YouTube channel to help navigate the new system - personalised demonstrations for doctors, nurses and allied health professionals - clinician RTT training - virtual discharge masterclasses held to demonstrate discharge processes for inpatients, outpatients, emergency department and same day emergency care to assist staff to successfully discharge a patient using the e-PR system and create full discharge summaries, with recordings routinely available from the e-PR hub on OLI - power chart and revenue cycle (RPAS) e-learning videos covering a wide range of patient journey demonstrations such as; - ED triage covering patient summary, staff check in to shift and work location, adult triage and assessment forms, Manchester triage, discriminators and dictionary, presenting complaints, nursing notes and observations - ED doctors covering clerking, ordering tests and medication, patient status view, specialty referrals, documentation of decision to admit, bed requests, ED discharge workflow - nursing inpatient admissions covering care compass, patient status overview and activity timeline, tasks to complete, admissions assessments including observations, pain assessments, EWS scoring, medicines administration and drug charts, discharge care plans, day of admission checklist, discharge planning risk assessment - inpatient admission – doctor covering doctors worklist, admission documentation including auto text example, book patient for theatre, admission clerking notes including ability to forward to other recipients and available previous documentation within record - inpatient preoperative checklist and discharge care plan (nursing) covering preoperative checklists, prior to discharge plan and discharge dashboard - discharge (doctors) covering fit for discharge, discharge documentation and summary, discharge medication and discharge letter - discharge (nursing) covering day of discharge checklist, key discharge information and PM conversation discharge of patient		

	Emergency preparedness, response and resilience - policy and procedural controls in place relating to emergency preparedness, response and resilience, major incident and business continuity planning - paper based contingencies remain in place to allow and record data capture Governance - e-Lancs managed from one command centre Digital - national data and digital strategy in place to help drive successful implementation of e-PR system - stability of existing systems i.e. clinical and patient flow system (including capture of nursing documentation), digital dictation and scanning - improved digital infrastructure, network upgrades and digital solutions including storage to maintain and manage existing systems in place to help best utilise data sets and information from e-PR system - extended contracts on existing digital systems that provide current cover - register of non-core systems capturing patient information (feral systems) - decommissioning programme of digital systems underway - IT helpdesk and self-service portal in place to help resolve technical and general issues Patient and staff safety - staff access to a wide ranging staff health and wellbeing support mechanisms e.g. occupational health and wellbeing teams, employee assistance programmes, external organisations, staff side, freedom to speak up guardians etc. Task based - improved digital infrastructure and investment in new technology and equipment e.g. connectivity, large screen monitors for status and track boards, bed planning and control centres, use of barcode scanners for medication, patient wristband supply and scanning, workstations on wheels, laptop trolleys 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 07/11/2024** **No change in risk score** A full review of the risk controls and assurances is being undertaken by the data and digital senate group which will focus on system based issues, clinical management issues, governance issues, education and training issues, competency and behavioural issues that will support mitigation of this risk and a reduced risk score **Next Review Date 06/12/2024**	**Date last reviewed**	**07/11/2024**
		Risk by quarter 2024-25	**Q1** | **Q2** | **Q3** | **Q4** **20** | **20** | **20** |
		8-week score projection	**15**
		Current issues	System wide external influences

No	ID	Title				
7	9746	**Inadequate funding model for research, development and innovation**				
Lead		Risk Lead: Julia Owen Exec Lead: Katie Quinn / Matt Ireland	**Current score**	**16**	**Score Movement**	⟺

Description	The Research, Development and Innovation Service within DERI is not centrally funded by the Trust. It is financed through complex funding streams such as the National Institute for Health Research (NIHR), Clinical Research Network (CRN) Greater Manchester and from income generated from commercial and non-commercial research activity. This model of funding is no longer sustainable	**Gaps and potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1 Commercial and non-commercial study income subject to change without warning leading to fluctuations in income or performance expected for funding provided and is non recurrent making forecasting extremely challenging. 2 Failure to look at funding model of Research, Development and Innovation could result in significant and rapid loss of highly skilled workforce and infrastructure severely damaging the Trust's ability to deliver vital ground breaking research for patients. These staff groups are specialised and once lost will take a considerable amount of time to re-establish. 3 Income generated from research and innovation rarely provides a within financial year return on investment in staffing resource and can take a few years for a new post to develop the surrounding portfolio within the service and is subject to exterior pressures within clinical and support services. 4 Research support function and SMT does not directly generate income, but is vital to support the research activity, be that developed research or hosted. The skilled expertise and advice given to prospective researchers helps increase potential for successful funding applications. Average success rate for grant applications is 17%, with unsuccessful grant applications still requiring support. 5 Not replacing staff has increased risk of not being able to deliver certain functions of the service, as well as increased pressure and stress on staff remaining, with current pressures unsustainable. **Gaps / weaknesses in assurances** 1 Rebalancing research portfolio to include more income generation from commercial research is happening but takes time to grow and establish. 2 Generated income limited without a dedicated research facility as clinical priority will take precedence for capacity (including support services). 3 Current recruitment freeze to non-clinical roles having an impact on staffing capacity to deliver current and expand research portfolio in line with DERI strategy and Research Plan. 4 Future benefits of investment realised over a longer trajectory such as research capability funding and income generation
Controls and Assurances in place	**Controls** 1. Finance within DERI moved from substantive education posts into research. 2. Investment in additional resources (B6 0.4 WTE and B4 0.2 WTE) for a six month period has allowed for better scrutiny and control of contractual and financial assessment of projects, timely raising of invoices and chasing aged debt. 3. Agreed proposals within business plan will see consistency in approach and alignment with other NHS organisations. 4. Procurement of Edge Research Management System allows for improved efficiency at capturing and costing for research activity and better financial oversight that was previously held. **Assurances** 1. Annual negotiations held with NIHR and CRN to proportionately increase investment to reflect balance and expansion of research portfolio across services allowing for movement of some posts to the CRN funding stream. 2. Fortnightly finance meetings between R&I Accountant, Deputy Divisional Manager for DERI and Head of R&I Department to review income and budgets. 3. Additional funding routes and benchmarking of financial models across other NHS organisations being explored. 4. Engagement with senior finance personnel and good lines of communication with executives to form a collaborative approach to the business plan.		

Update since the last report	**Update 06/11/2024** **No change in risk score.** Income recovery work progressing at pace with a dedicated team set up and seconded to the role of recovering historical income, cross referencing study activity and invoices as well as setting up new processes on EDGE for new studies opening. Agreement reached for this work to continue to Mar-25 that will support mitigation of this risk and a reduced risk score. **Next Review Date 06/12/2024**	**Date last reviewed**	**06/11/2024**			
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			16	**16**	**16**	
		8-week score projection	**12**			
		Current issues	System wide external influences			

No	ID	Title				
8	8061	**Patients experiencing delays past their intended clinical review date may experience deterioration**				
Lead		Risk Lead: Alison Marsh Exec Lead: Sharon Gilligan	**Current score**	**16**	**Score Movement**	⟺
Description		Patients are waiting past their intended date for review appointments and subsequently coming to harm due to a deteriorating condition or from suffering complications as a result of delayed decision making or clinical intervention.	**Gaps and Potential actions to further mitigate risk**			
Controls and Assurances in place		**Controls** 1 Red, Amber, Green (RAG) ratings included on all outcome sheets in outpatient clinic. 2 Restoration plan in place to restore activity to pre-covid levels. 3 RAG status for each patient to be added to the comments field on the patient record in Outpatient Welcome Liaison Service (OWLS) to capture current RAG status. This will allow future automated reports to be produced. 4 All patients where harm is indicated or flagged as a red rating to be actioned immediately. Directorates to agree plans to manage these patients depending on numbers. 5 A process has been agreed to ensure all follow up patients in the future are assigned a RAG rating at the time of putting them on the holding list. 6 Process has been rolled out and is monitored daily. 7 Underlying demand and capacity gaps must be quantified and plans put in place to support these specialities in improving the current position and reducing the reliance on holding lists in the future. 8 Administrator appointed to review all unknown and uncoded patients requesting clinical input and micromanagement of red patients in chronological order to find available slots. **Assurances** 1 Updates provided at weekly Patient Transfer List (PTL) meetings. 2 Daily holding list report circulated to all Divisions to show the current and future size of the holding list. 3 Meetings held between Divisional and Ophthalmology Triads to discuss current risk and agree next steps. 4 Requests made to all Directorates that all patients on holding list are initially assessed for potential harm due to delays being seen, with suitable RAG ratings applied to these patients. 5 Specialties continue to review patients waiting over 6 months and those rated as red to ensure they are prioritised. 6 Audit outcomes highlighted no patient harm due to delays. 7 Meetings held with Directorate Managers from all Divisions to understand position of all holding lists. 8 Individual specialities undertaking own review of the holding list to identify if patients can be managed in alternative ways. 9 Updates provided weekly to Executive Team.		**Gaps / weaknesses in controls** 1 Holding list remains high due to backlog from COVID-19. 2 General lack of capacity across specialties impacting on reducing holding list numbers. 3 Not all staff are following standard operating procedures for RAG rating of patients, leaving some patients without a rating. **Gaps / weaknesses in assurances** 1 Automated reporting system in development that will ensure oversight of risk stratified lists by specialty. 2 Current level of patients without a RAG rating classed as uncoded and unknown. 3 Patient appointments not RAG rated will drop onto the holding list if appointments are cancelled. 4 Patients added onto the holding list from other sources such as theatres, wards etc will not have a RAG identified.	
Update since the last report		**Update 06/11/2024** **No change in risk score** No change in risk score due to continuing increase in the volume of patients and time constraints due to competing waiting list demands **Next Review Date 04/12/2024**	**Date last reviewed**	**06/11/2024**		
			Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
				16	**16**	**16**	
			8 week score projection	**16**			
			Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title
9	8033	**Increased requirement for nutrition and hydration intervention in patients resulting in delays**

Lead	Risk Lead: Mandy Davies Exec Lead: Peter Murphy	**Current score**	**16**	**Score Movement**	⟺

Description	Failure to meet nutrition and hydration needs of patients as set out within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which sets out the requirements for healthcare providers to ensure persons have enough to eat and drink to meet nutrition and hydration needs and receive support in doing so.
Controls and Assurances in place	**Controls** 1 Regulatory requirements and guidance written into nutrition and hydration provision to inpatients, parental nutrition, enteral feeding, refeeding, mental capacity and safeguarding adults policies and procedures. 2 Standard operating procedures and tools in place i.e. ward swallow screen, electronic malnutrition screening tool, food record charts and fluid balance, nasogastric tube care bundle, food for fingers and snack menus and nutrition and hydration prompts on ward round sheets. 3 Inclusion within Nursing Assessment and Performance Framework (NAPF) and ward managers audits 4 Training provided to staff that includes malnutrition screening, nasogastric tube replacement, nasogastric x-ray interpretation and nasogastric bridle, mouthcare, malnutrition identification and management, fluid balance, Percutaneous Endoscopic Gastronomy (PEG) management and food hygiene. **Assurances** 1 Nutrition and hydration prompt on ward round sheets 2 Inclusion within ward manager audits. 3 Monitoring of incidents and levels of harm, complaints, patient experience outcomes etc. as part of divisional reports. 4 Outcome results form part of the work plan of the Nutrition and Hydration Steering Group. 5 Inclusion via Nursing Assessment and Performance Framework (NAPF).
Gaps and Potential actions to further mitigate risk	**Gaps / weaknesses in controls** 1 Non adherence to policy and procedural controls. 2 Inconsistent, inaccurate assessments and recording of malnutrition risk. 3 Lack of appropriate use of safeguarding processes. 4 Limited capacity of speech and language therapists, dietetics, endoscopy and nursing, including bank and agency, delaying assessments and impacting on feeding routes. 5 Limited capacity of nutrition support team undertaking ward rounds. 6 Lack of available housekeepers at weekends. 7 Training gap regarding nutrition and hydration training identified within doctors curriculum. 8 No process in place for the recording and review of non-mandatory training compliance. **Gaps / weaknesses in assurances** 1 Staff knowledge and confidence questionable in use of safeguarding processes in these cases. 2 No review of nutrition and hydration at ward rounds or timely best interest decisions. 3 Not all patients are weighed, with an over reliance on estimation of weight, not actual. 4 Recording of information in multiple places. 5 Current electronic 'MUST' toolkit insufficiently used to gather compliance reports and prevents healthcare assistants inputting weights. 6 Access to the nutrition support team is limited and instigated by dieticians and nutrition nurses rather than referral from ward. 7 Insufficient information provided in referrals to dieticians and speech and language therapists. 8 Timely review of blood results relating to parenteral feeding. 9 No medical representation at the Nutrition and Hydration Steering Group.
Update since the last report	**Update 06/11/2024** **No change in risk score.** MUST compliance remain static at 51% completion within 23hrs, 27% after 24hrs and 21% of patients with no MUST. Data triangulated from retrospective report generated by Power BI/EPR and NAPF data. Multifactorial issues associated with patients not being weighed and challenges of completing MUST tool with correct data. A recent review has found MUST eLearning to be out of date. MUST remain part of the NAPF auditing process. The impact of poor MUST compliance has been highlighted at the Clinical Effectiveness Group along with similar compliance to care planning, fluid balance chart and food record completion which also continues to be audited via NAPF. Nutrition questions in NAPF have been revisited and are more visible as NAPF adopts an MDT approach. Policy and procedural arrangements regarding nutrition and hydration provision are being reviewed. **Next Review Date 06/12/2024**

Date last reviewed	06/11/2024			
Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
	16	**16**	**16**	
8 week score projection	**16**			
Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
10	7165	**Failure to comply with RIDDOR**				
Lead		Risk Lead: John Houlihan Exec Lead: Tony McDonald	**Current score**	**16**	**Score Movement**	⟺
Description		Failure to provide quality assurance of legislative compliance regarding the reporting of certain types of injuries, diseases and dangerous occurrences to the Health and Safety Executive (HSE) within set regulatory timescales	**Gaps and Potential actions to further mitigate risk**			
Controls and Assurances in place		**Controls** 1. RIDDOR reporting requirements contained within scope of incident management policy and procedure. 2. Responsibilities of staff to report any health concerns embedded within organisational health and safety at work policy. 3. Improved data capture and utilisation of Datix incident management module. 4. Centralised process firmly established for the health and safety team to review and submit RIDDOR reportable incidents externally to the HSE. 5. Days lost off work as a result of a workplace accident or injury captured as part of the HR sickness management and return to work processes. 6. Increased management and staff awareness and understanding of RIDDOR i.e. what is and what is not reportable, consequences and timescales involved, relevant work examples and the issue of guidance. 7. RIDDOR awareness training developed by health and safety team and rolled out to targeted staff groups i.e. members of the health and safety committee, lead specialisms and or subject matter experts, occupational health services, divisional quality and safety leads and teams and patient safety investigation leads. Further ad hoc training across divisional groups available, where necessary. 8. Increased senior management awareness of RIDDOR to help drive and reinforce the importance of ensuring legislative compliance. 9. New Occupational Health Management System OPAS-G2 now being used to capture and inform of the types of medically diagnosed occupational related disease, infections and ill health identified as being RIDDOR reportable. **Assurances** 1. Full review of legislative requirements completed and reviewed. 2. Specialist advice, support and guidance on RIDDOR reporting requirements readily available from the health, safety and risk team. 3. Continuous monitoring and review of all accidents and incidents to staff, patients, contractors and members of public reported in DATIX undertaken by the health, safety and risk team. 4. Thematic review of RIDDOR performance against legislative requirements included as an agenda item of the Health and Safety Committee, with escalation and or exception reporting to the TWQG and Quality Committee, where necessary. 5. RIDDOR reportable occupational disease more explicitly included within occupational health performance reporting. 6. Collaborative working partnerships strengthened with clinical and non-clinical service specialisms and safety critical roles e.g. matrons, ward managers, patient safety lead investigators, incident and triage team, infection control, occupational health, estates and facilities, human resources, legal services, falls lead, manual handling lead, security management etc. should any significant trends be identified. 7. Attendance of health and safety team at weekly complex case review meetings to help identify and determine potential RIDDOR reportable incidents to patients. 8. RIDDOR performance included as part of Quality and Safety KPI performance metrics for senior management oversight and review. 9. Increase in RIDDOR compliance has increased from 56% in 2023/24 to 71% at present		**Gaps / weaknesses in controls** 1. Delays experienced determining RIDDOR status due to increasing volume and complexity of accidents and incidents requiring review and investigation. 2. Limited assurance policy or procedural controls regarding the timely reporting of accidents or incidents are being followed, of this being highlighted or captured within management systems or processes or it being performance managed. 3. No standardised investigation process or quality management system used to capture numbers of days lost off work as a result of workplace accident or injury leading to its absence, avoidance or duplication. 4. Introduction of patient safety learning response timescales identified as part of the new Patient Safety Incident Response Framework (PSIRF) may delay incident investigations and impact on external regulatory reporting requirements. 5. Improvements in compliance heavily reliant on major changes to the incident management and triage processes and limited capacity and resource within the health and safety team. 6. Lead specialisms and or subject matter experts are not being utilised effectively with regards the review and investigation of incidents within their own areas of responsibility and control and of determining external reporting requirements of RIDDOR when undertaking investigations. 7. Investigations to determine RIDDOR reportable incidents highlighting gaps in quality safety management systems or processes and of policy/procedural controls and risk assessment processes not being followed. **Gaps / weaknesses in assurance** 1. RIDDOR performance increasingly attracting the interest of the HSE and CQC. 2. No evidence of assurance lead specialisms or subject matter experts in safety critical roles are benchmarking or using RIDDOR performance as an important driver in reducing mitigating risks or improving safety management systems, processes or behaviours. 3. Numbers of accidents and incidents being reviewed or investigated by the health, safety and risk team to determine RIDDOR status account for 25-30% of all accidents and incidents reported in DATIX. This continues to significantly impact on the work and resources of the team e.g. 6,539 were reviewed or investigated in 2021/22, this increased to 6,713 in 2022/23 and 6.725 in 2023/24. Current FYTD incidents total 3,539 (Oct-24) with numbers projected to exceed previous year figures. 4. There has been a 50% increase in RIDDOR reportable incidents compared to the previous FYTD from 38 in 2022/23 to 57 in 2023/24. A total of 28 RIDDOR reportable incidents have occurred this FYTD, 8 of which have been reported outside of timescales.		
Update since the last report		**Update 06/11/2024** **No change in risk score.** A new RIDDOR process went live on 1 Oct-24 to help support a reduced risk score. All stakeholders consulted on changes in process. Notifications to the HSE remain centrally coordinated by the health, safety and risk team. RIDDOR awareness training including the new process has been rolled out to support divisional services. Compliance rates have improved from 56% to 71% at present **Next Review Date 07/12/2024**	**Date last reviewed**	06/11/2024		
			Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
				16	16	16	
			8 week score projection	12			
			Current issues	Systems, capacity and workforce pressures			

No	ID	Title
11	6190	**Insufficient capacity to accommodate patients in clinic within timescales**

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

Description	Insufficient clinic capacity for patients to be seen in outpatient clinics resulting in unbooked new patients and very large holding lists of overdue patients, in some cases, there is significant delay and increased risk to patients. The demand far outweighs capacity and waiting lists have increased significantly over the past few years. All patients are risk stratified (red, amber, green rated) but still cannot be seen within timescales with an added risk those patients identified as amber could become red over time.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Clinical management policy and procedural controls for managing patient lists requires full review in line with implementation of Cerner Millennium. 2. Relaunch of Outpatient Transformation Group to take place, with all services looking at project streams with the support of improvement managers. 3. Insufficient workforce and resource to provide capacity or carry out validation of all waiting lists. 4. Limited outpatient space to provide required clinics. 5. Increasing service demand and improved medical advancements are resulting in increased appointments and complexity of cases. 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. 3. Possibility of meetings being stood down due to operational pressures 4. Increasing staff burnout and wellbeing due to constant pressures.
Controls and Assurances in place	**Controls** 1. Action plan and ongoing service improvements identified to reduce demand. 2. Expanded non-medical roles e.g. orthoptists, optometrists, specialised nurses etc. 3. Use of clinical virtual pathways where appropriate 4. Additional capacity sessions offered to clinicians when opportunity arises 5. Operational management team in place including administrative support for waiting list validation 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.		

Update since the last report	**Update 29/10/2024** **No change in risk score.** Working further towards having accurate data from waiting list information within the EPR, with external support BI teams are now able to access the front end of REV Cycle within the EPR and building new reports. This should be available within the next 2 months to support with validation and data cleanse and provide accurate waiting list information to clinical services that will support mitigation of this risk and a reduced risk score. **Next Review Date 29/11/2024**	**Date last reviewed**	**29/10/2024**		
		Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
			16	16	16	
		8 week score projection	12			
		Current Issues	Recovery and restoration pressures, recruitment and retention			

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

Description	The aseptic units are not being maintained to external standards and there is a risk the air handling units, specialist equipment such as pharmaceutical isolators and HEPA filters in both units will fail due to planned and reactive failure in the maintenance and replacement schedule and a number of potential issues: ▪ Temperature fluctuations may lead to environmental breaches. ▪ Product degradation may lead to contaminated products being administered to patients. ▪ Delays in chemotherapy service provision when equipment fails may hinder cancer recovery plans and breaches in cancer targets. ▪ An increased higher risk of dispensing and reconstitution of high risk products in clinical areas if incorrect stock is used or staff exposure to products that may cause health issues. ▪ A reduced ability to support clinical trials of investigational medicinal products requiring aseptic preparation. ▪ Outsourcing is not possible for supporting research and development where aseptic preparation is required due to air handling unit or equipment failure. ▪ The clinical trials team are based in the aseptic unit and if the unit closes, clinical trials dispensing will cease and research will stop which may impacts on commercial viability, reputational damage.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Failure to comply with health technical memorandum guidance and quality assurance standards. 2. Dispersed oil testing and pressure differential failure in clean rooms visible on magnahelic gauges, interlocking doors not working. 3. A chemotherapy port has exceeded its life span with no plans in place regarding lifecycle management. 4. Contract with JLA (formerly Atlas) now expired, reports not being sent through, so having to review maintenance contract which is more expensive. 5. Difficult to manage all reports being recorded on the unit. 6. No environmental control in the old outpatient dispensary so not suitable for storing clinical trials unless upgrade works carried out. 7. Delays of up to forty four weeks ordering isolators adds to existing financial pressures and work programme constraints. 8. Growth restriction of aseptic unit with at least one pharmaceutical isolator not operational in last two years. 9. CIVA service has been stopped. 10. Outsourcing of parenteral nutrition service due to failing equipment. 11. Increased waste due to shelf life of outsourced products. 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. PFI agreed to upgrade aseptic unit but awaiting dates for lifecycle works to commence. 4. There has been a 15% increase in aseptic service provision in last two years with capacity and demand intensive. 5. Chemo and clinical trial demand growing and exceeding capacity of unit. 6. Review of capacity data highlighting workforce issues. 7. Environmental monitoring results have a two week response time causing delays in picking up any breaches. 8. Limitations in mutual aid due to age and condition of units across NHS organisations in the LSC area. 9. Workforce issues are leading to increased psychosocial risks. 10. Difficult to assess safety of MABs when in phase 2 of development, as COSHH data not available.
Controls and Assurances in place	**Controls** 1. Auditing of aseptic units being undertaken by external service providers via the Interactive Quality Assurance of Aseptic Preparation Service Quality Management System. 2. Staff preparations using aseptic none touch technique to reduce contamination risk 3. Old outpatient dispensary identified to be able to store clinical trials 4. Risk assessment of monoclonal antibodies designed to look at new products being accepted on the formulary. 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 **Assurances** 1. The aseptic team is reviewing the system for any environmental breaches on a monthly basis via pharmacy quality meetings. 2. Quality exception report excursions are being investigation and error rate reviews undertaken 3. Monthly meetings taking place and urgent response service plans sent through from clean room specialist company. 4. Regular environmental testing undertaken of the unit and the workforce. 5. Transformation plans for aseptic unit in place, with an integrated care systems working group looking at long term service provision. 6. A north west pharmaceutical quality assurance regional audit is undertaken every 18 months. 7. Outsourcing of products is undertaken where possible to meet service demand. 8. Non aseptic medicine trials and other alternatives being explored to prepare aseptic products in clinical areas.		
Update since the last report	**Update 04/11/2024** **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. **Next review date 02/12/2024**	**Date last reviewed**	**04/11/2024**

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

No	ID	Title				
13	10062	**Risk of significant harm and poor experience for patients attending with mental health concerns**				
Lead		Risk Lead: Lyndsay Parsons Exec Lead: Peter Murphy	**Current score**	**15**	**Score Movement**	⟺
Description		The Trust is registered with the Care Quality Commission for the assessment and treatment of patients on the emergency care pathway who are subject to sections 136, 5,2 or 5.4 of the Mental Health Act. Patients are being admitted onto hospital wards who, whilst their acute physical health needs are being met, can present a risk in relation to their mental health needs when awaiting a more formal mental health assessment, a suitable mental health bed or transfer to other more suitable clinical pathways outside of the Trust and lead to patients not receiving coordinated care against standards, poor patient experience in the absence of specialist care and a deterioration in mental health condition.	**Gaps and Potential actions to further mitigate risk**			
Controls and Assurances in place		**Controls** 1. Shared care protocol in place with Lancashire and South Cumbria NHS Foundation Trust (LSCFT). 2. Daily escalation of mental health patients via gold command. 3. Multi agency s.136 pathways in place 4. Enhanced Care Support Team in place to support complex patients with internal staff trained in physical restraint and experienced in care of patients presenting with challenging behaviours 5. Lead Nurse for Mental Health now in post. **Assurances** 1. Enhanced care lead nurse informally monitors and escalates gaps in completed risk assessments to the mental health liaison team based in the emergency department. 2. The mental health liaison meeting reports to the emergency department divisional management board meetings and facilitates joint working between the emergency department and mental health liaison team. 3. A new mental health interface meeting has been set up to provide assurances against established measures. 4. LSCFT multi agency oversight group monitors patient mental health activity and is chaired by the Integrated Care Board. 5. Incidents of harm involving patients with mental health or learning disabilities reported in Datix.		**Gaps / weaknesses in controls** 1.LSCFT are routinely unable to staff the requirements of the Shared Care Protocol for 1:1 etc. 2. Enhanced Care Team is not fully recruited to at present, including formal lead for the service. 3. Mental Health risk assessments only provided by MHLT for patients with medical recommendations in place and often provide limited information. 4. Infrequent availability of resource to address escalated patients via gold command due to mental health bed availability. 5. Access to specialist advice for mental health concerns can only be accessed externally from LSCFT. Lead professional is now in place and working on a pathway to increase support for complex patients. 6. Lack of ability for specialised care plans to be written by mental health nurses to support patients within general adult acute ward environments. 7. Limited control of other patients witnessing distress and deterioration in mental health conditions within ward environments. 8.Staffing levels not able to manage associated risk when gaps are not covered by specialist teams. 9.Acute staff often manage mental health risks without adequate training placing themselves and patients at risk. No training plan available. 10.Incomplete or unsuitable environmental and clinical risk management processes. 11.Lack of formal agreed shared care model results in inconsistent levels of support and gaps in provision. 12. No specific Trust policy for the care of mental health patients. **Gaps / weaknesses in assurances** 1. No specific Trust policy for the care of mental health patients. 2. Assurance processes not embedded or visible against jointly agreed standards. 3. No specialist input from mental health nurses to ensure appropriate actions are being taken. 4. The mental health liaison meeting is not linked to formal governance arrangements. 5. Compliance against s.136 pathway requirements not visibly reported across the Trust. 6. The LSCFT multi agency oversight group is not linked into formal governance arrangements 7. No access to specialist internal support for adult mental health concerns. 8. No access for staff to undertaken mental health training to support patients and families. 9. Requirements from treat as one documentation are outstanding 10. No formal oversight of ligature risk assessments	
Update since the last report		**Update 29/10/2024** **No change in risk score.** A review of incident reports shows 17 self-harm incidents all of low or minor harm. A review of treat as one actions have assigned leads. A regular review of incidents is taking place to understand causation and address issues. A mental health nurse has been appointed in Sept-24 awaiting recruitment checks and commencement date which will support mitigation of reduced risk score. **Next review date 29/11/2024**	**Date last reviewed**	**29/10/2024**		
			Risk by quarter 2024/25	**Q1**	**Q2**	**Q3**	**Q4**
				15	**15**	**15**	
			8-week score projection	**12**			
			Current issues	System wide influences			

No	ID	Title				
14	9900	**Poor identification, management and prevention of delirium**				
Lead		Risk Lead: Paul McManamon Exec Lead: Jawad Husain	**Current score**	**15**	**Score Movement**	⟺
Description		National Institute of Clinical Excellence (NICE) guidance relating to the identification, assessment, management and prevention of delirium in acute hospital settings is partially and or not being met				
Controls and Assurances in place		**Controls** 1. A paper based delirium bundle and assessment in place for clinical teams investigating and managing delirium. 2. A delirium awareness training module is available to staff with rapid tranquilisation training in support. 3. Available guidance on agitated delirium in elderly persons. 4. Patients with suspected delirium can be referred to relevant specialist nursing teams for support and review where required. **Assurances** 1. Delirium reports and updates produced and shared at dementia strategy meetings and the patient experience group. 2. Diagnostic data has identified a downward trend in delirium diagnosis since the introduction of the electronic patient record system. 3. A dementia champion documentation audit is being piloted monthly that includes seeking assurances of the effectiveness of delirium assessments. 4. A share point site has been created for signposting and resource identification. 5. A change request for the identification, management and prevention of delirium workflow has been approved with work underway to produce a single assessment question to identify delirium (SQID). 6. A training programme is in place to deliver delirium awareness key points training with training delivered to c.`40 staff members between Jan-24 to May-24. 7. A nationally accredited delirium awareness e-learning module has been added to the learning hub.		**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Existing digital clinical assessment does not fully identify delirium or populate a problem list. 2. Existing paper based delirium bundle does not utilise the 4AT delirium assessment and is not being routinely used in practice. 3. Compliance with dementia audits and outcomes requires stronger divisional support. 4. The training module for delirium is not a mandatory training requirement and does not fully mitigate the risks associated with delirium. 5. Published guidance and recommendations (agitated delirium in elderly) are not always followed. **Gaps / weaknesses in assurances** 1. Poor compliance with pilot assurance measures. 2. No reported compliance of delirium assessments for clinical areas captured. 3. No digital pathway for delirium management available. 4. A revised care plan for the prevention and management delirium is to be integrated into Cerner e-PR. 5. Work to create an investigation prompt for clinicians as part of the delirium diagnostic work flow and to assist clinical judgement underway.
Update since the last report		**Update 07/11/2024** **Change of risk handler. No change in risk score.** The initial results from a national audit of dementia has identified limited assurances regarding the effectiveness of delirium assessments on patients that require them with the delirium pathway significantly reducing effectiveness. **Next review date 06/12/2024**		**Date last reviewed**	**07/11/2024**	
				Risk by quarter 2024/25	**Q1**	**Q2**	**Q3**	**Q4**
					15	**15**	**15**	
				8-week score projection	**15**			
				Current issues	System wide influences			

No	ID	Title				
15	9895	**Patients not receiving timely emergency procedures in theatres**				
Lead		Risk Lead: Nicola Tingle Exec Lead: Jawad Husain	**Current score**	**15**	**Score Movement**	⟺

Description	There is a risk that increasing demand on the emergency theatre due to increased hospital acuity may lead to delays in patients not receiving timely emergency procedures.	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. No systematic approach in alerting and reviewing patients once listed. 2. No alert system when emergency patients have breached NCEPOD categorisation and not had timely emergency procedure. 3. Standing down of elective theatres or opening second theatres not always possible due to capacity and clinical priorities of elective patients. 4. Financial impact of cancellations on day of elective patients. 5. No bed capacity for surgical patients. 6. Not all cases are appropriately listed due to MDT requirements, times unknown, case complexity etc. which impacts on oversight at scheduling. 7. Known complex overruns are not always staffed requiring emergency staff to cover. 8. Regular overrun of elective theatres requires staff to relieve others who have to go home. Only six theatre staff available resulting in stopping of theatre six. 9. Limited assurance policy and procedural controls are effective or are being followed. 10. Reliance on voluntary staffing of capacity lists. **Gaps / weaknesses in assurances** 1. Potential for inappropriate categorisation when booking emergency patients. 2. Failure to discuss patient safety and risk at theatre triad and at divisional and directorate meetings. 3. Incident reports not always completed or capture severity of harm as unknown if there is a delay to surgery or disease progression. 4. Issues not highlighted if coordinator is not on duty. 5. Actions from meetings may not be enacted upon 6. Failure to manage capacity list due to lack of resource.
Controls and Assurances in place	**Controls** 1. All patients listed in accordance with NCEPOD guidance and time to theatre. 2. Patients reviewed by medical team to ensure they remain appropriately categorised and have not deteriorated. 3. Standing down of elective theatre based on clinical urgency and prioritisation. 4. Escalation standard operating procedure in place for patient flow. 5. Scheduling to ensure elective theatres are run in accordance with session time. 6. Senior theatre coordination and duty anaesthetist ensure efficient running of all operating theatres to prevent overrun. 7. Policy arrangements in place for ensuring elective procedures are booked in a timely manner to facilitate correct staffing for the elective capacity. 8. Additional second theatre at weekends to cover capacity. **Assurances** 1. Daily review of acuity of emergency list and capacity to assess availability of opening a second emergency theatre where required. 2. Theatre triad, directorate meetings held to discuss patient safety and risk at divisional and theatre directorate level. 3. Monitoring and review of incidents. 4. Emergency coordinator highlights capacity issues to duty anaesthetist and theatre operational manager. 5. Scheduling and oversight meetings in place for elective lists 6. Business case being made for additional theatre sessions.		
Update since the last report	**Update 22/10/2024** **No change in risk score** A number of NCEPOD category targets have been achieved but the risk score remains the same due to 62 category breaches. A second emergency list currently runs on Sundays on a capacity basis to help alleviate breach issues **Next review date 22/11/2024**	**Date last reviewed**	**22/10/2024**
		Risk by quarter 2023-24	**Q1**: 15 · **Q2**: 15 · **Q3**: 15 · **Q4**:
		8 week score projection	**15**
		Current issues	Recovery and restoration pressures, recruitment and retention

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

Description	The introduction of Cerner e-PR system has created changes in documentation processes. There are numerous ways to navigate the system and document information in Cerner. As a result there is a lack of standardisation in documentation. This requires a coordinated way of standardisation and of providing policy and procedural guidance, education and support and effective ways to audit compliance of new systems and processes. A lack of standardisation when documenting in Cerner could result in the omission of documentation, evidence of care, duplication or contradictory information relating to the provision of care and potential that processes no longer align to clinical management policies, standard operating procedures and national guidance, with elements of documentation captured in existing audits no longer available to view.	**Gaps and Potential actions to further mitigate risk**	
Controls and Assurances in place	**Controls** 1. Appointment of a Chief Nursing Information Officer (CNIO) now in post. 2. New Integration Architect has been recruited to assist and upskill system analysts to execute change requests. 3. Head of Nursing leading review of the effectiveness of clinical management policy and procedural controls, risk assessment processes and care plans. 4. Library of quick reference guides on step by step instructions on common processes available via e-coach. 5. Training videos available on OLI, YouTube and the Learning Hub. 6. Review of clinical documentation included as part of Nursing Assessment and Performance Framework (NAPF). 7. Standardisation of clinical information and records management now obtained and can be audited. 8. Ward manager training delivered by CNIO to all ward managers to standardise nursing documentation. **Assurance** 1. Key processes lacking in standardisation are being identified. 2. Assurances provided by policy authors of the effectiveness of policy, procedural and risk assessment controls being aligned to Cerner. 3. Escalation process for Cerner related issues in place. 4. Engagement groups with staff and subject leads in progress to understand the issues. 5. A clinical records management group has been established to monitor and receive assurance of compliance. 6. Nursing risk assessments now available via systems reporting portal with other reports awaiting development. 7. Mini NAPF and audits of clinical areas undertaken by matrons with outcomes shared and enacted upon. 8. 93% of staff have received training on Cerner e-PR before 'go-live' date and all new staff complete training on commencement of employment. 9. Ongoing updates, including changes or handy tips, issued via trust wide approved communication systems. 10. Creation of One LSC model allows for pooling of resources across the region that will help address capacity.		**Gaps / weaknesses in controls** 1. Staff unaware of variation of processes in Cerner at go live so all processes need review and agreement to standardise. 2. Compliance audit reporting for some elements may not be possible or align to Cerner. 3. Unable to set up compliance reports until agreement of standardised process. 4. No electronic document management system or guidance on scanning in place. **Gaps / weakness in assurance** 1. Due to the volume of change requests and system analyst capacity, the alignment of system builds, audit and policy review is taking time to work through and prioritise. 2. Availability of lead experts to review system and advise and update policies is a timely process. 3. Limited assurance of monitoring scanning activity. 4. Limited capacity of reporting team to work on clinical reporting due to pressure for business as usual reports and resolving data quality issues for operational reporting.
Update since the last report	**Update 07/10/2024** **No change in risk score** Number of recent incidents in relation to poor completion of fluid balance and food charts shows gaps in assurances and highlights further training is required **Next Review Date 07/11/2024**	**Date last reviewed**	07/10/2024

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

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

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

Description

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

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

Controls and Assurances in place

Controls

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

Assurance

1. Signature sheets kept with assessment and compliance of its use audited as required.
2. Extra equipment in use to support bed space e.g. patient call alarm, bedside table and crate for any belongings are being managed as per policy and procedural controls.
3. When equipment is not in use, it is the wards responsibility to ensure the electronic patient buzzer is kept on charge at the nurses station and checked twice daily as part of safety huddles.
4. Use of extreme escalation trolleys is monitored, incidents are reviewed, linked to the risk and investigated as appropriate, with lessons learned shared with staff.
5. The Electronic Patient Tracking System is updated to ensure the correct ward area is used at all times of extreme escalation.
6. Quarterly review of risk assessments undertaken by the health and safety team via use of audits and incident review.
7. Monthly meetings set up to review any incident reports received to identify any ongoing themes or increased risk.
8. Beds utilised in surge spaces as necessary to maximise area usage and increased capacity on wards across MEC and SAS

Gaps and Potential actions to further mitigate risk

Gaps / weaknesses in controls

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

Gaps / weakness in assurance

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

Update since the last report

Update 07/11/2024
Risk reviewed. No change in risk score.
Difficulties in sourcing appropriate patients at times of extreme pressure to be nursed on trolleys as a surge patient on the ward. SAS have reviewed this position and have sourced beds to allocate patients onto instead of surge trolleys to maximise the use of these areas. This does reduce space between these two bed and has been risk assessed.

