East Lancashire Hospitals
NHS Trust
A University Teaching Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

Personal

Effective

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD MEETING (OPEN SESSION)

10 NOVEMBER 2021, 13.00

VIA MS TEAMS

AGENDA

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

OPENING MATTERS				
TB/2021/124	**Chairman's Welcome**	Chairman	v	
TB/2021/125	**Apologies** To note apologies.	Chairman	v	
TB/2021/126	**Declaration of Interest Report** To note the directors register of interests and note any new declarations from Directors.	Chairman	v	
TB/2021/127	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 8 September 2021.	Chairman	d✓	Approval
TB/2021/128	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2021/129	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2021/130	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2021/131	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Interim Chief Executive	d✓	Information
QUALITY AND SAFETY				
TB/2021/132	**Patient/Staff Story** To receive and consider the learning from a patient story.	Executive Director of Nursing	p	Information/ Assurance
TB/2021/133	**Corporate Risk Register** To receive an update on the Corporate Risk Register and approve revisions based on the 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/2021/134	**Board Assurance Framework Review** To receive an update on the Board Assurance Framework and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Executive Medical Director	d✓	Assurance/ Approval
TB/2021/135	**Serious Incidents Assurance Report** To receive information in relation to incidents in month or that may come to public attention in month and be assured about the associated learning.	Executive Medical Director	d✓	Information/ Assurance

ACCOUNTABILITY AND PERFORMANCE				
TB/2021/136	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed, with items being raised by exception: a) Introduction (Interim Chief Executive) b) Safe (Executive Medical Director and Executive Director of Nursing) c) Caring (Executive Director of Nursing) d) Effective (Executive Medical Director) e) Responsive (Chief Operating Officer) f) Well-Led (Executive Director of HR and OD and Executive Director of Finance)	Executive Directors	d✓	Information/ Assurance
TB/2021/137	**Workforce Race Equality Standard (WRES) Action Plan Update**	Executive Director of HR & OD	d✓	Information/ Assurance
TB/2021/138	**Behavioural Framework Launch**	Executive Director of HR & OD	d✓	Information/ Assurance
STRATEGIC ISSUES				
TB/2021/139	**North West Staff Health and Wellbeing Programme and Pledges** a) NHSE Pledge Card	Executive Director of HR & OD Executive Director of HR & OD	d✓ d✓	Information/ Assurance Approval
GOVERNANCE				
TB/2021/140	**Patient Safety Incident Response Plan** *Mrs J Hardacre, Assistant Director of Safety and Risk to attend for this item*	Executive Medical Director	d✓	Approval
TB/2021/141	**Doctors Appraisal and Revalidation Annual Report**	Executive Medical Director	d	Approval
TB/2021/142	**Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Statement and Report 2020/2021**	Executive Director of Integrated Care, Partnerships and Resilience	d✓	Information
TB/2021/143	**Finance and Performance Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information

TB/2021/144	**Quality Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2021/145	**Audit Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2021/146	**Trust Board Part Two Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
TB/2021/147	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
FOR INFORMATION				
TB/2021/148	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2021/149	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2021/150	**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/2021/151	**Date and Time of Next Meeting** Wednesday 12 January 2022, 1.00pm, via MS Teams	Chairman	v	

East Lancashire Hospitals NHS Trust
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TRUST BOARD REPORT

Item 127

10 November 2021

Purpose Approval

Title	Minutes of the Previous Meeting
Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The minutes of the previous Trust Board meeting held on 8 September 2021 are presented for approval or amendment as appropriate.

Report linkages

Related strategic aim and corporate objective	As detailed in these minutes
Related to key risks identified on assurance framework	As detailed in these minutes

Impact

Legal	Yes	Financial	No
Maintenance of accurate corporate records			
Equality	No	Confidentiality	No