Next Review Date 06/12/2024

Date last reviewed	07/11/2024			
Risk by quarter 2024-25	Q1	Q2	Q3	Q4
	15	15	15	
8 week score projection	15			
Current Issues	System wide influences			

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

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

Description	Failure to prevent patient slips trips and falls resulting in avoidable harm due to lack of compliance / assurance with Local and National policies / procedures	**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Lack of consistency / compliance with local assurance tools including enhanced care scoring tool and patient risk assessments 2. Lack of consistency in approach following a fall with harm on a ward (currently bespoke input to ward area to assure patient safety for all patients on the ward which is dependent on initial review findings 3. Falls checklist to be built directly into DATIX to reflect other checklists, i.e. pressure ulcers 4. No trust wide falls action plan as patients coming to harm following a fall are reported through DATIX and investigated through divisional processes. This information is presented through a divisional quarterly report which are specific to their areas and provide assurance of actions, themes. trends and wider learning 5. Inconsistencies with staffing in relation to increased level of observation requirements for patients in our care and in accordance with the enhanced care policy 6. Inconsistencies with staff training in relation to understanding and delivery of enhanced levels of patient observation as per SOP004 (Levels of Enhanced care) 7. Inconsistencies in documentation on e-PR for falls prevention and management (change requests made Dec 23) **Gaps / weaknesses in assurances** 1. Increase in fracture neck of femurs as in-patient past 6/12 - 11 since Jan 23 any avoidable harm will be captured through the Falls Checklists completed and presented at divisional DSIRG meetings - learning shared at monthly Falls strategy group meeting and assurance through Divisional quarterly reports uploaded to ACTIONS within this risk 2. Increase in number of falls with avoidable harm to inpatients which have potentially contributed to the patient's death 3. Due to increase in falls contributing to patient death which has not seen previously the risk has been re-scored at 15 (understand that a consequence score should not change however death had not been seen previously so not scored as such but now this is evident this is felt to be a more accurate reflection of the risk 4. Due to this change it is felt that the falls collaborative work undertaken in 2015 should be revisited and reviewed in line with current practice and changes since COVID
Controls and Assurances in place	**Controls** 1. Patient falls included as part of the Trust's Patient Safety Incident Response Framework as a local priority for learning 2. 5 investigations completed on falls leading to #NOF and themed to identify safety improvements 3. Completion of investigations for all inpatient falls resulting in moderate or above harm in line with the ELHT Patient Safety Incident Response Framework 4. Falls investigation reports are carried out by appropriately trained nurses from the clinical areas which are reviewed through the DSIRG process for Patient Safety Response investigations at Divisional level and by PSIRI for STEIS reportable incidents monthly 5. Enhanced care scoring tool in place with appropriate SOP (SOP004 Levels of enhanced care) enhanced care e-learning accessible on the learning hub, enhanced care lead nurse in post and developing a digital solution for staff to undertake a patients enhanced care score (this is currently a paper process) 6. Multifactorial patient falls risk assessments in place monitored through monthly ward audits for assurance (following the implementation of e-PR) it was evident that a change request was urgently required as the information from the falls risk assessment was not being correctly pulled through to request a multi-factorial falls risk assessment which potentially led to lack of risk assessment compliance at patient level - this change request has now been actioned and issue resolved) 7. Falls strategy group meets monthly and represented by all divisions 8. Divisional falls action plans monitored through the falls steering group and uploaded to the risk quarterly. themes and trends following falls investigations are shared for learning across all divisions at the falls strategy group 9. Yellow ID badge introduced to identify staff undertaking enhanced care for patients at high risk of falls 10. Cohort bays are identified through appropriate "C" logo on doors entering the bay to increase staff awareness 11. Patients at risk of falls are identified daily at ward safety huddles 12. Enhanced care lead is recruiting a team of 30 enhanced care support workers who will support the most vulnerable patients in our care with appropriate supervision, interaction and observation 13. Falls checklist now aligned with PSIRF **Assurances** 1. Good monitoring tools in place across the wards and also links into Trust meetings at all levels (Directorate, Divisional sharing of incidents and lessons learned) 2. Falls summit action plan approved 3. Workshop planned with the falls strategy group to use a start stop continue approach to share and spread falls prevention strategies Trust wide		
Update since the last report	**Update 06/11/2024** **Risk reviewed. No change to risk score.** Falls summit undertaken and actions agreed. No deaths following inpatient falls since Jan-24. One fall with potential lapse in care in Sep-24 on AMU reported to the HSE under RIDDOR. **Next Review Date 07/12/2024**	**Date last reviewed**	06/11/2024

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

8 week score projection	15
Current issues	System wide influences

No	ID	Title				
19	8808	**Breaches to fire stopping and compartmentalisation at BGH**				
Lead		Risk Lead: John Houlihan Exec Lead: Tony McDonald	**Current score**	**15**	**Score Movement**	⟺
Description		Phase 5 breaches to fire stopping compartmentalisation in fire walls and fire door frame surrounds due to poor workmanship or incorrect product usage may result in faster spread of smoke or fire between compartments within a timescale <1 hr or 30 mins that compartments and doors are designed to provide.				
Controls and Assurances in place		**Controls** 1. Contractual arrangements in place between the Trust and its PFI partners in establishing duty holder responsibilities of building controls, testing and servicing of alarm systems and planned preventative maintenance programme. 2. Upgrade of suitable building fire detection systems in place to provide early warning of fire. 3. Fire risers and fire-fighting equipment in place, tested and maintained. 4. Fire safety management policy and procedural controls in place. 5. Fire safety risk assessments in place for occupied (Trust) and non-occupied (Consort) areas. 6. Fire safety awareness training forms part of core and statutory training requirements for all staff. 7. All relevant staff trained in awareness of alarm and evacuation methods. 8. Emergency evacuation procedures and business continuity plans in place across services. 9. Fire protection remedial works and find and fix process in place and project managed. 10. Random sampling and audit of project works being undertaken. **Assurances** 1. A fire safety committee has been established, chaired by an exec lead, to seek assurance and monitor progress and compliance. 2. Collaborative working arrangements in place between the Trust, its partners and third parties to identify and prioritise higher risk areas, address remedial works and defect corrections to fire doors and frame sealings 3. All before and after photographic evidence of remedial works recorded and appropriately shared 4. Fire wardens in place with additional fire wardens provided by partner organisations to maintain extra vigilance, patrol common areas across hospital sites and undertake fire safety checks 5. Provision of on-site fire safety team response in place. 6. External monitoring, servicing and maintenance of fire safety alarm system and suitable fire safety signage in place. 7. Agreement of external response times and project management overview by Lancashire Fire and Rescue Service and NHS England. 8. Independent consultant employed to review and oversee project.		**Gaps and Potential actions to further mitigate risk**	**Gaps / weaknesses in controls** 1. Delays in implementing works 2. Lack of confirmation of integrity of fire door architrave surrounds and general gaps around and under fire doors. 3. The adequacy of fire stopping compartmentalisation between phase 5 and adjacent building (Wilson Hey) via survey remains outstanding, with no decision made on work to progress. 4. Not all locations within occupied areas have an updated fire safety risk assessment. 5. The review of the effectiveness of collaborative working arrangements regarding the completion, review and sharing of fire safety risk assessments for both occupied and non-occupied areas is required. **Gaps / weaknesses in assurances** 1. Lack of cooperation from partner organisations with information relating to construction drawings, test evidence and material in situ which is slowing down survey and project remedial / management works 2. Limited assurance of the robustness of fire safety management policy and or procedural controls regarding the risk assessment process and effectiveness of on-site fire wardens.
Update since the last report		**Update 06/11/2024** **Risk reviewed. No change to risk score.** A formal review of the risk is being undertaken by key stakeholders and reported at the next Fire Safety Committee meeting scheduled to take place in Dec-24 for approval that will support a reduced risk score **Next Review Date 06/12/2024**		**Date last reviewed**	**06/11/2024**	
				Risk by quarter 2024-25	**Q1**	**Q2**	**Q3**	**Q4**
					15	**15**	**15**	
				8 week score projection	**12**			
				Current issues	Recovery and restoration pressures, recruitment and retention			

No	ID	Title				
20	4932	**Patients who lack capacity to consent to hospital placements may be being unlawfully detained (Tolerated Risk)**				
Lead		Risk Lead: Rebecca Woods / Lyndsay Parsons Exec Lead: Peter Murphy	**Current score**	**15**	**Score Movement**	⟺
Description		Patients referred to Lancashire County Council (LCC) and Blackburn with Darwen Council (Supervisory Body) for a Deprivation of Liberty Safeguards (DoLS) authorisation are not being assessed by these agencies within the statutory timescales, or at all, which means the DoLS is in effect unauthorised.		**Gaps and Potential actions to further mitigate risk**		
Controls and Assurances in place		**Controls** 1. Policy and procedures relating to the Mental Health Capacity Act (MCA) and DoLS updated to reflect 2014 Supreme Court judgement ruling. 2. Mandatory training on MCA and DoLS available to all clinical professionals. 3. Improvement plan introduced for the management of DoLS applications following internal audit to enable timely and accurate recording of applications made and to demonstrate application of MCA in absence of Local Authority (LA) review. 4. Applications being tracked by the Safeguarding Team 5. Changes in patient status relayed back to the LA acting as the Supervisory Body. 6. Ability to extend urgent authorisations for all patients up to 14 days in total. 7. LCC hospital DoLS process now in place to priorities any urgent DoLS applications where increasing restrictions are being put in place to keep the patient safe. **Assurances** 1. Risk known to both Local Adult Safeguarding Boards for Blackburn with Darwen and Lancashire Local Authority. 2. Quarterly audits of MCA and DoLS being undertaken by the Safeguarding Team and reported to the NMLF and Safeguarding Committee on a quarterly basis. 3. DoLS data monitored via the Safeguarding Committee each month via the dashboard. 4. Additional legal advice obtained via Trust legal Team regarding current DoLS escalation process. 5. Patients not known to suffer any adverse consequence or delays in treatment.			**Gaps / weaknesses in controls** 1. In the absence of assessments patients will not have a DoLS authorised and will not have had relevant checks undertaken to ensure they are legally detained, leading to patients being detained without authorisation as not doing so would present an even greater risk. 2. Plans to change DoLS to Liberty Protection Safeguards (LPS) remains on hold by the Government, with no date set for their implementation or subsequent publication of new National Approved Codes of Practice. **Gaps / weaknesses in assurances** 1. No gaps or weaknesses identified that remain the responsibility of the Trust. 2. Little evidence of assurance received from the supervisory body of it meeting its obligations for the assessment of patients	
Update since the last report		**Update 10/10/2024** **Tolerated Risk. Risk reviewed. No change in risk score.** Mitigation of this risk continues to remain outside the control of the Trust. Assurances required from supervisory body it is advancing mitigation of this risk and addressing resource requirements for assessment of patients as part of its statutory obligations that will support a reduced risk score. **Next review date 10/11/2024**		**Date last reviewed**	**10/10/2024**	
				Risk by quarter 2024/25	**Q1**	**Q2**	**Q3**	**Q4**
					15	**15**	**15**	
				8-week score projection	**12**			
				Current issues	External influences regarding mitigation of risk beyond the control of the Trust			

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

20 November 2024

Item **153**

Purpose **Approval**

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

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

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

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

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

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

Deputy Directors and Executive Directors, October 2024

Finance and Performance Committee, 28 October 2024

Quality Committee, 30 October 2024

People and Culture Committee, 4 November 2024

Introduction

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

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

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

5. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
6. There have been no updates to the controls or assurances section of the risk.
7. With regard to the actions section of this risk, there have been a number of updates, including revised due dates for three of the actions to address gaps in control (1, 2 and 8), all of which have been moved to April 2025. Action 8 has been RAG rated from green to amber due to the need to sign off the Trust's Performance Assurance Framework by the end of November 2024.
8. There have also been updates to all bar one of the actions, the details of which can be found in the detailed BAF sheet.

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

9. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
10. There has been a number of small updates/revisions to the controls section which are highlighted in green in the detailed BAF sheet.
11. With regard to the actions section of the risk, there have been updates provided to the progress section for each action. In addition, action 4 has been re-RAG rated from amber to red to more adequately reflect the current financial pressures.
12. The deadline for action 5 has been revised to November 2024, based on the agreement of further business cases at the Board meeting in September 2024.

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

13. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.

14. There have been no further updates to the controls section of the risk.
15. The actions that had been completed at the last review have now been closed on the action section and moved into the assurances section of the detailed BAF sheet, these are highlighted in green.
16. There have been updates to all of the actions which are clearly marked in green in the detailed BAF sheet. In addition actions 4 and 8 have been identified as completed and will be moved to the sources of assurance section at the next review. Action 6 has been re-RAG rated from amber to green following the approval of the business case for right sizing of the bed base at the board meeting in September 2024.

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

17. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
18. There have been no amendments to the controls and minor updates to the assurances section of the risk, these are highlighted in green in the detailed BAF sheet.
19. There have been updates to all of the actions, with the first two having had revised deadline dates added, the rationale for which is set out in the detailed BAF sheet.

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

20. The current risk score remains unchanged for this risk, as do the tolerated and target risk ratings.
21. There have been a small number of minor updates to the controls section of this BAF risk, all are highlighted in green on the detailed BAF sheet.
22. There have been no changes to the assurance section of the risk.
23. There have been updates to all actions, with action 1 being re-RAG rated as amber. The remaining action points have had revised timelines for completion, the rationale for these changes will be provided at the Board meeting on 20 November 2024.

BAF 6: (Risk Score 20 (C4 x L5) (As Host): Increased staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services.

BAF 6: (Risk Score 20 (C4 x L5) (As Partner): One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations.

24. The current risk scores remain unchanged for this risk, as do the tolerated and target risk ratings.
25. Controls and assurances have been updated to reflect that the transfer of staff occurred and One LSC came into operation on 1st November 2024
26. All actions have been updated to reflect the actions taken to support the work undertaken to support the transfer on 1 November 2024. All actions are marked as green to reflect these deadlines with the exception on action 7 where it has been agreed to review this as part of the post-transfer action plan.
27. Work is now underway to change the emphasis of this BAF risk from one focussed on risks associated implementation to a focus on risks associated with the day to day running of One LSC and implications of this from a host point of view and the future of One LSC in terms of benefits realisation.

Recommendation

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

BAF Risk 1 – Integrated Care / Partnerships / System Working

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

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

Strategy: ELHT Strategic framework (Partnership Working)

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

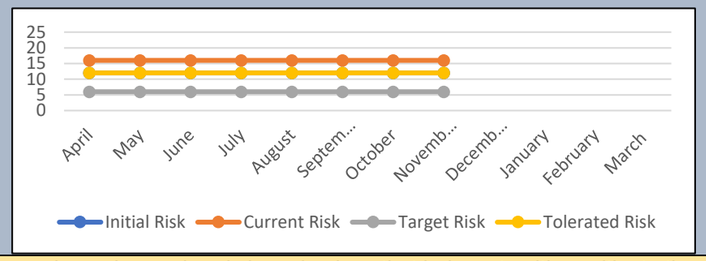
Date of last review: Executive Director - October 2024

Lead Committee: Finance and Performance Committee

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

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

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



Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite: Open/High

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

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

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

Provider Collaborative Board (PCB):

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

Place-Based Partnership (PBP):

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

ELHT:

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

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

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

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

Specialist support, policy and procedure setting, oversight responsibility:

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

Independent challenge on levels of assurance, risk and control:

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

BAF Risk 1 – Integrated Care / Partnerships / System Working

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	System strategies will continue to be developed and aligned as they are agreed.	Work with system partners to finalise system strategies and ensure full alignment with commissioning intentions and delivery plans.	Director of Service Development and Improvement with SRO leads	April 2025	With the exception of clinical strategy development work all actions complete and focus is now on delivery of benefits for 202425 and 20265/26 (refer to actions 3, 4 and BAF risk 6 on OneLSC). Work ongoing on development of system clinical strategy and roadmap.	G
2.	System (LSC, PCB, Place) delivery structures are still maturing to support effective implementation and realisation of benefits	Work with system partners to optimise delivery structures	Executive leads	April 2025	Initial development of plans and alignment across the system complete. Clear programmes in place which now need to focus on delivery of benefits for 2024/25 and 20205/26 (refer to actions 3, 4 and BAF risk 6 on OneLSC).	G
3.	Clear Clinical Transformation Programme development and delivery plans	Agreement of clear timescales for delivery of key priority programmes and benefits	Chief Executive and lead SROs	April 2025	Clinical strategy work to inform a roadmap to delivery of priority programmes over next 5 years and long-term plan linked to New Hospital Programme Work progressing on fragile service specialty priorities with clear programmes established. System stroke event held in September 2025. Work underway to accelerate programmes of work on fragile services and focus on delivery of benefits for 2024/25 and 2025/26.	A
4.	Benefits for community services/out of hospital priorities not yet fully realised.	Work with Place + partners to further develop community services in line with the Community Transformation Programme to maximise benefits to support patients to receive care in their own home where possible.	Executive Director of Integrated Care, Partnerships and Resilience	April 2025	Co-production and co-delivery with place partners of service development and transformation including enablement hub, UEC pathways, End of Life, Care Home improvements, Integrated Neighbourhood Tean development and Acute Respiratory Infection (ARI) hub mobilisation. Special cause improvement observed in Frailty programmes for numbers of over 65s attending ED.	G
5	Lack of clarity and understanding of decision-making mechanisms between Place and Trust footprint resulting in disconnect and/or micro-management by Place(s)	Lead Trust Executive for Place Partnerships, Robust Divisional Leadership Structure via Community and Intermediate Care Division (CIC) and engagement in Place based structures.	Executive Director of Integrated Care, Partnerships and Resilience	April 2025	Lead Trust Executive is Executive Director of Integrated Care, Partnerships and Resilience with regular meetings wit Place Leads. CIC Divisional Leadership mirrors Clinical Divisional triumvirate structure. Representation on Place Partnership structures with delivery on Place Plus basis where appropriate (e.g. UECDB). Monitoring of strategies and impact of Place strategies to ensure appropriate linkages to Trust Strategic Framework and footprint.	A
6.	Trust planning process will continue to mature to support floor to board connections of goals and priorities alongside wider system alignment	Ongoing review and improvement of planning processes at organisational and system level	Director of Service Development and Improvement	April 2025	All Trust strategy plans 2024/25 signed off via sub-committees with reporting mechanisms throughout 2024/25 agreed. Ongoing alignment of place with place and system partners. Ongoing work with Divisions to support connection of Trust goals to teams and individual objectives. Work underway to launch planning processes for 2025/26.	G
7.	Ongoing development of SPE+ improvement Practice to support delivery of key improvement priorities and to build improvement capability across the organisation/system	Ongoing review and development of SPE+ Improvement Practice at organisational and system level to build capability and support delivery and refresh of SPE+ Practice Plan/Strategy in line with NHS Impact	Director of Service Development and Improvement	April 2025	'Year of Improvement' launched to develop SPE+ training offer to reach 3000 staff in 2024/25 – second improvement week complete which is informing changing to communication strategy for SPE+ improvement. Third improvement week will focus on roll out of daily management/production boards to support waste reduction programme. Improvement hub team capacity identified to support key improvement priorities for 2024/25, increased monitoring in place to support realisation of benefits for 2024/25. Scoping of work to refresh Trust SPE+ Practice Plan/Strategy commenced to align to the new NHS Impact framework and ongoing engagement with NHS Impact. Continue to review the offer from NHS Impact to align organisational and national improvement priorities. Improvement update and overview of key programmes of work presented to September Trust Board meeting, Progress on programme continues to be presented to key Trust sub0committees and review at Executive Improvement Wall.	G

BAF Risk 1 – Integrated Care / Partnerships / System Working

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
8.	Trust Accountability Framework can mature further to support and assure delivery of Trust priorities and realisation of benefits.	Review effectiveness of Trust Accountability Framework and further improve to support delivery	Director of Service Development and Improvement	April 2025	Review commenced of Accountability Framework including effectiveness of Divisional Quarterly Performance meetings, measurement and reporting framework Review of Integrated Performance Report (IPR) underway and to be published in September. Plans in place to update and sign off updated Accountability Framework by end November, Board Development Workshop on revised IPR completed and new IPR agreed to run in shadow form, review of quarterly performance meetings complete. Review of Improvement Walls underway to refresh for 2024/25 priorities Improvement Walls being rolled out to operational areas e.g. ED, pathology	A

BAF Risk 2 – Quality and Safety

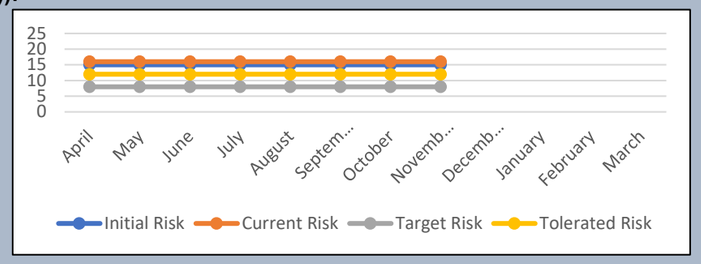
Risk Description: The Trust may be unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.		**Executive Director Lead:** Executive Medical Director and Chief Nurse	
Strategy: Quality Strategy	**Links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

Links to Corporate Risk Register:

Risk ID	Risk Descriptor	Risk Rating
10086	Lack of adequate online storage for images may result in missed or delayed diagnosis	**20**
9545	Potential interruption to surgical procedures due to equipment failure	**20**
9336	Increased demand with a lack of capacity within ED can lead to extreme pressure and delays to patient care	**20**
8126	Poor records management due to sub optimal implementation of new e-PR system	**20**
8941	Increased reporting times in histology due to increased activity outstripping resource	**20**
8061	Patients experiencing delays past their intended clinical review date may experience deterioration	**16**
8033	Increased requirement for nutrition and hydration intervention in patients resulting in delays	**16**
7165	Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).	**16**
6190	Insufficient capacity to accommodate patients in clinic within timescales	**16**
9851	Lack of standardisation of clinical documentation processes and recording in Cerner	**15**
8808	Breaches to fire stopping and compartmentalisation in walls and fire door surrounds – Burnley General Teaching Hospital.	**15**
4932	Patients who lack capacity to consent to hospital placements may be unlawfully detained	**15**
10065	Pharmacy Technical Service refurbishment programme	**15**
10062	Risk of harm and poor experience for patients with mental health concerns	**15**
9900	Poor identification, management and prevention of delirium	**15**
9653	Increased demand with a lack of capacity within ELHT can lead to extreme pressures and delays to patient care	**15**
9601	Risk of avoidable patient falls with harm	**15**

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

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



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Minimal

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

Strategy and Planning:

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

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

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

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

- Monitoring against Model Hospital, Getting it Right First Time (GIRFT), National Institute for Health and Care Excellence (NICE) guidelines, Internal and Clinical Audits (local and national), specialist commissioning, CQC insight data (monthly)
- Quality Walkrounds including Executive and Non-Executives (not sure that these are if you look at the activity)
- Establishment of 3s visits to all areas of the Trust, to listen to both staff and patients/carers, receive feedback and take action.
- Nursing Assessment Performance Framework (NAPF) Process ongoing and reports to Quality Committee
- Safe, Personal, Effective Care (SPEC) process and the ratings of green/silver/gold wards/areas (mapped to the CQC Key Lines of Enquiry).
- Co-ordination of GIRFT through Audit and Effectiveness Team to identify Trust wide efficiency and effectiveness gains and reported to the Quality Committee regularly.
- Direct patient referrals into Same Day Emergency Care (SDEC) pathways to help bypass urgent care and ED.
- Admission avoidance through the use of Intensive Home Support Service (IHSS) in ED.
- Acute Care Team supporting resus in ED.
- Acute medical physician in-reach into A&E from 8.30am to 8.30pm

BAF Risk 2 – Quality and Safety

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

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

Specialist support, policy and procedure setting, oversight responsibility:

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

Independent challenge on levels of assurance, risk and control:

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

BAF Risk 2 – Quality and Safety

	• Regular GIRFT assessment and bench marking • Annual organ transplant report to NHSE • Patient Safety Walkrounds • Board sign-off for SPEC recommendations • Review of MHUAC with Stakeholders • ICB Quality reviews of services

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

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

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
	Functionality of ePR causing issues with data quality, performance and affecting users capability to maximise the potential of the electronic system.	There is a need for relevant clinical document formats to be standardised and uploaded to Cerner eLancs team best use of resource needed to manage data cleansing and accuracy issues to enable timely reporting and performance monitoring and acting on change and service requests from staff/departments. Within current contract The upgrade of the Cerner system has been put back to April 2025 due to financial constraints. This will impact the functionality of the EPR system.	Executive Medical Director	Delay in implementation due to lack of resource 2025	Issues with ePR and Data Quality continue to be escalated and are being managed through the Data and Digital Senate/Board.	A
3.	Management of Deprivation of Liberty Safeguards processes.	Continuous programme of audit Trust wide and implementation of action plan including: • Strengthened MCA/DoLS training offer • Development of 'heat map' to identify areas in need of greatest support • Development of 7 minute briefings • Development of a 'myth-busting' animation which will be mandatory for all level 3 staff • Strengthened documentation on Cerner • Working with the NAPF team to ensure a consistent approach	Executive Director of Nursing/ Executive Medical Director/ Executive Director of Integrated Care, Partnerships and Resilience	This date has been removed and there is no further date for implementation confirmed.	On trajectory for improved referrals. The number of DoLS applications was 187 in August and 184 in September. Whilst there is a drop between August and September there is still an overall upward trajectory, when compared whilst compared with September 2023. 27 (increase from 136 in May 24). The number of DoLS are still below the expected number given the size of the organisation. 31 ward/departments audited in Q1. Audit activity feedback is increasing Ward Manger/Matrons knowledge of what is expected to meet the requirements. Formal action to be taken by the Deputy Chief Nurses. Meeting to be held with Divisional Chief Nurses to support in increasing compliance. Revised MCA assessment has gone live within Cerner on 3rd July 24. 7 Minute Briefing for MCA was presented at the Nursing and Midwifery Forum on 25th July. A 7 minute briefing for DoLS is under development and is due to be shared at the Nursing Midwifery Forum on 26th September 24. Awareness raising ongoing. Potential significant workload associated to cover approx. 260 annual applications. An announcement was made on 05.04.2023 that the implementation of LPS would be delayed 'beyond the life of this Parliament'. As a result, all internal and external local and national working groups have been stood down for the immediate future. The Trust will await any update from the new Labour government in relation to if and how this will progress. Lancashire and South Cumbria NHS Foundation Trust (LSCFT) have agreed in principle to formalise support of Mental Health (MH) registration through the management of psychiatric medication, oversight of MH care plans, management of MH Act paperwork for any Section 5(2)s applied within ELHT and to provide training to staff on MH and Restraint. LSCFT have proposed a formal Service Level Agreement (SLA) at cost. SLA is in the process of being signed. Individual patient MH risk assessment and MH strategy shared by LTHT, currently being adapted for adoption at ELHT.	G
4.	Financial Constraints	Constraints in finances will result in lack of investment into workforce, development of service, capital investment and revenue. This has the potential to negatively impact on quality and safety.	Executive Director of Finance / all Executive Directors	March 2025	Organisational focus on improvement methodology to improve productivity and efficiencies. Waste reduction programme with Execs leading as SRO for various workstream – chaired by the CEO. Consolidation of previously approved schemes and QIA for ongoing projects and the ones which have been deferred for a later date. Ongoing work through PCB on clinical strategy and services.	R

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Recruitment and retention campaign being undertaken as well as work to improve recruitment from overseas. This has now been reviewed and stopped as registered nurse vacancies recruited to with a trajectory that assures sufficient registered nurse supply New arrangements: better care, better value meetings now in place, with SLG members meeting twice per week (chaired by Clinical Executive Director) and once per week with Executive Team members (chaired by CEO). Agreed a standardised QuIRA process.	
5	Lack of capacity to manage increased activity across the Trust	Bed remodelling for managing increased activity Work with Place based partners in improving patient pathways Implement GIRFT and Model Hospital best practice approaches to care Data submission to national teams on activity, mortality, coding, audit to ensure that accurate and validated assumptions on income, HSMR/SHMI and activity. Quality of information added to the system remains an issue. Training is taking place with clinical/admin colleagues Coding and quality and affects mortality indicators too.	Executive Director of Finance / Executive Medical Director / Executive Chief Nurse / Chief Operating Officer	Quarterly review November 2024 – on track	Established relationships through interface meetings with Place based leadership. Clinical Lead with responsibility for GIRFT and Model Hospital working with Q and S team. Ongoing work with our East Lancs team, coders and the Mortality Steering Group (with deep dives into outliers). Working with divisions on ensuring that that we capture activity levels. Working with national teams. Bed remodelling exercise about to complete. Improvement Case being developed to open permanent clinical accommodation to reduce corridor care. Further capital work planned to increase ED footprint Improvement case being developed to increase senior medical presence in UEC. In July 2024 the Trust opened a further 24 medical beds on ward C2 and intend to open a further 28 beds on the newly created b3. This was agreed at the Board meeting held on 10 September 2024.	G

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

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

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

Strategy: Clinical Strategy & Operational Strategy

Links to Key Delivery Programmes: Elective and Emergency Pathway Improvement

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

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register

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

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

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

Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite: Moderate

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

Overall planning and delivery processes:

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

Operational Management processes:

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

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

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

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

Specialist support, policy and procedure setting, oversight responsibility:

-
- Executive meet all with all divisions every morning (Monday – Friday) at 8.00am to support delivery manage risks and address any issues.
- Benchmarking data available from Getting It Right First Time (GIRFT), Model Hospital.
- Cancer Alliance support on focussed areas requiring improvement.

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

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

Oversight arrangements:

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

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

Independent challenge on levels of assurance, risk and control:

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

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Activity 109% of 2019-20 levels not achieved consistently.	The controls and weekly monitoring taking place to work towards the achievement of the 107% of 2019/20 activity.	Chief Operating Officer	March 2025	Plans are in place to achieve in 2024/25. Q2 for 2024/25 Performance (not fully validated for September) RESTORATION ELHT V's PLAN New Outpatient 108% EL/DC 108.2% Outpatients & EL/DC: 106.90% Year to date New Outpatient – 118.40% EL/DC - 102.60% Outpatient, EL/Dc - 106.90%	A
2	Diagnostic clearance to 95% of patients receiving a diagnostic test within 6 weeks of referral by March 2025.	Implementation of Modality level delivery plans.	Chief Operating Officer	March 2025	ICS wide modelling completed, and discussion are ongoing around mutual aid to across the Lancashire and South Cumbria area ensuring patients have equity of access. The Trust continues to performance better than the national average and a trajectory is in place to meet the	A

<table>
<tr><th>No.</th><th>Gap in controls and/or assurance</th><th>Action Required</th><th>Exec Lead</th><th>Due Date</th><th>Progress Update</th><th>BRAG</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>95% standard by March 2025 in the in-line with the planning guidance. Endoscopy remains the biggest pressure area, but recovery plans are in place and monitored by the Chief Operating officer.

Echocardiogram, performance has deteriorated due to staffing levels due to sickness – recruitment being undertaken to address workforce challenges and improve performance, July performance has seen improvements with performance at 101.50% - however in Aug Performance was 92.7%, Sept saw an improvement at 99.20% - the service continues to work on improvement of position</td><td></td></tr>
<tr><td>3</td><td>Meeting Cancer Standards
National Ambition for the standards
62 day – 70% by March 2025
31 day – 96%
28 day – 75% (77% by March 2025</td><td>Joint work with the Cancer Alliance on improvement

Continued Tumour site level detail to prevent backlog

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

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

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

Current Performance against the National Ambition
<table><tr><th>August Performance (Trust)</th><th>National Ambition by 2025</th></tr><tr><td>62-day standard 71.2%</td><td>70%</td></tr><tr><td>31-day standard 97.5%</td><td>96%</td></tr><tr><td>FDS standard 78.4%</td><td>77%</td></tr></table></td><td>A</td></tr>
<tr><td>4</td><td>Maintain capped theatre utilisation at a minimum of 85%</td><td>Performance oversight and support

Sustain improvements in achieving specialties and intensive support for other specialties</td><td>Chief Operating Officer</td><td>April 2024</td><td>The Division has actions they are undertaking to improve performance for both capped and uncapped theatre utilisation

Performance for Capped Theatre Utilisation was at 88.08% for week ending 29th September 2024 and 93.69 for uncapped.

The Trust is now submitting theatre utilisation data to Model Hospital and performance is back to pre Cerner levels. This is closely monitored by the Chief Operating officer and oversight will be provided by the EPIG.

This action had been completed and will move to sources of assurance at the next review.</td><td>B</td></tr>
<tr><td>5</td><td>Continued risk of >78 week RTT breaches and risk of not delivering < 65 week maximum wait by March 2024.</td><td>Demand and capacity at specialty review completed with improvement actions

Consultant and Junior Doctor strikes remain a risk to delivery. Mitigating plans in place focusing on clinical urgency, cancers and long waits as priority groups for any residual activity during this time. Rescheduling managed a working day before the strike to ensure managed displacement of slots.</td><td>Chief Operating Officer</td><td>November 2024</td><td>There are daily meetings with divisional reps on managing all patients at risk of breaching 78 and 65 weeks.

The new planning guidance has altered the target for managing <65-week maximum wait from March 2024 to September 2024

The Trust achieved the target by September but for one patient that was waiting on corneal graft, this was out of the Trusts control Daily monitoring continues to maintain this position of 65 weeks.</td><td>A</td></tr>
</table>

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
6	Bed model for medicine suggests a gap of around 100 beds (including the 53 de-escalated beds). This is further exacerbated with the immediate need to create decant wards at BGTH and RBTH sites resulting in a 53-bed reduction from 17th April 23.	Monitor impact of 53 bed reduction. Increased efforts around pathway 0 discharges with the discharge matron team. Continued admission avoidance via ED and SDEC pathways as well as IHSS team. Home including rehab as a default for pathways 2. Increased use of pathway 1. Use of escalation beds and trolleys when required in extreme pressures	Executive Director of Integrated Care Partnerships and Resilience/ Chief Operating Officer	November 2024	Improvement case to support the right sizing of the acute medical bed base has been completed and is scheduled to be taken to the Finance and Performance Committee on 2 September 2024 and the Trust Board on 11 September 2024. This case also addresses the Trust's winter plan for 2024-25. This is linked to the right sizing of the medical acute bed base business case that was approved at the Board in September 2024. Ward B3 is due to come onstream in December 2024 as the winter escalation ward for acute medicine.	G
7	Ambulance handover times	As part of an LSC collaboration the Trust is working with NWAS colleagues to improve ambulance handover times, admission avoidance and direct streaming to alternative pathways and service	Chief Operating Officer	End of March 2025	As part of the 2024-25 planning, the Trust is committed to improving ambulance handovers within 30 minutes. Working collaboratively with NWAS colleagues on handover times and processes including the improvement of the HAS compliance data There has been an improvement of patients' handovers within 30 minutes and HAS compliance in From April to August showing a reduction in > 60 mins handovers, however September has been a challenging month and has seen a significant increase in 60 minute handovers Our Service Development and Improvement are working alongside the ED & community team and NWAS representatives on improvement schemes to avoid conveyance, direct to Same Day Emergency Care services and direct into appropriate community services – focus improvement week to be held 7th October Ongoing evidence to confirm positive results in diverting activity to alternative provision with community services, care homes and NWAS with a reduction in care home attends and 2UCR	A
8	Temporary lack of data, including theatre utilisation data as a result of the implementation of Cerner (this was an expected outcome of the implementation of the system).	As a first step there is a need to rebuild all operational reports to the previous standard, with the second stage of the work to improve upon the quality of reports.	Chief Operating Officer/Chief Nurse	End of Jan 2025	The BI team continue to work internally and with Cerner on on-going data quality issues and monitoring through data quality reports. Issues are managed as identified. There is considerable work ongoing and mitigation in place around the UEC pathways, particularly regarding redefining datasets. An Executive Director led assurance meeting has been established and is chaired by the Chief Nurse to consider improvements within ED. In January a triple A system is being established which will also consider datasets and will be led by the Chief Nurse, Executive Medical Director and Chief Operating Officer. The Trust BI team are now able to replicate the worklists within Cerner, October development and teams are now reviewing methods to cleanse data. This action has been addressed and will move to sources of assurance from the next review.	B

BAF Risk 4 – Culture Workforce Planning & Redesign

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

Executive Director Lead: Executive Director of People and Culture

Strategy: People Plan

Links to Key Delivery Programmes: People Plan Priorities

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

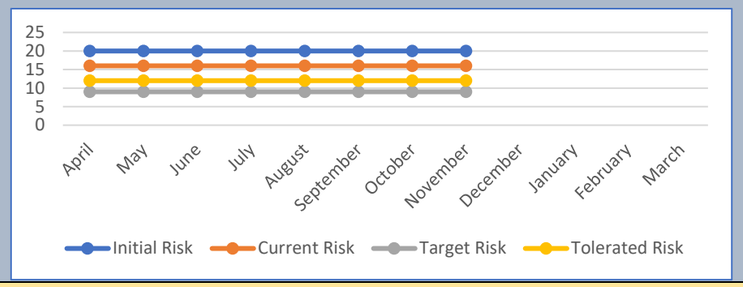
Lead Committee: People and Culture Committee

Links to Corporate Risk Register:

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

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

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



Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite: Open/High

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

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

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

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

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

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

BAF Risk 4 – Culture Workforce Planning & Redesign

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

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Reducing the Trust vacancy gap	To achieve zero registered nurse vacancies and improve turnover through recruitment and workforce transformation activity.	Executive Director of People and Culture	End of November 2024 See update for rationale for change to due date	A recruitment and retention group continues to work towards a trajectory to deliver zero vacancies by September 2024. This group is also developing initiatives to assist in retention of staff through greater flexible careers, flexible working, benefits etc. The Trust is working with colleagues across the ICS to deliver a workforce capacity programme aimed at reducing vacancies and securing future workforce pipelines. Specific work is underway to address shortages in specific roles, leading to fragile services such as diagnostics. International recruitment has been a success, delivering on plans and a decision has been taken to reduce the next intake and review future plans, so as not to impact on opportunities for newly qualified nurses, where we have a very strong pipeline. Some additional vacancies, due to creating new clinical space – start dates now planned for newly qualified nurses, who will all be in post by November 2024, which will achieve zero vacancies.	G
2	Improve Trust retention levels / Develop Retention Strategy	Implementation of targeted plan to deliver the national People Promise of Flexible Working and development of a Trust Retention Strategy.	Executive Director of People and Culture	November 2024 Please see update section for reason for extended due date	Work on developing the Trust's strategic approach to is ongoing through participation with the People Promise Exemplar programme. Regular updates are taken to the Executive Team (July/August 2024), Staff Sponsor Group and then be presented to People and Culture Committee (September 2024). Following the submission of the PID, the People Promise Manager (PPM) reports through to the national and regional teams and was identified as being an exemplar who has gone further faster than other Trusts, leading to an invitation to present to the national and regional teams. The PPM has developed a suite of 'you said we listened' posters to share back with teams. This includes highlighting improvements to appraisal, new line manager induction and share point site, handbook for line managers and greater support for clinical teams with team based rostering and opportunities for flexible working.	G

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					The PPM is making good progress and held a visit with the national, regional and local team to share our progress in key aspects of the people promise plan and next steps. Some priorities have had to be phased due to capacity. Starting to submit data to national team. Received positive feedback from the national team so far.	
3	Risk of staff leaving the NHS due to burnout.	On-going delivery of the ELHT People strategy underpinned by a compassionate and inclusive culture	Executive Director of People and Culture	A milestone report will be provided to the People and Culture Committee in November 2024	The People & Culture Directorate continue to explore how staff can be further supported during this ongoing period of unprecedented demand. Given the on-going need identified regarding supporting staff with their mental health an external review has been commissioned to review the existing staff mental health pathways and interventions. This work is due for completion by 12 July 2024 Project M – a peer support group for line manager wellbeing was launched in January 2024 by the CEO with 300+ managers engaged with the sessions. The LSC occupational health and wellbeing collaborative programme has been identified as one of the functions to move across to OneLSC. PCB OH and Wellbeing services are currently scoping a future service specification in readiness for the future model. People Promise Exemplar programme – project initiation includes a pilot project linked to burnout, full project plans to be completed by August 2024. Areas currently being highlighted, and budget being allocated subject to approvals in light of financial challenges. This project has funds allocated but has not yet commenced. PPM and Associate Director of OD to confirm a pilot site and appropriate model for delivery. Line manager development in place with people promise induction for new managers Feedback has been very positive, plans to extend to full day to enable greater use of case studies and hot topics to be explored. Wellbeing for leaders programme is now available in the Trust (NHS England) and will be revised for cohort 2 from 2 day to 1 day programme	A
4	Risk of loss of service due to national industrial action.	Ongoing management of action through Industrial Action Cell.	Executive Director of Integrated Care, Partnerships and Resilience	Ongoing with next update to the Board in November 2024.	The potential impact of any industrial action is monitored through the Industrial Action cell which now meets as/when action is called. A live strike mandate remains in place for Junior Doctors (BMA, HCSA, Unite), but BMA are recommending acceptance of latest offer. Details of 2024/25 now known and will be enacted in October 2024, with backpay to April 2024. Unions are putting the offer to their members, with ballot outcomes in September. Expected to be accepted. RCN have rejected the pay offer for 2024/25, although there is no indication that this will be followed by any industrial action. Industrial action is a standing item at the People and Culture Committee.	G
5	Risk of impact of colleagues experiencing discrimination, abuse and harassment from colleagues, managers and patients due to the specific impact of racism.	Trust becoming anti-racist. Progress being made through using improvement science, adoption of NW BAME Assembly framework. Programme of transformational culture change to be developed through allyship as a journey of development.	Executive Director of People and Culture	End of March 2025	**Anti-Racism** Project team established with support from the improvement team taking forward four themes and targeting work to within Family Care Division in first instance. CEO as Executive Sponsor. Diagnostic work underway to support the design of a board development sessions now held. Actions now to strengthen the zero-tolerance approach and to the actions that all Executive Directors will take. This includes messaging at Induction.	G

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					Communication strategy and campaign in place and launched as part of the ELHT Big Get Together, Photoshoot for the face of campaign taking place October 2024 to develop posters and wall display. Train the trainer activity took place in September to support full training launch in October 2024. Too Hot to Handle report – review ongoing by HR, EDI, FTSU and Staff Side in respect of cases at ELHT to ensure we reflect on practices and ensure we learn from these findings, through our existing monthly case review meetings and Professional Standards Group. This needs to be progressed. Trust developed divisional EDI dashboards which will support EDI goals. Divisions nominated EDI lead. Gap Analysis tool to be tested in DCS to supplement the data. Aarushi Project team presenting at different forums within the Trust to raise awareness Regular updates to be provided in the overall EDI update paper that will come to the PCC (July) and to Board. Achievement of Bronze Award. Silver action plan developed. Anti-Racism Summit took place. CQA group to continue. Anti-racism pledge cascade from Board through to senior leaders to their teams.	
6.	Risk of impact of colleagues experiencing discrimination, abuse and harassment from colleagues, managers and patients due to protected characteristics.	Development of a culture of inclusion and belonging. Ensuring that inclusion is embedded as everyone's business. Person-centred approaches to people practices, through informed and engaged line managers. Processes for reasonable adjustments are improved and embedded. Vibrant staff networks.	Executive Director of People and Culture	End of March 2025	**General** Inclusion Group has been reset. All divisions to confirm their EDI lead, and to present to the next meeting. Template for networks to assist with planning shared with Chairs. Gap analysis tool being developed to aid awareness of actions and supporting offers. EDI audit carried out. Management response in progress. **Inclusive recruitment** - A working group has been formed, to review attraction, recruitment, selection and progression, through an inclusion lens. The outcome will be a manager toolkit and updated manager training, focussing on quality and inclusion, with changes made to policy based on improvement work. Initial pilot of toolkit to take place from July 2024, finalised toolkit and training by end of November 2024. Training is fully booked. Train the trainer carried out and training plan being developed. **DAWN** Following valuable feedback through the People & Culture Committee staff story and a recent presentation to Executives, a working group has been formed to improve how we support colleagues with a disability, including making reasonable adjustments in a timely manner. An initial meeting was held on 25 June 2024to commence a QI.A business case has been developed to support a centralised process, enhance staff experience, support for managers and navigation and recharge from Access to Work. Business case getting approval so that we can put resources in place. Training has been developed. Metrics to support divisions to manage this locally being developed so hot spots can be identified. **Mental Health** Review into the provision of MH support for colleagues is underway following the MH staff survey carried out by the network. **Neurodiversity**	A

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					TAFG in place for 12 months and has recently become a network. Aim is for group to lead the development of a positive culture regarding neurodiversity including a toolkit, training, and support. A hidden disabilities project has launched with greater awareness in key teams like people and culture, awareness for line managers. **LGBTQ+** The Network is aware of the impact of national messages related to gender identity having a negative impact on wellbeing of the community. It will join with system partners to advance LGBTQ+ inclusion and help to develop the allyship framework for the Trust whilst the future of the Rainbow Badge accreditation becomes clearer. **Women's Network** Is supporting the advancement of the Sexual Safety charter in the Trust which is being led by the Head of Safeguarding with support from HR and other teams.	

BAF Risk 5 – Financial Sustainability

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

Providing VFM needs to be explicit in the descriptor

Executive Director Lead: Executive Director of Finance

Strategy: Finance Strategy

Links to Key Delivery Programmes: Waste Reduction Programme

Date of last review: Interim Executive Director of Finance, October 2024

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register (CRR):

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

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

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

Initial Risk Rating: C5 x L4 = 25

Tolerated Risk Rating: C5 x L3 = 15

Target Risk Rating: C5 x L2 = 10

Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Cautious/Moderate

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

Organisation

- Moved to IMTcell Better Care Better Value – senior leaders 3 times per week with targeted finance actions, using improvement methods
- Financial Recovery plan in place including additional Trust level controls, weekly one-hour financial recovery meetings with each Division (Divisional Management Teams alternate weeks), Weekly workforce control meetings, weekly Non pay Control Group and a Fortnightly Pay Control Group
- The Pay Control group is reviewing the oversight and process behind all payments to staff and contractors.
- The 2024 Medium-term financial strategy has been shared with the Executive team and has been presented to Finance and performance Committee in August and has been shared with the Trust Board in September 2024.
- Financial plan for 2024-25 has been developed via the annual planning process, and the updated breakeven plan for 2024-25 was signed off at the Trust Board in September 2024
- An early forecast outturn for 2024-25 submitted to ICB and national team (2nd August 2024)
- The Trust Standing Financial Instructions (SFI's) are reviewed annually and updated for any national guidance and regulations. The last review was completed in July 2024
- The financial position, forecasting for the year, capital spend against programme and progress towards achievement of the Waste Reduction Programme (WRP) are reported and scrutinised through the monthly Finance Assurance Board with Executive and cross-Divisional team representation, Capital Planning Board chaired by the Director of Finance, and Finance and Performance Committee, sub-committee of the Board.
- A new Waste Reduction Programme governance structure is in place that is now integrated across the Trust. Supported by dedicated resource by way of the Benefits Realisation Team and the Improvement Team in addition to divisional transformation leads.
- The Trust has commissioned PA Consulting to support the Trust for a 12 week period with a review of the financial controls, analytical support and service reviews of the loss making services.

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

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

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

Specialist support, policy and procedure setting, oversight responsibility:

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

BAF Risk 5 – Financial Sustainability

System	Independent challenge on levels of assurance, risk and control:
• System finances monitored through System Finance Group (includes representation of all providers and Integrated Care Board (ICB)) to facilitate understanding and actions associated with the overall system financial position. • One LSC Central services collaborative programme underway with ELHT confirmed as hosts, a planned transfer date of 1st November 2024. • System financial controls implemented from August 2023 and remains in place	• Internal and external audit – agreed internal audit plan for 2024-25, clean Head of Internal audit opinion received, clean external audit of annual accounts for 2023-24. Counter fraud workplan for 2024-25 agreed. • One NHS Finance Towards Excellence Accreditation shows that the finance team's processes and procedures are working. It proves that we have developed a culture where staff feel appreciated, and successes are celebrated. ELHT Finance Team are accredited at the highest level (Level 3). High level of qualified staff in department (53%) with a further 35% in training. The 3-year reaccreditation is due in the Autumn of 2024. •

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Lack of full knowledge of system financial flows recognised in the NHSE review	Work with system CFOs to determine full flows and impact on ELHT	Executive Director of Finance	Q4 2024-25 An update will be provided in November 2024	Remains outstanding – Block contract review underway, part of financial strategy and recovery Work to continue through Provider Finance Groups. Work is ongoing to achieve full transparency A full contract review will take place as part of the 2024-25 review process. With the appointment of a PCB Managing Director in July 2024, we should see an improvement in the governance and oversight	A
2	ICB/PCB workplan identification and capacity	Work with system to ensure plan developed and capacity gaps rectified and mitigated	Executive Director of Finance	Updates due in November 24	2 system meetings to identify specifics. Joint meeting CFOs/Operational colleagues to take place. Work on the system roadmap to be continued with new PCB finance lead. System transformation programme in place. Benefits realisation currently being defined System Investigation and Intervention process in place. First draft reports out, which identify areas of support required across providers and ICB.	R
3	No agreed System Financial plan for 2024-25 – it is still a draft plan awaiting NHSE confirmation that the £175m deficit financial plan has been accepted	Continue to develop plans for system, region and national sign off, and documenting all risks of reducing expenditure in line with expectations.	Executive Director of Finance	In Progress updates will be provided in November 2024	The System plan has been agreed across the LSC System but not formally accepted by NHSE. The financial plan was signed off by the Trust Board in June 2024 with full documentation on the risks attached to the delivery of such a high-risk plan	A
4	No signed Contract for 2024-25	To work with the ICB to agree the contract disputes	Executive Director of Finance	In Progress updates will be provided in November 2024	The trust has signed and returned the contract to the ICB with a detailed side letter of contract disputes that need resolving in the coming months.	A

One LSC BAF Risk- ELHT as Host

Risk Descriptor

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

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

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

Strategy: Indirectly links to all and overall Trust strategy.

Links to Key Delivery Programmes: Provider Collaborative

Date of last review: Executive Directors: ~~August/September 2024~~November ~~October~~ 2024

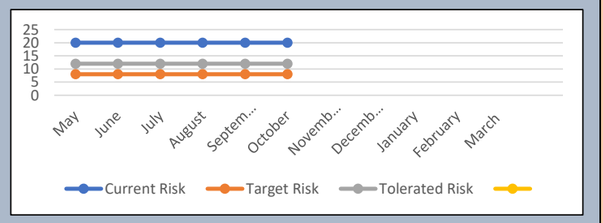
Lead Committee:
Finance and Performance Committee
People and Culture Committee

Links to Corporate Risk Register (CRR):

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

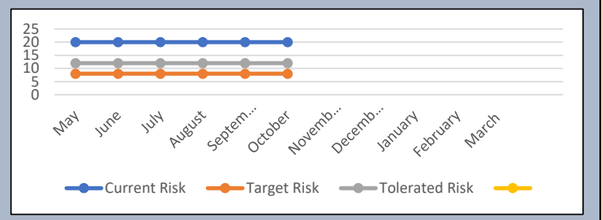
As Host

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



As Partner

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



Effectiveness of controls and assurances:

As Host

	Effective
x	Partially Effective
	Insufficient

As Partner

	Effective
x	Partially Effective
	Insufficient

Risk Appetite: Open/High

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

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

The process included identifying a host Trust (ELHT) with a comprehensive programme for the planned transfer in ~~October~~ November2024. Services successfully transferred on 1 November 2024.

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

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

1. Progress being reported into the Recovery and Transformation Board

Provider Collaborative Board (PCB):

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

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

Service delivery and day to day management of risk and control:
Internal One LSC planning group contunes to meet post transfer with a defined terms of reference links into the operational governance via ERAG and Executive Team
~~Formation of the~~ELHT Hhosted Serivces~~ing~~ Board will add an additional layer of governance to ensure seamless service delivery and management and mitigation of risks at host and partnership level
Project delivery structure to support management of risks and control of transition.

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

Independent challenge on levels of assurance, risk and control:
MIAA as internal auditors will audit the governance and management processes of One LSC
ICB as the regulatory body will also provide a scrutiny of the collaborative arrangements for central services.
Legal Due Diligence completed as part of the transfer process, risks identified and mitigation plans agreed.

One LSC BAF Risk- ELHT as Host

~~advance of the transfer date on 1 October~~ ~~November~~ ~~2024. The governance infrastructure sitting below the SCA is being organically developed with the input of the professional groups.~~Trust Boards signed off the Business Transfer Agreements and Supply Agreements prior to transfer on 1st November 2024.

~~3.~~4. Professional Working Groups will oversee performance and planning of all portfolios of One LSC.

ELHT

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

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	Strategic collaboration agreement, business transfer agreement and supply agreement has not yet been signed off.	Sign off by all partner Boards before the transfer date in ~~October~~ November 2024	Executive Director of Finance Director of Corporate Governance (partners for own Trusts)	~~End September 2024~~ By 1st November 2024	~~Various work through the professional groups with external lawyers continue~~ ~~July Board round will receive the latest draft for socialisation for review with sign off planned for August/September for all partners.~~ ~~Further work completed to review the SCA from a host perspective to ensure all risks identified with plan for mitigation agreed which will be monitored through Trust processes.~~ SCA signed off by Boards in August and ~~Bdraft b~~usiness transfer agreements and supply agreements ~~being reviewed ready for~~ signed off prior to 1st November transfer date. These are supported by the completed legal due diligence process for the transfer.	GA
2.	Agreement not yet reached with NHSE on the sign off process to establish One LSC from a partner or host perspective.	Continued liaison with NHSE to build on the positive work in relation to the sign off procedure with the regulator.	Executive Director of Service Development and Improvement/ Managing Director of One LSC	~~End September 2024~~ By 1st November 2024.	~~Positive developments following liaison with NHSE on the process for regulatory sign off. Regular review process in place to support monitoring of sign off requirements and completion of self-certification processes in advance of transfer date which will be co-ordinated via CSEC.~~ Sign off process agreed with NHSE, led by One LSC Project Director. ~~Regular communication ongoing with NHSE to final transfer.~~NHSE confirmed completion of the process and provided confirmation in advance of transfer.	GA
3.	The governance infrastructure sitting below the SCA needs to be organically developed with the input of the professional groups. No formal governance structure in place for a number of workstreams at this time and the overall One LSC governance and performance framework	Working through the professional groups and one LSC leadership on a multi-disciplinary approach in finalising the governance infrastructure sitting underneath the SCA. Move from the informal working groups into a more formalised model.	Director of Corporate Governance Managing Director of One LSC Executive Directors for professional groups	End September 2024 COMPLETE Monitoring continues	~~A number of regular professional group meetings in place with workgroups undertaken in August for a multi-disciplinary approach to establish the building components of the governance and operational infrastructure before the transfer date.~~ ELHT One LSC Planning Group meeting regularly to oversee due diligence processes from a Host perspective.	GA

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One LSC BAF Risk- ELHT as Host

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
	which will seamlessly dovetail into the governance processes of the partners organisations				Daily touchpoint meeting across Host and One LSC in preparation for 1st November transfer which continues to meet to ensure oversight of post-transfer actions and close down of transfer project plans into business as usual arrangements. Professional groups now set up to take forward transition and post transfer work for One LSC.	
4.	Establishing the monitoring of the One LSC and other services hosted by ELHT through the Hosted Services Board.	Developing the terms of reference and agreeing them at ELHT level, linking into existing Trust governance processes and socialising with system partners.	Executive Director of Finance Executive Director of Service Development and Improvement Director of Corporate Governance	End September 2024 **COMPLETE**	~~Work commenced on the Terms of Reference (TORs) and will be taken through the One LSC Planning Group in August with the Hoste3d Services Board to be established September 2024.~~ ELHT hosted Services Board met on 8th October and will report to Finance and Performance Committee.	GA
5.	TUPE transfer and consultation processes and resources are to be determined.	This is dependent on numerous factors, including the resolution of the union grievance.	Executive Director of People and Culture	End ~~September~~ October 2024	~~Progress being made in this area with the professional group leading on advising on the governance for TUPE and constructive engagement with staff. Positive progress with union colleagues with regard to resolving the grievance.~~ ~~Employee Liability Information (ELI) received from all Trusts.~~ ~~Initial consultation period has been extended, following an amendment to measures letter – to run to 25.10.2024.~~ ~~Grievance received by UHMB by Unite in relation to the amended measures letter.~~ TUPE transfer processes completed in line with implementation plan and to support transfer on 1st November 2024. Ongoing engagement with staff side and unions.	GA
6.	Due diligence not yet assessed and will potentially impact the cash position of ELHT as the host.	Commencement of the due diligence with each of the services leads, including asset transfers	Executive Director of Finance Executive Director of People and Culture	Commenced and ongoing to transfer date in ~~October~~ November 2024	~~Plans in place for the due diligence process to commence and be monitored through the One LSC Planning Group and Finance Assurance Board, ERAG and Executive Team.~~ ~~Board level monitoring through Audit Committee and Finance and Performance Committee.~~ Host due diligence readiness assessment completed on 18th October 2024 and via CSEC on 28th October 2024. Legal due diligence completed and signed off by CSEC and Trust.	AG
7.	Corporate capacity to support the set-up of One LSC is still to be fully scoped and transferred in advance.	Close liaison with Managing Director for One LSC and Directors for confirmation and linking into the One LAS performance and governance framework which is being established.	Executive Directors of all corporate functions	~~End August 2024/early September 2024~~December 2024	Mapping of processes continues to be undertaken and progress to be monitored through the ELHT One LSC Planning Group. Paper delivered to CSESC on 14/10/2024 raising concerns around ELHT corporate capacity. Plans to be worked through by next meeting on 21/10.2024. Combination of collaborative working and mutual aid support in place. Ongoing review as part of post implementation workplan.	A
8.	Further work to ensure that the communication plan and co-ordination of it delivers its desired objectives and results in positive and constructive engagement with all stakeholders.	Collaborative working with the One LSC MD, SRO for LSCPCB to ensure that the communication plan is enhanced.	Executive Director of Communications and Engagement Executive Director of People and Culture	End July 2024 COMPLETE	Discussions at Executive level and system level on the best approach to communication and staff engagement. Monitoring to take place through the One LSC Planning Group. Communications to support the implementation of One LSC complete. Now being built into business as usual plans for One LSC.	GA

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Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT

20 November 2024

Item	**154**
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

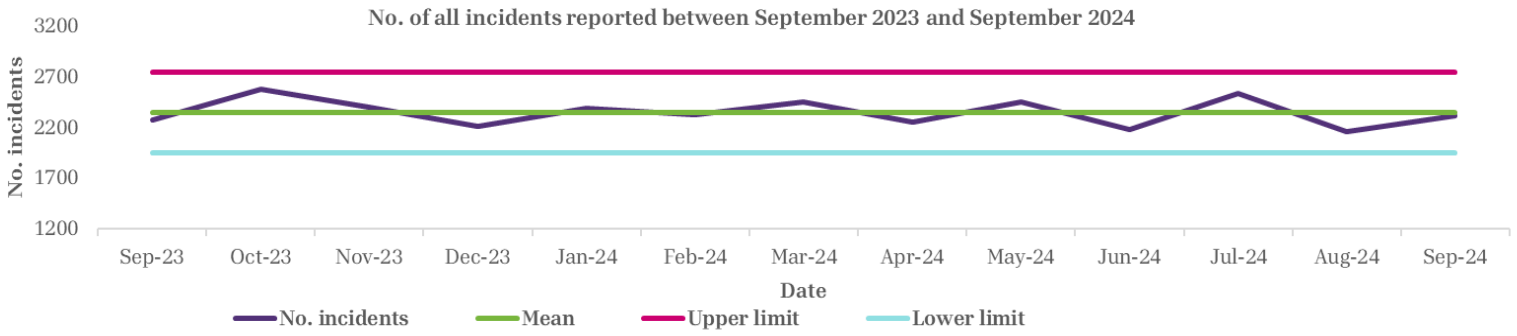
(154) Patient Safety Incident Response Assurance Report

Patient Safety Incident Response Framework Report

Reporting Period:		August - September 2024
Date and name of meeting:		Information within this report forms part of the Patient Safety Incident monitoring dashboard and PSIRF which is discussed and reviewed at the bi-monthly Patient Safety Group. The last meeting held was 24th September 2024 with 23 members in attendance and the meeting was quorate.
1a.	**Alert**	A reduction in incident reporting in the Surgical and Anaesthetics Division over the last two months. The reduction has mainly been in the Theatres teams with some reduction also in Urology and Cancer Services. Cancer Services could be explained by the process for identification and reporting of 104-day cancer breaches being improved reducing the need for batch reporting of incidents. Training on incident reporting and management undertaken with BGH theatre teams and planned for RBH theatres teams. Indication is that the introduction of the LFPSE question has increased the amount of time to complete the form. Need to allow time to see if the training influences this trend in incident reporting.
1b.	**Advise**	Following a spike in July 2024 the number of moderate physical harms has reduced for the last two months. This may be indicative of staff becoming more comfortable with the new harm categories, as we also saw an increase in low physical harms in the same months. Ongoing monitoring will continue. Indication of a sharp increase in Severe physical harm. These equate to an increase of 3 from the previous month, this correlates with an increase in the number of Slips/Trips/Falls incidents recorded as Severe physical harm, due to fractured hips/neck of femurs. These have occurred in 3 separate areas and are currently under investigation. Ongoing monitoring will continue.
1c.	**Assure**	Position for overdue Trust wide Policies and SOPs has now recovered. There are currently no Trust wide SOPs over their review date, and only 20 out of 294 policies are currently overdue their review date. The Incidents and Policy team has worked closely with the authors and relevant departments, and taken a proactive approach to address their backlogs. Continue to work with departments and authors to proactively prevent documents from going overdue. Reduce the reminder for review date in 6 months to 3 months.

1. Incident Reporting

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



Graph 1: Incidents reported over last 12 months.

1.2 Psychological harm has now been included on the above charts, however there is only a few months data, so we cannot yet map this against an accurate average.

1.3 Following a spike in July 2024 the number of moderate physical harms has reduced for the last two months, this may be indicative of staff becoming more comfortable with the new harm categories, as we also saw an increase in low physical harms in the same months.

1.4 The charts in appendix A indicate a sharp increase in Severe physical harm, these equate to an increase of 3 from the previous month, this correlates with an increase in the number of Slips/Trips/Falls incidents recorded as Severe physical harm, due to fractured hips/neck of femurs. These have occurred in 3 separate areas and are currently under investigation.

2. Duty of Candour

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

3. Safety Incident Responses (IR2s)

3.1 In line with the New Patient Safety Incident Response Framework all incidents not being investigated as a Patient Safety Response, or a Patient Safety Incident Investigation the Trust has set a target that these should be reviewed and actioned within 30 days of reporting. A KPI of 90% has been set and appendix B provides an overview by division.

3.2 There has been a decrease in August 2024 in IR2 completion in most Divisions and overall, as a Trust. There has also been increase in the number of IR2s open more than 30 calendar days in most divisions. All divisions have stated this is due to pressures within the system and annual leave.

4. Patient Safety Responses (PSR)

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

4.2 There has been an overall decrease in the number of open PSRs and the number of those that have been open more than 90 calendar days. Family Care Division have booked extra Divisional Patient Safety Incidents Review Group meetings to support the review and closure of outstanding PSRs.

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

5.1 In August 2024 and September 2024, the Complex Case meeting reviewed 9 new incidents of which all 7 met the PSIRF Priorities for reporting and require a PSII, these have been allocated to lead investigators within the Patient Safety Team. All PSII reports and safety improvement plans are presented at the Patient Safety Incidents Requiring Investigation (PSIRI) Panel for Trust approval and signoff.

5.2 A KPI dashboard of PSIIs is provided is appendix D. At the end of September 2024, the Trust had 27 open PSII incidents of which 5 were being investigated by MNSI.

5.3 At the end of September 2024 there were 3 PSIIs which had been open longer than 6 months and 2 MNSI reports.

5.3.1 2 x MNSI reports were overdue which are outside of the control of trust.

5.3.2 At the time of writing the 3 PSIIs were overdue all had been drafted and awaiting sign off:

5.3.2.1 1 had been completed and awaiting PSIRI approval

5.3.2.2 1 draft report completed, delayed due to staff sickness (interviewees)

5.3.2.3 1 local priority investigation delayed due to lead investigator having to prioritise inquest cases which must be completed within 4 months. The report has been drafted and is awaiting Divisional approval.

5.4 In August 2024 and September 2024, 3 PSII reports have been approved by PSIRI with learning and closed.

6 PSIRI Panel Approval and Learning from Reports

6.2 During August and September 2024 6 new reports were reviewed, of these there were 4 new PSII reports.

6.2.1 Incident resulting in death (eIR1269904) – The report was approved with some minor amendments required. The areas identified for improvement were:

- The Trusts IT department to review the electronic intravenous cannula care plan to ensure useability in recording.

6.2.2 Incident resulting in death (eIR1279062) – The report was approved with some minor amendments required and to return to the next panel with the improvement plan. The areas identified for improvement identified were:

- Review of processes to consider implementing a radiology protocol for staff to follow should there be any vetting issues both in and out of hours.
- Some actions that had already been put in place by the relevant divisions were also identified in the report.

6.2.3 Incident resulting in death (eIR1282368) – The report was approved with the addition of a safety recommendation required. The areas identified for improvements were:

- Community Podiatry team to review the referral, triage and booking process to ensure full, accurate and relevant podiatric and medical assessment criteria is considered when informing prioritisation of community podiatry care and treatment.
- Community Podiatry team to complete audit of their referral, triage and booking process to provide assurance that the process is

workable and embedded into practice. Evidence of assurance must be reported to the relevant monitoring committees within the Trust.

- Emergency Department to identify all relevant substantive staff which require access to the ambulance service patient reports and liaise with Data and Digital to ensure access is granted.
- Review the SBAR handover process with the Emergency Department.
- Emergency Department to provide education to nursing and medical staff in the diabetic management of patients.
- Review the messaging, media and visibility of the Emergency Department 'Tell Me Today' campaign.

6.2.4 Perinatal Mortality Review (eIR1284568) – The report was approved, with the amendment of some typographical errors and the action plan to be strengthened. The areas identified for improvement were:

- Community Midwifery leaders to review the referral pathway with the Enhanced Midwifery Care Team.
- Pathway of care for women with previous feta loss to be reviewed.

7 Patient Safety Specialist (PSS) Annual Report

7.1 The first Patient Safety Specialist Annual update report was presented at Trust Wide Quality Governance Part B meeting on Tuesday 15th October 2024 and being presented to Quality Committee on 30th October 2024, the report provided an overview of:

- The role of the Patient Safety Specialist (PSS)
- The board and leadership responsibilities in relation to the PSS
- National requirement for PSS to be trained in Patient Safety Level 3 & 4
- Highlighted key aspects of the role that require further review/improvement which include:
  - Capacity of PSS (National requirement that role is full time) – currently only one named PSS for the Trust, which has been incorporated into their current full-time role.
  - Board and Leadership Responsibilities – at present time the PSS does have immediate and direct access to an executive lead for patient

safety, but do not meet on a regular basis to discuss the National Patient Safety Strategy

- Current PSS has limited capacity to oversee and report on the Patient Safety National Improvement Programmes

7.2 Three recommendations were made within the report and approved by Trust Wide Quality Governance:

1. Trust to review the current capacity and cover for the PSS post in line with NHS standard contract to gain insight into what options the trust can take to ensure they met the needs of the National Patient Safety strategy.
2. To consider setting up regular monthly meetings with Executive Lead for Patient Safety
3. Provide a National Patient Safety Strategy Local Priorities bi-monthly report to the appropriate boards and groups.

8 Mandatory National Patient Safety Syllabus Training Modules

8.1 At the end of September 2024, the Trust has achieved 94.30% Level 1a, 85.10% Level 1b and 91.10% Level 2 for National Patient Safety Training since making it mandatory for all staff to complete within the Trust.

8.2 Both Level 1a and Level 2 have achieved over 90% of all staff who have competed the Training. At the present time this is not mandated training by NHS England but is expected for Trust to encourage staff to complete to ensure and health and care services are as safe as possible for patients and service users.

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

Patient Safety Training Modules	KPI Target	% of staff completed training
Patient Safety Level 1a – all staff	95%	94.30%
Patient Safety Level 1b – Boards and senior leadership	95%	85.10%
Patient Safety Level 2 – Essential to role	95%	91.10%

9 Patient Safety Training for PSRs

9.1 A review has taken place of the requirements for Patient Safety training for staff within divisions who complete PSR investigations in line with national standards and the Trusts Investigation of Incidents Policy C012 has been updated.

9.1.1 National Patient Safety Syllabus Level 1a and 2 – available now on the learning hub.

9.1.2 Introduction to Human Factors Training Part 1 and 2 – available now on the Learning Hub.

9.1.3 PSR Investigation Training - Monthly training dates are now available to book on the Trusts Learning Hub with the first session booked for January 2025

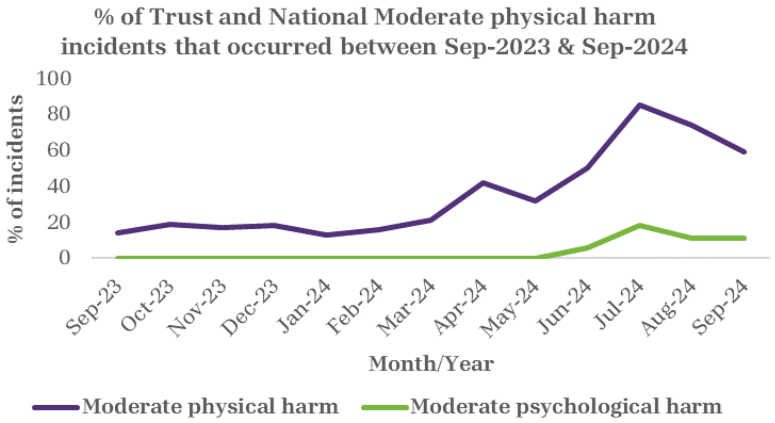
9.2 Divisions have been instructed that any staff who will complete PSRs will be required to complete all training by the end of 2025.

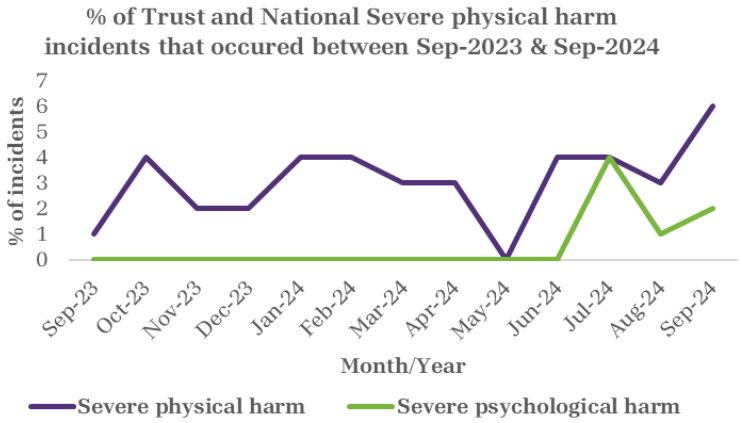
10 Maternity specific serious incident reporting in line with Ockenden recommendations

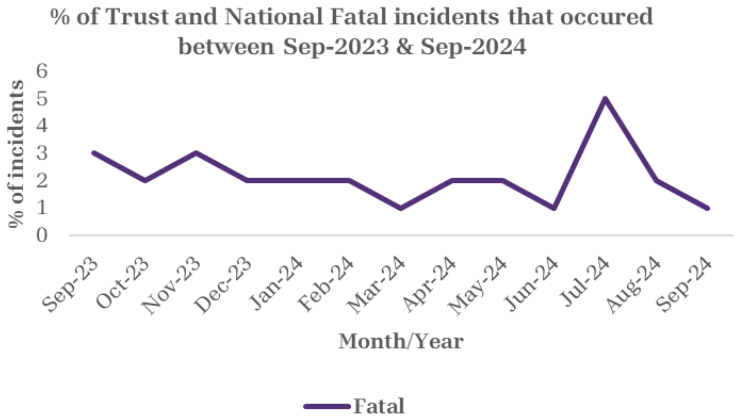
10.1 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS and the status of the open investigations. Since March 2020 69 maternity related incidents have been reported on StEIS of which:

- 41 have been approved and closed
- 15 have been agreed for de-escalation from StEIS
- 2 have had closure on StEIS requested are currently being investigated by MNSI
- 7 are currently being investigated by MNSI
- 1 was reviewed by PSIRI and not approved for closure the panel is awaiting re-submission
- 1 is currently awaiting amendments to be made following review at PSIRI
- 1 is currently under investigation and is due for review by PSIRI on 16th October 2024
- 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%	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Trend
CIC	Total IR2 reported	331	306	362	314	410	378	341	315	360	344	471	375	
	(total number investigated) % complete within 30 calendar days	(300) 90.63%	(283) 92.48%	(313) 86.46%	(247) 78.66%	(354) 86.34%	(333) 88.10%	(300) 87.98%	(281) 89.21%	(323) 89.72%	(289) 84.01%	(424) 90.02%	(316) 84.27%	↓
DCS	Total IR2 reported	139	174	143	148	138	129	110	112	136	103	149	125	
	(total number investigated) % complete within 30 calendar days	(75) 53.96%	(99) 56.90%	(90) 62.94%	(104) 70.27%	(101) 73.19%	(90) 69.77%	(85) 77.27%	(93) 83.04%	(91) 66.91%	(75) 72.82%	(103) 69.13%	(77) 61.60%	↓
FC	Total IR2 reported	252	348	307	245	237	221	284	283	314	239	272	232	
	(total number investigated) % complete within 30 calendar days	(171) 67.86%	(259) 74.43%	(173) 56.35%	(193) 78.78%	(177) 74.68%	(185) 83.71%	(222) 78.17%	(228) 80.57%	(240) 76.43%	(189) 79.08%	(198) 72.79%	(169) 72.84%	→
MEC	Total IR2 reported	877	926	880	947	947	915	992	903	899	873	936	849	
	(total number investigated) % complete within 30 calendar days	(601) 68.53%	(732) 79.05%	(772) 87.73%	(793) 83.74%	(823) 86.91%	(762) 83.28%	(863) 87.00%	(762) 84.39%	(752) 83.65%	(742) 84.99%	(804) 85.90%	(694) 81.74%	↓
SAS	Total IR2 reported	391	542	425	346	415	397	434	344	426	371	393	346	
	(total number investigated) % complete within 30 calendar days	(264) 67.52%	(366) 67.53%	(332) 78.12%	(270) 78.03%	(304) 73.25%	(335) 84.38%	(291) 67.05%	(276) 80.23%	(362) 84.98%	(291) 78.44%	(315) 80.15%	(304) 87.86%	↑
Corp	Total IR2 reported	78	79	78	69	82	89	83	87	97	85	82	52	
	(total number investigated) % complete within 30 calendar days	(55) 44.87%	(44) 55.70%	(39) 50.00%	(14) 20.29%	(40) 48.78%	(44) 49.44%	(37) 44.58%	(47) 54.02%	(63) 64.95%	(33) 38.82%	(45) 54.88%	(24) 46.15%	↓
Trust Total	Total IR2 reported	2068	2375	2195	2069	2229	2129	2244	2044	2232	2015	2303	1979	
	(total number investigated) % complete within 30 calendar days	(1466) 70.8%	(1783) 75.0%	(1719) 78.3%	(1621) 78.3%	(1799) 80.71%	(1749) 82.15%	(1798) 80.12%	(1687) 82.53%	(1831) 64.95%	(1619) 80.35%	(1889) 82.02%	(1584) 80.04%	↓

Total number of IR2s open on DATIX over 30 calendar days old						
Division	CIC	DCS	FC	MEC	SAS	Corp
No. open	55	94	47	175	89	309

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

Appendix C: KPI Dashboards for PSRs

Division	Number of PSRs open	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Trend >90
CIC	No. open	47	51	73	47	29	39	55	40	44	61	56	51	↓
	No. open more than 90 calendar days	7	2	2	7	5	7	5	5	9	8	2	1	
DCS	No. open	17	19	19	19	21	7	9	8	9	22	14	24	↓
	No. open more than 90 calendar days	9	4	2	3	5	2	1	0	1	2	1	2	
FC	No. open	36	43	43	40	47	40	53	54	51	55	54	37	↓
	No. open more than 90 calendar days	11	13	12	12	16	9	11	17	14	11	14	7	
MEC	No. open	168	141	105	107	125	94	124	115	88	102	96	93	↑
	No. open more than 90 calendar days	45	28	12	19	15	16	18	24	25	28	27	32	
SAS	No. open	55	57	71	76	60	56	51	50	31	47	34	37	↓
	No. open more than 90 calendar days	13	11	21	19	15	16	13	17	17	16	12	10	
Trust	No. open							292	277	223	287	254	242	↓
	No. open more than 90 calendar days							48	66	66	65	56	52	

Appendix D: KPI Dashboards for PSIIs

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

TRUST BOARD REPORT **Item** **155**

20 November 2024 **Purpose** Approval
Assurance
Information

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

Summary: The purpose of this report is to provide:
1. An overview of the safety and quality programmes of work within the maternity and neonatal services resulting from the National Perinatal Safety Ambitions, specific to the ten CNST (Clinical Negligence Scheme for Trusts) maternity safety actions included in year six of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. (Appendix 1 - CNST Year 6 criteria)

2. Updates regarding ELHT (East Lancashire Hospitals Trust) maternity services response to the NHS England/Improvement (NHS E/I) – Ockenden recommendations and maternity/ Neonatal Three-year delivery plan.

3. Safety intelligence within maternity or neonatology care pathways and programmes that pose any potential risk in the delivery of safe care to be escalated to the trust board.

4. Continuous Quality and Service improvements, progress (Bimonthly report presented at trust wide quality committee) with celebrations noted.

Recommendation: The Board of Directors are asked to.

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

Report linkages

Related Trust Goal

Deliver safe, high-quality care

Compassionate and inclusive culture

Improve health and tackle inequalities in our community

Healthy, diverse, and highly motivated people

Drive sustainability

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

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

Impact

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

Previously considered by:

1. INTRODUCTION

The purpose of this report is to provide:

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

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

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

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

2. CNST - MATERNITY INCENTIVE SCHEME

2.1 Summary overview

Blue indicates complete

Green indicates progressing without concern

Orange indicates barriers/ risk to compliance identified

Red indicates non-compliance identified

Safety Action	Progress	Assurance/Exceptions
1. Perinatal Mortality Review Tool (PMRT)		● **Non-compliance risk** - 2 reviews have not met the 2-month deadline for answering all technical guidance/ Factual Questions (FQs). This places current compliance at 93.6%. Overall Target for the reporting period is 95%. Steps taken to mitigate this risk are detailed in the report below. ● Q2 PMRT report covering Jul-Sep cases has been included in the report below (**Appendix 2**).
2. Maternity Services Data Set (MSDS)		● The July 2024 scorecard shows all metrics as 'Pass'. July is the month reviewed for compliance of this safety action. The action is therefore complete and has been signed off at the Local Maternity and Neonatal System (LMNS). See dashboard below.
3. Transitional Care (TC)		● The quarter 2 Transitional Care (TC) audit has been completed and is included in the below report (**Appendix 3**) ● A temperature management quality improvement (QI) has been registered with the central improvement team and an update on this will be provided at Floor to Board on the 27th of November 2024.
4. Clinical Workforce		● Audit for employing short- and long-term locums has been completed showing compliance with CNST requirements. **(Appendix 4).** ● Q2 July-Sep consultant attendance audit assurance is included in the below report (**Appendix 5**).
5. Midwifery Workforce		● Midwifery Safe staffing August-December 2024 report to be submitted to 15th January Trust Board. ● **Identified risk** - Current funded midwifery establishment does not reflect Birthrate + findings and recommendations. Steps taken to mitigate this risk are detailed in the report below.
6. Saving Babies Lives v3 Care Bundle (SBLv3)		● ELHT are currently at 92% overall implementation following the LMNS assurance visit on 6th of November 2024. ● Further progress and sustainability of current implementation plan with associated actions continues with close oversight from Obstetrics Clinical Director/Perinatal Quadrumvirate.
7.User Feedback		●**Identified risk** – Following a demand and capacity review of the Maternity and Neonatal Voices Partnership (MNVP) Lead role in partnership with Healthwatch, an Engagement

		Lead has been appointed to support the MNVP tasks within Safety Action 7. ● The Maternity Transformation Team have met with the Engagement Lead and MNVP Lead to plan the schedule of works to meet and deliver the asks of SA7, this will mitigate the identified risks.
8. Training		● **Identified Risk** – multi-disciplinary emergency training (PROMPT) 90% attendance required as per the CNST ask. Anaesthetists' compliance has dropped to 67% in October. The maternity training team are closely monitoring this, and all non-compliant anaesthetists are booked onto the upcoming sessions in November 2024. ● Obstetric compliance has increased to 91% in October 2024.
9. Board Assurance		● This safety action has been signed off as complete at the LMNS assurance visit on the 6th of November 2024. ● Floor to Board bi-monthly meetings with Board-level, maternity, and neonatal safety champions in place. (**Appendix 6**). ● Perinatal Quality & Surveillance Model (PQSM) September 2024 data set submitted. ● Two bespoke meetings, chaired by the Executive Maternity Safety Champion and attended by the Non-Executive Safety Champion, took place between May-September 2024 for triangulation of claims, incidents and complaints. The report produced is attached below (**Appendix 7**).
10. MNSI (Maternity and Newborn Safety Investigation) / NHS Resolution		● Assurance from governance leads that all requirements for Maternity and Newborn Safety Investigation (MNSI) reporting are met. Quarterly report included below (**Appendix 9**).

2.2 Key updates and exceptions per Safety Action

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

Table 1 Perinatal Mortality Review Tool – Dashboard of PMRT Cases

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

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

CNST - PMRT
(All measures reported against month of death)

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

		Reporting Measure	Thresh	Sep-	Oct-	Nov-	Dec-	Jan-	Feb-	Mar-	Apr-	May-	Jun-	Jul-	Aug-	Monthly Trend
SAFETY ACTION 1	PMRT01a	Total Number of Stillbirths (= 24 weeks)		1	1	2	1	1	1	1	2	3	0	1	1	
	PMRT01b	Number of Neonatal Deaths		0	0	3	1	0	1	1	3	3	3	3	0	
	PMRT01c	Number of late fetal loss between 22+0 and 23+6 weeks		1	0	0	0	0	1	0	0	0	0	1	0	
		Total Eligible Cases		2	1	5	2	1	3	2	5	6	3	5	1	
	PMRT02a	a) i Number of cases reported to MBRRACE within 7 days		2	1	5	2	1	3	2	5	6	3	5	1	
			100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	PMRT06a	c) i Number PMRT tool started 2 months		2	1	5	2	1	3	2	5	5	2	2	0	
			95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	66.7%	*	*	
	PMRT05a	c) ii Number PMRT published reports by 6 months		2	1	4	2	1	2	2	3	1	0	0	0	
			60%	100.0%	100.0%	80.0%	100.0%	100.0%	66.7%	100.0%	60.0%	16.7%	*	*	*	
	PMRT05b	Number PMRT published reports not due		0	0	0	0	0	0	0	2	5	3	5	1	

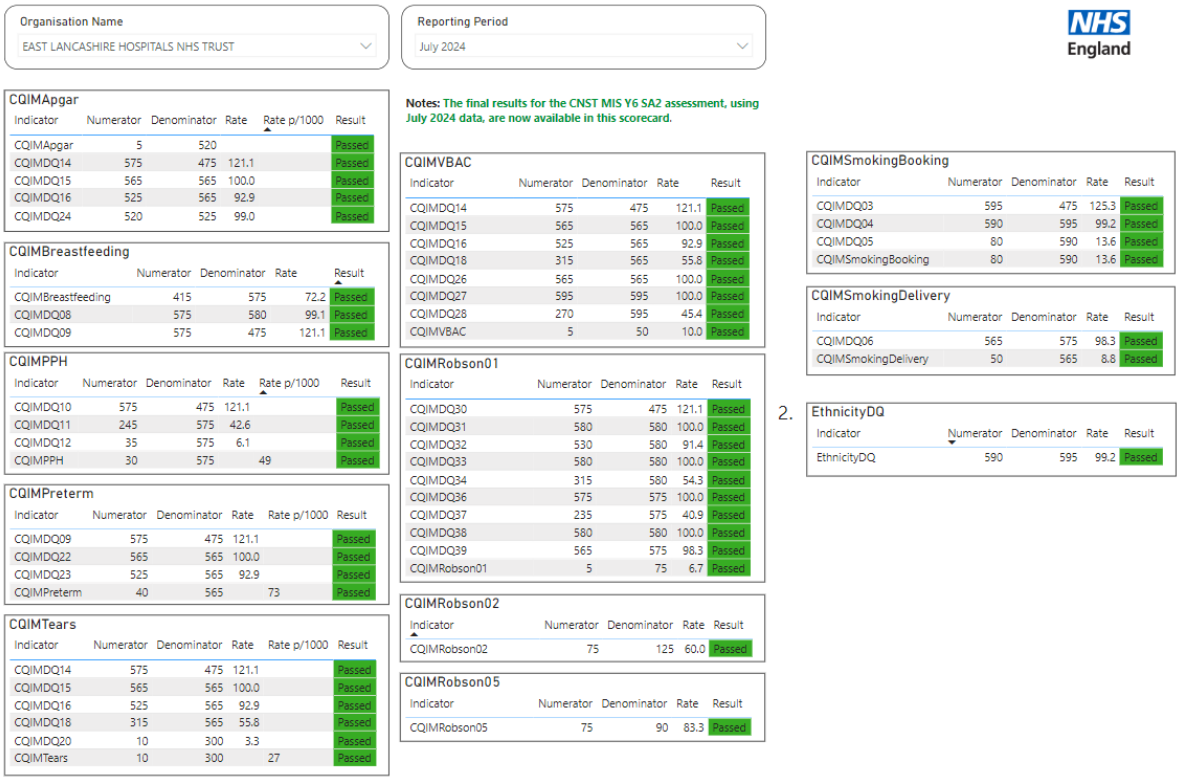
As demonstrated via the above Perinatal Mortality Review Tool (PMRT) dashboard, the required time limits for reporting to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) within 7 days (a) and PMRT published reports by 6 months (cii) have been met to the required compliance thresholds within the reporting period. For two of the cases eligible for PMRT review, the review was started within the required 2-month timeframe (ci), however it was identified that some Factual Questions (FQs) were unanswered, putting the measure at 93.6% overall compliance. The target threshold as per CNST guidelines is 95%.

A deep dive into both cases was completed by the PMRT lead consultant, however there is no audit trail to review which FQs were not answered. As such, helpful guidance from MIS was sought. ELHT have been advised by MIS to submit a mitigation request to be reviewed by MBRRACE-UK as the external validation organisation and verify the process of confirmation with FQs in both cases.

Further, in immediate response to this, the maternity safety champions have reviewed failsafe processes, to ensure that all criteria are met for PMRT reviews. A weekly report is submitted to the Maternity Safety Champions and the Maternity Transformation Team for assurance with all aspects of governance aligned with CNST requirements. A weekly meeting is also in place every Thursday for any discussions with summaries to support.