Previously considered by: NA

(127) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST
TRUST BOARD MEETING, 1.00PM, 8 SEPTEMBER 2021
MINUTES

PRESENT

Professor E Fairhurst	Chairman	Chairman
Mr M Hodgson	Interim Chief Executive/Accountable Officer	
Mrs P Anderson	Non-Executive Director	
Mrs M Brown	Executive Director of Finance	
Mrs S Gilligan	Chief Operating Officer	
Mr J Husain	Executive Medical Director	
Miss N Malik	Non-Executive Director	
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience	Non-voting
Mr K Moynes	Joint Executive Director of HR and OD (ELHT and BTHT)	Non-voting
Mrs F Patel	Associate Non-Executive Director	Non-voting
Mrs C Pearson	Executive Director of Nursing	
Mr K Rehman	Non-Executive Director	
Mr R Smyth	Non-Executive Director	
Mr M Wedgeworth	Associate Non-Executive Director	Non-voting
Miss S Wright	Joint Executive Director of Communications and Engagement (ELHT and BTHT)	Non-voting

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Director of Corporate Governance/ Company Secretary	
Mr D Byrne	Corporate Governance Officer	Minutes
Mrs S Chapman	Deputy Divisional Director of Estates and Facilities	Agenda Item: TB/2021/106
Mrs P Cross	Head of Integrated Care Partnership Development (Interim)	Agenda Item: TB/2021/112
Mrs E Davies	Deputy Director of HR&OD	

Mrs S Germaine-Cox	Associate Director of Workforce and Organisational Capacity, Birmingham and Solihull Mental Health NHS Foundation Trust	Observer
Miss K Ingham	Corporate Governance Manager/ Assistant Company Secretary	
Mr J Maguire	Divisional Director of Estates and Facilities	Agenda Item: TB/2021/106
Mrs R Malin	Programme Director, New Hospitals Programme	Agenda Item: TB/2021/111
Mr S McGirr	Director of Clinical System Analytics	
Mr M Pugh	Corporate Governance Officer	Minutes
Mrs L Whalley	Independent Management Consultant	Observer

APOLOGIES

Professor G Baldwin	Non-Executive Director
Mr S Barnes	Non-Executive Director
Mrs K Quinn	Operational Director of HR and OD

TB/2021/098 CHAIRMAN'S WELCOME

Professor Fairhurst welcomed Directors and members of the public to the meeting. She welcomed Mr Hodgson to the meeting as Interim Chief Executive Officer for the Trust and stated that she looked forward to work with him in his new role.

TB/2021/099 APOLOGIES

Apologies were received as recorded above.

TB/2021/100 DECLARATIONS OF INTEREST REPORT

There were no changes to the Directors Register of Interests and no declaration of interest made in relation to agenda items.

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

TB/2021/101 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 14 July 2021 were approved as a true and accurate record.

TB/2021/102 MATTERS ARISING

There were no matters arising from the minutes of the previous meeting.

TB/2021/103 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 the meeting or subsequent meetings.

RESOLVED: Directors noted the position of the action matrix.

TB/2021/104 CHAIRMAN'S REPORT

Professor Fairhurst updated Directors on the work she had been involved in since the previous meeting. She advised that she had participated in the opening of the Trust's new Garden of Memories at the Royal Blackburn Teaching Hospital (RBTH) site and praised the efforts of colleagues and people from the local community in its development. Professor Fairhurst stated that the occasion had provided an opportunity not just to remember those colleagues that had given their lives during the pandemic but had also allowed people to reflect on their experiences over the previous 18 months.

Professor Fairhurst informed Directors that she had also been involved in a significant amount of activity associated with the development of the system at a place-based, Pennine Lancashire and Integrated Care System (ICS) level. She advised that a Provider Collaboration Board (PCB) development session had been arranged for the 23 September 2021 and that the systems working agenda was now starting to move at a pace.

Professor Fairhurst concluded her update by confirming that she continued to attend regular meetings of the Health Sector Board (HSB). She explained that the work of the HSB Board was to contribute to Lancashire County Council's production of a Greater Lancashire Strategy and focus on the relationship between good health and economic prosperity.

RESOLVED: Directors received and noted the update provided.

TB/2021/105 CHIEF EXECUTIVE'S REPORT

Mr Hodgson referred Directors to the previously circulated report and highlighted several matters for information across national, regional and Trust specific areas. He referred to the funding announcements made in the House of Commons the previous day and stated that, while any additional funding for health and social care was welcome, it remained to be seen whether it would be enough and what additional level of elective activity would be required to secure it.