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

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: July 2024

NHS England

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

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	520			Passed
CQIMDQ14	575	475	121.1		Passed
CQIMDQ15	565	565	100.0		Passed
CQIMDQ16	525	565	92.9		Passed
CQIMDQ24	520	525	99.0		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	415	575	72.2	Passed
CQIMDQ08	575	580	99.1	Passed
CQIMDQ09	575	475	121.1	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	575	475	121.1		Passed
CQIMDQ11	245	575	42.6		Passed
CQIMDQ12	35	575	6.1		Passed
CQIMPPH	30	575		49	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	575	475	121.1		Passed
CQIMDQ22	565	565	100.0		Passed
CQIMDQ23	525	565	92.9		Passed
CQIMPreterm	40	565		73	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	575	475	121.1		Passed
CQIMDQ15	565	565	100.0		Passed
CQIMDQ16	525	565	92.9		Passed
CQIMDQ18	315	565	55.8		Passed
CQIMDQ20	10	300	3.3		Passed
CQIMTears	10	300		27	Passed

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	575	475	121.1	Passed
CQIMDQ15	565	565	100.0	Passed
CQIMDQ16	525	565	92.9	Passed
CQIMDQ18	315	565	55.8	Passed
CQIMDQ26	565	565	100.0	Passed
CQIMDQ27	595	595	100.0	Passed
CQIMDQ28	270	595	45.4	Passed
CQIMVBAC	5	50	10.0	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	575	475	121.1	Passed
CQIMDQ31	580	580	100.0	Passed
CQIMDQ32	530	580	91.4	Passed
CQIMDQ33	580	580	100.0	Passed
CQIMDQ34	315	580	54.3	Passed
CQIMDQ36	575	575	100.0	Passed
CQIMDQ37	235	575	40.9	Passed
CQIMDQ38	580	580	100.0	Passed
CQIMDQ39	565	575	98.3	Passed
CQIMRobson01	5	75	6.7	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	75	125	60.0	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	75	90	83.3	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	595	475	125.3	Passed
CQIMDQ04	590	595	99.2	Passed
CQIMDQ05	80	590	13.6	Passed
CQIMSmokingBooking	80	590	13.6	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	565	575	98.3	Passed
CQIMSmokingDelivery	50	565	8.8	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	590	595	99.2	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. As evidenced above, all metrics have been passed for July, meaning that Safety Action 2 is now complete.

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 quarter 2 TC audit has been completed and is attached to this report (**Appendix 3**). The audit found no evidence that babies were admitted to Special Care Baby Unit (SCBU) with the mother an inpatient on postnatal ward where they could have been managed in TC. However, in a small number of cases transfer to postnatal ward would have been possible sooner if Nasogastric Tube (NGT) feeding support could have been offered in TC. Due to high TC activity and pressure on postnatal ward beds however, this was not possible.

As per the CNST requirement, a temperature management quality improvement (QI) has been registered centrally. This QI is focussing on a trial of specific incubators to reduce incidents of hypothermia in winter months whilst keeping baby and mother together.
The QI lead has put in a Small Business Research Initiative (SBRI) grant bid and is currently awaiting outcomes. An update on progress with this QI was provided at the LMNS Quality Assurance Panel on the 17th of September 2024, and a further update will be provided to the Safety Champions at the Floor to Board meeting 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?

An audit for employing short and long-term locums has been completed in addition to a checklist for long term locums, evidencing compliance with the relevant CNST requirements. These have been attached as an appendix to this report (**Appendix 4**)

The Royal College of Obstetricians and Gynaecologists (RCOG) requires that compensatory rest is incorporated into consultant job plans in accordance with the British Medical Association (BMA) and local Trust guidance. CNST requirements for safety action 4 therefore mandates that a plan must be in place to implement compensatory rest into the department. An options appraisal was carried out and brought to Trust Board for discussion in 2023, and the current position was set out in the Obstetrics and Gynaecology medical staffing paper which was presented to the Trust Professional Judgement review panel for medical staffing in July 2024 and is currently awaiting outcomes.

The Q2 July to September consultant attendance audit has been completed and is included for submission (**Appendix 5**). This will be presented at Perinatal Governance Board on the 22nd of November 2024.

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

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

The bi-annual midwifery staffing report for the period of January to July 2024 was presented at September Trust Board as per the CNST requirement. The current risk identified remains as the funded midwifery staffing budget, currently not reflecting birth rate plus requirements. A business case for the deficit in funding has been completed and presented through the relevant ELHT business case process. Outcome to be confirmed.

A round table midwifery staffing exercise has been completed in October 2024 with LMNS/Integrated Care Board (ICS) colleagues to review the Birthrate+ recommendations together with the application of professional judgment and the deliverables set out in the national report recommendations to fulfil. The findings from the round table exercise will be presented to Trust Board within the year 6 reporting period.

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

The Birthrate+ Acuity App continues to be used to monitor supernumerary status and provision of one-to-one care in active labour on Central Birth Suite (CBS) as per the CNST requirement. Close surveillance of Midwifery red flags is standard practice triangulating with the birth rate plus acuity app.

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

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

A quarterly review (July-September) of the 6 elements of Saving Babies' Lives (SBL) was conducted on the 6th of November 2024. Compliance has increased to 63/70 interventions implemented overall, which equates to 92%. This is an increase from 84% at the previous LMNS assurance visit in September. A breakdown of elements is provided below.

SBL Element	Current Implementation (as assured by LMNS)
Element 1 - Reducing Smoking in Pregnancy	7/10 interventions implemented and evidenced **(70%)**
Element 2 - Fetal Growth Restriction	19/20 interventions implemented and evidenced **(95%)**
Element 3 - Reduced Fetal Movement	2/2 interventions implemented and evidenced **(100%)** [1 intervention contains 4 asks]
Element 4 - Effective fetal monitoring during labour	5/5 interventions implemented and evidenced **(100%)**
Element 5 - Reducing preterm births and optimising perinatal care	24/27 interventions implemented and evidenced **(89%)**
Element 6 - Management of Diabetes in Pregnancy	6/6 interventions implemented and evidenced **(100%)**

Meetings with the LMNS have been diarised throughout the CNST Y6 reporting period as below, this provides the forum to meet the ask '*continued quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to*

demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle.' Two of these meetings have now taken place, with the final assurance meeting to take place in January.

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

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

ELHT collaborated with the Maternity and Neonatal Voices Partnership (MNVP) lead to determine key themes from the Care Quality Commission (CQC) survey. Themes identified were: 'feeling left alone during early labour', 'gaining the help you need during labour', and 'postnatal care'. The MNVP lead attended a session at Brierfield Baby Club to gather service user feedback around these themes, several ELHT midwives circulated feedback cards to collate additional opportunistic feedback. Feedback was triangulated and discussed with the MNVP lead and at the Maternity/ Neonatal Patient Experience and Lessons Learned Group to further the ongoing work.

It was highlighted that a 15 steps exercise led by the MNVP lead would support to further understand issues raised. The MNVP lead with MNVP champions visited the Neonatal Intensive Care Unit (NICU) on the 7th of October 2024. A visit to Antenatal Ward, Postnatal Ward and Transitional Care on the 16th of October 2024 to complete 15 steps exercises alongside the Maternity Transformation Team. A report of the findings alongside any recommendations and improvement ideas will be provided by the MNVP lead.

The MNVP lead also attended the NICU coffee morning on the 7th of October 2024 with the service user lead for the Operational Delivery Network (ODN) to engage with neonatal families. Feedback will be provided to the Maternity Transformation Team following this session.

The MNVP Engagement Lead has now been appointed. The Maternity Transformation Team met with the MNVP Lead and Engagement Lead on Monday the 4th of November to review work schedules to ensure alignment with the CNST Safety Action 7 requirements, specifically

around engagement with those at risk of experiencing the 'worst outcomes' as per the LMNS Equity and Equality guidance. A further induction meeting is also due to be scheduled between the MNVP Engagement Lead, the Director of Midwifery and Nursing for Family Care, and the Transformation Team.

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

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

- ***Fetal monitoring and surveillance (in the antenatal and intrapartum period) training*** – 90% attendance for midwives, obstetric consultants and all other obstetric doctors who contribute to the obstetric rota. October 2024 dashboard shows 99% compliance for all relevant groups.
- ***Maternity emergencies and multi-professional training (PROMPT)***
  - 90% attendance for obstetric consultants and doctors, midwives, maternity support workers, and anaesthetic consultants. October 2024 dashboard shows an average of 95% attendance across all required groups.
  - Anaesthetic compliance has dropped below the required 90% from May to October. The October dashboard shows compliance at 67%. This is being monitored by the Maternity Training Team who are actively contacting these colleagues to arrange their training dates. Staff are booked onto sessions throughout November, meaning compliance is on track to recover.
  - Obstetrician compliance has increased to 91% in October. Non-compliant staff are also booked onto upcoming sessions.
  - An update was provided by the Maternity Incentive Scheme in July 2024 removing the requirement for 70% attendance for non-obstetric anaesthetists on the on-call rota. This will therefore no longer be monitored as part of the CNST requirements.
- ***Neonatal basic life support*** –

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

All relevant staff groups are currently meeting the 90% compliance threshold.

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

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

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

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

Perinatal Quality Surveillance Dataset

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

	Metric	Standard	May 24	June 24	July 24	August 24
Perinatal Data	1:1 care in labour	100%	100%	100%	100%	100%
	Stillbirth rate	<4.4/1000	9.42	2.10	0	3.68
	Term admissions to NICU	<7%	4.21%	4.61%	4.46%	3.96%
	Obstetric haemorrhage >1.5 litre (within 24hrs)	<10%	3.05%	3.19%	5.55%	4.47%
	3rd/4th degree perineal tear	<5%	4.81%	3.40%	2.96%	3.74%

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

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

Stillbirth rate:
There have been 2 stillbirths this month; both of these were antepartum stillbirths.

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

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

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

	Metric	Standard	May24	June24	July 24	August 24
Feedback	Service user feedback (MNVP)		2 sessions attended	0 sessions attended	0 sessions attended	0 sessions attended
	FFT satisfaction rated as good	>90%	78.03%	85.48	90%	87.8%
	Number of level 4 complaints	-	0	3	1	0
	Executive safety walkaround	Bi-Monthly	1	2	0	1
	Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly	1	1	2	1

	Metric	May 24	June 24	July 24	August 24
External Reporting	Maternity incidents graded moderate or above	6	6	3	1
	Cases referred to MNSI	2	0	0	0
	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	0	0	0	0
CNST	Metric	May 24	June 24	July 24	August 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%

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MNVP Service User Feedback:
A schedule of engagement sessions has been implemented which highlights key sessions for the MNVP to attend and hear the voices of priority service user (BAME, high deprivation, neonatal families). MNVP lead has attended sessions and is providing feedback with support from the Maternity Transformation Team to collate and inform improvements. A meeting was held in June with attendance from Mat/Neo services and MNVP.

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

Level 4 Complaints
There were no level 4 complaints in August.

Executive Safety Walkarounds:
An executive and non-executive walkaround took place on Postnatal Ward/Transitional Care – feedback requested from this walkround.

Moderate or above incidents:
There has been 1 reported incident: a women who had massive PPH and required hysterectomy. All care given in line with guidance.

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

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

CNST:
The quarter 1 visit took place on the 11th September 2024 and assurance we are working towards all ten safety actions. Risks around SA1 were highlighted to the LMNS.

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

A task and finish group has been set up and several meetings arranged between July and September 2024, with the Maternity and Neonatal safety champions, the Maternity Transformation Team, the Quality and Safety Team and the trust Datix manager to review the updated 2024 claims scorecard alongside the incidents and complaints data from the last

6 months (**Appendix 7**). All maternity safety champions were involved in the improvement piece with the meetings chaired by the Executive Maternity Safety Champion (Chief Nurse) and Non-Executive Safety Champion.

This exercise supported the team to further inform persistent trends reflected within complaints, incidents, and claims. Numerous demonstrable improvements are in place as a response to themes. One example is the recurrent funding for a Fetal Monitoring Specialist Midwife and consultant obstetrician with the introduction of a fetal monitoring study day (full day) for all multi-disciplinary team (MDT) members, this has been in place for two years. Fetal monitoring training for the MDT is currently at 99% compliance. Fetal monitoring specialists review all Patient safety reviews (PSRs) aligned with immediate and essential action two/Ockenden requirements. This is demonstrated in a themed action plan.

A further key focus for improvements is strengthening the education aligned with the continued implementation of the Saving Babies' Lives care bundles. In addition, as part of the triangulation exercise going forwards, safety champions have requested that the data used is further broken down by ethnicity, to gain a better understanding of how service users from ethnic minorities are impacted by the themes identified.

An ELHT dashboard is in the process of being developed by the trust Datix manager to evidence the triangulation of complaints, incidents and claims going forwards. This will facilitate ongoing triangulation of data and embed this as standard practice for the Quality and Safety Team. Trends can therefore be identified on a continuous basis, improving our responsiveness. The overall aim is to work on the data to enable the triangulation piece to include ethnicity and deprivation, yet this is very much in the infancy period.

'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 (**Appendix 8**) as informed by the results of the Safety, Communication, Operational, Reliability and Engagement (SCORE) culture survey is monitored and lead by the Maternity and Neonatal Quadrumvirate, who meet monthly with a direct focus on safety and culture listed within the agenda.

The Perinatal Quadrumvirate is working with the Maternity Transformation Team to explore options for disseminating the results and themes of the survey. In addition to the infographic shared previously, a podcast will be produced to support with this dissemination, led by the Quadrumvirate and area leads. Communications with comms team taken place, date to be confirmed.

Following on from previous updates, ELHT maternity and neonatal services were offered the opportunity to train Culture Coaches to hold regular culture conversations and support the delivery of local culture improvements. The Culture Coaches have now completed this training from the NHS England Perinatal Culture and Leadership Team. They have met with the Quadrumvirate to provide feedback on this training and have been given access to the SCORE survey results to guide their culture conversations with staff. The next steps will be for the culture coaches to begin holding the cultural conversations with feedback within both Maternity and Neonatology services.

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 document submitted (**Appendix 9**).

3. CONCLUSION

On behalf of ELHT maternity and neonatology services this bimonthly assurance report to ELHT trust board will continue to inform progress of the ten CNST maternity safety actions

throughout the year 6 reporting period. Final LMNS quality assurance meeting is the 8th of January 2025, trust board report for year 15th January 2025.

Board declaration to be completed with Trust CEO and AO of clinical commissioning group/integrated care systems sign off. This is due to be submitted by the 17th of February 2025.

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

Perinatal Quadrumvirate:
Tracy Thompson, Divisional Director of Midwifery and Nursing
Martin Maher, Clinical Director of Obstetrics
Savi Sivashankar, Clinical Director of Neonatology
Charlotte Aspden, Directorate Manager of Maternity and Neonatology
November 2024

Appendix 1 – CNST-MIS Y6 Guidance

Appendix 2 – Quarterly PMRT Report

Appendix 3 – Q2 TC Audit

Appendix 4 – Short- and Long-Term Locum Audit

Appendix 5 – Q2 Consultant Attendance Audit

Appendix 6 – Floor to Board Minutes

Appendix 7 – SA9 Scorecard Triangulation

Appendix 8 – Culture Improvement Plan

Appendix 9 – MNSI Reporting Overview

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 156

20 November 2024

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 September 2024

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

Report linkages

Related Trust Goal

Deliver safe, high quality care

Secure COVID recovery and resilience

Compassionate and inclusive culture

Improve health and tackle inequalities in our community

Healthy, diverse and highly motivated people

Drive sustainability

Related to key risks identified on Board Assurance Framework

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

2 The Trust may be unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.

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

4 The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result its inability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.

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

(Item Number) Integrated Performance Report

	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/No

Board of Directors, Update

Corporate Report

Executive Overview Summary

Positive News

- Average fill rates for registered nurses/midwives and care staff remain above threshold.
- The 'Emergency Care 4 hour standard' (Pennine A&E Delivery Board) was above the 77% target in September at 78.94%.
- Performance against the ELHT four hour standard was 78.00% in September.
- No patients waited over 78 weeks and the number of RTT pathways over 65 weeks in September is 1 against the trajectory of 0.
- In September, the Referral to Treatment (RTT) number of total ongoing pathways has reduced on last month to 68,142.
- The Cancer 28 day faster diagnosis standard was above target in August at 78.4%.
- Performance against the cancer 31 day standard was above the 96% threshold in August at 97.5%.
- Performance against the cancer 62 day standard was above the 70% threshold in August at 71.2%.
- Friends & family scores remain above threshold for inpatients, outpatients, and community in September.
- The overall Trust performance from the range of patient experience surveys was above the threshold of 90% for 4 of the 4 competencies.
- There were no maternal deaths in September.
- The Trust turnover rate continues to show usual variation compared to pre-covid levels at 7.48% and remains below threshold.
- The Trust vacancy rate is below threshold at 4.7%.

Areas of Challenge

- There were 4 Steis reportable incident in September. There were no never events.
- There were 9 healthcare associated clostridium difficile infections identified in September.
- There were 11 post 2 day E.coli bacteraemia identified in September.
- There were 2 P.aeruginosa bacteraemia identified in September.
- There were 5 Klebsiellas detected in September.
- There are some issues impacting the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR). This includes: coding backlog, removal of SDEC data and data quality in the submission. As a result, neither metric is currently considered a robust measure of mortality.

- There were 3 stillbirths in September.
- There were 1146 breaches of the 12 hour trolley wait standard (54 mental health and 1092 physical health).
- There were a total of 3032 ambulance attends with 1104 ambulance handovers > 30 minutes and 514 > 60 minutes.
- Friends & family scores in A&E and maternity are below threshold.
- The 6wk diagnostic target was not met at 20.61% in September.
- In September, there were 3,049 breaches of the RTT >52 weeks standard, which is above the trajectory.
- In September, there were 6 breaches of on the day operations cancelled and not rebooked within 28 days.
- Sickness rates are above threshold at 6.30%
- Compliance against the Appraisal (AFC staff) remains below threshold.
- Temporary costs as % of total pay bill remains above threshold at 12%.
- The Trust is reporting a deficit of £6.8m for the 2024-25 financial year to date, £0.9m behind the revised breakeven plan.

No Change

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

Data Completeness

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

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

Metric	Data Source	Lead	Sep-24	Date available
C diff, e coli, p.aeruginosa, klebsiella		Infection Control - Laura Moores		
Mixed sex breaches		Corporate information		
Average fill rates		Corporate information		
Staffing narrative		Heather Coleman		
Nurse Staffing - Fill rate table		Heather Coleman		
Steis		Incidents team		
VTE		Corporate information		
Pressure ulcers		Jane Pemberton		
Friends & Family		Corporate information		
Number of complaints	Datix	Corporate information		
Complaints per 1000 contacts		Corporate information		
Patient experience		Quality - Sarah Ridehalgh/ Melissa Almond		
SHMI trend	National published SHMI	Performance team		Awaiting update following resubmission
HSMR	Dr Foster	Performance team		Awaiting update following resubmission
LeDeR		Julie Clift/ Alison Brown		
Structured judgement reviews (SJR)	Datix	Performance team		
Stillbirths	Maternity dashboard	Kathryn Sansby/ Carol Bell		
Maternal deaths	Maternity dashboard	Kathryn Sansby/ Carol Bell		
CQUIN	CQUIN Update	Andrew Costello		CQUINs paused nationally 2024/25
A&E ELHT performance	Submitted performance	Corporate information		
A&E national performance	NHS Statistics	Performance team		
12 hr trolley waits		Performance team		
Ambulance handovers	NWAS	Performance team		
Ambulance handovers ELHT breaches	NWAS	A&E - Adele Dibden/ Claire Ashcroft		
RTT ongoing, over 40, over 52 wks	Submitted performance	Corporate information		
RTT ongoing graphs	Submitted performance	Corporate information		
RTT admitted/non-admitted	Submitted performance	Corporate information		
RTT average wait and ongoing %	Submitted performance	Corporate information		
RTT national	NHS Statistics	Performance team		
ELHT cancer - ELHT	Submitted performance	Cancer services - Victoria Cole		
ELHT cancer - national position	NHS Statistics	Cancer services - Victoria Cole		
Delayed Discharges Chart		Andrea Isherwood/ Kathryn Heyworth		
Emergency readmissions		Corporate information		Metric in development
Diagnostics % waiting over 6 weeks		Corporate information		
Diagnostic national performance	NHS Statistics	Performance team		
Average lengths of stay		Corporate information		
Operations cancelled on the day		Corporate information		
Sickness, vacancy, turnover		HR - Mudassir Gire		
Overtime & Temporary costs		Finance - Ammaarah Yakub		
Appraisals		Learning hub team		
Appraisals AFC		Learning hub team		
Job plans		Salauddin Shikora		
Information governance		Learning hub team		
Core skills training		Learning hub team		
Finance/use of resource		Finance - Allen Graves		

Safe

	Indicator	Target	Actual	Variation	Assurance
M65	MRSA	0	0		
M64	Clostriduim difficile (C.diff) - 'Hospital onset healthcare associated (HOHA)'	n/a	6		
M64.3	Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)'	n/a	3		
M64.4	Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA)	n/a	57		
M124	E-Coli (HOHA)	n/a	6		
M124.ii	E-Coli (COHA)	n/a	5		
M124.iv	E-Coli cumulative from April (HOHA & COHA)	n/a	74		
M155	P. aeruginosa bacteraemia (HOHA)	n/a	1		
M155.ii	P. aeruginosa bacteraemia (COHA)	n/a	1		
M155.3	P.aeruginosa bacteraemia cumulative from April (HOHA& COHA)	n/a	7		
M157	Klebsiella species bacteraemia (HOHA)	n/a	3		
M157.ii	Klebsiella species bacteraemia (COHA)	n/a	2		
M157.3	Klebsiella species bacteraemia cumulative from April (HOHA& COHA)	n/a	25		
M66	Never Event Incidence	0	0		
M67	Medication errors causing serious harm (Steis reported date)	0	1		
M68	Maternal deaths	0	0		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)	No Threshold Set	18.9		
M69	Serious Incidents (Steis)	No Threshold Set	4		
M70	Central Alerting System (CAS) Alerts - non compliance	0	1		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	84%		

Caring

	Indicator	Target	Actual	Variation	Assurance
C38	Inpatient Friends and Family - % who would recommend	90%	95%		
C31	NHS England Inpatients response rate from Friends and Family Test	No Threshold Set	29%		
C40	Maternity Friends and Family - % who would recommend	90%	90%		
C42	A&E Friends and Family - % who would recommend	90%	71%		
C32	NHS England A&E response rate from Friends and Family Test	No Threshold Set	12%		
C44	Community Friends and Family - % who would recommend	90%	96%		
C38.5	Outpatient Friends and Family - % who would recommend	90%	94%		
C15	Complaints – rate per 1000 contacts	0.40	0.12		
M52	Mixed Sex Breaches	0	0		

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	N/A	N/A		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at May-23)	N/A	N/A		
M74	Hospital Standardised Mortality Ratio - Weekday (as at May-23)	N/A	N/A		
M75	Hospital Standardised Mortality Ratio - Weekend (as at May-23)	N/A	N/A		
M159	Stillbirths	<5	3		
M160	Stillbirths - Improvements in care that impacted on the outcome	No Threshold Set	n/a		
M89	CQUIN schemes at risk	CQUIN schemes have been reintroduced for 2022/23			

Responsive

	Indicator	Target	Actual	Variation	Assurance
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	77.0%	78.0%		
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	77.0%	78.9%		
M62	12 hour trolley waits in A&E	0	1146		
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	1104		
M84	Handovers > 60 mins (Arrival to handover)	0	514		
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	38.7%		
C3	Referral to Treatment (RTT) non- admitted pathways: percentage within 18 weeks	No Threshold Set	56.3%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	75,608	68142		
C37.4	Referral to Treatment (RTT) 65 Weeks (Ongoing)	0	1		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	3026	3049		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	5.0%	20.6%		
C50.1	62d General Standard	70.0%	71.2%		
C50.2	31d General treatment standard	96.0%	97.5%		
C50.3	28d General FDS	75.0%	78.4%		
M9	Urgent operations cancelled for 2nd time	0	0		
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	6		
M138	No.Cancelled operations on day	No Threshold Set	113		
M55	Proportion of delayed discharges attributable to the NHS	New reporting in development			
C16	Emergency re-admissions within 30 days				
M91.1	Emergency average length of stay (excluding 0 and 1 days)	No Threshold Set	11.0		
M91.2	Emergency average length of stay (including 0 and 1 days)	No Threshold Set	8.2		

Well Led

	Indicator	Target	Actual	Variation	Assurance
M77	Trust turnover rate	12.0%	7.5%		P
M78	Trust level total sickness rate	4.5%	6.3%		?
M79	Total Trust vacancy rate	5.0%	4.7%		F
M80.3	Appraisal (Agenda for Change Staff)	90.0%	82.0%		F
M80.35	Appraisal (Consultant)	90.0%	99.0%		?
M80.4	Appraisal (Other Medical)	90.0%	97.0%		?
M80.2	Safeguarding Children	90.0%	95.0%		P
M80.21	Information Governance Toolkit Compliance	95.0%	94.0%		?
F8	Temporary costs as % of total paybill	4%	12.1%		F
F9	Overtime as % of total paybill	0%	0%		
F1	Cumulative variance to planned financial performance (deficit) (£m)	£0.0	-£0.9		
F2.1	WRP achieved YTD - variance to plan (£m)	£0.0	£0.0		
F3	Liquidity days	-21.1	-10.0		
F4	Capital spend v plan	85.0%	75%		
F18a	Capital service capacity	0.3	0.4		
F19a	Income & Expenditure margin	-4.4%	-1.8%		
F21d	Agency spend as a proportion of total pay bill (£m)	3.2%	2.2%		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	80.5%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	94.0%		
F14	Better Payment Practice Code (BPPC) NHS No of Invoices	95.0%	89.1%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	97.5%		

NB: Finance Metrics are reported year to date.

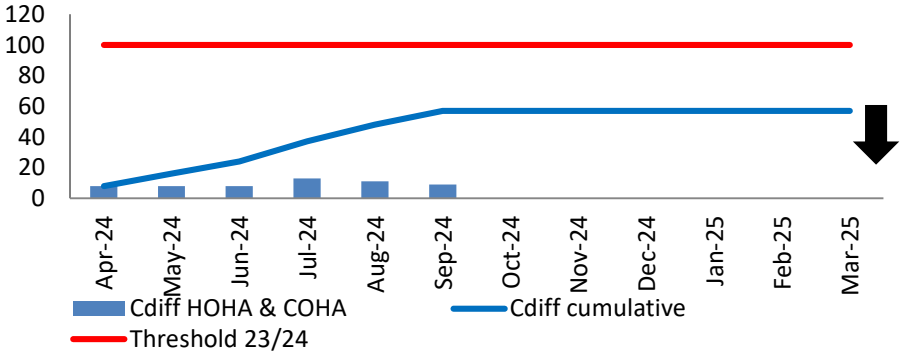
KEY

SPC Control Limits

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

SAFE

C Difficile (HOHA &



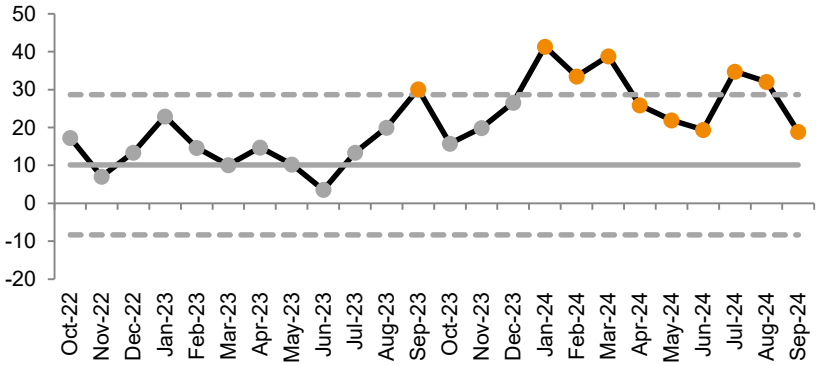
From April 2024 there will be a change in reporting of hospital acquired HCAI data as per updated guidance from UKHSA (UK Health Security Agency). Where a patient has been admitted directly after attendance to A&E it is requested the decision to admit date is entered as the A&E decision to admit date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

There were 0 post 2 day MRSA infection reported in September. So far this year there has been 1 case attributed to the Trust. The objective for 24/25 is to have 0 MRSA cases.

The Clostridium difficile toxin objective for 24/25 is to have no more than 100 cases 'Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)'. The year to date cumulative figure is 57. There were 9 Clostridium difficile toxin positive isolates identified in the laboratory in September; 6 HOHA and 3 COHA.

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

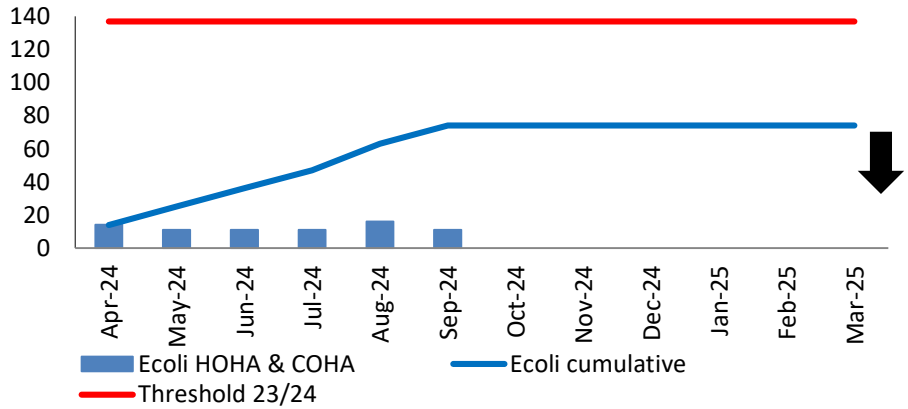
C Diff per 100,000 Occupied Bed Days (HOHA)



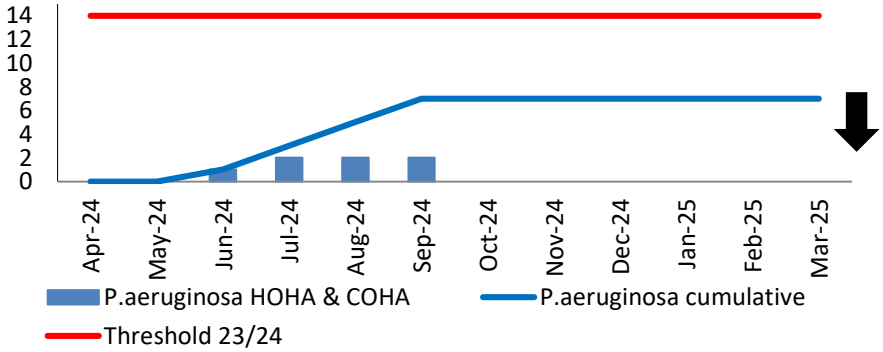
The rate of HOHA infection per 100,000 bed days is significantly higher than normal variation in September.

SAFE

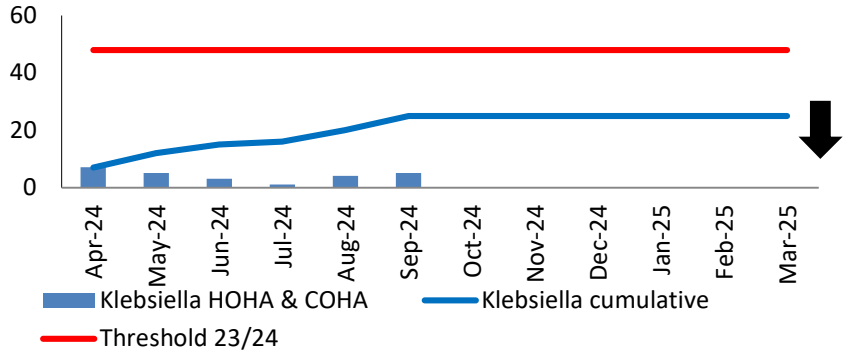
E. Coli (HOHA & COHA)



P.aeruginosa



Klebsiella



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

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

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

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

The 24-25 trajectory for reduction of E.coli is 137 HOHA & COHA. The year to date cumulative figure is 74. There were 11 reportable cases of E.coli bacteraemia identified in September; 6 HOHA and 5 COHA.

The 24-25 trajectory for reduction of Pseudomonas is 14 HOHA & COHA. The year to date cumulative figure is 7. There were 2 reportable case of Pseudomonas identified in September, 1 HOHA and 1 COHA.

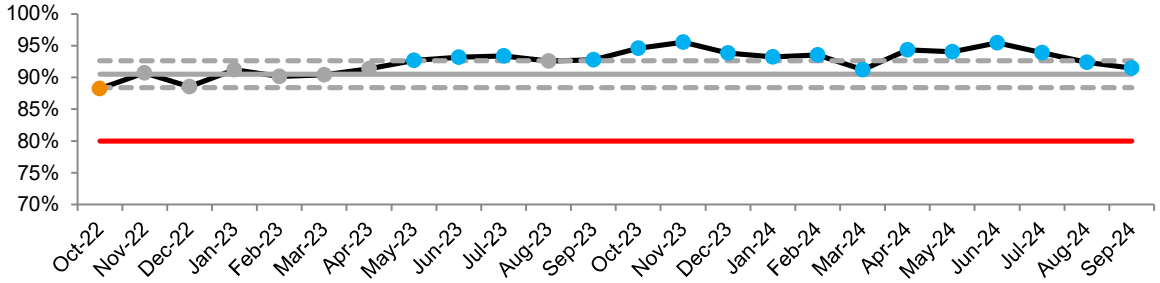
The 24-25 trajectory for reduction of Klebsiellas is 48 HOHA & COHA. The year to date cumulative figure is 25. There were 5 reportable cases of Klebsiella identified in September, 3 HOHA and 2 COHA.

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

SAFE

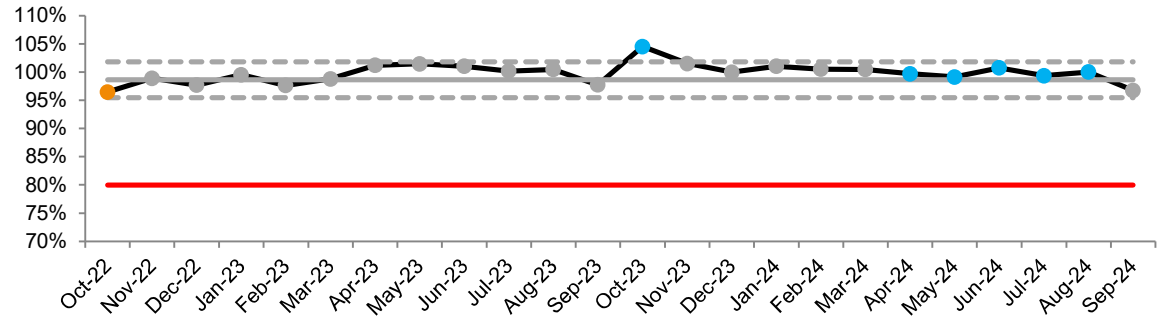
NB: Mar - May 20 figures were not collected due to COVID 19, so are estimated here for purposes of calculating the Statistical Process Control (SPC) limits

Registered Nurses/ Midwives - Day



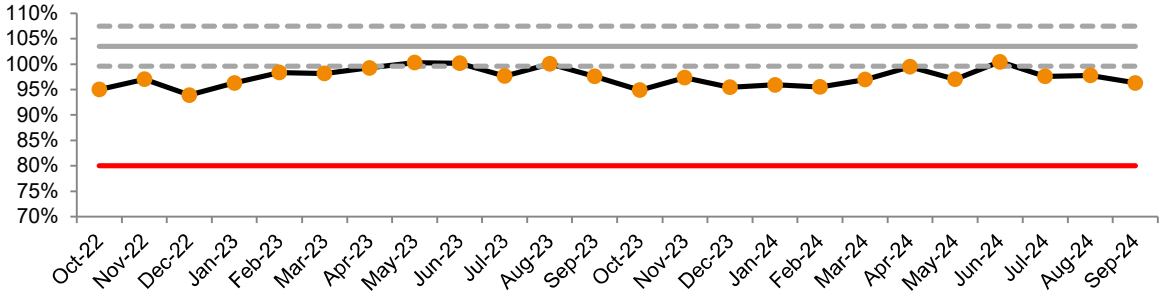
The average fill rate for registered nurses/ midwives during the day is showing improving variation when compared to the pre covid levels. Based on current variation it will consistently be above threshold.

Registered Nurses/ Midwives - Night



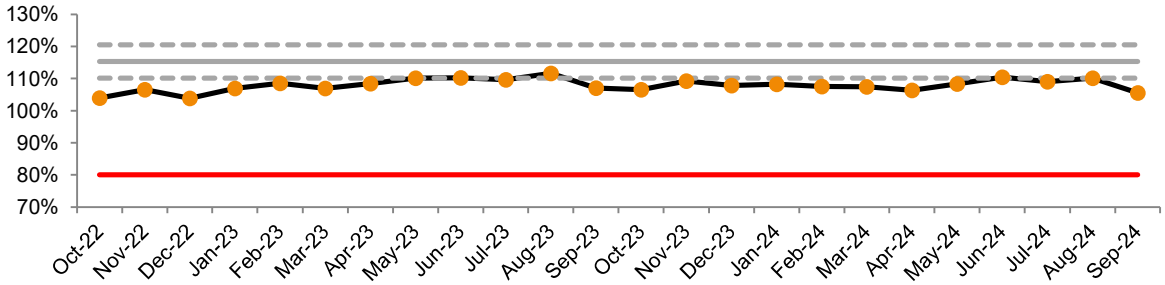
The average fill rate for registered nurses/ midwives at night is showing usual variation when compared to pre-covid levels. Based on current variation it will consistently be above threshold.

Care Staff - Day



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

Care Staff - Night



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

SAFE

Throughout the month, the planned nursing and midwifery staffing levels for the 45 inpatient wards at East Lancashire Teaching Hospitals were compared with the actual staffing levels daily. This allows the calculation of a percentage fill rate for each ward, day, and night,
The table below demonstrates the overall fill rates and the average fill rates per hospital site at ELHT in September.

	Day Average Fill Rate %		Night Average Fill Rate %	
Hospital site	**Registered nurses / midwives (%)**	**Care staff (%)**	**Registered nurses / midwives (%)**	**Care staff (%)**
Royal Blackburn	90.9	94.6	97.3	107.9
Burnley General	94.0	95.8	93.6	102.8
Clitheroe Community	85.3	113.8	100.0	105.0
Pendle Community	94.2	105.7	100.0	94.6
Total	**91.5**	**96.3**	**96.7**	**105.6**

*Clitheroe Community (Ribblesdale Ward) have high long and short sickness, this was 11.25% in July, reduced to 9.20% in August and further reduced to 5.87% in September, no particular themes. 4.7 WTE band 5 vacancies and one NQN started in September. Due to the geographical location, it is difficult to place internationally recruited nurses here. The ward was safely staffed throughout September.

Latest Month - Average Fill Rate

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
Month	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff
Sep-24	91.5%	96.3%	96.7%	105.6%	31713	7.92	1	2	1	1

SAFE

Monthly Trend

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

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Sum of Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)
Aug-23	92.6%	100.1%	100.5%	111.7%	30,062	8.54	1	2	0	0
Sep-23	92.8%	97.6%	97.8%	107.2%	29,886	8.26	0	2	2	1
Oct-23	94.6%	94.9%	104.5%	106.6%	31,679	8.09	0	2	0	1
Nov-23	95.5%	97.4%	101.5%	109.3%	30,083	8.35	0	3	0	0
Dec-23	93.4%	95.4%	100.0%	108.0%	30,111	8.52	1	2	0	1
Jan-24	93.2%	95.9%	101.0%	108.3%	31,392	8.19	0	4	0	1
Feb-24	93.5%	95.5%	100.5%	107.6%	29,830	8.04	1	2	1	1
Mar-24	91.2%	97.0%	100.5%	107.5%	30,877	8.23	0	2	0	1
Apr-24	94.3%	99.5%	99.7%	106.4%	30,852	8.05	0	1	1	1
May-24	94.1%	97.1%	99.2%	108.3%	31,886	8.02	0	1	0	0
Jun-24	95.5%	100.5%	100.7%	110.4%	30,887	8.34	0	1	0	0
Jul-24	93.9%	97.6%	99.4%	109.1%	31,622	8.24	2	1	0	0
Aug-24	92.4%	97.8%	100.0%	110.2%	31,181	8.3	4	0	0	0
Sep-24	91.5%	96.3%	96.7%	105.6%	31713	7.92	1	2	1	1

During September <80% fill rate:

< 80% Registered staff		
Day	Blackburn birth centre	68.80
Night	Blackburn birth centre	56.70

< 80% Care staff		
Day	Coronary care unit	74.20
Night	Blackburn birth centre	56.70

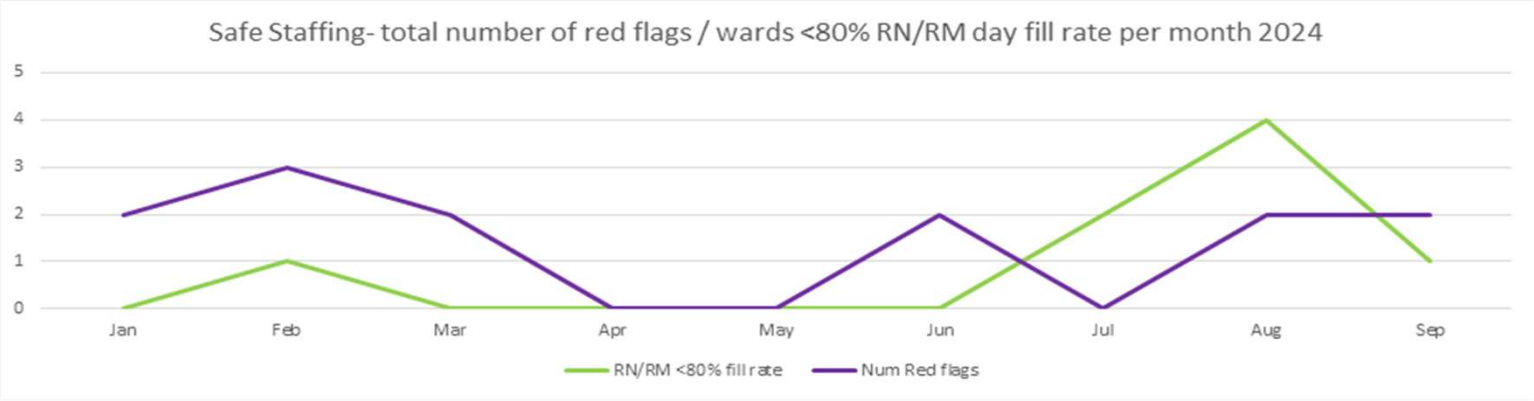
Blackburn Birth Centre – this is largely due to staffing gaps as a result of vacancies and sickness within the area, and on occasion needing to support the main site due to increased sickness, acuity and dependency.

Coronary Care Unit – HCAs moved to other areas to support but good presence of students which mitigates the risk.

National Red Flags

0 national nursing red flags reported in September.
2 maternity red flags reported in September.

FC – both incidents have been reviewed and reported. Staffing on duty at the time reflected safe staffing for acuity.
6th September 2024 - Delayed recognition of and action on abnormal vital signs. No harm or impact on outcome.
Delay of two hours or more between admission for induction and beginning of the process. No harm or impact on outcome.



SAFE

Family Care

Month	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Staffed to full Establishment	01:26	01:26	01:27	01:26	01:26	01:26	01:25	01:26	01:26	01:26
Excluding mat leave	01:26	01:27	01:26	01:27	01:27	01:27	01:26	01:28	01:28	01:28
Maternity leave	4.40	6.40	6.40	6.40	9.60	9.60	15.76	17.12	17.12	0.77
With gaps filled through ELHT Midwife staff bank	Bank usage	Bank usage	Bank usage	Bank usage	Bank usage	Bank usage	Bank usage	Bank usage	Bank usage	Bank usage
Per week	15.60	24.36	24.19	23.16	28.47	20.65	9.20	19.92	21.85	16.22
Midwifery vacancies (Maternity VRS) -11wte	12 wte (11) Backfill for mat leave included	12 wte backfill for Maternity leave incl	10 wte backfill for Maternity leave incl	12 wte backfill for Maternity leave incl	15 wte Backfill 11 for Maternity leave incl	15 wte Backfill 11 for Maternity leave incl	12 wte Backfill 6 for Maternity leave incl	6 wte Backfill 11 wte for maternity leave	5 wte Mat leave included start dates pending	10 wte Mat leave included

Maternity - Safe midwifery staffing levels also continue to be reviewed with the appropriate risk assessments 4 times a day at each safety huddles. Additional staffing/ leadership huddles will take place in periods of extreme staffing pressures to mitigate throughout maternity services; midwives are redeployed to other areas to support acuity and activity as and when required. There has been a slight increase in bank filled duties, this is due to short term sickness and vacancies. Maternity leave increased to 18.32 WTE in September.

Antenatal Clinic Outpatients services throughout July/August/September have reduced staffing levels due to vacancies and sickness. A rota is in place for Specialist Midwives to support clinical shifts across this area of Maternity to support safe staffing. Escalation and discussion with the Chief Nurse/ Executive Maternity Safety Champion when risk to post-natal flow/ patient care in the absence of a 7-day coordinator/ 7 days a week. Risk assessment to commence 1.51 WTE per week to cover the additional hours required. Out to bank initially to recruit to the VR process, this 1.51 WTE has been requested via BR plus business case/ additional requirements and the improvement case for C/sections.

Local midwifery red flags noted at each handover and reviewed by the local governance team on a weekly basis. 2 areas <89% filled as per above.

All start dates for new midwifery posts allocated early October, induction weeks planned prior to clinical allocations.

Neonatology – Staffing levels meet the requirements for the acuity/ activity aligned with the NW connect safe staffing tool. The planned versus actuals meet the safe staffing requirements for the days in month of September 2024, this is equal to the number of infants required intensive, special, and high dependency care. Daily maternity/ Neonatology safety huddles inclusive of safe staffing tool completed twice daily, more frequently if required. Risk assessments prior to agency nurse cover requests are discussed with the Deputy Chief Nurse and Chief Nurse. No agency cover used in September.

Paediatrics – No <80% fill rate in September. Acuity/ dependency and activity comparatively low compared to maximum bed occupancy. No nursing red flags.

Gynaecology – Safe Care reflected some exceptions in September, this is historical and will continue to reflect inaccuracies until the eroster template is amended for the ward as one of the RN's are allocated to work on SDEC/EPAU pathway on the twilight shift. Request to erostering by the matron to rectify.

Nurse and Midwifery Staffing Data - September

Current vacancies

Vacancies	Establishment	SIP	Vacant	Vacant %
Midwife	295	291	4	1.35%
Nurse	2780	2695	85	3.05%
HCA	1309	1186	123	9.39%
Grand Total	**4384**	**4172**	**212**	**4.83% ↓**

Ethnicity

Ethnicity	HCA	Midwife	Nursing	Grand Total
BME	275	44	859	1178
Not Stated	8	0	12	20
White	1084	315	2108	3507
Grand Total	**1367**	**359**	**2979**	**4705**

Gender

Gender	HCA	Midwife	Nursing	Grand Total
Female	1196	358	2789	4343
Male	171	1	190	362
Grand Total	**1367**	**359**	**2979**	**4705**

HCA Vacancies Band 2&3

Vacancies	Establishment	SIP	Vacant	Vacant %
Band 2	821	726	95	11.54%
Band 3	445	414	32	7.17%
Grand Total	**1266**	**1140**	**127**	**10%**

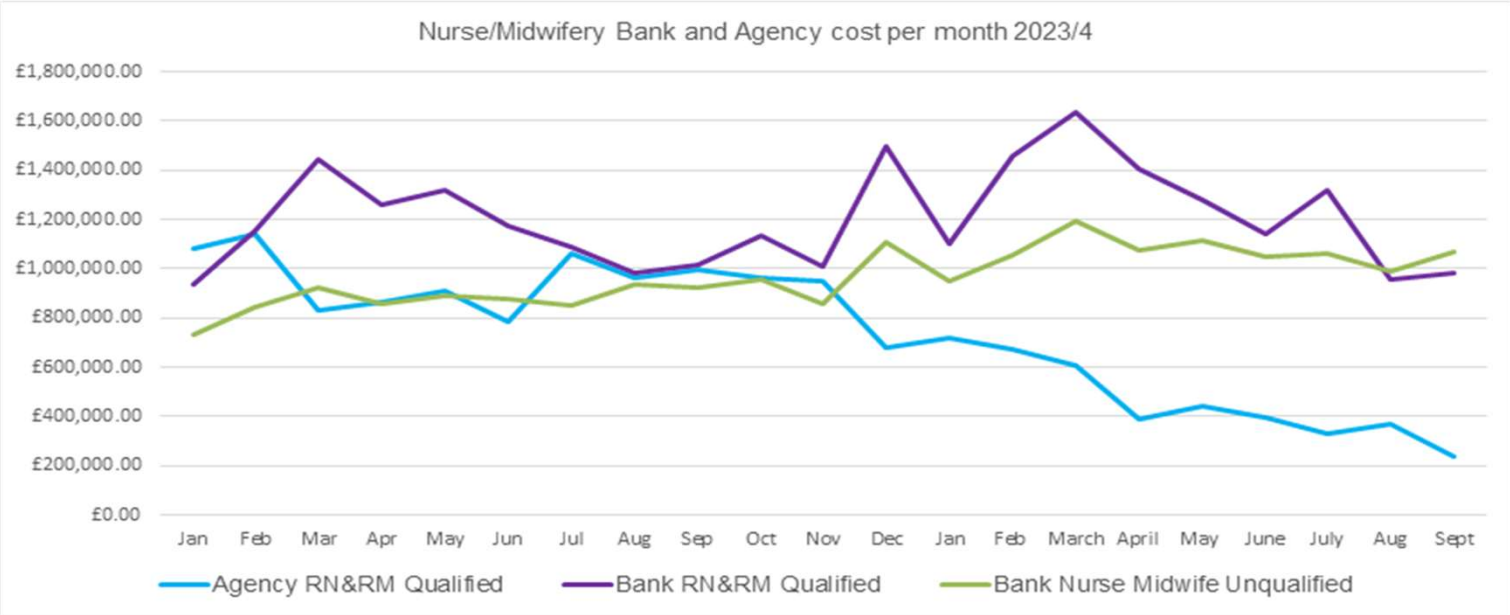
Age Band	HCA	Midwife	Nursing	Grand Total
<=20 Years	23	0	0	23
21-25	91	26	168	285
26-30	121	50	409	580
31-35	187	58	520	765
36-40	166	61	461	688
41-45	144	54	345	543
46-50	153	36	331	520
51-55	185	28	344	557
56-60	183	29	234	446
61-65	101	16	143	260
66-70	10	1	18	29
>=71 Years	3	0	6	9
Grand Total	**1367**	**359**	**2979**	**4705**

SAFE

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

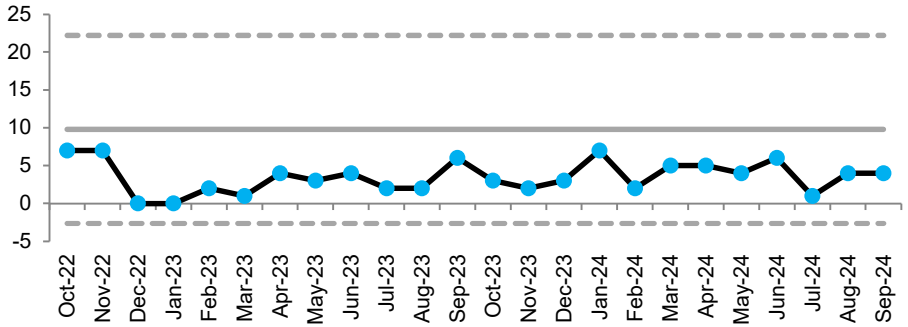
Recruitment / Retention Nursing and Midwifery Trust Activity overview
HCA Recruitment - event in planning for 15th October. Awaiting confirmation of numbers. VR completed. Clinical support agreed for the day.
International Nursing Recruitment - July cohort of 5 sit their OSCE on 9th October. Allocations for this cohort are still required. We have 1 nurse returning from maternity leave in October who will go back to OSCE prep to sit her 2nd OSCE.
NQN - Allocation for September qualifiers in progress. Next cohort to qualify in March 2025. Plan for recruitment of these to be discussed.

Nursing and Bank and Agency Spend



SAFE

Serious Incidents



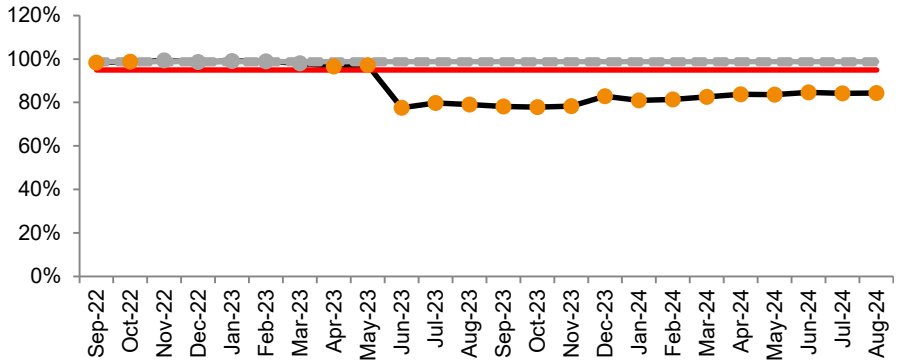
There were no never events reported in September.

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

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

PSIRF Category	No. Incidents
National priority - incident resulting in death	2
National priority - every baby counts	2

VTE assessment



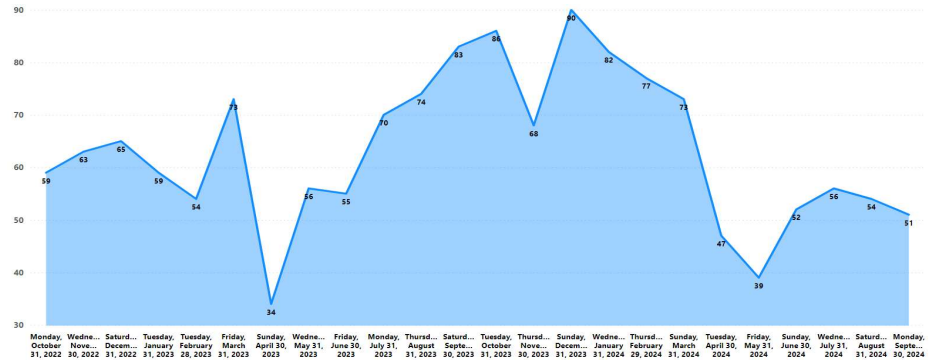
Venous Thromboembolism (VTE) data between June 23 and March 24 was not submitted nationally, figures are calculated retrospecively.

SAFE

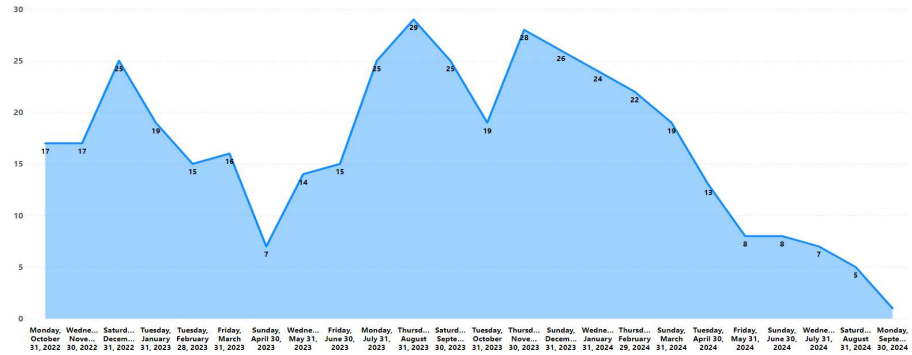
Pressure Ulcers

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

Total pressure ulcers - developed in ELHT



Total pressure ulcers - developed in ELHT - lapses in care



The number of pressure ulcer incidents occurring under ELHT has been relatively stable over the last 4 months between 49 – 56 per month. Since the 1st April 2024, 298 pressure ulcer incidents have been reported on patients under the care of the ELHT with 42 confirmed lapses in care however there are 45 outstanding checklists from the 1st July 2024 – 30th September 2024 still to be finalised which may alter the numbers of lapses in care

The Trust continues to see high attendances through the ED department 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. The District Nursing service continues to average 1300 daily visits with a caseload of approx. 4,200 patients.

Compliance with the pressure ulcer and moisture associated damage e-learning is 93.49% and 93.79% retrospectively - each Divisional Lead as part of the Pressure Ulcer Steering Group has actions in place to increase the compliance to 95%. As part of the quality improvement project managing continence a new inpatient continence formulary is due to be launched in October which aims to ensure that the right product is being used where necessary which should improve both patient experience and outcomes

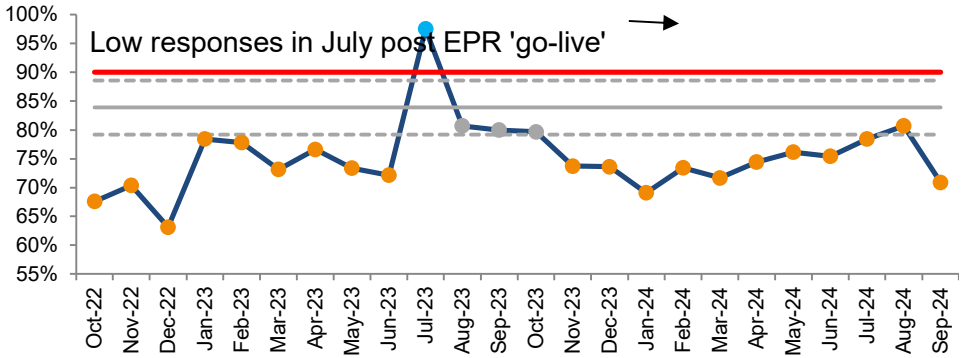
	Total Number of Incidents developed under ELHT Care	
	2023 - 2024	1.4.2024 – 31.8.2024
	847	298
Category of Pressure Ulcer	Total Number of Incidents developed under ELHT Care	Total Number of Lapses in Care
2	78	15
3	17	25
4	10	2

CARING

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

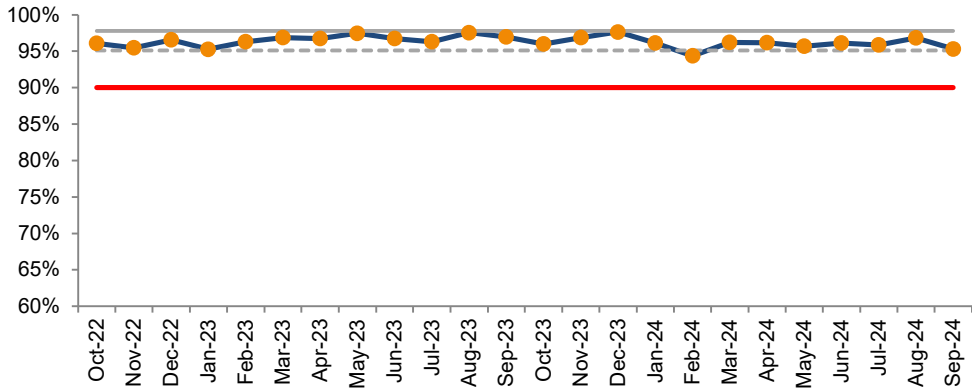
Baseline period for SPC comparison is Apr 18 - Mar 20

Friends & Family A&E



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

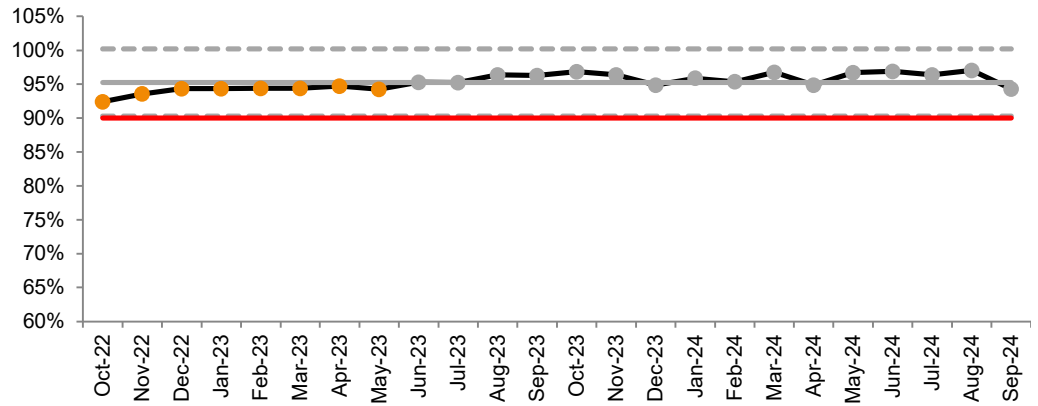
Friends & Family Inpatient



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

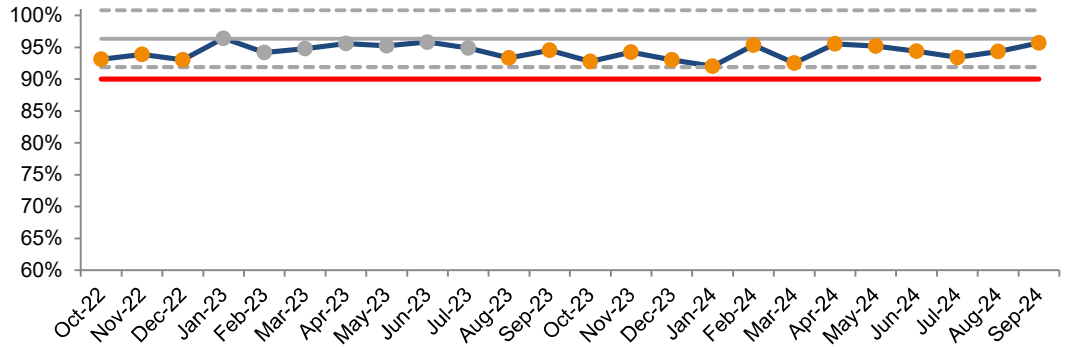
CARING

Friends & Family Outpatients



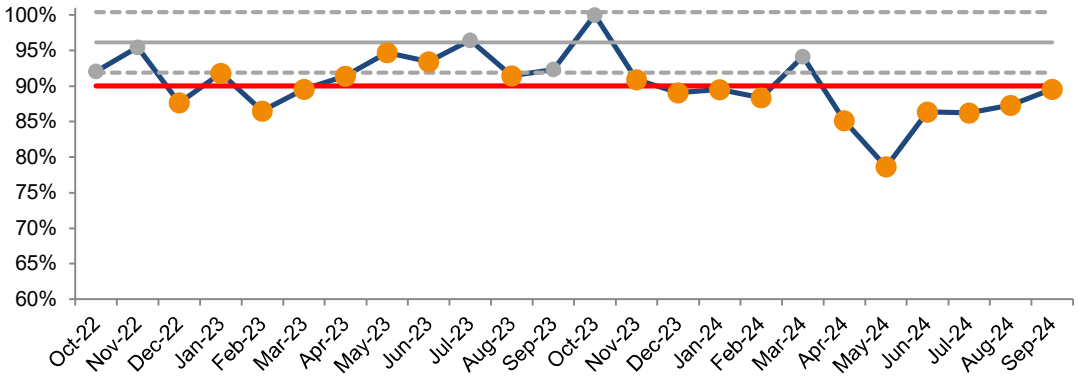
Outpatient scores continue to be above target and are within the normal range when compared to the pre-covid baseline. Based on current variation this indicator should consistently hit the target.

Friends & Family Community



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

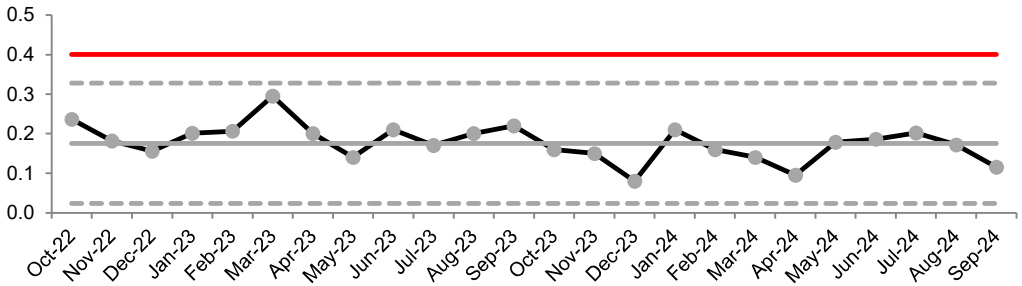
Friends & Family Maternity



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

CARING

Complaints per 1000 contacts



The Trust opened 16 new formal complaints in September.

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

For September the number of complaints received was 0.12 Per 1,000 patient contacts.

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

Patient Experience

		Dignity	Information	Involvement	Quality	Overall
Type	**Division**	Average Score	Average Score	Average Score	Average Score	Average Score
Antenatal	Family Care	100.00	-	100.00	97.50	98.96
Community	Community and Intermediate Care Services	93.86	90.84	91.31	94.13	92.35
Community	Diagnostic and Clinical Support	100.00	100.00	100.00	100.00	100.00
Community	Family Care	100.00	-	-	83.36	89.29
Community	Surgery	100.00	97.58	-	-	98.25
Delivery	Family Care	100.00	-	100.00	100.00	100.00
ED_UC	Diagnostic and Clinical Support	-	-	-	95.00	95.00
Inpatients	Community and Intermediate Care Services	85.18	80.51	84.36	81.89	83.32
Inpatients	Diagnostic and Clinical Support	100.00	85.16	94.18	98.24	95.63
Inpatients	Family Care	96.93	93.62	97.70	95.95	96.31
Inpatients	Medicine and Emergency Care	90.51	79.62	89.03	88.34	87.04
Inpatients	Surgery	92.68	95.65	88.98	90.35	89.34
OPD	Diagnostic and Clinical Support	98.69	95.72	98.26	96.64	97.00
OPD	Family Care	100.00	100.00	100.00	95.75	98.52
OPD	Medicine and Emergency Care	98.64	93.02	97.80	95.06	95.61
OPD	Surgery	100.00	100.00	100.00	100.00	100.00
Postnatal	Family Care	100.00	100.00	100.00	100.00	100.00
SDCU	Family Care	99.17	97.83	96.71	100.00	98.13
	Total	**94.70**	**91.19**	**91.80**	**93.64**	**92.66**

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

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

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

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

EFFECTIVE

SHMI Published Trend

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

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

HSMR

EFFECTIVE

Structured Judgement Review Summary

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

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

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

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

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

The post responsible for managing Doctors revalidation reports and the SJR process is vacant as of 30 June 24. The post has been approved by HR 15/10 and will go out to advert ASAP.

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

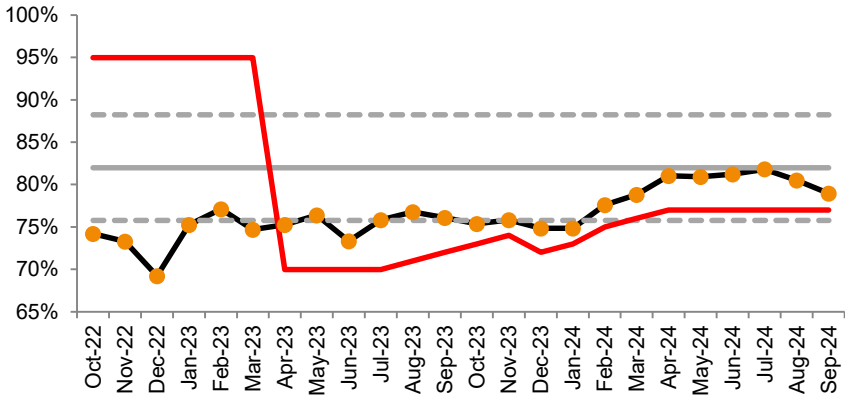
Learning Disability Mortality Reviews

3 completed reviews in Sept 2024
There are currently reviews 16 outstanding for SJR1
2 referred for SJR2
1 Death notified to LeDeR in Sept 2024

Issues noted in reviews this month
Alternative pain tool for ED where Abbey pain tool not appropriate
ensure recommendations from allied healthcare professionals are reviewed. In this case the LD team recommended a formal capacity assessment, consideration of DoLs and IMCA referral and these matters were not addressed.

RESPONSIVE

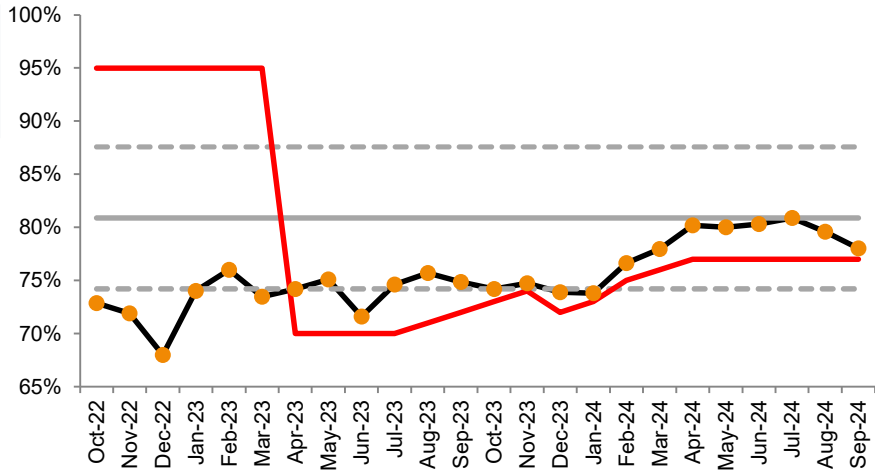
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 78.94% in September, which is above the 77% target.

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

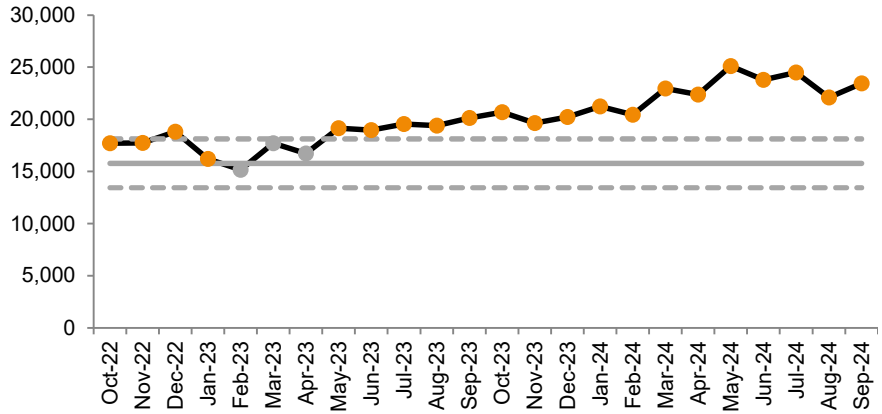
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 78.00% in September, above the 77% trajectory.

The national performance was 74.2% in September (All types).

A&E Attendances - Trust

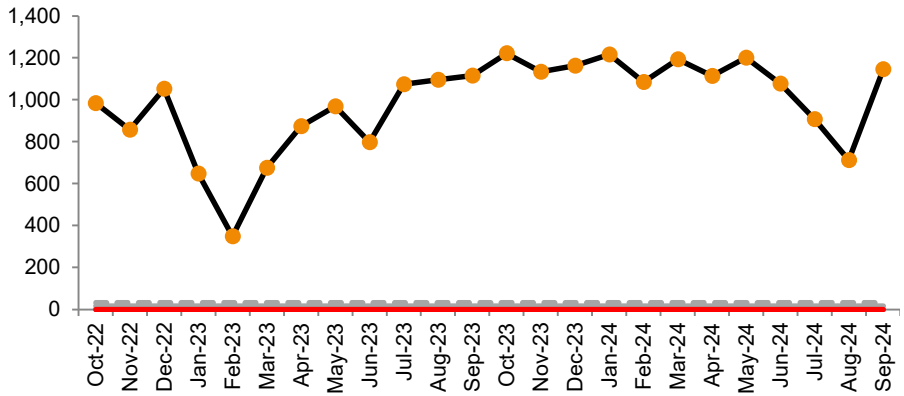


The number of attendances during September was 23,442, which is above the nornal range when compared to the pre-covid baseline.

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

RESPONSIVE

12 Hr Trolley Waits

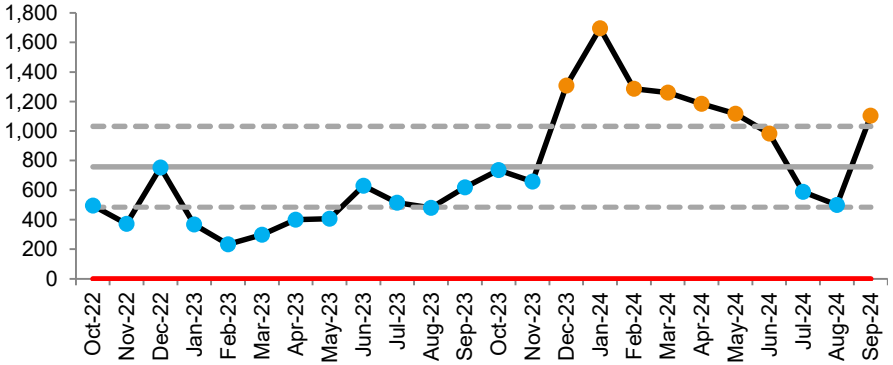


There were 1146 reported breaches of the 12 hour trolley wait standard from decision to admit during September, which is higher than the normal range. 54 were mental health and 1092 were physical health.

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

	Mental Health	Physical Health
No. 12 Hr Trolley Waits	54	1092
Average Wait from Decision to Admit	53hr 02min	25hr 26min
Longest Wait from Decision to Admit	144hr 34min	62hr 63min

Ambulance Handovers - >30Minutes

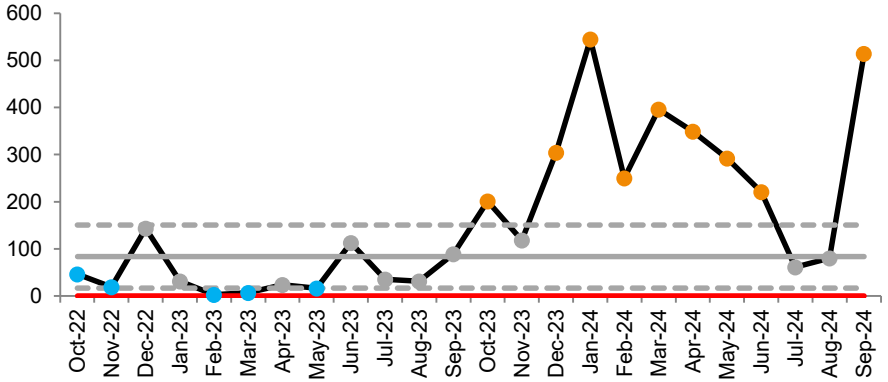


There were 1104 ambulance handovers > 30 minutes in September. The trend is showing a increase on previous variation, and based on current variation is not capable of hitting the target routinely.

There were a total of 3032 ambulance attends with 1104 ambulance handovers > 30 minutes and 514 > 60 minutes.

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

Ambulance Handovers - >60 Minutes



The average handover time was 51 minutes in September.

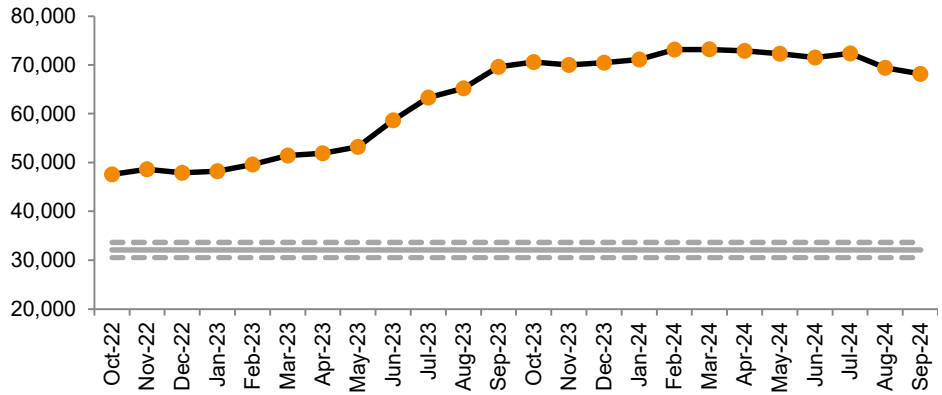
The longest handover in September was reported as 8hr 6 minutes. We are working with NWAS to reduce longer waits due to cohorting since the introduction of the HALO system.

RESPONSIVE

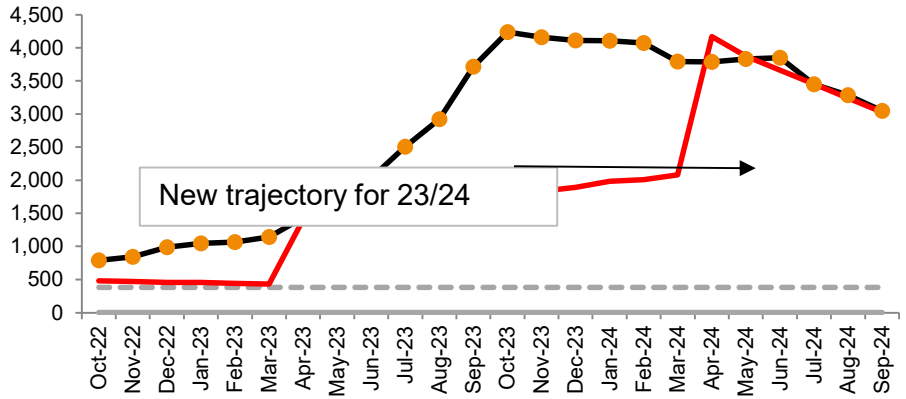
At the end of September, there were 68,142 ongoing pathways, which has reduced on last month but is above pre-COVID levels.

There were 3049 patients waiting over 52 weeks at the end of September which has reduced on last month and is above trajectory.
There was 1 patient waiting over 65 weeks at the end of September which has reduced on last month and is above trajectory.
We are aware of a number of data quality issues impacting on performance post EPR go live, which the Trust is working on to resolve.
There were 0 patients waiting over 78 weeks.

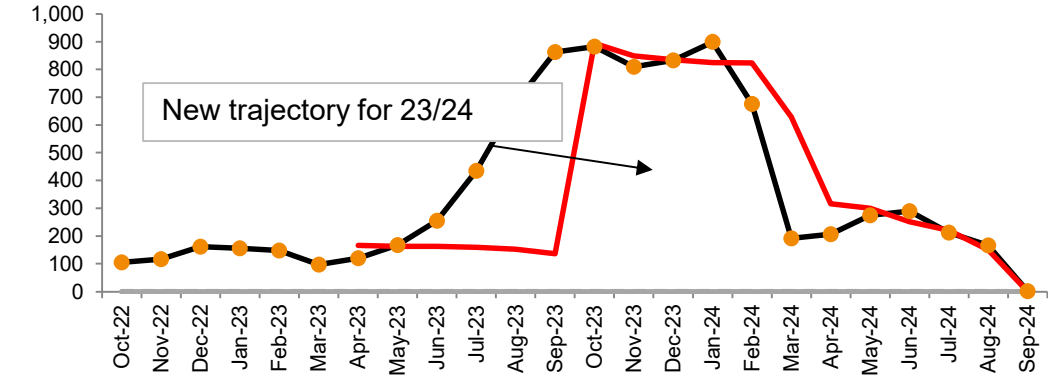
Referral to Treatment (RTT) Total Ongoing



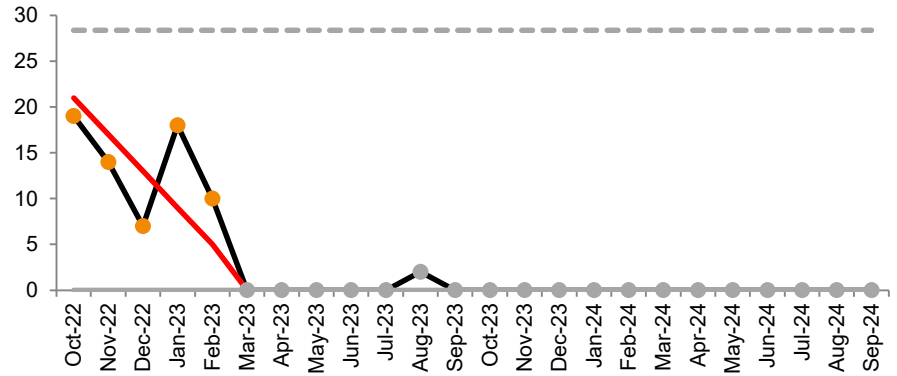
RTT Total Over 52 wks



RTT Total Over 65 wks



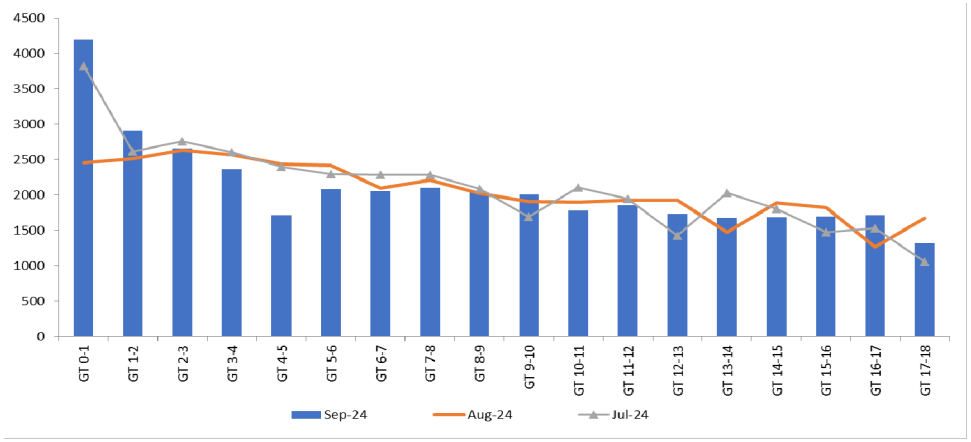
RTT Total Over 78 wks



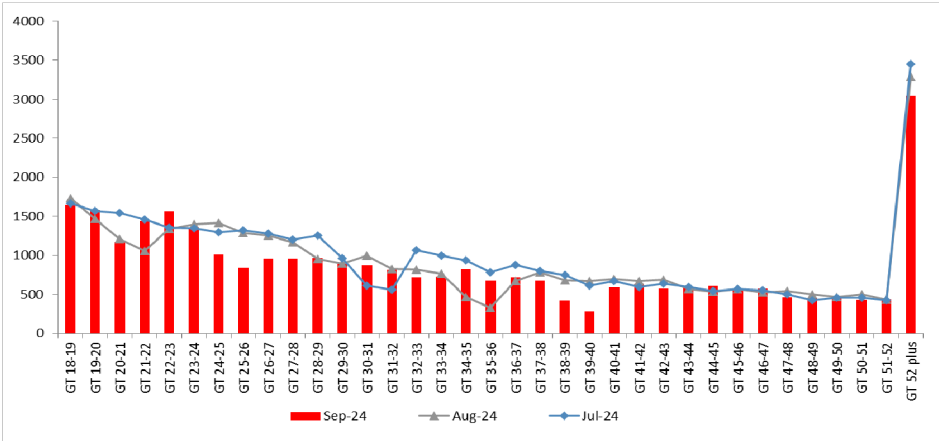
RESPONSIVE

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

RTT Ongoing 0-18 Weeks

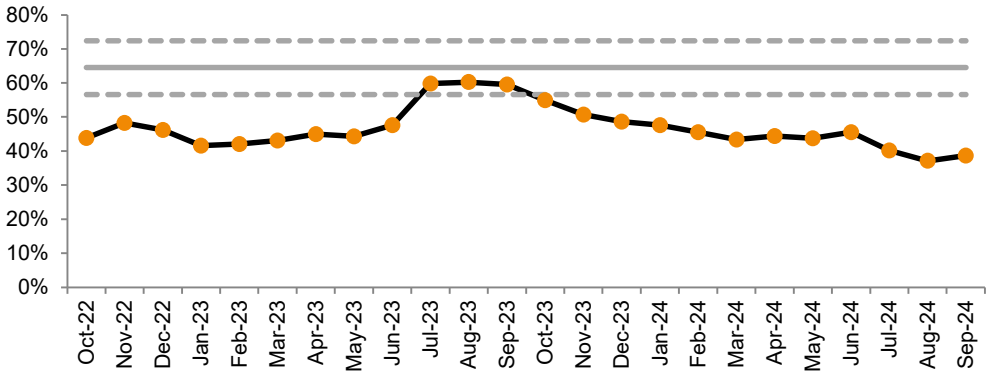


RTT Over 18 weeks

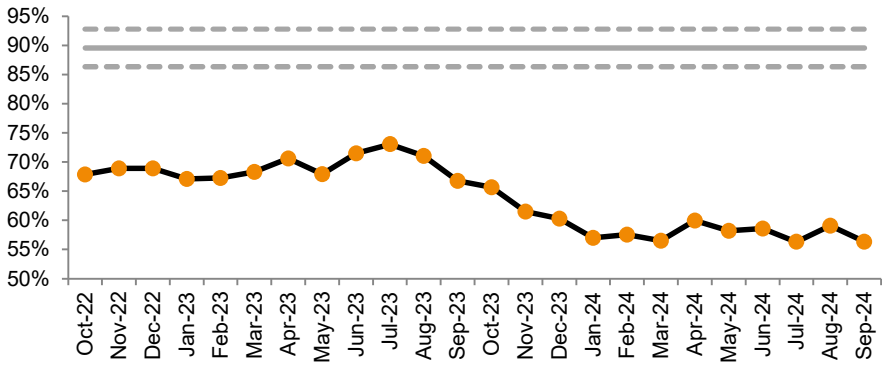


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.