Mr Hodgson reported that the national COVID-19 vaccination programme continued to make good progress but drew Directors' attention to the ongoing lack of clarity around the autumn vaccine booster programme. He advised that no guidance had been received from the Joint Committee on Vaccination and Immunisation (JCVI) and that the Trust may need to consider decoupling its flu vaccination programme for the current year as a result. He went on to inform Directors that a raft of new guidance had been published in August 2021 linked to ICSs becoming statutory bodies, as well as associated guidance relating to the establishment of provider collaborations.

Mr Hodgson advised that Amanda Pritchard had now been appointed as Chief Executive Officer (CEO) of the NHS and was in the process of gaining a consensus on integrated and system working. Directors noted that a new five-year action was in place to drive down the numbers of tuberculosis (TB) cases in England and that a warning had been issued in relation to a rise in childhood respiratory infections ahead of the winter period. Mr Hodgson stated that the Trust was well prepared to manage this expected surge and reported that, while it had seen an initial uptake in Respiratory Syncytial Virus (RSV), its total number of incidents had remained low since.

Mr Hodgson reported that the success seen in the national COVID vaccination programme had been replicated in Pennine Lancashire. He also informed Directors that the region was making good progress in terms of elective recovery and was currently operating at over 100% of base activity in 2019 for outpatient, inpatient and diagnostic pathways. Directors noted that Amanda Doyle had been appointed as NHS England/Improvement (NHSE/I) Regional Director for the North West and that Andrew Bennett would become the Interim Chief Officer for the Lancashire and South Cumbria (LSC) ICS. Mr Hodgson added that the recruitment process for the CEO of the statutory ICS would commence later in the month and was due to conclude by the end of October 2021. He commented that the Trust was well placed to contribute to ICS level work, as much of the required infrastructure was already in place and advised that David Flory had now been appointed as the NHS Integrated Care Board (ICB)

Chair-designate for LSC. Mr Hodgson reported that great strides had been made to clarify the vision and purpose around provider collaboration and advised that a Clinical Collaborative Board, overseeing restoration, and a Corporate Collaboration Board, to consider support functions, had now been established.

Mr Hodgson informed Directors that Professor Fairhurst had been reappointed to the Trust for a further two years and that one of the Trust's Associate Non-Executive Directors, Mr Harry Catherall, had recently agreed to taken a sabbatical from his NED duties to take up the post as interim CEO of Oldham Council for a period of 12 months; he reported that there had been several recent complaints from members of the public in relation to the wearing surgical face masks and stressed that national guidance still mandated for masks to be worn in healthcare settings, although them no longer being required in wider public settings. Mr Hodgson concluded his update by reporting that a number of Trust staff had received awards from the Pancreatic Cancer Rapid Diagnostic Service (RDS) and that its maternity services had once again attained the United Nations International Children's Emergency Fund (UNICEF) UK Gold Baby Friendly Status Award.

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

TB/2021/106 **PATIENT/STAFF STORY**

Mrs Pearson explained that a staff story was being presented and that Mr Maguire and Mrs Chapman had been invited to share their experiences during the pandemic. She noted that while the Estates and Facilities (E&F) team had always played a key role in the Trust over the years, the previous 18 months had demonstrated just how crucial this role was.

A short video, showcasing the achievements of the E&F team during the pandemic, was shared with Directors which can be seen here.

Mr Maguire stated that he was proud of the work that had been done through the pandemic. He confirmed that the E&F team would continue to support restoration as well as the delivery of the Emergency Village scheme and the Elective Care Centre at Burnley General Teaching Hospital (BGTH). Mr Maguire informed Directors that two chefs from the Trust's catering team had successfully reached the Chef of the Year finals and stated this showed the Trust's commitment to pushing boundaries of the food it provided for staff and patients. He advised that the E&F team continued to focus on workforce transformation and that the work done to transform the Trust's portering and domestic services had been vital to managing the pandemic.

Mrs Chapman also stated that she was proud of the E&F team. She explained that the video had been developed to support the 'Big Conversation' process and to enable team members to reflect on all they had accomplished.

Mrs Gilligan commented that she and her colleagues would not be able to achieve what they did without the support of the E&F team and extended her thanks to them as well as Mr Maguire and Mrs Chapman.