RTT Admitted



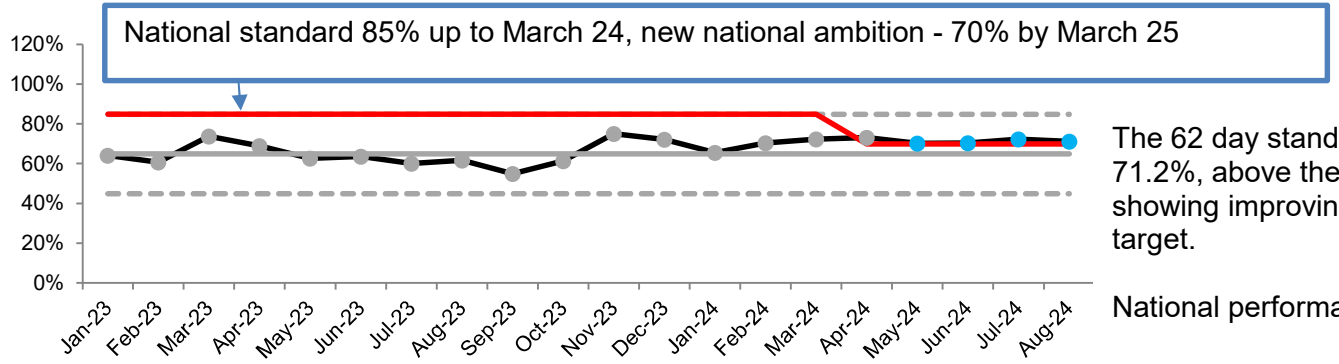
RTT Non-Admitted



RESPONSIVE

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

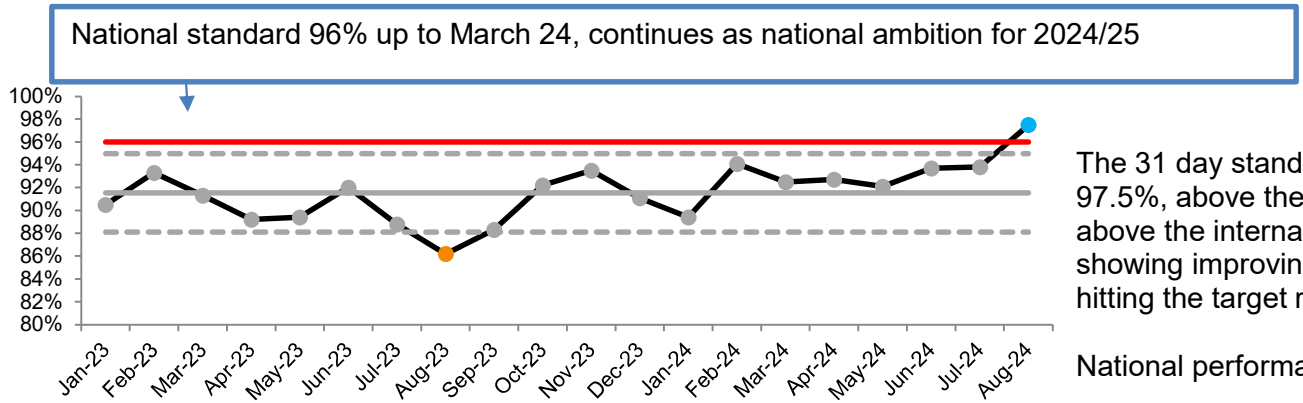
Cancer 62 day general



The 62 day standard was acheived in August at 71.2%, above the 70% trajectory. The trend is showing improving variation and may deliver the target.

National performance August - 69.2%

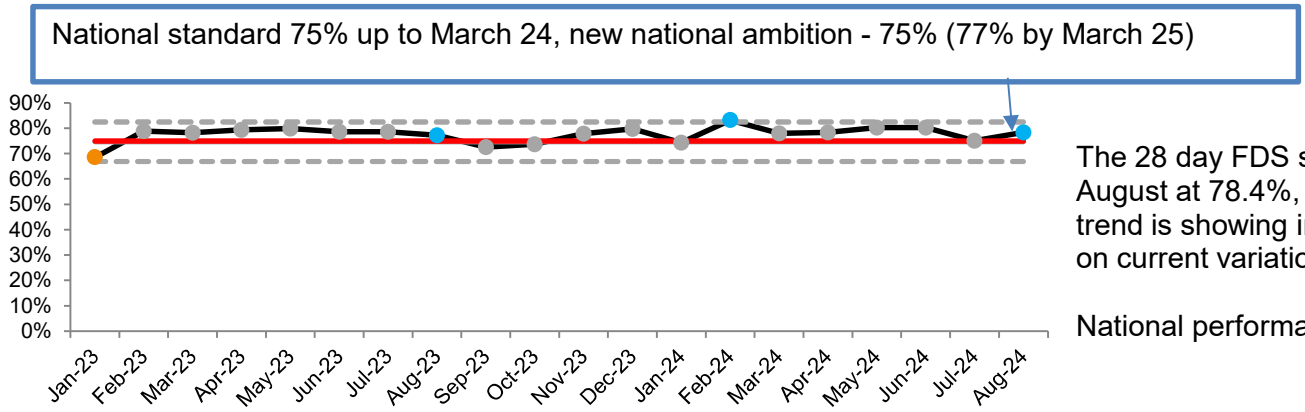
Cancer 31 day general treatment



The 31 day standard was achieved in August at 97.5%, above the 96% trajectory. This is also above the internal trajectory of 90%. The trend is showing improving variation but is not capable of hitting the target routinely.

National performance August - 91.7%

28 day general FDS

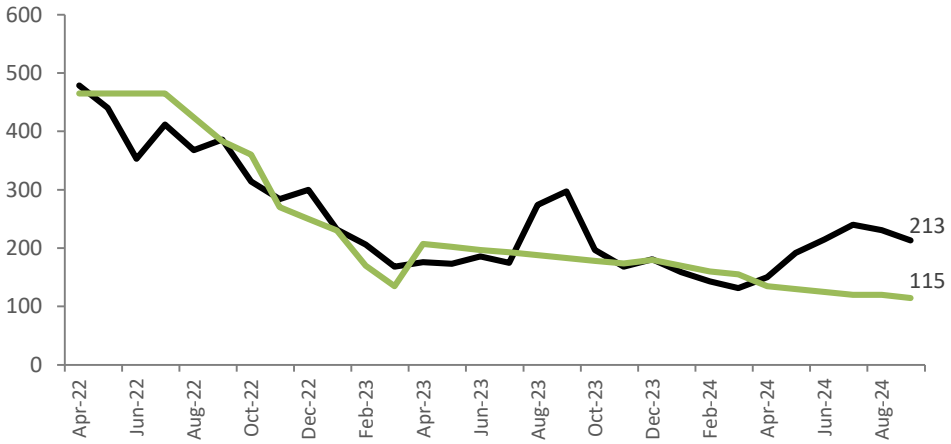


The 28 day FDS standard was achieved in August at 78.4%, above the 75% trajectory. The trend is showing improving variation and based on current variation will consistently hit the target.

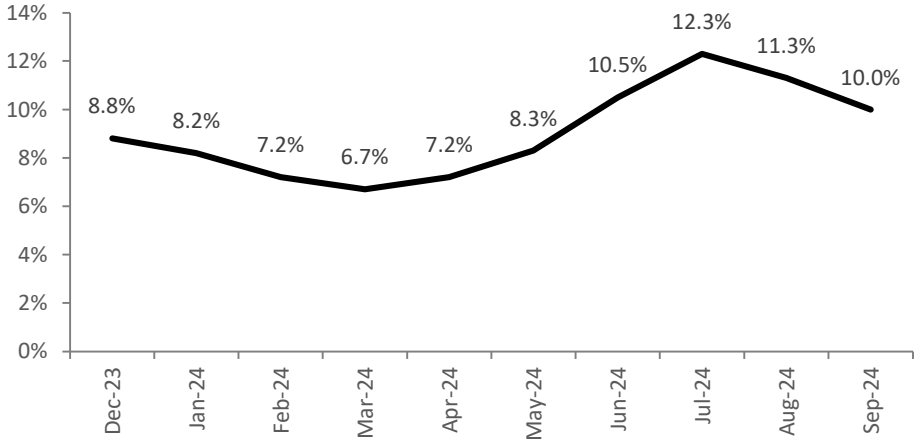
National performance August - 75.5%

RESPONSIVE

Cancer >62 day vs trajectory



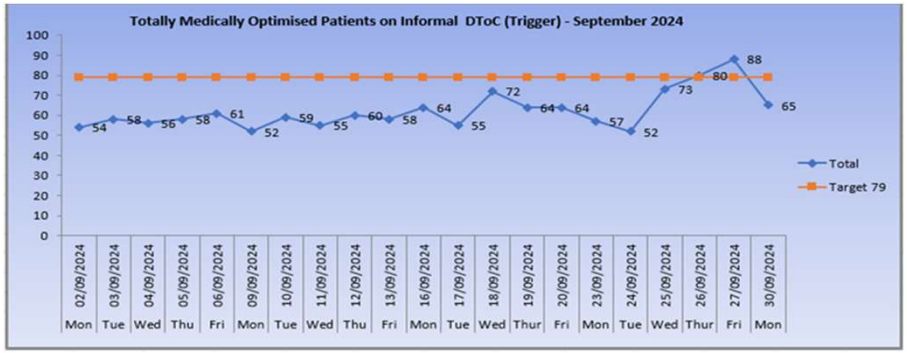
Cancer % Waiting >62days (Urgent GP Referral)



At the end of September the number of patients >62 days was 213 vs 115 trajectory. This was 10.0% of the total wait list.

RESPONSIVE

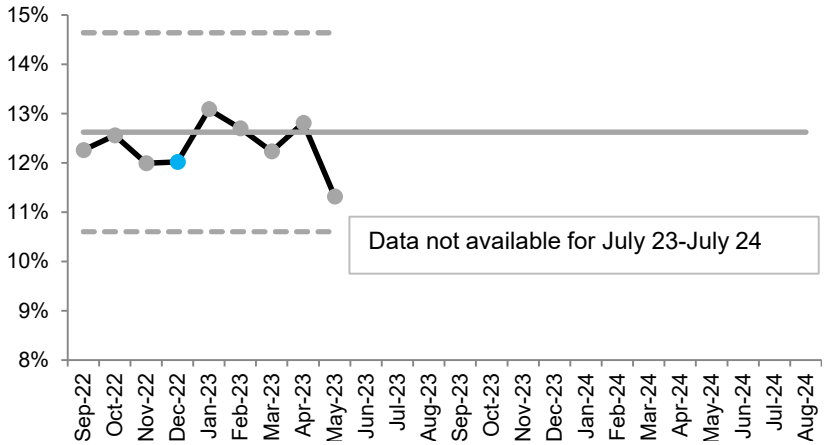
Delayed Discharges



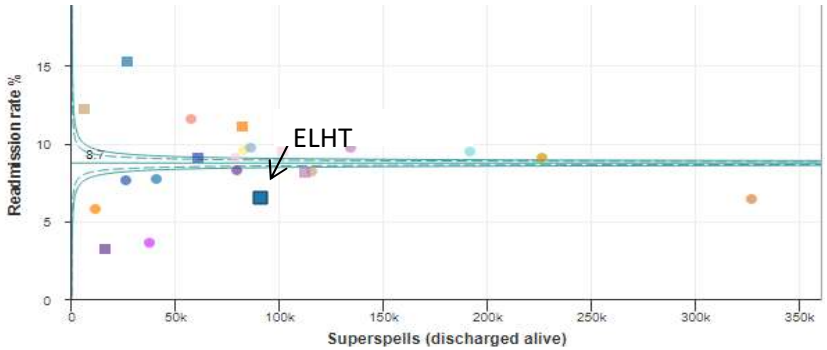
We continue to discharge patients using the rapid discharge principles set out in the Hospital discharge and community support: policy and operating model government guidance, utilising pathways 0-3. Pathways are being used to ensure patients have a discharge plan identified from admission, with pathway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

Dr Foster benchmarking (March 23 - March 24) shows the ELHT readmission rate is lower than the North West average. April and May 23 data is missing from this period for ELHT.

Emergency Readmissions

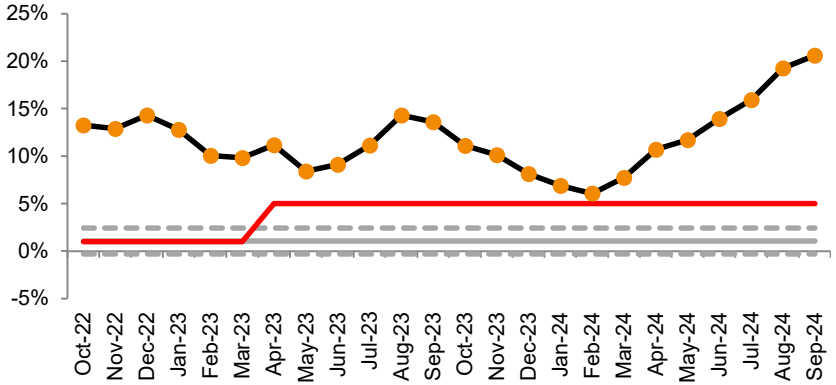


Readmissions within 30 days vs North West - Dr Foster



Data not available for emergency readmissions.

Diagnostic Waits



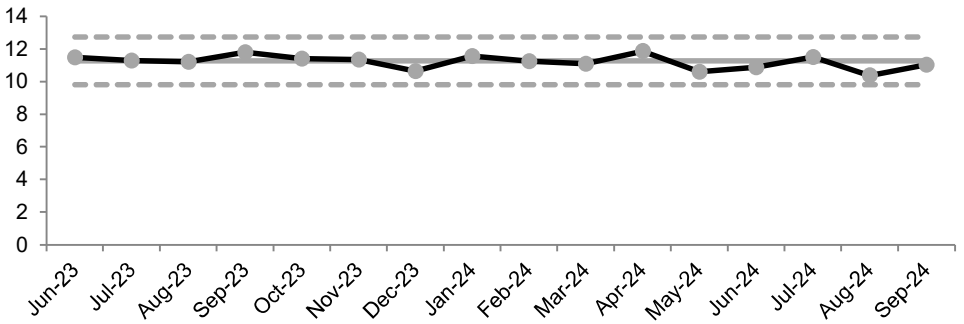
In September, 20.61% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is above the 5% threshold. (95% of patients to receive a diagnostic test within 6 weeks by March 2025)

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

Nationally, the performance is failing the 5% target at 23.9% in August.

RESPONSIVE

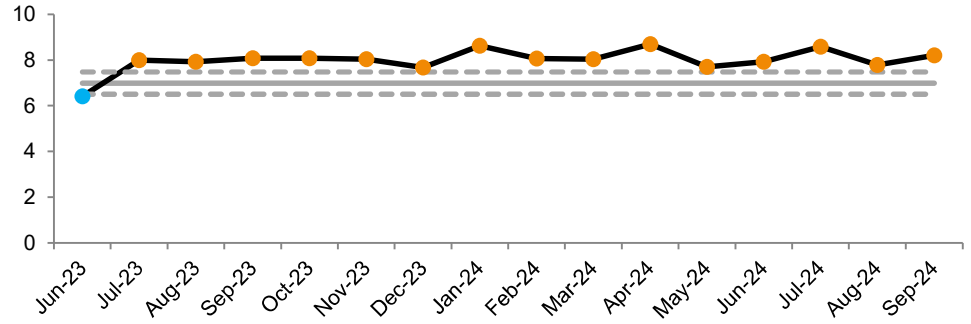
Emergency average length of stay - excluding 0 and 1



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

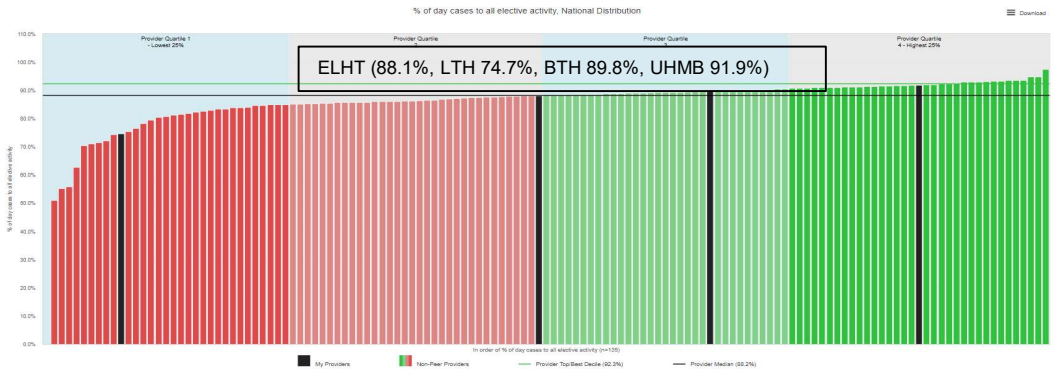
Please note, there are known data quality issues with recorded discharge date after true discharge discharges.

Emergency average length of stay - including 0 and 1



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

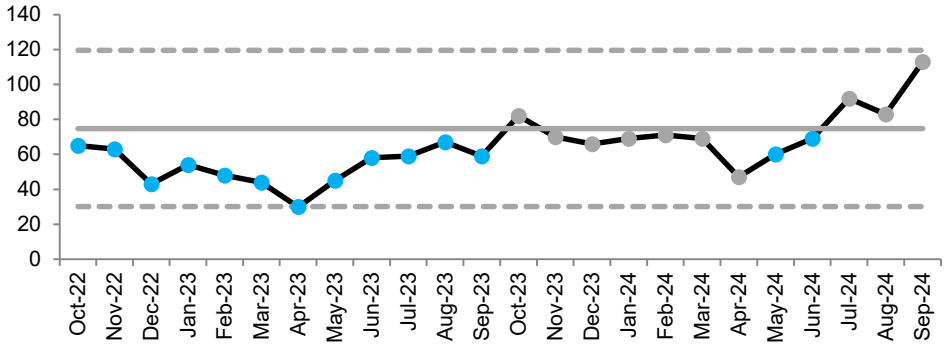
Daycase Rate



Model health data shows ELHT in the second quartile for daycase rates at 88.1% (July 24). Due to a change in model health reporting, this graph includes all elective activity whereas the previous graphs included only BADS procedures.

RESPONSIVE

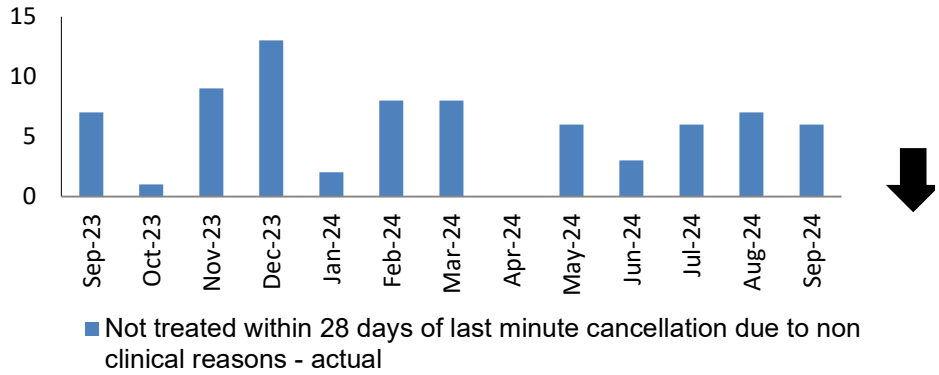
Operations cancelled on day



There were 113 operations cancelled on the day of operation - non clinical reasons, in September. Work is ongoing to better understand the reason for these cancellations with a view to reducing them.

The trend is similar to pre-covid levels.

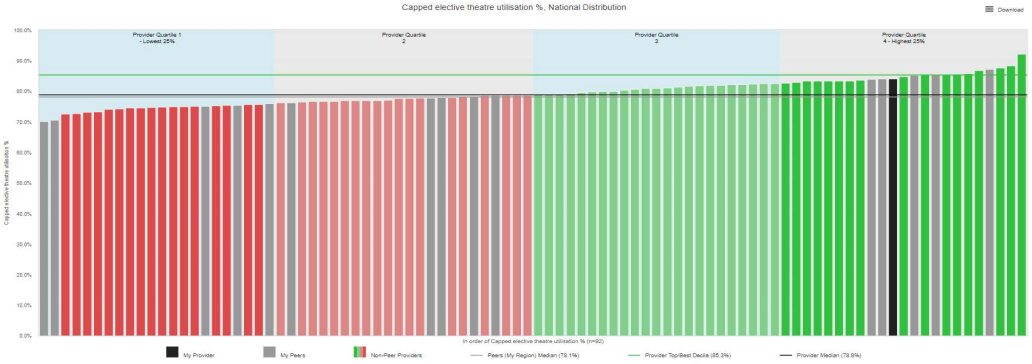
Operations cancelled on day - breaches of 28 day



There were 6 ‘on the day’ cancelled operations not rebooked within 28 days in September.

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

Theatre Utilisation



Data taken from 'The model hospital' shows capped theatre utilisation at 84.1% for the latest period. This is in the fourth quartile nationally, with 4 being the highest and 1 the lowest.

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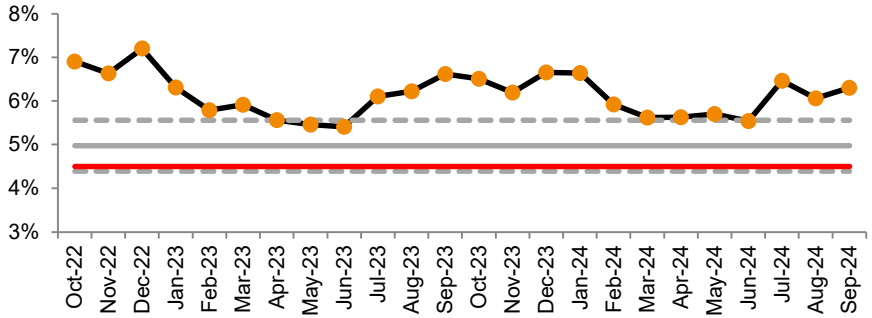
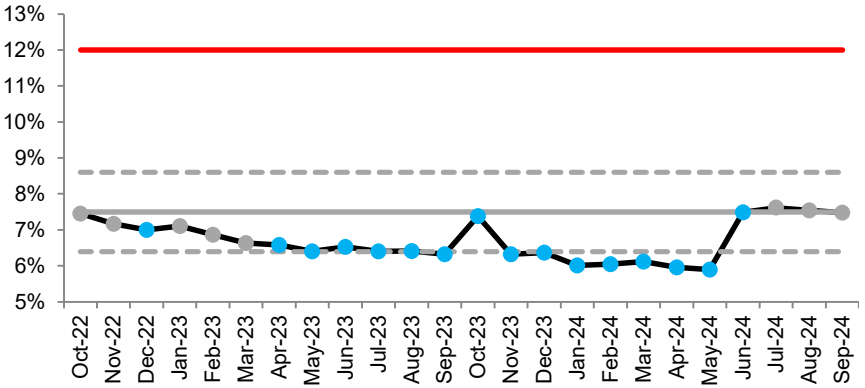
Sickness



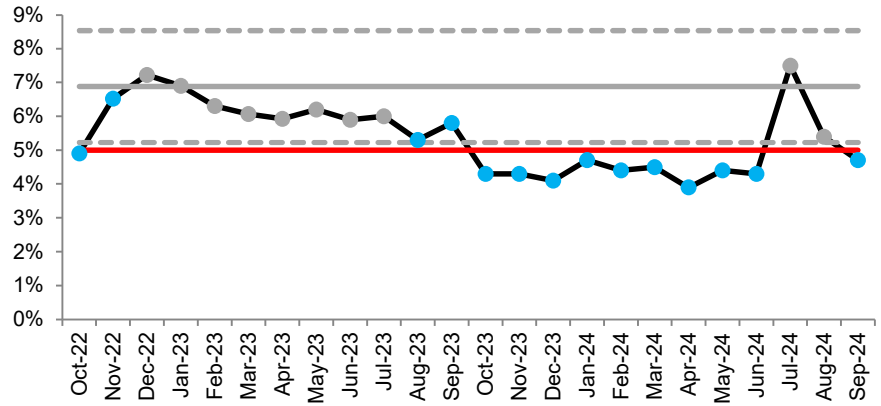
The sickness absence rate was 6.30% for September which is above the threshold of 4.5%. The trend is significantly higher than the pre covid baseline and based on the current level of variaton, is at risk of being above threshold.

Turnover Rate



The trust turnover rate is at 7.48% in September and remains below threshold. This is showing usual variation this month when compared with baseline. Based on current variation, the indicator will consistently be below the threshold.

Vacancy Rate



The vacancy rate is 4.7% for September which is below the 5% threshold. The trend is below usual variation and this indicator is not capable of hitting the target routinely.

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

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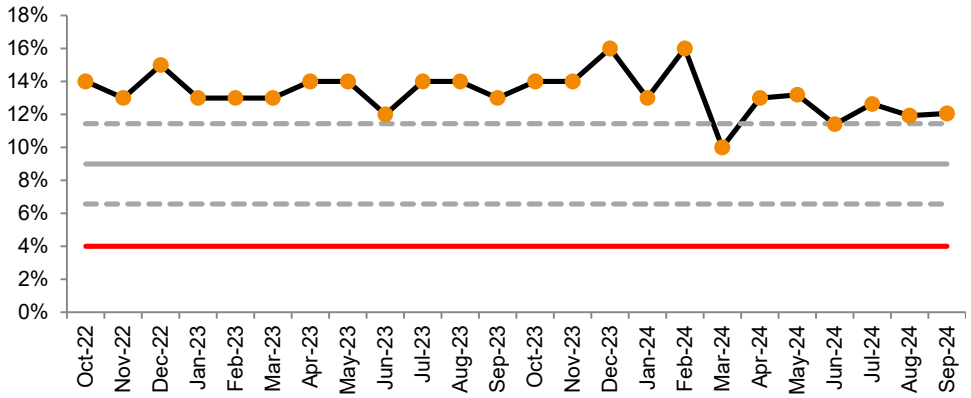
Temporary costs and overtime as % total pay bill



In September 2024, £5.2m was spent on temporary staff, consisting of £0.9m on agency staff and £4.3m on bank staff.

WTE staff worked (9,994 WTE) was 311 WTE less than is funded substantively (10,305 WTE).

Pay costs are £1.3m more than budgeted establishment in September 2024.

At the end of September 24 there were 461 vacancies.

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

Job Plans

Stage	Consultants	Non consultant grades
Awaiting Signatures	162	43
Complete	57	26
Due Soon	1	0
In Progress	98	16
No Current Job Plan	19	6
Not Started	36	15
Referred Back	9	1
Uploaded	2	0
Total	384	107

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

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

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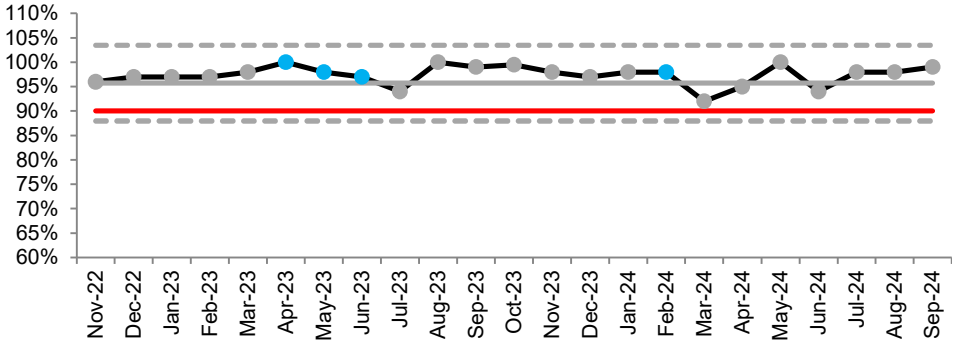
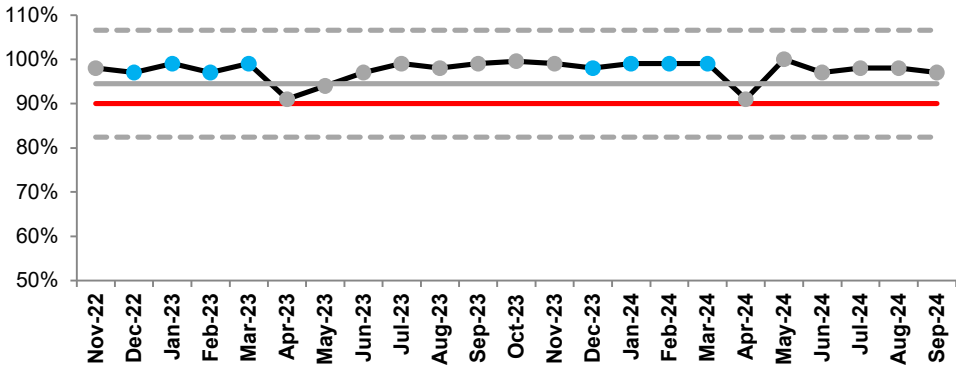
Appraisals, Consultant



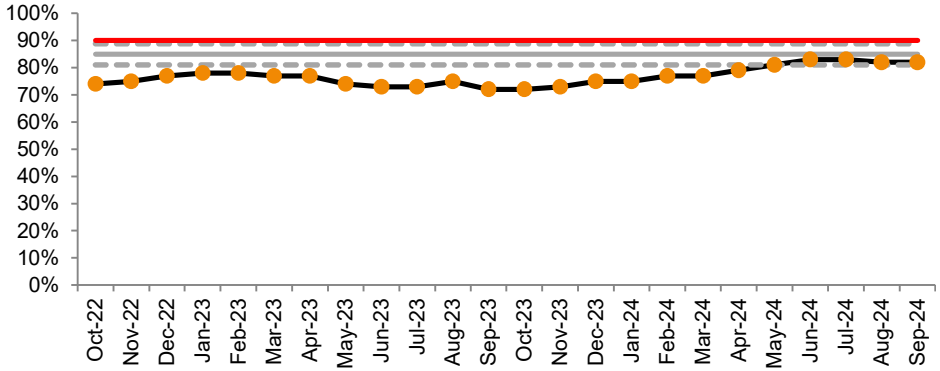
The appraisal rates for consultants and career grade doctors are reported for September 24 and reflect the number of reviews completed that were due in this period.

They both continue to be above target with 99% (consultants) and 97% (other medical) completed that were due in the period.

Appraisals, Other Medical



Appraisals Agenda for Change (AFC) Staff



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

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

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

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Core Skills Training % Compliance

	Frequency	Target	Compliance at end September
Basic Life Support	2 years	90%	89
Conflict Resolution Training L1	3 years	90%	96
Equality, Diversity and Human Rights	3 years	90%	96
Fire Safety L1	2 years	95%	94
Health, Safety and Welfare L1	3 years	90%	96
Infection Prevention L1	3 years	90%	97
Infection Prevention L2	1 year	90%	91
Information Governance	1 year	95%	94
Preventing Radicalisation Level 1	3 years	90%	95
Preventing Radicalisation Level 3 †	3 years	90%	94
Safeguarding Adults L1	3 years	90%	96
Safeguarding Adults L2	3 years	90%	95
Safeguarding Adults L3*	3 years	90%	83
Safeguarding Children L1	3 years	90%	95
Safeguarding Children L2	3 years	90%	94
Safeguarding Children L3	3 years	90%	84
Safeguarding Children L4	3 years	90%	75
Safer Handling Level 1	3 years	95%	94
Safer Handling Level 2 (Patient Handling)	3 years	95%	88

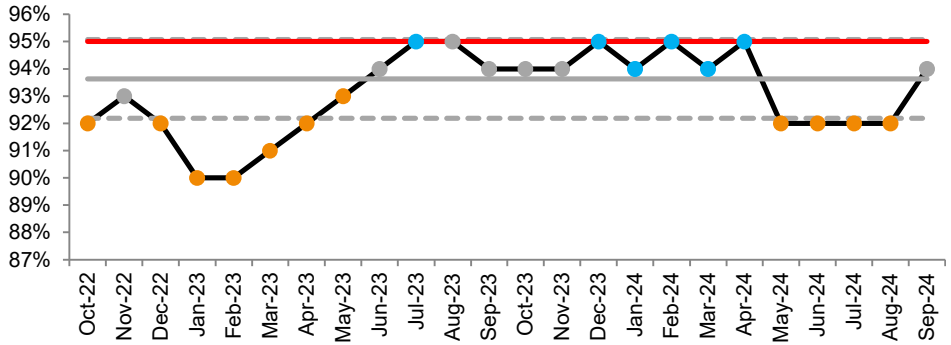
The core skills framework consists of eleven mandatory training subjects, with 19 modules in total. Training is via a suite of e-learning modules and knowledge assessments on the learning hub.

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

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

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

Information Governance Toolkit Compliance

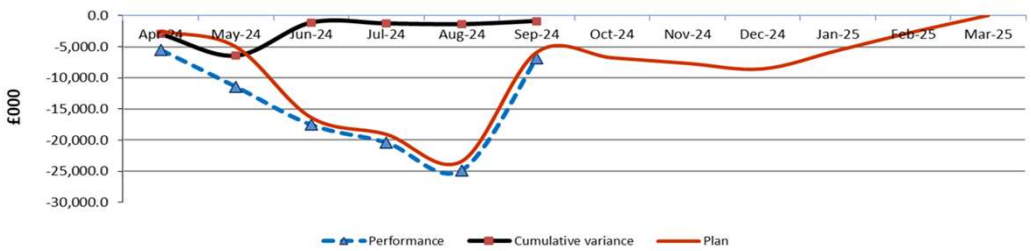


Information governance toolkit compliance is 94% in September which is below the 95% threshold. The trend is at risk of not meeting the target.

WELL LED

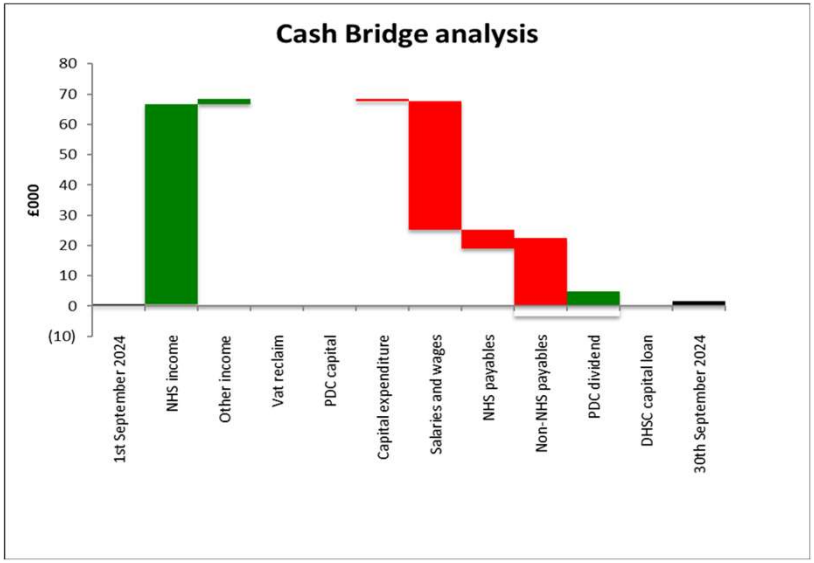
Adjusted financial perfomance

Adjusted financial performance surplus (deficit)



The Trust is reporting a £6.8m deficit for the 2024-25 financial year to date, £0.9m behind plan.

Cash



The Trust's cash balance is £1.5m as at 30th September 2024.

The Trust is reporting a deficit of £6.8m for the 2024-25 financial year to date, £0.9m behind the revised breakeven plan.

The 2024-25 capital programme remains unchanged at £33.1m with year to date capital spend at £4.5m, £1.5m behind plan

The cash balance on 30th September was £1.5m, an increase of £0.8m compared to the previous month. This position continues to be supported by £18.2m of Provider Revenue Support Public Dividend Capital (PDC).

Largely as a result of the continued effect of the Trust having to withhold payments to suppliers due to its cash position, Better Payment Practice Code (BPPC) performance has further deteriorated in September, as expected. While the Trust is now only meeting the target to pay 95% of invoices on time for the financial year to date by value for NHS invoices, performance for the value of non-NHS invoices paid on time is just below target at 94.0%.

Year to date spend on agency staff represented 2.2% of total pay against the ceiling set by NHS England (NHSE) for 2024-25 of 3.1%.

The Waste Reduction Programme for the 2024-25 financial year is £59.7m, of which £11.6m has been delivered in the year to date, in line with plan, including £10.5m of recurrent efficiencies.

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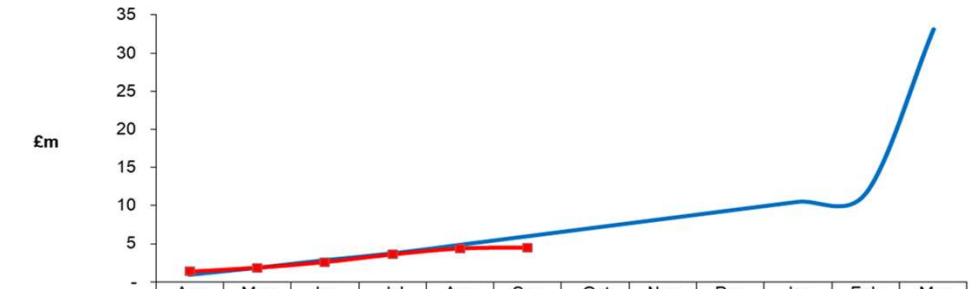
Capital expenditure

Capital expenditure profile



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Revised Plan	0.92	1.84	2.84	3.73	4.85	5.98	7.11	8.23	9.36	10.49	11.61	33.10
Actual	1.37	1.87	2.61	3.59	4.36	4.48						

The Trust is £1.5m behind planned capital spend as at 30th September 2024.

Waste reduction programme

WRP schemes analysis

Division	Annual Target £000s	Identified £000s	To Identify £000s	Number of Schemes	Year to Date Target £000s	Year to Date Achieved £000s	Year to Date Variance £000s	Year to Date Achieved Rec £000s	Year to Date Achieved Non Rec £000s	Annual Achieved Total £000s	Annual Achieved Rec £000s	Annual Achieved Non Rec £000s	Annual Achieved FYE Total £000s
Trust Wide Schemes	8,991	44,220	(35,230)	35	(13,791)	6,120	19,911	6,120	0	6,120	6,120	0	6,120
Medicine & Emergency Care	11,620	5,736	5,884	27	5,810	2,136	(3,674)	2,136	0	3,090	2,777	313	2,777
Community & Intermediate Care	3,619	1,003	2,616	15	1,809	573	(1,236)	31	542	588	46	542	46
Surgical & Anaes Services	11,649	1,027	10,622	27	5,825	393	(5,431)	393	0	678	380	298	380
Family Care	6,686	1,076	5,610	13	3,343	489	(2,854)	489	0	978	978	0	978
Diagnostic & Clinical Support	8,485	2,137	6,348	32	4,242	443	(3,799)	277	167	1,230	553	676	553
Estates & Facilities	4,498	1,600	2,898	19	2,249	286	(1,963)	186	100	320	201	119	202
Corporate Services	2,956	1,705	1,252	18	1,478	617	(861)	338	279	961	682	279	827
Education, Research & Innov'N	1,175	1,175	0	10	588	495	(93)	495	0	649	649	0	649
Total	**59,679**	**59,679**	**0**	**196**	**11,553**	**11,553**	**(0)**	**10,465**	**1,088**	**14,615**	**12,386**	**2,229**	**12,532**
Divisional Position	**50,688**	**15,459**	**35,230**	**161**	**25,344**	**5,433**	**(19,911)**	**4,345**	**1,088**	**8,495**	**6,266**	**2,229**	**6,412**

Schemes to the value of £11.6m have been transacted in the year to date. Additional identified schemes will be assessed for delivery

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **157**

20 November 2024 **Purpose** Approval

Assurance

Title	East Lancashire Hospitals NHS Trust Self-Assessment Report 2023-24 for Department of Education, Research and Innovation (DERI)
Report Author	Mrs J Owen, Deputy Director of Education, Research & Innovation
Executive sponsor	Mrs K Quinn, Executive Director of People & Culture
Date Paper Approved by Executive Sponsor	

Summary: Heath Education England (HEE) now merged within NHSE/I require all placement providers to submit an annual Self-Assessment (SA). The SA relates to the standards within the Quality Framework that organisations are expected to have in place to provide a quality learning environment for the learners they have responsibility for. The reporting period for this SA is April 2023-March 2024.

Recommendation: In order for the SA to be submitted to NHSE/I Board approval is required.

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: 9777 Loss of Education, Research and Innovation accommodation and Facilities
Related to recommendations from audit reports	
Related to Key Delivery Programmes	Place-based Partnerships Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement People Plan Priorities
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by:

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

EAST LANCASHIRE HOSPITALS NHS TRUST

SELF-ASSESSMENT (SA) 2023-2024

EXECUTIVE SUMMARY

Heath Education England (HEE) now merged with NHSE/I require all placement providers to submit an annual Self-Assessment (SA). The SA relates to the standards within the Quality Framework that organisations are expected to have in place to provide a quality learning environment for the learners they have responsibility for https://www.hee.nhs.uk/our-work/quality It is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation and subsequent evaluation.

Placement providers are asked to complete an online form indicating where they have or have not met the standards as set out in the SA. There is the opportunity under most of the questions for placement providers to provide comments to support their answers.

The SA covers the time period from April 2023-March 2024.

In summary it is clearly evidenced that ELHT provides a high-quality experience for all of our learners, but the ongoing capacity/demand and resource challenges have impacted on this. Any sections that need addressing have related action plans in place and we have evidence of many areas where our offer has been enhanced and developed.