Mr Husain praised the work done by the team and agreed that while there was not always clear recognition of the work being done behind the scenes, the pandemic had clearly shown how important the work they did was to everyone in the Trust.

Mr Hodgson noted that there were a lot of different facets to the E&F team and that the sheer number of ward moves and the speed at which they had been done during the pandemic had been remarkable.

Mrs Brown stated that it was good to see the team getting the recognition that they deserved and commented that the pandemic had clearly shown the benefit of the decisions that the Trust had made in the past, such as keeping an in-house laundry service.

Mr McDonald noted that none of the work done during the pandemic would have been possible without Mr Maguire and Mrs Chapman and stated that they deserved recognition for their compassionate leadership.

Professor Fairhurst thanked Mr Maguire and Mrs Chapman for attending the meeting and for sharing their experiences with the Board.

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

TB/2021/107 CORPORATE RISK REGISTER (CRR)

Mr Husain referred Directors to the previously circulated report and requested it be taken as read. He informed Directors that the Trust had now rolled out its Risk Strategy Framework along with associated e-learning modules and face-to-face training. Mr Husain reported that this had resulted in a 3% reduction in overall risk numbers from the previous month and a 53% reduction in the number of overdue live risks. Directors noted that there had been an overall increase in the number of risks associated with Health and Safety due to the greater amount of risks assessments being carried out in relation to social distancing, use of Personal Protective Equipment (PPE) and compliance with the Trust's COVID-19 guidelines. Mr Husain explained that only risk 5 (Lack of recurrent investment and review of CNP (Community Neuro Developmental Paediatrics services) resulting in services at risk had been determined to have

poor effectiveness of controls in place. He confirmed that the work taking place on the new Electronic Patient Record (EPR) system in relation to risk 2 was progressing well.

Mr Rehman acknowledged the mitigations and assurances in place in relation to risk 6 (insufficient capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescale) but requested more clarification on a potential end point for rebalancing of the ophthalmology service with the demand that had now built up. He also enquired if there was any learning that could be taken from risk 5 as to why the Trust had been unable to recruit to posts in the CNP service. Mr Husain clarified that the difficulties with recruitment for risk 5 had been caused by workforce shortages nationally and were also being seen at other organisations He added that these issues had been exacerbated by more staff choosing to retire early due to the pandemic.

In relation to risk 6, Mr Husain explained that one of the main aims of the PCB was to address variation which currently existed across the system. He confirmed that this process had already started for Ophthalmology but currently was unable to provide an exact date when the situation was likely to improve.

Mrs Gilligan agreed that it would be difficult to provide an exact timeline but advised that, in the interim, the Trust was working with the Getting It Right First Time (GIRFT) team to determine if there was any scope to improve the productivity of its services. She explained that part of this process was to consider best practice at other organisations which the Trust could adapt for itself and provided assurances to Directors that every avenue was being explored to address the issues raised.

Mr Wedgeworth commented that it was his understanding that the ongoing lack of funding for the Trust's High-Dependency Unit (HDU) beds in relation to risk 3 (risks associated with providing HDU care in DGH with no funding for HDU provision) had been caused by delays in Clinical Commissioning Group (CCG) decision making. He noted that CCGs were now in the process of being wound down as part of the wider system development and enquired if it was likely that the situation would be resolved in the near future. Mr Husain stated that he was hopeful that this issue and any other elements of commissioning would be resolved through the development of the LSC Integrated Care System (ICS) and the ICB. He added that the issues with the Trust's CNP service would also be addressed through the ICB but reiterated that it would not be possible to provide a firm date or time for when this would be done.

Professor Fairhurst noted that there was a reference to poor controls being in place for risk 5 at the start of the report and suggested that it may be worthwhile to consider amending the wording for future iterations as the specific circumstances surrounding this risk were out of the

Trust's control. Mr Husain confirmed that this would be addressed for the report provided at the next meeting in November 2021.

RESOLVED: **The wording used to describe the controls in place for Risk ID 8221 will be revised for the next iteration of the CRR report.**

TB/2021/108 BOARD ASSURANCE FRAMEWORK (BAF)

Mr Husain summarised the main changes to the BAF and explained that a number of new controls had been added to each risk since it was previously presented to the Board. He advised that more information around the PCB and its assessment of clinical services across the ICS referred to during the previous item had now been added to risk 3. Directors also noted that references to the additional funding from the National Accelerator Programme had now been added to risk 4.

Mr Hodgson commented that the BAF was now in a much better position in terms of recognising the wider system dynamics of the PCB and ICS as well as those taking place within the Trust.

Professor Fairhurst observed that risk 3 still referred to a lack of effective engagement with partnership organisations of the ICS and suggested that the score assigned to it may need to be reassessed considering the amount of successful partnership working now taking place. She requested that Directors consider this before the next meeting.

Directors confirmed that they were content with the assurance provided in relation to the risks identified by the BAF.

RESOLVED: **Directors received, discussed and approved the updated Board Assurance Framework.**

Directors to consider revising the score assigned to risk 3 on the BAF to more accurately reflect the current levels of partnership working.

TB/2021/109 SERIOUS INCIDENTS ASSURANCE REPORT

Mr Husain referred Directors to the previously circulated report and requested it be taken as read. He advised that the Trust had now concluded the reviews of three Never Events that had been reported at the previous meeting and discussions were taking place with the CCG's regarding de-escalation. Directors noted that the Serious Incidents Requiring Investigation (SIRI) Panel had confirmed that all relevant safety process had been completed and documented in line with national expectations.

Mr Husain reported that there had been no breaches of Duty of Candour (DOC) and that 62 Strategic Executive Information System (StEIS) incidents had been deescalated on completion of investigations. He also reported the top three incident categories as pressure ulcers, slips, trips and falls, and diagnostic. Directors noted that appropriate action had been taken following a recent string of security related incidents and that a new translation service had been successfully rolled out across the Trust. Mr Husain advised that from April 2022 it would be mandatory for all NHS organisations to take part in the new Patient Safety Incident Response Framework (PSIRF) and confirmed that an update on this would be provided at the next meeting.

Mr Smyth observed that there had been a good deal of learning from the recent Never Events and enquired how much of this would be disseminated, both across the Trust and to other organisations, to prevent similar incidents occurring in the future. Mr Husain explained that this information was fed back to the CQC and CCGs and that these were the forums by which this learning would then be spread across the wider NHS.

Mr Hodgson pointed out that the Trust would be embarking on the development of its EPR system soon and enquired if the Trust had an appropriately designed incident reporting system in place that could be linked to it. Mr Husain explained that the Trust currently used the Datix system for incident reporting and confirmed work was already underway to determine if it would be compatible with the new EPR system. He stressed that there was still sufficient time available to explore this but advised that it may require further investment and approval from the Board to get an appropriate system in place. In response to a query from Professor Fairhurst, Mr Husain stated that an update would be provided at the next meeting.

RESOLVED: **An update on the Patient Safety Incident Response Framework (PSIRF) will be provided at the next meeting.**

An update on the integration of the Trust's Datix system with its new Electronic Patient Record (EPR) system will be provided at the next meeting.

TB/2021/110 INTEGRATED PERFORMANCE REPORT (IPR)

a) Introduction

Mr Hodgson introduced the item and confirmed that it covered the period to the end of July 2021. He confirmed that there had been a continuation of the pattern from previous months in terms of ongoing COVID-19 cases, increases in urgent and emergency care activity and restoration activity. Mr Hodgson reported that the 'pingdemic' had put a significant amount of

additional pressure on the workforce during this time and stressed that the report should be considered in this context. He acknowledged that there had been challenges but stated that Directors should take assurance from the contents of the report, adding that the Trust's performance had remained in the middle of Trusts in England.

b) Safe

Mr Husain requested that the safe section of the report be taken as read and provided a summary of its highlights. He reported that there had been no cases of Methicillin-resistant Staphylococcus Aureus (MRSA) or medication errors in the reporting period. Three cases of Clostridium Difficile (c. diff) had been confirmed but Mr Husain provided assurances that no lapses of care had been identified for any of the patients affected. He went on to advise Directors that no c. diff trajectory had been set by NHSE/I for the current year and that there had been a total of 20 cases identified since April 2021. Directors also noted that a Never Event had recently occurred involving a patient who had undergone wrong site surgery and that a full investigation had been carried out following this, which had determined that no harm had been caused. Mr Husain reported that there had been one probable and two definitive hospital onset cases of nosocomial COVID-19 infections in July. He concluded his update by informing Directors that the outbreak of Escherichia coli (E. coli) on the Trust's Neonatal Intensive Care Unit (NICU) was ongoing, however there had been no new cases and the unit was continuing to operate for external admissions and transfers. He confirmed that the situation continued to be closely monitored through the Quality Committee.