The top three successes and challenges identified for the reporting period are as follows:

Successes:
- Placement management
- Increased SIM for Training
- Recruitment and Retention Initiatives

Challenges:
- Placement Capacity
- Training Space and Facilities
- Wellbeing

BACKGROUND INFORMATION, REPORT AND KEY POINTS

In accordance with the Care Act 2014, NHS England is responsible for the leadership of all healthcare education and training for those employed by the NHS and for those seeking NHS employment. NHS England also has the statutory obligations for the quality of the services delivered that it funds, as well as for the safety and protection of students and patients.

The NHS England Education Quality Framework identifies the standards that organisations are expected to meet to provide high quality learning environments. The NHS Education Funding Agreement (2024) requests all providers to fulfil the obligations of its roles and responsibilities set out in the NHS England Education Quality Framework and to submit a

return to NHS England on their compliance with the contract. There is the requirement, via the NHS Education Funding Agreement that organisations will undertake this annually.

During 2024 NHSE/I reviewed the SA and it has been updated in accordance with the NHS Education Funding Agreement 2024-27. Some additional questions have been added to reflect its alignment with the Long-Term Workforce Plan.

The SA is divided into several main sections:

- Section 1. Challenges within education and training.
- Section 2. Achievements within education and training.
- Section 3. Compliance with the obligations and key performance indicators of the NHS Education Funding Agreement.
- Section 4. Compliance with the quality, library, reporting concerns and patient safety training obligations and key performance indicators of the NHS Education Funding Agreement.
- Section 5. Your policies and processes in relation to equality, diversity and inclusion.
- Sections 6 - 11. Consider NHS England's Education Quality domains and standards and declare any areas, by exception, where standards are not met for each main professional group.
- Section 12. Sign off and submission.

Analysis and feedback to placement providers

Information from the SA will be triangulated with other evidence gathered through existing quality processes. This combined picture is used to determine how well an organisation is fulfilling the requirements of the Education Funding Agreement. The SA is also an opportunity to identify and confirm best practice which could be shared within and across organisations.

A national findings report will be produced outlining national themes and national compliance across England against the NHS Education Funding Agreement key performance indicators and the Education Quality Framework standards.

Regional and local education quality team will use the data contained within the SA and provide feedback to placement providers, if required, via local quality assurance processes. The threshold for follow-up review meetings will be determined by regional teams as part of their ongoing quality management processes.

How we will share the Self-Assessment

The SA itself will not be a public document and as such will not be published on NHS England's website.

The information contained within the SA (either whole or in part) may be shared with:

- Higher Education Institutes
- Undergraduate Medical and Dental Schools
- Healthcare Regulators
- NHS England Internal Teams
- Other Arms-length Bodies
- Integrated Care Boards

The SA could also be shared under a Freedom of Information Request.

NHS ENGLAND SELF-ASSESSMENT FOR PLACEMENT PROVIDERS 2024

10. TRAINING PROFESSION SELECTION

Q2. Please select from the list below those professional groups your organisation currently train, please select all those which apply:

	Yes we train in this professional group	N/A we do NOT train in this professional group
Allied Health Professionals	✓	
Dental	✓	
Dental Undergraduate	✓	
Healthcare Science	✓	
Medical Associate Professions	✓ Physician Associate, Anaesthetic Associates	
Medicine Postgraduate	✓	
Medicine Undergraduate	✓	
Midwifery	✓	
Nursing	✓	
Paramedicine	✓	
Pharmacy	✓	
Psychological Professions	✓	
Social Workers	✓	

11. SECTION 1 - PROVIDER CHALLENGES

Q3. This section asks you to provide details of (up to) 3 challenges within education and training that you would like to share with us. Please consider whether there are any challenges which impact your ability to meet the education quality framework standards. Please select the category which best describes the challenge you are facing, along with a brief description/narrative of the challenge (*the character limit is set at 2000 characters*). In the event you cannot find an appropriate category select other and add the category at the start of your narrative.

Categories:
Apprenticeships / Burnout/wellbeing / COVID/Post COVID return to norm / Culture / Curricula/training standards / Education governance & strategy / Funding-requirements/unpredictability/timeliness / HEI issues/processes / Increase in LTFT/reasonable adjustment requests / IT systems / NHS England issues/processes / Other / Placement management/capacity / Supervisors/educators (investment) / Supervisors/educators (recruitment/retention) / Supervisors/educators (training) / Training

affected by service pressures (cannot release staff) / Training equipment/systems / Training space/facilities / Trust merger/reconfiguration / Workforce challenges (recruitment/retention)	
1	Placement Capacity: Student, trainee and learner numbers across the organisation are high and due to the ongoing national and local drivers for increase plus service pressures this has the potential to adversely affect quality and experience of provision. Undergraduate The Trust has now reached maximum capacity for undergraduate medical placements. Pressure exists from HEI's and NHSE/I to increase our numbers and take new courses and cohorts, including commencement of a MDD Apprenticeship in 2025. We are working with our HEI's and system partners to explore how simulation, enhanced placement teaching activity and regional placement mapping can alleviate capacity pressures and how coordination in terms of placement structures can maximise utilisation of clinical opportunities. Postgraduate Medical Expansion in foundation nationally and on-going demand for extra training posts alongside increase in multi-professional undergraduate placements all needing supervision is difficult in the current climate with additional demands on increase in clinical activity. We are currently reviewing all provision and ensuring that education provision is recognised and supported in job roles.
2	Training Space and Facilities: Delivering a high-quality education offer within available resources and finances, both Trust wide and as part of the ICS/B, is an ongoing challenge. The financial position within LSC and the NHS nationally during the last 12 months has exacerbated some issues. The education and training facilities across ELHT are a challenge and this is on the Trust risk register scored at 16 with mitigations and action plan in place.
3	Wellbeing: We are still seeing an on-going expansion of foundation doctors needing registration as TRES both for personal challenges affecting wellbeing but also for professional and educational support. We have an increase in LTFT doctors mainly due to concerns surrounding wellbeing and work life balance. This has an impact on rota gaps and pressures in the clinical workplace. The short-term funding of wellbeing support posts has now ceased, members of the Education and occupational health team are providing support, but this is not equivalent to specifically funded previous posts in this area. Time constraints for supervisors, programme directors and administrators are significant factors in the challenge in providing consistent accessible support. With the over expansion within foundation training, we have seen a significant rise in international NHS naive graduates requiring specific additional support at the start of training.

	The levels of sickness across all grades of medical staff have increased, managing the needs associated with this in terms of support of the trainees, in addition to the management of gaps in rotas and structures to monitor sickness remains a challenge. We are currently undertaking a review the processes within the Trust to help resolve some of these issues.

12. SECTION 2 - PROVIDER ACHIEVEMENTS AND GOOD PRACTICE

Q6. This section asks you to provide details of (up to) 3 achievements within education and training that you would like to share with us. Please select the category which best describes the achievement you wish to share, along with a brief description/narrative (*the character limit is set at 2000 characters*). In the event you cannot find an appropriate category select other and add the category at the start of your narrative

Categories:
Collaboration/Partnerships / COVID – response/catchup / CPD / Culture / Development of TEL provision / Improved facilities / Increased SIM for Training / Innovative Training/Course Development / Learner/Trainee Support or Wellbeing / Multi-professional Initiatives / New/Improved Strategy or Governance / Other / Placement Capacity/Expansion / Quality – Improvement initiatives/response to data/positive feedback / Recruitment/Retention Initiatives / Supervisors/Educators (investment) / Supervisors/Educators (training)

1	Placement management/capacity: Partnership working across system to consider placement mapping of nursing and medical students. Expansion of placement capacity through use of simulation
2	Increased SIM for Training: We opened our new simulation facility on Burnley General Teaching Hospital site at the beginning of 2024. This includes immersive technology. It has been fully utilised for multi-professional training delivery and we are now looking at research in this area. We have supported system partners including HEI's in simulation and have an established simulation faculty and LSC working group.
3	Recruitment/Retention Initiatives: At ELHT we have increased our international nursing numbers and supported them through training to complete OSCE examinations and register with the NMC. We have also undertaken a number of recruitment events and have employed our nursing students with a plan that we will be fully recruited to all Band 5 nursing roles by November 2024, which is a significant achievement from the recurrent 240 vacancies over the last 5 years.

13. SECTION 3 - CONTRACTING AND THE NHS EDUCATION CONTRACT

Q9. Please confirm your compliance with the obligations and key performance indicators set out in Schedule 3 of the NHS Education Funding Agreement (EFA).	Y	N
There is board level engagement for education and training at this organisation.	Y	
The funding provided via the NHS Education Funding Agreement (EFA) to support and deliver education and training is used explicitly for this purpose.	Y	
We undertake activity in the NHS Education Funding Agreement which is being delivered through a third-party provider.	Y	
The Provider or its sub-contractor did not have any breaches to report in relation to the requirement of the NHS Education Finding Agreement (EFA)	Y	
We are compliant with all applicable requirements of the Data Protection Legislation and with the requirements of Schedule 5 of the NHE Education Funding Agreement	Y	
The Provider did not have any health and safety breaches that involve a learner to report in the last 12 months.	Y	
The organisation facilitates a cross-system and collaborative approach, engaging the ICS for system learning.	Y	
We have collaborative relationships with our stakeholders (e.g. education providers) which provide robust mechanisms to deliver agreed services.	Y	

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

The Directorate of Education, Research & Innovation (DERI) is fully supported by the Trust Board and Executive team. We present to the Execs on a 6 monthly basis, including achievements, challenges and risks. We have a DERI Strategy and Education Plan in place which underpins the ELHT Strategic Framework and Clinical Strategy. We report bi-monthly through DERI governance processes and also report into the People and Culture Committee. The Directorate has developed systems and processes to ensure the correct attribution of education income across the Trust. This work has involved developing networks and contacts with NHSE/I and colleagues across LSC in order to understand income flows and ensure an equitable approach. The palliative care aspect of the Cancer Care/End of Life module is provided by Pendleside and East Lancashire Hospices, these are the only Learning Objectives which cannot be achieved at ELHT. This is co-ordinated by the DUE team to ensure student timetables are at their most efficient. Payment is received for these placement days and channelled to the appropriate hospice via Financial

Services (invoice raised by hospice/paid via purchase order). UCLan do have SLAs with both hospices to provide placements which details what their responsibilities are. There have been no breaches in the requirements of the NHS Education and Training Contract for any sub-contractor reported. We are fully compliant with all education and training data requests. There have been no health and safety breaches involving a student, trainee or learner. We work in partnership across the system and have core membership in all education meetings, this includes for example LSC Strategic Education & Training Collaborative and LSC Collaborative Education Forum. We are currently leading on key tasks within the system to map medical and non-medical undergraduate placement capacity and to develop and deliver the Medical Doctor Degree Apprenticeship.

14. SECTION 4 - EDUCATION QUALITY

Q12. Can you confirm as a provider that you...	**Y**	**N**
Are aware of the requirements and process for an education quality intervention, including who is required to attend.	Y	
We are reporting and engaging with the requirements and process to escalate issues, in line with NHS England's education concerns process.	Y	
Have developed and implemented a service improvement plan to ensure progression through the Quality and Improvement Outcomes Framework for NHS Funded Knowledge and Library Services.	Y	
Has the provider been actively promoting, to all learners, use of the national clinical decision support tool funded by NHS England?	Y	
Have a Freedom to Speak Up Guardian and they actively promote the process for raising concerns through them to their learners.	Y	
Have a Guardian of Safe Working (if postgraduate doctors in training are being trained), and they actively promote the process for raising concerns through them to their learners,	Y	
Are aware of the Safe Learning Environment Charter (SLEC)	Y	
Are actively implementing and embedding the SLEC multi-professionally.	Y	

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Library service improvement plan aligned to 2022 QIOF return, highlighted development areas in outcome measures 1, 4 & 5 which have been addressed and will be reflected in future returns.

Promotional materials displayed throughout the Trust and Freedom to Speak Up Guardian referred to in all Trust inductions. A dedicated page on the Trust Intranet for the Guardian Services. Mandatory training available on the Trust Learning Hub.

The GOSW works closely with the DME and all stakeholders and participates in induction of various trainees. A Resident Doctors' Forum is held bi-monthly for those in formal training posts and Locally Employed Doctors. Feedback is given to this group surrounding exception report patterns and outcomes and the GOSW also reports regularly to the Trust Leadership Team.

A bimonthly Medical Education Quality Assurance Meeting chaired by DME, with attendance/reports provided by TSTLs and leads specific training areas, in addition to input from the Patch Dean. Concerns, feedback (e.g. NETS, GMC survey), and positive innovations are shared via this meeting.

As an education team we communicate regularly with heads of specialty schools and collaborate in addressing any concerns raised. Some examples from the last 12 months of areas discussed at a Head of School and Deanery level are:

- Concerns raised via Trainees in ED surrounding workload and acuity: significant changes have been made in the patterns of allocation of places of work, timing of shifts (self-rostering is being considered), allocation to the paediatric area and the distribution of consultant staff and supervision.
- Concerns raised by trainee in the O&G Department surrounding Equality & Diversity within the wider team. A collaboration with clinical and educational leadership has led to a Trust wider strategy, increased profile of the Freedom to Speak up Guardian and allyship training focussing initially on the Trust and divisional leadership teams.

Q13. As an organisation, have you been referred to a regulator for education and training concerns in the last 12 months (with or without conditions) (e.g., GMC, GDC, HCPC, NMC, etc)	
We have not been referred to a regulator	✓
We have been referred to a regulator	

Q14. Did you actively promote the National Education and Training survey (NETS) to all healthcare learners?	
Yes	✓
No	
Please briefly describe your process for encouraging responses including your organisations response rate for the 2023 NETS.	

Undergraduate - learners who undertook placements at ELHT were emailed the link to complete the NETS survey. Posters displayed in both education centres. NETS discussed and promoted in placement review meetings. HEI's were also asked to promote.

Postgraduate – encouragement to complete the survey was distributed via email, publicity in the education centres, and via the departmental education leadership. Dissemination of information through year reps and Foundation What's App groups, and to the Trust leadership groups via the Medical Directors meetings.

Response rate for 2023: 226 across all professions.

Q15. Have you reviewed at Board Level, and where appropriate, taken action on the outcome of the results of the National Education and Training Survey (NETS).

Yes	✓
No	

Please provide a brief description of the action you have taken as a result; if 'no' please provide further details including your plans to use the NETS data for quality improvement activity in the future:

NETS outcomes discussed at Divisional Education Boards and at the Trust's Education Operational Delivery Board. NETS results triangulated against other sources of student feedback e.g. P@RE evaluations for non-medical leaners, HEI placement feedback for medical students and at ELHT end of placement and end of course reviews.

NETS feedback is provided to the Medical Education Quality Assurance group and the Medical Directors group.

NETS results presented to Exec Team as part of the regular review meetings and through People & Culture Committee which reports into Board.

Q16. 2024's NETS will be open from 1 October 2024 until 26 November 2024. How will your organisation increase their NETS response rate for 2024?

Undergraduate - encourage students at inductions. Ask educators to highlight and disseminate link at the end of teaching sessions. Continue to email all students with link.

Postgraduate - use of What's App groups, forums and Foundation Year reps to encourage engagement. Foundation Team will send reminder e-mails out to both cohorts for completion. This is carried out throughout the period where the survey is open.

ELHT is taking part in the current evaluation of the NETS platform that will hopefully improve the ease of use and help increase uptake.

Q17. Patient Safety and the promotion of a Patient Safety culture is integral to the Education Quality Framework. Please provide the following information:	
Name and email address of your Board representative for Patient Safety.	Jawad Husain, Medical Director - Jawad.husain@elht.nhs.uk
Name and email address of your non executive director representative for Patient Safety.	Richard Smyth, Non-Executive Director – richard.smyth@elht.nhs.uk
Name and email address of your Patient Safety Specialist/s.	Jacquetta Hardacre – Jacquetta.hardacre@elht.nhs.uk
What percentage of your staff have completed the patient safety training for level 1 within the organisation (%).	On 19/08/24: 1a 93.30% completed 1b 84.20% completed against a target of 95%

15. SECTION 5 - EQUALITY, DIVERSITY AND INCLUSION

Q19. Please confirm whether your organisation has an Equality, Diversity and Inclusion Lead (or equivalent):	
Yes	✓
No	

If 'yes' please add comments to support your answer sharing details of governance and links with education and training alongside the nominated name of your EDI lead for education and training; if 'no' please provide further detail.

Nazir Makda is the Inclusion & Belonging Lead.

The Directorate of Education, Research, and Innovation (DERI) has strong links with the Trust's EDI Lead. The Lead actively engages with the Education and Training function, contributing to governance meetings and ensuring training is accessible to diverse groups. They deliver EDI training on topics like unconscious bias, inclusive recruitment, and anti-racism, while education staff participate in Inclusion and staff network meetings. EDI efforts are data-driven, guided by frameworks such as the NHS EDS2, WRES, WDES, and NHS Rainbow Badge Accreditation. Education staff also support the Trust's annual BIG Get Together and the Anti-Racism Quality Improvement program.

In collaboration with NHSENW Ms Uma Krishnamurthy and Senior OD lead Emma Dawkins are the leads for the Allyship project with the drive for ELHT to become an antiracist organisation. The Senior Leadership Team are engaged in this work and

cascade training the trainers has begun in this area in addition to the provision of accessible training courses to staff members of all professions and grades.

EDI competencies are part of the mandatory training for all staff.

The Trust is also signed up to the Sexual Safety Charter.

Workshops surrounding Neurodiversity have been undertaken, cascade training amongst those in educational roles is being undertaken.

Q20. Please confirm that you liaise with your Equality, Diversity and Inclusion Lead (or equivalent) to...	**Y**	**N**
Ensure reporting mechanisms and data collection take learners into account?	Y	
Implement reasonable adjustments for learners with a disability?	Y	
Ensure policies and procedures do not negatively impact learners who may have a protected characteristic(s)?	Y	
Ensure International Graduates (including International Medical Graduates) receive a specific induction into your organisation?	Y	
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	Y	
Ensure a policy is in place to manage Sexual Harassment in the Workplace?	Y	
Do you have initiatives to support reporting of sexual harassment?	N	
Has your organisation signed up to the NHS England Sexual Safety in Healthcare - Organisational Charter?	Y	
Does your organisation have a designated sexual safety lead, such as a Domestic Abuse and Sexual Violence (DASV) lead?	Y	

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

As part of the WRES, WDES and MWRES, the Equality, Diversity & Inclusion Lead has responsibility to collect and monitor learning & development and CPD activity by protected characteristics.

All learning activities are recorded on the Trust's Learning Hub system which is capable of producing full reports on staff learning & development and CPD by protected characteristics.

At the point of recruitment all trainee doctors commencing work in ELHT are recorded on the ESR system. We currently collect information on race, gender, age, sexual orientation, religion, disability and marital/ civil partnership status and location of obtained primary medical qualification religion, disability and marital/ civil partnership status and location of obtained primary medical qualification.

Course documents take into consideration the individual needs of the learner Inc. Initial Assessment at appraisal and Individual Learning Plan.

All learners, prior to attending any learning event are asked for their access requirements and/or if any reasonable adjustments are needed.

The learning environment is conducive to learning e.g. layout, accessibility including Car Park Access, Wide doors, Lifts, Toilets. Auxiliary aid e.g. hearing loops, Assistive technology (Software/hardware), Enlarged Handouts, Dietary needs 1:1 or small group support.

Q21. How does your organisation manage sexual harassment reports?

From a member of staff themselves, a union colleague representing a member of staff, reported via the whistleblowing policy, the police or via the Staff Guardian.

Each report of this nature would be subject to an informal preliminary investigation to establish some basic facts and a commissioning manager would be appointed to commission and oversee a formal investigation. The investigation would follow ELHT's Disciplinary Policy as sexual harassment is considered potential gross misconduct.

The commissioning manager would appoint an Investigating Manager who with support from a Divisional HR Manager would fully and formally investigate the case. The investigation report would go back to the investigating manager who would then decide, based on the evidence if there was a case should be heard at a formal hearing.

Depending on the details of the case, safeguarding and the Police could also be involved and feed into the investigation process as appropriate.

Q22. Postgraduate Deans and their teams are keen to consider responses and initiatives and share good practice. Please share details on EDI initiatives that are specific to or have an impact on education and training in your organisation and the email address for someone we can contact to discuss this further.

EDI Masterclass and Unconscious Bias Training for Educators: Educators undergo regular unconscious bias training to enhance their awareness of diversity-related challenges and foster more inclusive learning environments. This training is designed to reduce biases in assessment and interactions with learners.

Career Clinics/Coaching & Mentoring for Underrepresented Groups: We have introduced **Coaching & Mentoring** specifically tailored to support learners from underrepresented backgrounds. This has been particularly impactful in boosting

confidence, improving retention rates, and encouraging progression within their chosen fields.

Foundation teaching includes wellbeing and EDI sessions.

For more information contact Nazir Makda, Inclusion & Belonging Lead, nazir.makda@elht.nhs.uk

Q23. For education and training, what are the main successes for EDI in your organisation?

The Trust has improved the WRES Indicator 4: likelihood of BAME staff undertaking non-mandatory training compared to white colleagues. The ratio improved from 1.84 in 2023 to 1.00 in 2024, this suggest that more BAME staff are accessing learning and education that supports career development and progression.

Developed the Reasonable Adjustments training for all staff.

Resource boxes in training rooms/available from Reception with coloured overlays, magnifiers and reading rulers.

Information available on how to install Colorveil on to computers/laptops.

Portable Hearing Loop Systems available in both the Learning Centre RBTH and Training and Development Centre BGTH.

Created a space on the ground floor of the Training and Development Centre BGTH to purchase drinks/snacks.

Amended the room descriptions on the room booking system to include accessibility information.

Bite size session on - how to be more inclusive in your training.

Accessibility Group.

Q24. For education and training, what are the main challenges for EDI in your organisation?

- **Accessibility of Training**: Ensuring that all learning and development opportunities are fully accessible to staff from diverse backgrounds, particularly those with disabilities, neurodiversity, or other specific needs. This includes making reasonable adjustments and providing the necessary support resources.
- **Cultural Awareness and Bias**: Addressing unconscious bias and ensuring that educators and staff are well-trained in cultural competency. This is crucial for creating inclusive learning environments where all learners feel represented and supported.
- **Data Collection and Monitoring**: While the Trust has mechanisms in place, such as the Learning Hub, the challenge lies in consistently collecting and analysing data by protected characteristics to identify gaps and ensure equity in training outcomes.
- **Support for Underrepresented Groups**: Providing tailored mentorship, coaching, and career development support for learners from underrepresented backgrounds is essential, but resources are often stretched.
- **Capacity and Resources**: The growing demand for EDI training and support across the Trust can strain resources, especially with the limited capacity of our EDI lead and training teams.
- **Managing Discriminatory Behaviours**: Ensuring that policies around managing discriminatory behaviour from patients or within learning environments are consistently applied, and that staff feel confident in addressing such issues.
- **Engaging International Graduates**: Delivering comprehensive inductions for international graduates and ensuring they feel supported in transitioning to UK clinical practice requires sustained effort and resources.

Addressing these challenges requires ongoing collaboration, training, and allocation of resources to embed EDI fully into the education and training framework.

16. SECTION 6 - ASSURANCE REPORTING: LEARNING ENVIRONMENT AND CULTURE

Q26. Thinking about the learning environment and culture of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Undergraduate:
Raising Concerns mailbox for students to raise issues. Restructure of early years timetables to include time allotted to pastoral support. Visibility of the team in clinical environments. Feedback session and feedback forms sent to students. Comments both positive and negative escalated to ward teams.

Postgraduate Medical training:
Foundation training - organising foundation teaching to facilitate prayers through appropriate break times, prayer mats and rooms available on site. Wellbeing Committees within the foundation doctors organising all-inclusive activities. Away days with a culturally sensitive sports day for all new foundation doctors in their shadowing week and at the end of the year. IMG foundation doctor's introduction to IMG Lead and invitation to join appropriate IMG sessions.

Year 5 medical students at ELHT completed simulated on-call sessions, shadowed the crash team and shadowed foundation doctors during their assistantship placement.

International Medical Graduates (IMG):
All new trainees are signposted to national and regional resources relevant to new to the NHS graduates. Induction and a welcome meeting are arranged with the postgraduate team and essential pastoral care needs identified. A local checklist has been developed to ensure trainees and supervisors can consistently address key challenges encountered on starting in the NHS.

Following this a face-to-face monthly teaching program is run within the Postgraduate Department with a mixed approach of taught clinical and non-clinical content and simulation.
On-going pastoral care, support with training, career progress and addressing any other concerns via the clinical supervisors, TSTLs and Education Leadership team.

For more information email julia.owen@elht.nhs.uk

Q27. Quality Framework Domain 1 - Learning environment and culture	**We meet the standard** for all professions / learner groups	**We have exceptions to report** and provided narrative below
The learning environment is one in which education and training is valued and championed.	✓	

The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.	✓	
The organisational culture is one in which all staff, including learners, are treated fairly, with equity, consistency, dignity and respect.	✓	
There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.	✓	
Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.	✓	
The environment is one that ensures the safety of all staff, including learners on placement.	✓	
All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.	✓	
The environment is sensitive to both the diversity of learners and the population the organisation serves.	✓	
There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence led practice activities and research and innovation.	✓	
There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.	✓	
The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to library and knowledge services and specialists.	✓	
The learning environment promotes multi-professional learning opportunities.	✓	
The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.	✓	

17. SECTION 7 - ASSURANCE REPORTING: EDUCATION GOVERNANCE AND COMMITMENT TO QUALITY

Q31. Thinking about the educational governance and commitment to quality of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you to would like share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Undergraduate - ongoing feedback meetings with HEIs regarding quality and standard of medical and non-medical student placements. Feedback requested from students at the end of teaching sessions (via QR code – Kiel.Shoja@elht.nhs.uk). Annual quality assurance visits from HEIs. Bi-monthly quality assurance meetings with partner representatives from HEIs.

Postgraduate – six-weekly forums for FY1 and FY2 groups attended by Foundation Programme Directors, DME and Medical Director. Peer chosen year reps who represent foundation doctors at the Trust both regionally and nationally. Encouraged to share this through the forums and What's App groups. ELHT Rep meetings 6-weekly. Specialty reps to highlight issues raised in placement and feedback. Formal ARCP process with checklist shared with all trainees and supervisors; external NHSE member present at ARCP.

Resident Doctors Forum occurs bimonthly with representatives from medical staff groups (foundation reps, chief registrars, and clinical fellow reps), the BMA, and the LNC. The meetings are chaired by the GOSW and attended by members of the education clinical and non-clinical team. An active action matrix is populated capturing actions and feedback regarding issues raised including exception reports and initiatives such as the improving doctors Working Lives initiatives.

Q32. Quality Framework Domain 2 – Education governance and commitment to quality	**We meet the standard** for all professions / learner groups	**We have exceptions to report** and provided narrative below
There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-professional and, where appropriate, inter-professional approach to education and training.	✓	
There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.	✓	
The governance arrangements promote fairness in education and training and challenge discrimination.	✓	
Education and training issues are fed into, considered and represented at the most senior level of decision making.	✓	

The provider can demonstrate how educational resources (including financial) are allocated and used.	✓	
Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.	✓	
There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.	✓	
Consideration is given to the potential impact on education and training of service changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including WT&E and Education Providers).	✓	

Q34. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

There are full governance processes in place across the DERI to ensure we deliver a high-quality education and training experience for all staff and learners and that any issues raised are addressed and escalated appropriately.

18. SECTION 8 - ASSURANCE REPORTING: DEVELOPING AND SUPPORTING LEARNERS

Q36. Thinking about how you develop and support learners within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Undergraduate contact: kiel.shoja@elht.nhs.uk

- Undergraduate Teaching Committee: facilitated by foundation doctors within the Trust. Providing teaching and training to undergraduate students. Supporting formal University funding teaching and training
- Final year medical students shadowing foundation doctors prior to qualifying on placement.
- 'Sim on-call'/on-call shifts: students experience pressures of being on-call via simulated sessions as preparation.

Postgraduate Medical contact: anna.sibley@elht.nhs.net

- Enhanced Foundation Programme Structured learning including community facing learning objectives and experience; presentation at Best Practise Conference 2024.
- ARCP checklist; increasing confidence of trainees and supervisors in expectations and competencies.
- Constantly adapting teaching programme, informed by current curriculum, feedback, and triangulation of incident themes in the trust / national drivers.
- Foundation led Surgical Skills Course, interview and careers events, international poster event.
- Grand Round for medical trainees including multi-disciplinary involvement to enhance cross specialty education.
- Simulation training; simulation facility allowing delivery of local resuscitation courses and simulation for specific trainee groups such as foundation trainees and IMT2-3. Simulation training is also embedded in training for Locally employed and international medical graduates as apart of bespoke training including both clinical and human factors learning outcomes.
- The development of a buddy system for international graduates new to the NHS.
- The development of innovative regional projects such as Allyship training and Compassionate leadership training (training for trainers in place teaching planned for 2025).

Multiprofessional contact: Andrew.keavey@elht.nhs.uk

- ELHT has hosted a L&SC TPEP project that has developed a new L&SC Placement Learning Philosophy that is being shared with learners and placement providers across the region.

Q37. Quality Framework Domain 3 – Developing and supporting learners	**We meet the standard** for all professions / learner groups	**We have exceptions to report** and provided narrative below

There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.	✓	
The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.	✓	
Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.	✓	
Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.	✓	
Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	✓	
Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and learning outcomes.	✓	
Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.	✓	
Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.	✓	
Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.	✓	
Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.	✓	
Learners are encouraged to access resources to support their physical and mental health and wellbeing as a critical foundation for effective learning.	✓	

19. SECTION 9 - ASSURANCE REPORTING: DEVELOPING AND SUPPORTING SUPERVISORS

Q41. Thinking about how you develop and support supervisors within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Undergraduate:

- Supervisor education days in collaboration with HEIs, sharing best practice, curriculum updates and training.
- Education JCEFs offered PG Cert/Dip in Medical Education.
- ELHT foundation supervisor training sessions on curriculum changes and ACRP tools.
- ELHT delivers in-house Train the Trainer programmes for NMC & HCPC registrants to develop into Practice Supervisors and upon completion of a further Train the Trainer verification can become Practice Assessors.

Postgraduate medical:

- The development of a local checklist for new locally employed doctors with enhanced information and support, shared with supervisors to ensure all are aware of predicted and evidenced needs and requirements.
- Educator Updates 3 times yearly for all supervisors to maintain GMC competencies; subjects focus on current needs such as International medical Graduates and Wellbeing of trainees.
- Additional bitesize educator sessions to update re training issues and developments.
- Medical Education Quality Assurance Group meeting bimonthly to assure up to date knowledge shared with TSTLs and via this group supervisors.
- Sharing of information to Trust leadership team via the Medical Directors Group to encourage information sharing to Divisional Leadership teams including issues concerning time allocated for supervision and current themes and concerns.
- Involvement of supervisors in the ARCP processes for higher specialist and foundation trainees.
- The development of SAS and Specialist Doctors into Educational and Clinical Supervisors in addition to Appraiser roles via the SAS Lead.

Q42. Quality Framework Domain 4 – Developing and supporting supervisors	**We meet the standard** for all professions / learner groups	**We have exceptions to report** and provided narrative below
Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.	✓	
Those undertaking formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and	✓	

expectations of partner organisations (e.g. Education Provider, WT&E).		
Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.	✓	
Educational Supervisors are familiar with, understand and are up-to-date with the curricula of the learners they are supporting. They also understand their role in the context of learners' programmes and career pathways, enhancing their ability to support learners' progression.	✓	
Clinical supervisors are supported to understand the education, training and any other support needs of their learners.	✓	
Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.	✓	
Supervisors can easily access resources to support their physical and mental health and wellbeing.	✓	

Q44. For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

All trainees and students are impacted by workload challenges within acute trusts. The numbers and acuity of patients is an opportunity in providing a fertile environment for learning from exposure and experience however this can lead to an increase in pressure on the time dedicated by clinical teams to education.

The majority of named supervisors have time dedicated in their job plans, clinical support and time allocated to teaching during Direct Clinical Care is not recognised nationally. We are currently reviewing funding support for medical education supervision across ELHT.

Q45. Thinking about the Educator Workforce Strategy, please confirm that your organisation:	**Y**	**N**
Is aware of the Educator Workforce Strategy	Y	
Ensures educators/supervisors undertake a skills gap / learning development needs analysis for this role.	Y	
Ensures educators/supervisors have formal development to undertake this role.	Y	
Considers the educator workforce in wider clinical workforce planning.	Y	

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

ELHT delivers an in-house Train the Trainer programme for NMC & HCPC registrants to develop into Practice Supervisors and upon completion of a further Train the Trainer verification can become Practice Assessors.

ELHT has hosted a review of Educator development in L&SC through the delivery of a NHSE funded TPEP project.

ELHT hosts Educational and Clinical Supervisor courses via an external provider and runs local Educator Update sessions 3 times per year.

We are in the process of completing a review of all educator roles and have an established Education Quality Governance meeting in place. We are currently aligning our work to the Strategy to identify any gaps.

Q46. Implementation of the Educator Workforce Strategy:	
We have **fully implemented** the recommendations of the Educator Workforce Strategy.	
We have **partially implemented** the recommendations of the Educator Workforce Strategy.	✓
We have **not yet started** implementation of the recommendations of the Educator Workforce Strategy.	

20. SECTION 10 - ASSURANCE REPORTING: DEVELOPING PROGRAMMES AND CURRICULA

Q48. Thinking about how you deliver programmes and curricula to support training within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Medical Postgraduate training:
Foundation training / Enhanced training:

- Introduction of compassionate conversations to all FY2.
- On-going lessons learned.
- Simulation and small group teaching with lots of hands-on skills designed across FY1 and FY2 to map to the curriculum and flow across the 2 years.
- Ongoing development of the Foundation Clinics and Theatre protected training time to allow a doctor to embrace enhanced training and availability in all specialties.
- Input into the foundation teaching program from specialty teams.
- Input into foundation teaching by Quality Improvement and Quality & Safety Teams

Specialty and Higher Specialist training (including locally employed doctors):

- Collaboration is undertaken with specialty schools via TSTL roles and regular updates attended by the education leadership team.
- Sharing of information and updates via Medical Education Quality Assurance Group and Educator Updates to TSTLs and supervisors within departments.
- Local teaching within specialty including embedded simulation (very regular in ED and neonatology, developing in other specialties such as paediatrics with the increasing use of joint simulations)
- Good record for release of rotational trainees to attend training sessions.
- Local programs of delivery tailored to and open to locally employed doctors.
- Competency frameworks for progression of locally employed doctors in development (already in use in some specialties as criteria to progress in level of seniority).

Education JCEFs complete a PG Cert/Dip in Clinical Education. This offer has been expanded this year to include member of our PEF Team and Pharmacy Education Leads.

Q49. Quality Framework Domain 5 – Developing programmes and curricula	**We meet the standard** for all professions / learner groups	**We have exceptions to report** and provided narrative below
Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.	✓	
Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.	✓	

Placement providers collaborate with professional bodies, curriculum/programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.	✓	
Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.	✓	
The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.	✓	
Timetables, rotas and workload enable learners to attend planned/timetabled education sessions needed to meet curriculum requirements.	✓	

21. SECTION 11 - ASSURANCE REPORTING: DEVELOPING A SUSTAINABLE WORKFORCE

Q53. Thinking about developing a sustainable workforce within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like you share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Foundation training: Enhanced initiative, pilot site:

New initiatives from NHSE have come with the need for more time away from the clinical arena. We have worked with NHSE to adapt these initiatives maintain the excellent theory but also with reduced time out of the clinical arena. Enhanced training contact: helen.coutts@elht.nhs.uk

The enhanced wellbeing offer with in-reach into the postgraduate department will be helpful in early intervention for wellbeing issues and therefore in retaining staff, this remains in development. A Deputy Director of Medical Education has Wellbeing as part of her portfolio.

Those doctors in training requiring additional support are discussed confidentially withing the core team and a management plan reviewed at trainee wellbeing collaborative meetings with the presence of HR and Occupational Health.

An open culture is in place to encourage doctors in training to raise concerns about their own wellbeing in addition to any wider concerns and structures to do this are publicised such as the open-door policy in the Education Department and wider Trust structures such

as the Freedom to Speak Up Guardian. This can mean that concerns are raised and acted upon.

Q54. Quality Framework Domain 6 – Developing a sustainable workforce	**We meet the standard** for all professions / learner groups	**We have exceptions to report** and provided narrative below
Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	✓	
Does the provider provide opportunities for learners to receive appropriate careers advice from colleagues.	✓	
The provider engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	✓	
Transition from a healthcare education programme to employment and/or, where appropriate, career progression, is underpinned by a clear process of support developed and delivered in partnership with the learner.	✓	

Julia Owen

Deputy Director DERI

November 2024

Lancashire and South Cumbria Provider Collaborative

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **158**

20 November 2024 **Purpose** Information

Title	EPRR Annual Assurance Statement and Report for 2023-24
Executive sponsor	Mr T McDonald, Executive Director of Integrated Care, Partnerships and Resilience
Date Paper Approved by Executive Sponsor	6 November 2024

Summary: This paper describes the current position of the Trust in relation to the NHS Core Standards Assurance for emergency preparedness, resilience and response (EPRR) and provides the Trust Board with assurance that ELHT meets its statutory duties under the Civil Contingencies Act 2004 and the Health and Social Care Act 2012 and its other non-statutory obligations.

Recommendation: The Trust Board is requested:

a) To receive the action plan contained within this report to provide assurance that the trust is committed to declaring full compliance against the EPRR Core Standards by June 2025.

b) To receive this report as assurance that the Trust has robust, evidence based and tested EPRR practices in place and that it substantially fulfils its statutory and non-statutory duties and obligations.

Report linkages

Related Trust Goal	Deliver safe, high-quality care	
Related to key risks identified on Board Assurance Framework	1	The strategies and partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, do not align and/or deliver the anticipated benefits resulting in improved health and wellbeing for our communities.
	2	The Trust is unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.
	4	The Trust is unable to deliver its objectives and strategies (including the Clinical Strategy) as a result of ineffective workforce planning and redesign activities and its ability to attract and retain staff through our compassionate inclusive, wellbeing and improvement focused culture.
	5	The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	-	
Related to recommendations from audit reports	-	
Related to Key Delivery Programmes	-	

Related to ICB Strategic Objective -

Impact

Legal	Yes	Financial	No
Equality	Yes	Confidentiality	Yes

Previously considered by:

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

Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Statement and Report for 2024/25

Executive Summary

1. This report provides an overview of the Trusts emergency preparedness, resilience and response during the past 12 months and provides assurance that East Lancashire Hospitals Trust meets its statutory duties under the Civil Contingencies Act 2004, NHS Act 2006 and the Health and Social Care Act 2012 and its other non-statutory obligations.

2. This report also summarises the current position of the Trust in relation to emergency preparedness and business continuity arrangements based on the completion of the annual EPRR Core Standards Framework and Statement of Assurance submission.

Background/Introduction

3. The Trust under the Civil Contingency Act 2004 as a Category 1 Responder has the following responsibilities:

    - Carry out a risk assessment.
    - Have in place plans to respond to emergencies.
    - Have in place business continuity plans.
    - Collaboration and co-operation with other agencies
    - Warn and inform the public and other agencies.
    - Training and exercising.

4. The Trust has a statutory obligation to train and exercise with a live exercise every three years, and annual tabletop exercise and a six-monthly test of the communication cascade. An exercise programme for 2025 is in the process of being developed.

5. The NHS England Core Standards for EPRR 2024 set out how NHS organisations are to meet their responsibilities and the NHS England EPRR Framework (2022) states that NHS provider organisations are required to have appropriate systems in place.

6. The Trust's EPRR responsibilities are managed and overseen by:

    - Accountable Emergency Officer – Executive Director of Integrated Care, Partnerships and Resilience
    - Head of Emergency Planning Resilience and Response (EPRR)
    - Deputy Director of Integrated Care, Partnerships and Resilience – overseeing the work of the Head of EPRR.

Trust wide EPRR Plans

7. The following plans were reviewed as part of the annual review cycle:

    - Adverse Weather Plan
    - Evacuation and Shelter Plan
    - EPRR Policy
    - Pandemic Flu Plan
    - Major Incident Plan
    - Official Visitors Access Policy

8. Business continuity plans have been refreshed by all Directorates and will be reviewed again in light of lessons learnt from the Cyber Simulation exercise held on the 02 October 2024.

2023/24 EPRR Assurance Process

9. The Trust participated in the Assurance exercise. This annual assurance process marks compliance against the NHS England Core Standards for EPRR and ensures that NHS organisations are prepared to respond to an emergency and have the resilience in place to continue to provide safe patient care during a major incident or business continuity event.

10. All organisations were required to complete the Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Process self-assessment template.

11. The comprehensive EPRR core standards assurance process has been undertaken and ELHT has submitted an initial level of Partial Compliance, which this Trust Board is asked to ratify (Appendix A). The completed self-assessment and action plan can be found in Appendix B.

12. For the period 2024/25, the Trust has reviewed the core standards and assessed that full compliance has been achieved in 51 of the 62 standards. The percentage compliance will be 82% which is a 66% increase on our final submission for last year. As previously reported, this is a process of continuous improvement over a two-year cycle where we hope to be fully compliant across all standards by our 2025/26 submission. The Trust will now progress towards fully achieving these core standards with a robust action plan.

13. The Deep Dive area (non-mandatory standards) for 2024/25 related to Cyber Security. ELHT declared either full or partial compliance to all 11 standards at the time of submission.

Training

14. An EPRR training prospectus is currently under development for 2025.

15. An audit of current trained loggists has been carried out and those requiring refresher training have been requested to book onto the online course by UKHSA. The trust currently has twelve (12) members of staff who form the loggist cadre.

16. Throughout 2024 directors and senior managers on-call have been attending NHS England's Strategic and Tactical Health Commander training courses, receiving excellent feedback from the participants.

17. Further eLearning packages are to be rolled out to all directors and senior managers on call to ensure that we comply with EPRR minimal occupational standards.

18. Training has been provided to our Emergency Department colleagues for Initial Operational Response (IOR) HAZMAT response, as required by NHS England.

Testing and Exercising

19. A cyber simulation exercise took place in the Board Room at Birch House Trust Headquarters on 02 October 2024.

20. The exercise allowed several participants across the Trust to come together to test how effectively the Trust responds to a cyber incident. Participants included representation from the Strategic (Gold) and Tactical (Silver) on call rotas, board members, information governance, and the trust Data and Digital team.