Mrs Pearson advised that staffing during July 2021 for both maternity and ward areas had been extremely challenging, exacerbated by increased patient acuity and significant numbers of staff having to shield or self-isolate. She went on to report that, despite these challenges, only eight wards had dropped below the 80% safe staffing standard, with three red flags identified in accordance with National Institute for Clinical Excellence (NICE) guidance. Mrs Pearson concluded by informing Directors that morale amongst staff was low in some areas, particularly those still under significant pressure from COVID-19 admissions such as critical care.

Professor Fairhurst requested clarification on whether the low morale and tiredness in these areas was being addressed through the Trust's Health and Wellbeing (HWB) offer. Mr Moynes confirmed that the HWB offer was being utilised, as was the freedom to speak up process, but acknowledged that staff were getting more and more fatigued as time went on.

Mrs Davies reminded Directors that £1,500,000 of additional funding had been provided to support system wide HWB initiatives in recognition of the health inequalities across LSC. She confirmed that this funding would be used in part to support a number of schemes targeted at addressing the mental health effects of the pandemic.

Professor Fairhurst enquired if Directors were assured that the actions in place were appropriate to mitigate the issues discussed.

Mrs Anderson confirmed that she was assured that colleagues were doing as much as possible to resolve the issues raised and that every step was being taken to support staff.

Mr Hodgson stated that the Executive team made every effort to make themselves visible to other staff working in the Trust. He explained that this was a delicate balancing act in relation to unnecessarily increasing footfall and increasing the risk of nosocomial infections. He confirmed that appropriate measures were still being considered, adding that a good example of this was the work underway by Mrs Pearson to increase the frequency of the virtual quality walkrounds.

RESOLVED: **Directors noted the information provided within the Safe section of the Integrated Performance Report.**
An update will be provided on the E.Coli outbreak on the NICU.

c) Caring

Mrs Pearson referred Directors to the Caring section of the report and requested that it be taken as read. She reported that work was taking place with divisions to address a reduction in response rates for the Friends and Family Test (FFT) for patients going through the Emergency Department (ED) but confirmed that the figures from a general patient experience perspective were otherwise very positive. Directors noted that there had been 29 new formal complaints made in July 2021.

Mr Rehman noted that the figures were not as positive as they could be but stated that there needed to be recognition of the wider circumstances surrounding this. He enquired if any communication was taking place with local communities to explain some of the reasons that had led to the downwards trends being seen in some areas. Mrs Pearson acknowledged that more work was likely needed around communication but explained that she was content with the feedback currently being provided as it allowed the Trust to focus more easily on any areas requiring improvement.

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

d) Effective

Mr Husain drew Directors' attention to the Hospital Standardised Mortality Ratio (HSMR) and reported the Trust's performance at 109.6. He went on to explain that, when compared against its peers, this figure went down to 103.5 and when COVID-19 deaths were excluded fell further to 101.8, well within expected tolerances. Mr Husain reported crude mortality at 2.3%, down from 2.6% at the same time the previous year. Directors also noted the total number of deaths in August 2021 of 156 was less than the 167 reported in August 2019.

Mr Husain confirmed that, with the support of its Medical Examiner team, the Trust was now reviewing every death occurring in a hospital setting. He informed Directors that there had been a rise in cerebrovascular disease. This had been determined to be due to patients presenting later than they typically would and had led to poorer outcomes. He confirmed that new investments had been made in its end-of-life care team and that positive developments would be seen over the coming months.