21. The aim of the exercise was to evaluate how the Trust responds in the event of a cyber incident.

22. The simulation exercise dealt with several factors including service disruption, data loss and external notifications.

23. The exercise was received well and found to be extremely useful to all those who took part when questioned at the conclusion of the hot debrief.

24. Following the trusts continuous improvement cycle, a debrief report was produced and several lessons and actions were identified and will be incorporated into the annual work plan. One key piece that has already started is:

    - To ensure business continuity plans incorporate loss of IT with clearly documented processes on how critical information will be inputted into systems once they are available again.

Multi-agency Working

25. The Head of EPRR is a member of the following meetings and attends regularly, contributing accordingly.

    - Lancashire Resilience Forum – Mass Fatalities Subgroup
    - NHS England triannual review of NHS Core Standards for EPRR task group

26. The AEO attends the Local Health Resilience partnership meetings on a quarterly basis.

EPRR Update

27. Over the next year the focus will be to address EPRR training and exercising for the trust. The team are currently developing a training prospectus to cover all response roles and for staff who have a responsibility for writing, maintaining, and reviewing EPRR plans and arrangements (including Business Continuity).

28. Business Continuity incidents this year include Microsoft IT outage, SADU fire and site pressures. Responses to each incident were managed through the timely establishment of effective incident response teams. After each incident, facilitated debriefs are undertaken to identify any lessons to be learned and good practice that can further improve our responses to such incidents in the future and these are shared formally through the EPRR Committee.

Recommendations

29. The Trust Board is requested:

    a) To receive the action plan contained within this report to provide assurance that the trust is committed to declaring full compliance against the EPRR Core Standards by June 2025.

    b) To receive this report as assurance that the Trust has robust, evidence based and tested EPRR practices in place and that it substantially fulfils its statutory and non-statutory duties and obligations.

Tony McDonald
Executive Director Integrated Care, Partnerships and Resilience
Accountable Emergency Officer
05 November 2024

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

Appendix A

Lancashire and South Cumbria Local Health Resilience Partnership (LHRP) Emergency Preparedness, Resilience and Response (EPRR) assurance 2024-2025

STATEMENT OF COMPLIANCE

East Lancashire Hospital Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, East Lancashire Hospital Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Partial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

31/10/2024

Date signed

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

Appendix B – EPRR Core Standards Assessment 2024/25

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken
Domain 1 - Governance								
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	AEO Chief Executive, delegated to Exec. Dir of Integrated Care, Partnerships and Resilience	Fully compliant	
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR Policy in place C159	Fully compliant	
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	EPRR reports submitted throughout the year to Board outlieing training and our compliance in relation to the core standards assurance process	Fully compliant	
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Reporting process within the EPRR Policy statement which also covers the workplan	Fully compliant	Add to quarterly EPRR committee meeting agenda
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	The EPRR Policy requires that sufficient and appropriate resources are allocated to the EPRR functions. Currently we are receiving support from Bank 1 day per week to support service	Partially compliant	
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	The EPRR Policy statement and Corporate Business continuity Plan outlie how the trust will learn from incidents and exercises.	Fully compliant	Need to add board reports

Lancashire and South Cumbria Provider Collaborative

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Domain 2 - Duty to risk assess								
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	EPRR risks are discussed at EPRR Committee. EPRR risk reviewed every 3 months	Fully compliant	
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Risk Management Policy in place where all risk are considered including EPRR	Fully compliant	
Domain 3 - Duty to maintain Plans								
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Where appropriate partner organisations are consulted with. Currently done through EPRRC	Partially compliant	Develop system for requesting consultation and recording outocmes
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Corporate Business Continuity Plan and Major Incident Plan reviewed 2024. Elements of the plan have been tested recently with our Site Pressures - IMT have been stood up twice daily with representation from all divisons	Fully compliant	Major incident exercise to be planned for 2025
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	Plan in place Weather warning shared with divisions	Fully compliant	
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	The infection Control team has a Hospital Outbreak Policy Policy IC14 v5.1 that's was ratified in December 2023 The trust also has a RPE Policy IC30 v1.0 MERs/SARS/Avian flu Policy - IC08 Management and control of Viral haemorrhagic fever - IC21 IC23 Influenza Policy including pandemic influenza guidance Recent measles outbreak tested these procedures	Fully compliant	
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The infection control team have developed an influenza policy that includes the new pandemic guidelines ELHT/IC23	Fully compliant	
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Information included within the CBRN Plan	Fully compliant	
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an	The trust has a MIP which can be used to respond to a mass casualty incident. LRF mass casualty plan in place and accessible via the EPRR and On call Sharepoint sites. These are supplemented by the NHS England Concept of Operations for managing Mass Casualties and the Guidance for managing mass casualty events in the lancashire and South Cumbria Major trauma network.		ICB led exercise in next 6 months

16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evacuation and Shelter Plan in Place. Partial Invacuation was required in September due to sewage leak on C9	Fully compliant	check with duncan re monitoring of local plans
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lockdown Policy in place. Walkthrough of actions within policy was conducted during Southport Riots in August. Lessons identified.	Fully compliant	
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Reviewed by Director of Comms Sept 2024 current version remains fit for purpose. Plan used in 2023 for a number of visitors to the blackburn site	Fully compliant	
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	LRF Mass Fatalities Plan in place. Head of EPRR involved in review and attends LRF meetings along with Mortuary manager. Previous Plan tested as part of Exercise Goshawk 2022. ELHT mortuary Plan outlines process if we were activated as part of the Resilience Mortuary activation.	Fully compliant	Desktop exercise with Lanc Police has been postponed - awaiting new date
Domain 4 - Command and control								
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	On Call Policy sets out standards and expectations. Switchboard 24 hour access to alert SMOC/DOC/SCOC and to receive incident notifications.	Fully compliant	
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	All strategic, tactical and operational staff have received training either via department of attending Health Commander training	Partially compliant	UKHSA Kallidus elarning packages to be shared with SMOC/DOCs
Domain 5 - Training and exercising								
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	<u>Evidence</u> • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	TNA included within EPRR Strategy and any other training is included in incident response plans as required	Partially compliant	Portfolios to be completed going forward. Elearning packages to be shared and completed by SMOC/DOCs inline with MOS for EPRR
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Corporate Business Continuity Plan and Major Incident Plan reviewed 2024. Elements of the plan have been tested recently with our Site Pressures - IMT have been stood up twice daily with representation from all divisons	Partially compliant	Develop exercise programme for 2025

24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Training records kept by Head of EPRR and senior sister in ED for training in department	Partially compliant	Portfolios to be completed going forward. Elearning packages to be shared and completed by SMOC/DOCs inline with MOS for EPRR
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	Training of SMOC/DOCs included in Board Reports. Training attendance recorded via Head of EPRR.Awareness of EPRR and Business Continuity included with Corportate Induction. Staff awareness also via departments for BCPs to guide staff on their roles/actions during an incident	Fully compliant	Add training and exercising attendance to future board reports
Domain 6 - Response								
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	The trust uses the Board Room within Trust HQ - Birch House as its location for an Incident Coordination space. Further facilities are also available from Consort in their meeting room in XXX Can use virtually ICC via teams as well. All documented within Oncall pack	Fully compliant	further resources required to make fully functioning i.e radios Add ICC training to training programme for 2025
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	Planning arrangement are available on Sharepoint and on the network drive for all staff and Senior managers and Directors on call. Hard copies are also stored in the major incident store room	Fully compliant	
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	The trust has a corporate Business Continuity Plan and each department also has a local BCP which includes an escalation process	Fully compliant	
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	The trust has a substantial cohort of trained loggists available to support the decision makers. The on call pack contains details on how to contact in and out of hours via switchboard who also keep a list. On call pack details how to keep personal records and decision logs	Fully compliant	Send out elearning package from UKHSA Kallidus packages
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Process is documented with the On Call Pack	Fully compliant	
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	ED have guidelines available in the department	Fully compliant	
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies	ED have guidelines available in the department	Fully compliant	
Domain 7 - Warning and informing								
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	The Comms Team are aware of the Trusts EPRR arrangements and attend EPRRC. There is an on call rota in place for the comms team (24/7). This enables the Trust to provide support during an incident. All comms are logged centrally for future reference.	Fully compliant	
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Major incident Comms Plan in place which includes action cards	Fully compliant	

35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	The trust communicates with staff during incidents by sending out trust wide emails, notices placed on OLI (Internal website) and via emails to the Divisional OCC email inbox for verbal cascade. The Comms Team hold a list of stakeholders to enable the trust to warn and inform during an incident. We also use facebook and twitter to push messages out to the community.	Fully compliant	
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Social Media Policy in place along with Major Incident Comms plan	Fully compliant	
Domain 8 - Cooperation								
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	AEO attends. Marrix shared by ICB. Current compliance 100% (Standard 75%)	Fully compliant	
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	ELHT Head of EPRR and Mortuary Manager attend Mass fatalities meeting. ICB attends other LRF meetings on behalf of LSC Trusts	Fully compliant	
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	ELHT developed Mutual Aid agreement across LSC. AEO signed just waiting final signoff across Trusts and ICB	Partially compliant	Chase signoff from other AEOs - clarity needed around staffing to be discussed at LHRP
40	Cooperation	Arrangements for multi area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all			
41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency			
42	Cooperation	LHRP Secretariat	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas			
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	No standard protocol. Each agreement is unique based on the data being shared/processed	Fully compliant	
Domain 9 - Business Continuity								
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	Outlined in the ELHT EPRR Policy and Corporate BC Plan	Fully compliant	
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	Included within Corporate Business Continuity Plan	Fully compliant	Bite size briefing presentation to be added to EPRR Sharepoint to raise awareness

46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	BIA are included within the departmental BCPs and reviewed annually by each division	Fully compliant	
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	BCP review compliance continues within divisions and monitored both within divisions and via the EPRRC	Fully compliant	
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	Simulation exercise conducted to look at loss of IT systems Lessons identified around actions re IT downtime in BCPs needs more focus	Fully compliant	cloudstrike
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	Non Compliance this year - plan in place to meet or approach meeting standards	Partially compliant	copy of action plan
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	The BCMS is monitored by the Head of EPRR and fed through the EPRR Committee. Currently isnt reported through boaard and no KPIs in place	Partially compliant	
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Internal audit of crtital services by Head of EPRR following NHS BC checklist. These BCPs are monitored through EPRRC. Need to plan for external review in 2025	Fully compliant	Needs to document at EPRRC How to close loop following audit report /continuous improvement
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Process outlines with EPRR Strategy and Corportae Business Continuity Plan action plans from incidents are discussed through EPRR Committee Exercise report s produced to outline lessons identified. Interna; audit in place	Fully compliant	
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	NHS supply chain manages own resilience. Email attached from Procurement on how they assess BCPs for providers	Partially compliant	Requires more evidence from ICB/.NHSE/LSC Procurement

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

Domain 10 - CBRN							
55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Y	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	EPRR Policy Detailed within the CBRN/hazmat policy	Fully compliant
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Y	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Partially detailed within the Corporate BCP and included on the EPRR Risk Register	Fully compliant
57	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Information is available to all staff and is kept within the areas of Resus, Majors and UTC and also written on the whiteboard within Nurse in charge office of ED	Fully compliant
58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Y	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	Detailed within the Corporate BCP that will be activated along with the CBRN plan.	Fully compliant
59	**Hazmat/CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Y	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	ELHT trains all staff with ED including band 2s, The lead nurse in ED for Major incidents develops and delivers monthly training. Rota identifies CBRN trained staff. Dry/wet decon for both self-decontamination and non-ambulatory can be facilated at ELHT.	Fully compliant
60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Y	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Equipment checklist is used by our ED department SOPs are available for all specialist equipment. PRPS suits are regularly maintained	Fully compliant

61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Y	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	PRPS - maintained by Respirex Ramgene - maintained by IRS Any other equipment is monitored, maintained and replaced internally and carried out by the lead nurse within ED.	Fully compliant	
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Y	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	NWAS Acute and Non Acute Trust MOU in place with Veolia	Fully compliant	
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Y	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	The trust has 9 members of staff within ED who have completed train the trainers but in the main sits with two senior sisters who deliver training on a monthly basis and content reviewed annually.	Fully compliant	
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Y	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Training on IOR principles delivered by lead nurse in ED via face 2 face training on a monthly basis	Fully compliant	
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Y	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	ELHT holds the minimum PRPS suits. All other PPE is stored within the ED department. Fit testing records are held by Fit testing team and are accessible via OLI	Fully compliant	
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Y	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	At the training sessions include a practical - going through the decon unit but no formal exercise has taken place	Partially compliant	Add to training and exercising programme for next year

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT		**Item**	**159a**
20 November 2024		**Purpose**	Approval
Title	Ratification of Board Sub-Committee Terms of Reference: Finance and Performance Committee		
Report Author	Miss K Ingham, Corporate Governance Manager		

Summary: The terms of reference for the Committee have been reviewed in line with the current work of the Committee and best practice. They have been presented to the Committee at its meeting in October 2024 and have been agreed by the members.

Recommendation: The Board is asked to ratify the revised terms of reference.

Report linkages

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

	6	(As Host of One LSC): Increased staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services. (As Partner of One LSC): One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations.
Related to key risks identified on Corporate Risk Register	None	
Related to recommendations from audit reports	-	
Related to Key Delivery Programmes	-	
Related to ICB Strategic Objective	N/A	

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

TERMS OF REFERENCE: FINANCE AND PERFORMANCE COMMITTEE

Constitution

The Board has established the Finance and Performance Committee to provide assurance about the delivery of the financial and operational plans approved by the Board for the current year and for the longer-term future, develop forward plans for subsequent financial years for consideration by the Board and examine in detail risks to the achievement of national and local performance and activity standards.

Purpose

To support the Trust Board in the analysis and review of Trust financial and performance plans, providing advice and assurance to the Board on financial and performance issues.

It will:

- Review the annual business plans prior to Board approval and submission to the Integrated Care System (ICS)/Regulator and review plans for the longer term.
- Review financial performance against income, expenditure and capital budgets and consider the appropriateness of any proposed corrective action.
- Review progress against waste reduction and improvement programmes, (including the procurement programme, estates and facilities programmes, ELFs Performance, PFI programme and business plans supporting new investment) and consider the appropriateness of any proposed corrective action.
- Consider the financial performance in the current year and look ahead to expected performance for the subsequent 2-5 years and review all significant financial risks.
- Regularly review cash flow forecasts, the adequacy of funding sources and receive assurance on the robustness of the Trust's key income sources.
- Provide the Board with a forum for detailed discussions and assurance of progress against the annual business plan including the delivery of the Waste Reduction Plan and Improvement Plan
- Assess the performance of the organisation against all national and system/local performance and workforce standards and consider plans for the longer term.
- Provide the Board with a forum for detailed discussions around the financial and performance elements of the Board Assurance Framework and the Corporate Risk Register.

- Review progress made against key delivery and improvement programmed and assess whether they are aligned to existing work programmes.

Reflection

- The Committee shall allocate a short amount of time at the end of each meeting to reflect on the discussions that have taken place, assurances gained and, where appropriate, challenge the purpose, focus and length of the papers presented. Specific areas of focus will be whether the papers have been aligned to these terms of reference and the clarity and assurances that they provide as well as issues escalated from sub-committees.
- The Committee will have a specific agenda item for matters escalated to them from other Committees, for matters to be escalated to the Board and actions to be delegated to other Board Committees. This item will be clearly captured in the minutes of the meeting and will feature in reports from the Committee to the Board.

System Working

In addition to the statutory duties to collaborate there is an increasing expectation for the Trust, and others within the Lancashire and South Cumbria Integrated Care System, to work together as a system for the betterment of the health of the population. With this in mind, the provider Boards and their sub-committees, within the Lancashire and South Cumbria (LSC) Integrated Care System (ICS), have, following the Board agreement, supported the delegation of the following functions to the PCB Joint Committee, where such matters affect the Trusts and can benefit the population of LSC.

a) service transformation priorities as defined by the ICS and commissioners
b) priorities for provider productivity improvement
c) opportunities for developing standardised approaches to service change and delivery
d) Shared clinical services for community services
e) Shared corporate services for: bank and agency workers procurement
f) Pathology Collaboration Network strategic decisions
g) And other matters as determined from time to time

In exercising these delegated functions, the PCB shall provide a single, collective view of the Provider Trusts and agree an annual work programme, each year, relating to the delegated functions, that promotes the best interests of the whole population.

The Trust Board and its sub-committees will ensure that they are fully involved in the

decision making and engagement process in relation to the strategic collaborative items and this will be enacted through an Executive function with representation from the Non-Executive contingent of directors.

As a host and partner organisation of One LSC ELHT has a pivotal role in relation to central services collaboration. The Finance and Performance Committee will have a standing item on its agendas on One LSC and will provide assurance to the Board about the financial and performance elements of the programme.

Membership

Three Non-Executive Directors/Associate Non-Executive Directors (a Non-Executive Director will be the Chair of the Committee)
Chief Executive
Executive Director of Finance
Chief Operating Officer
Executive Director of Service Development and Improvement
Executive Director of People and Culture

The Chief Nurse and the Executive Medical Director will attend the Committee meeting by invitation for items within their remit.

In attendance

Director of Corporate Governance/Company Secretary
Associate Director of Quality and Safety
Associate Director of Service Development and Improvement

A representative of the Trust's Internal Audit function will be invited to attend and observe each meeting. The Committee may direct the attendance of others at meetings as the Chair of the Committee deems appropriate.

Frequency

The Committee will meet a minimum of 10 times per year. Additional meetings may be called at the discretion of the Chair of the Committee as provided for in the Trust Standing Orders and the Standing Financial Instructions.

Quorum

Two Non-Executive Directors/Associate Non-Executive Directors and two Executive Directors. A quorum must be maintained at all meetings.

Members are expected to attend all meetings but will attend at least 75% of meetings. Members who are unable to attend will arrange for the attendance of a nominated deputy, whose attendance will be recorded in the minutes, making clear on whose behalf they attend but they will not count towards the quorum.

Regular Reports

Monthly Items

Integrated Performance Report
Finance Report
Improvement Report
One LSC Update
Finance Assurance Board Minutes (for information)
Finance, Performance and Workforce Divisional Meeting Summaries
Contracts over £1,000,000
Tenders Update
Private Finance Initiative (PFI) Report
System Issues

Alternate Meeting Items

Board Assurance Framework
Corporate Risk Register

Quarterly Items

National Cost Collection/Model Hospital Update

Strategic Dashboards
Community Services Update
Procurement Report
Tender Reporting (when required)

Annual/Alternate Years Items

National Planning Guidance/Financial Planning
Outsourced services report (Hosted Services)
Consultancy Services spend report (Trust and system level)
Integrated Care Board Finance Report
Population Health Reports
Digital/IMT Report
Community Care Performance (yearly report)
Estates Strategy Update
Review of Committee Terms of Reference

Authority

The Committee has no executive powers other than those specified in these Terms of Reference and by the Trust Board in its Scheme of Delegation.

The Committee is able to summon reports (and individuals) to enable the committee to discharge its duties.

The Committee forms the high-level Committee for financial and performance reporting.

The Committee is authorised to investigate any issue within the scope of its Terms of Reference.

The Committee is authorised, with the support of the Director of Corporate Governance/Company Secretary, to obtain any independent professional advice it considers necessary to enable it to fulfil these Terms of Reference.

Reporting

The Committee will report to the Trust Board.

In addition, the Committee will report any specific risks or matters identified for escalation to the Audit Committee.

Review

The effectiveness of the Committee will be reviewed on an annual basis, or as required as part of the Trust Board governance cycle and reported to the Board. The Committee will provide regular reports on its activities to the Trust Board. The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit Committee through the internal and external auditors and external regulatory bodies.

The Terms of Reference will be reviewed on an annual basis or on a more frequent basis should its be required.

Committee Services

Lead Director: Executive Director of Finance

Secretarial support: Corporate Governance Team

Committees reporting

Finance Assurance Board

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **159b**

20 November 2024 **Purpose** Approval

Title	Ratification of Board Sub-Committee Terms of Reference: Trust Charitable Funds Committee
Report Author	Miss K Ingham, Corporate Governance Manager

Summary: The terms of reference for the Committee have been reviewed in line with the current work of the Committee and best practice. They have been presented to the Committee at its meeting in October 2024 and have been agreed by the members.

Recommendation: The Board is asked to ratify the revised terms of reference.

Report linkages

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

	6	(As Host of One LSC): Increased staff transferring into the Trust increases activity across existing ELHT corporate services affects the Trust's ability to provide high quality corporate services to both One LSC and core ELHT services. (As Partner of One LSC): One LSC does not deliver the anticipated benefits of high-quality corporate services across partner organisations.
Related to key risks identified on Corporate Risk Register	None	
Related to recommendations from audit reports	-	
Related to Key Delivery Programmes	-	
Related to ICB Strategic Objective	N/A	

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

Charitable Funds Committee Terms of Reference

Constitution

The Trust Board has established this Committee to be known as the Charitable Funds Committee. The Committee will report its actions and decisions to the Trust Board.

The Committee has overarching responsibility for the monitoring and approval of activities relating to charitable fundraising and the uses to which charitable funds are applied, providing assurance to Trust Board members in their role of Trustees of the organisation's Charitable Funds.

The Committee has the authority to appoint short term, outcome focused subcommittees but does not routinely receive reports from other subcommittees.

Purpose and Delegated Responsibilities

The Trust receives funds for charitable purposes from a number of sources. The Trust, as a corporate body, is the Trustee of these funds. The Trust Board must therefore ensure that its duties as a Trustee are discharged correctly taking advice as necessary.

The Board, when acting as Trustees of the charitable funds, will act in accordance with guidance from the Charities Commission, and will discharge its function as Trustee as far as possible, separately from its duty as a Trust Board.

The Trust Board appoints this Committee to discharge this function. In addition, the Trust Board delegates to this Committee the authority to examine and approve the annual accounts of funds held on trust and recommend them for ratification to the Trust Board acting as the Trustee.

The Committee will oversee the management of funds held on trust and charitable funds. In particular the Committee will:

(a) Set a corporate strategy for the management of these funds

(b) Assure the Trust Board that the policies and procedures for the management and administration of these funds are adequate, effective and observed

(c) Review the investments held by the Trust at regular intervals

(d) Review the performance of funds on a regular basis

(e) Approve and review the application of funds

(f) Approve, accredit and support fundraising activities in accordance with the Trust's guidelines for fundraising activities

(g) Approve and review the appointment of those managing investments on behalf of the Trustees

(h) Make recommendations to the Trust Board regarding the management and performance of funds

(i) Provide regular reports to the Trust Board on the Committee's activities

Membership

Two Non-Executive Directors/Associate Non-Executive Directors (a Non-Executive Director will be the Chair of the Committee)
Executive Director of Finance
Chief Nurse
Executive Director of Communications and Engagement

In attendance

Director of Corporate Governance/Company Secretary, the Charity Manager, and Deputy Head of Financial Control will also be in attendance at the Committee meetings.

Any other Executive or Non-Executive Director may be in attendance at meetings in their role as Trustee of the Charitable Funds.
Divisional Directors of Operations will attend meetings where requests for funds from their Division appear as an agenda item.

Frequency of Meetings

The committee will meet a minimum of four times per year in line with the reporting schedule from the Investment Managers.

Quorum

One Non-Executive Director/Associate Non-Executive Director and one Executive Director.
A quorum must be maintained at all meetings. Members are expected to attend all meetings but will attend at least 75% of meetings. Members who are unable to attend will arrange for their nominated deputy to attend, their attendance will be recorded in the minutes, making clear on whose behalf they are attending.

Regular Reports

Financial Performance Report
ELHT&Me Fundraising and Performance Report
ELHT&Me Charity Hub and Retail Outlet Report

Twice Yearly Reports

Charity Strategy Update

Annual Reports

Report of the Investment Manager (annual report)

Annual Report of the Charity

Annual Charity Accounts

Reporting

The Committee will provide a summary of its decisions and actions to the next meeting of the Trust Board.

The Committee does not regularly receive reports from other subcommittees.

Review

The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board Business Cycle. The Committee will provide regular reports on its activities to the Trust Board.

The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit Committee through the internal and external auditors and external regulatory bodies.

Committee Services

Lead Director	Executive Director of Finance
Secretariat Support	Corporate Governance Team

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **160a**

20 November 2024 **Purpose** Assurance Information

Title	Triple A Report from Quality Committee
Report Author	Mrs L Sedgley, Non-Executive Director/Committee Chair

Summary: This report sets out the summary of the items discussed at the People and Culture Committee meeting held on 02 September 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the 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:	People and Culture Committee
Date of Meeting:	02 September 2024
Committee Chair:	Trish Armstrong
Attendance:	Quorate
Key Items Discussed:	Board Assurance Framework Corporate Risk Register Report Equality, Diversity and Inclusion (EDI) Annual Report Leadership Strategy and Update Report Staff Flu and Covid Vaccination Programme 2024 Update Report People Promise Exemplar Progress Update Senior Support and Share Update Professional Nurse Advocate Programme Industrial Action Update

ALERT

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

- The Committee received the Equality, Diversity, and Inclusion (EDI) Annual Report. This was timely given the Trust's increased focus on EDI particularly in the light of the recent civil unrest in the North West. It was noted that some staff had been the target of racist abuse, and it emphasised the need for an anti-racist approach. Whilst there has been some good progress it is clear that there is much to be done.

- Members received an update on progress with the Leadership Strategy. There is particular focus on one area that of 'inclusive talent management' which is currently rated RED and further to address it is planned.

ASSURE

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

- An update was received on progress with the Annual Staff Flu and Covid Vaccination Programme. Plans are also in place for staff transferring in to the Trust as part of One LSC.

- A report was received on the SSS process. Members were advised that 450 visits to units and departments had been carried out since January 2024 with 1326 staff and 357 patients being spoken to for their views.

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 updated on progress with People Promise Exemplar. Engagement of staff is ongoing and has recently focused on the One LSC programme and the potential on Corporate areas.

- Members were updated on progress with the Junior Doctors Industrial action after the latest survey on any future action closed the previous weekend. It was note that the pay offer for Agenda for Change had been accepted.

- Members received minutes from The Joint Negotiating and Consultative Committee, and from The Joint Local Negotiating Committee for information.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **160b**

20 November 2024 **Purpose** Assurance

Information

Title	Triple A Report from Quality Committee
Report Author	Mrs L Sedgley, Non-Executive Director/Committee Chair

Summary: This report sets out the summary of the items discussed at the People and Culture Committee meeting held on 07 October 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the report.

Report linkages

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

Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	Care Closer to Home Place-based Partnerships Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

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

Committee Name:	People and Culture Committee
Date of Meeting:	7 October 2024
Committee Chair:	Trish Armstrong
Attendance:	N/A
Key Items Discussed:	This meeting was a workshop to discuss and plan the future operating model of the People and Culture Committee.

ALERT

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

N/A

ASSURE

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

N/A

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 People and Culture Committee did not have a formally agenda'd meeting in October focusing instead on a facilitated review of progress to date given this is a new Committee, highlighting strengths weaknesses and opportunities for development in the coming 12 months. Written feedback is awaited.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT | **Item** | **161a**

20 November 2024 | **Purpose** | Assurance / Information

Title	Triple A Report from Quality 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 30 September 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the 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:	30 September 2024
Committee Chair:	Liz Sedgley
Attendance:	Quorate
Key Items Discussed:	Finance Reporting Finance, Performance and Workforce Divisional Meeting Summaries Improvement Update One LSC Update Integrated Performance Report Quarterly Community Services Transfer Review Report Tenders Update Contracts over £1,000,000 Private Finance Initiative (PFI) Update Systems Issues Finance and Performance Committee Terms of Reference

ALERT

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

- The Committee received updates on the Waste Reduction Programme (WRP) and noted the significant risks not only of the size of the ask being £57.9 million or 7% of expenditure but also the profiling of the programme within the annual plan for 24/25. The WRP is weighted to the later parts of the financial year with 81% of the programme forecast to be delivered in quarters 3& 4. This is in line with the rest of the profiling used by the provider Trusts within Lancashire and South Cumbria and for the Trust this means that savings of £30 million are expected in quarter 4.
- The Chief Executive advised the Committee that notification from the Integrated Care Board (ICB) of its commissioning intentions and the review of the Block contracts currently in place is expected imminently. The ICB has requested details of all services currently carried out which are underfunded or unfunded for 2025/26.

This will accelerate the need for all service provided by ELHT to undergo a comprehensive review process and could ultimately lead to changes in service provision and delivery across Pennine Lancashire.

ASSURE

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

- The Committee received an update on the OneLSC and were advised that the project was on track to TUPE staff across as planned on 1 November but that one of the biggest risks was the capacity of teams within the Trusts to review and sign off the due diligence given the pressures all the Trusts are experiencing.
- The Committee noted that the Trust would meet the 65-week rule and recorded its thanks to all staff involved in delivering this target. The Committee also heard that the Trust is meeting the standards set for the 3 new cancer targets and despite increasing numbers of patients accessing unplanned care in September the Trust hit 78%.
- The quarterly review of Community Services transfer will now be stood down given that the services are now fully integrated into ELHT and are performing well with no significant issues being escalated.
- A review of the Albion Mill test of change pilot will be carried out in January 2025 being month 6 of the 12-month pilot and report back to the committee in March ahead of the anniversary in July.

ADVISE

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

- The Committee received an update that the outturn deficit for 24/25 would be funded and that the Trust would be reporting a breakeven position. Whilst this is good news as it is cash backed and improves the cash position, it still means that the Trust has the WRP target of £57.9m to hit.
- The Chief Executive briefed the committee that the Trust is one of the 20 Trusts to receive targeted funding to reduce waiting times due to the levels of deprivation and high numbers of economically inactive residents due to ill health. Whilst no specifics

about the funding have been received yet this is a welcome announcement which will bring welcome resource into the health economy of Pennine Lancashire.

- The committee received a report on the proposed transfer of ELFS Shared Services to ELHT as part of the One LSC process and after discussing the proposal supported the rational for the transfer .

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **161b**

20 November 2024 **Purpose** Assurance

Information

Title	Triple A Report from Quality 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 28 October 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the report.

Report linkages

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

Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	Care Closer to Home Place-based Partnerships Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

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

Committee Name:	Finance and Performance Committee
Date of Meeting:	28 October 2024
Committee Chair:	Liz Sedgley
Attendance:	Quorate
Key Items Discussed:	Finance Reporting Finance, Performance and Workforce Divisional Meeting Summaries Board Assurance Framework Corporate Risk Register Improvement Update One LSC Update Integrated Performance Report Tenders Update Contracts over £1,000,000 Private Finance Initiative (PFI) Update Systems Issues Approval of Finance and Performance Committee Terms of Reference

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.

1. The Committee was advised that the cash position is still very tight and that the Trust is not meeting the Better Payment Practice Standard as a result.
2. Changes to the forecast outturn position were noted and the risks to achieving the financial plan and Waste Reduction Programme (WRP) target were discussed.
3. The Committee noted that the PA Consulting work had also highlighted shortfalls in Elective Recovery Fund income due in part to the implementation of Cerner and work and discussions would take place to recoup as much of this as possible.
4. The Committee heard that work is ongoing to better understand the changes in commissioning intentions as the Integrated Care Board (ICB) moves away from the block contracts.

ASSURE

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

1. The Committee were advised that the transfer of East Lancashire Financial Services (ELFS) has been deferred to ensure that all the teams involved have sufficient time to carry out the necessary Due Diligence.
2. The Committee approved a new lease arrangement and service maintenance of breast screening equipment at RBH & BGH.
3. The due diligence on the financials and legals for One LSC was approved and recommended for approval by the Board.
4. The committee was informed that NHSE has signed off on One LSC and the committee received an update on the consultation process with staff side with regards to staff transferring into One LSC.
5. An update was received on the current financial position and the WRP programme, the Committee could not be assured that the Trust will meet its WRP target for 24/25 but noted that all teams across the organisation are committed to delivering as much as possible in spite of the continuing demand for services especially unplanned care.
6. The committee received an update from PA Consulting on the work they are doing on behalf of the Trust and the ICB to help improve financial sustainability. It was especially pleasing to hear about the significant engagement and commitment shown by staff and teams to this project.

ADVISE

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

- As part of the performance update, the committee was informed that the Trust will not hit the A&E target of 78% for the year to March 2025. Current performance is just under 78% and despite all the projects to help deflect attendances away from A&E into a more appropriate care setting for patients, the emergency care teams on all sites are still facing increasing demand for treatment.
- The Trust hit the 31-day cancer standard in August.
- The Trust has been informed that it is part of the new national initiative to reduce elective care waiting lists – Further Faster 20 programme. The Committee will receive an update on what that means for the Trust and patients in Pennine Lancashire as more details are released from NHSE.
- The Committee heard about the improvement work in both Elective Care and Outpatients and what the benefits of the improvements are.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **162a**

20 November 2024 **Purpose** Assurance

Information

Title	Triple A Report from Quality Committee
Report Author	Mrs T Anderson, Non-Executive Director/Committee Chair

Summary: This report sets out the summary of the items discussed at the Quality Committee meeting held on 25 September 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the 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:	25 September 2024
Committee Chair:	Trish Anderson
Attendance:	Quorate
Key Items Discussed:	Urgent and Emergency Care Update Mortality Update Histopathology Update Quality Impact Risk Assessments Health and Safety at work Policy and Strategy Patient Safety Incident Response Framework Report (including update on National Patient Safety Training Compliance) Pressure Ulcer Progress Update Annual Complaints Report Patient Participation Panel Report Improvement Update 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.

- The Committee received a detailed update on staff/patient safety issues;
  - UEC remains very challenged and has worsened.
  - Numbers are increasing not reducing.
  - Care is being delivered in the main corridor.
  - Significant backlog of histopathology reports with routine samples going beyond expected time frames.
  - Maintaining the wellbeing of staff is a priority.
  - Additional pressures are being experienced due to the vacancy factor to meet the Trust financial target.

- All available clinical accommodation has been opened up to ensure patient safety and staffing models are being rebased
- Members were informed that despite the increased pressures in the ED the Trust continues to deliver on its elective targets.

- Members received a Mortality Report Update. Whilst assurance that the Trusts crude mortality rates have remained static and within control limits there are issues relating to data coding, and loss of expertise causing issues with structured judgement reviews. Assurance was provided that the Trust medical examiner team are reviewing every death.
- Members received a detailed report on the issues around the significant backlog of samples in the histopathology department arising from shortages in laboratory staffing, deanery allocations and growing demand in general. A range of actions are in place along with ongoing discussions with ICB colleagues to improve matters.
- Members received the Health and Safety at Work Policy and Strategy documents for approval.
- An Infection Prevention Committee summary was received which highlighted that there are concerns around general cleanliness. Urgent actions to address are being put in place.

ASSURE

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

- Members were provided with an update on Quality Impact Risk Assessments for information.
- Members received the Trust Wide Quality Group Triple A reports part A and B
- Members received the Patient Safety Incident Response Framework Report. An increase in the percentage of harms being reported was explained by changes in recording. Improvements have also been made to divisional reporting.
- An update on Pressure Ulcer progress was received. Proactive work continues and the Trust's position has improved significantly and was commended by ICB colleagues.

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 welcomed the report received from the Patient Participation Panel and note the range of involvement. • A range of minutes from sub committees were received and noted.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **162b**

20 November 2024 **Purpose** Assurance Information

Title	Triple A Report from Quality Committee
Report Author	Mrs C Randall, Non-Executive Director/Committee Chair

Summary: This report sets out the summary of the items discussed at the Quality Committee meeting held on 30 October 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board.

Recommendation: The Board is asked to note the report.

Report linkages

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

Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	Care Closer to Home Place-based Partnerships Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

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

Committee Name:	Quality Committee
Date of Meeting:	30 October 2024
Committee Chair:	Catherine Randall
Attendance:	Quorate (from 10:00 onwards, no items requiring decision were considered before this time)
Key Items Discussed:	Urgent and Emergency Care Update End of Life Care/Bereavement Service Update Organ Donation Bi-Annual Report Quality Impact Risk Assessments Floor to Board Report for Maternity and Neonatology Services Cervical Screening Provider Lead Annual Report 2023-24 Nursing and Midwifery Safe Staffing Report Patient Safety Incident Response Framework Report Patient Safety Specialist Annual Report Annual Complaints Report Board Assurance Framework Corporate Risk Register 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.

- Patients continuing to experience long wait times for elective treatment.
- A rise in referrals to the Trust's occupational health service.
- A planned visit from Integrated Care Board colleagues to the Trust's accident and emergency and urgent care areas.

ASSURE

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

- Members noted that changes had been made to the Trust's medical teams working in urgent care to facilitate improvements to patient care and experience. This was exemplified in the patient story provided at the Committee.
- The Committee received updates on the extensive work taking place in the wider system to promote better flow for mental health patients. These included but was not limited to daily clinically ready for discharge meetings to make capacity for new admissions, the introduction of mental health liaisons in emergency departments and core wards, reviews of recovery houses as alternatives to emergency care areas, a review of crisis alternatives and increasing community capacity across mental health services.
- Members received an update on the activities of the Trust's End of Life Care and Bereavement team.

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 meeting will be arranged between the Chairman, Executive Medical Director and Chief Nurse regarding the Trust's waste management programme and equality impact assessments.
- There have been ongoing reductions in use of agency staff, and it was confirmed that this would continue to be closely monitored over the coming months.
- There was recognition of the need for more robust communication around organ donation across Lancashire and South Cumbria.

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT **Item** **163**

20 November 2024 **Purpose** Assurance

Information

Title	Triple A Report from Audit Committee
Report Author	Mr K Rehman, Non-Executive Director/ Committee Chair

Summary: This report sets out the summary of the items discussed at the Audit Committee meeting held on 14 October 2024. The triple A format of this report sets out items for alert, action or assurance form the Committee to the Board

Recommendation: The Board is asked to note the report.

Report linkages

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

(163) Triple A Report from Audit Committee

Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	Care Closer to Home Place-based Partnerships Provider Collaborative Quality and Safety Improvement Priorities Elective and Emergency Pathway Improvement People Plan Priorities Waste Reduction Programme
Related to ICB Strategic Objective	Improve population health and healthcare. Tackle inequalities in outcomes, experience and access. Enhance productivity and value for money. Help the NHS support broader social and economic development.

Impact

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

Previously considered by:

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

Committee Name:	Audit Committee
Date of Meeting:	14 October 24
Committee Chair:	Khalil Rehman
Attendance:	Quorate
Key Items Discussed:	Corporate Risk Register, One LSC, NHS Green Plan. Internal Audit & Management Responses. Anti-fraud update, Internal & External Audit updates

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.

- There were no matters for the Committee to alert the Board of.

ASSURE

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

- The committee reviewed the CRR & noted the substantial work and progress. Further work planned on Datix and manager training for risk identification and mitigation.
- Noted progress and recommended the ELHT 22-25 Green Plan
- The committee noted the internal audit plan update and approved move of Accountability Framework IA review to Q4.
- External Audit – VFM report noted.

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.

- Internal audit plans should be reviewed during transition phase of 1LSC
- Advising P&C committee to discuss and seek assurances that Medical Staff leave (limited assurance) and Recruitment internal audit recommendations are actioned and impact assessed.

- Waivers – Estates & Facilities should explore proactive approach to contract end dates to reduce the need for waivers and ensure VFM.
- Divisional Finance checklists IA (limited assurance)

Lancashire and South Cumbria Provider Collaborative

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

TRUST BOARD REPORT		**Item**	**164**
20 November 2024		**Purpose**	Information
Title	Remuneration Committee Summary Report		
Executive sponsor	Professor G Baldwin, Non-Executive Director		

Summary: The list of matters discussed at the Remuneration Committee meetings held on 23 September and 25 October 2024 are presented for information.

Report linkages

Related Trust Goal	-
Related to key risks identified on assurance framework	-

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	Yes

(164) Remuneration Committee Summary Report

Meeting: **Remuneration Committee**
Date of Meeting: **23 September 2024**
Committee Chair: **Graham Baldwin, Non-Executive Director**

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 23 September 2024, the following matter was discussed in private:

a) Annual Report on the Remuneration of Executive Directors and Very Senior Managers/Staff
b) Executive Directors and Colleagues on Very Senior Manager Salaries: Annual Cost of Living Uplift
c) Proposal for the Remuneration for the Executive Director of Finance
d) Retiring Executive Director of Finance Allowance
e) Remuneration Policy Review and Approval
f) Remuneration Policy Review and Approval

Meeting: **Remuneration Committee**
Date of Meeting: **25 October 2024**
Committee Chair: **Graham Baldwin, Non-Executive Director**

ITEMS DISCUSSED

At the meeting of the Remuneration Committee on 25 October 2024, the following matters were discussed in private:

a) Retired Executive Director of Finance Allowance

Lancashire and South Cumbria Provider Collaborative

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT **Item** **165**

20 November 2024 **Purpose** Information

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

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 11 September 2024.

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

Report linkages

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

	5 The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.
Related to key risks identified on Corporate Risk Register	Risk ID: Risk Descriptor.
Related to recommendations from audit reports	Audit Report Title and Recommendation/s.
Related to Key Delivery Programmes	State which key delivery programmes the paper relates to here.
Related to ICB Strategic Objective	State which ICB Strategic Objective the paper relates to here.

Impact

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

Previously considered by:

Meeting: **Trust Board (Closed Session)**

Date of Meeting: **11 September 2024**

Committee Chair: **Shazad Sarwar, Chairman**

ITEMS APPROVED

The minutes of the previous meeting held on the 10 July 2024 were approved as a true and accurate record.

The minutes of the Extraordinary Trust Board held on 6 August and 20 August 2024 were also approved as Trust and accurate records.

ITEMS DISCUSSED

At the meeting of the Trust Board on 11 September 2024, the following matters were discussed in private:

a) Round Table Discussion: National ICB / PCB and Pennine Lancashire Update.
b) Round Table Discussion: PA Consulting Report: Investigation and Intervention
c) Round Table Discussion: UEC Update
d) Financial Performance Update
e) 2024-25 Q3 Provider Revenue Support Public Dividend Capital
f) One LSC Update
g) MARS Implementation
h) Adult Critical Care Transfer Services (ACCT) Tender – Bid/No Bid Decision
i) Pathology Update
j) Industrial Action Update
k) Communication Update and Horizon Scanning

ITEMS RECEIVED FOR INFORMATION

None.