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

e) Responsive

Mrs Gilligan reported that the ED was still experiencing significant challenges and that performance was falling short of where it should be. Directors noted that the department had seen 39 more patients per day on average in July 2021 than it had during the same period in 2019 and that this had risen to 47 more per day in August. Mrs Gilligan reported eight breaches of the 12-hour trolley standard in July, seven of which had been caused by waits for mental health beds to become available. She noted that this was a significant improvement over the Trust's position the previous month and that the hard work and commitment of staff had ensured that no further breaches had occurred.

Mrs Gilligan went on to summarise performance in other areas throughout the Trust. She reported that the Trust's 52-week position in relation to the Referral to Treatment (RTT) standard had fallen to 738 at the end of July, below trajectory and that a further five patients had waited 104 weeks or more for treatment. She added that all five of these cases had been due to patient choice. Restoration activity for July was reported at 90% for day cases, 106.6% for inpatients and 105.1% for outpatients and Mrs Gilligan confirmed that there had been further improvement in all areas in August. Similar improvements were reported for diagnostic performance. Mrs Gilligan informed Directors that the Trust had also maintained to achieve

the highest result of A from the Sentinel Stroke National Audit Programme (SSNAP) in its latest quarter.

Mr Hodgson noted that there was a significant national focus on stroke performance and commented that this result was a real testament to the work of the Trust's stroke team during a highly pressured period.

Mr McGirr informed Directors that it was likely that four new performance measures related to ED patient flow would be introduced across the wider NHS in the near future.

Mrs Gilligan confirmed that these new measures would be reflected in future iterations of the IPR once they had been introduced.

RESOLVED: **Directors noted the information provided under the Responsive section of the Integrated Performance Report.**

f) Well-Led

Mrs Davies reported the Trust's overall sickness rate at 6.1% and advised that 0.72% of this had been due to physical and mental health issues related to COVID-19. She informed Directors that a 'deep-dive' exercise was currently being carried out to look at the factors that may be contributing to the Trust's sickness and absence levels in more detail. Mrs Davies also reported that there had been a rise in staff turnover during June and July 2021 but advised that this had now fallen back down to the usual average of 7%. She confirmed that a report on the work taking place around the Trust's appraisal process would be provided at the next meeting.

Mrs Brown explained that there was still a marked lack of clarity regarding the envelope for the second half of the financial year (H2) and advised that a meeting with the national finance team was due to take place the following day to address this. She confirmed that although the Trust was on track to achieving a breakeven position for the first half of the financial year (H1), there was substantial risk to this position due to recent changes in the thresholds of the national accelerator programme and associated restoration of activity. Mrs Brown clarified that these changes would result in a reduction of between £20,000,000 and £30,000,000 income for the ICS and advised that work was taking place to determine the full impacts from this.

Professor Fairhurst noted that the Board was in a difficult position with regards to gaining assurance from the report due to the lack of clarity around the financial settlement for H2. She requested confirmation from Directors that they were content with the assurance provided in relation to H1 targets and would await the publication the following day of the financial settlement for H2. Directors confirmed that they were content with this approach.

RESOLVED: **Directors noted the information provided under the Well-Led section of the Integrated Performance Report.**

An update on the deep dive exercise being carried out into the sickness and absence rates at the Trust will be provided at the next meeting.

An update on the Trust's appraisal process will be provided at the next meeting.

TB/2021/111 **NEW HOSPITALS PROGRAMME UPDATE AND CASE FOR CHANGE**

Mrs Malin referred Directors to the previously circulated reports and requested they be taken as read. She stated that the Case for Change (CFC) document was a cornerstone document for the New Hospitals Programme (NHP) and confirmed that it had been finalised and circulated to all stakeholders earlier in the year.

Mrs Malin informed Directors that the framework model of care for the NHP had now been presented to the Clinical Oversight Group (COG) the previous month and that every effort was being made to ensure that any associated work was aligned with the PCB. She explained that the other key item was the development of a long list of proposals to explore different scenarios around new builds, rebuilds and refurbishments and that the next step would be refining these down into a short list. Mrs Malin advised that two sessions had been recently held with members of the public and staff to gather feedback about the NHP and reported that both had been largely positive, with significant enthusiasm from attendees to contribute to future 'Big Chat' meetings. She also advised that a series of face-to-face workshops had been arranged by Healthwatch to reach and gather feedback from digitally excluded, marginalised and other hard to reach groups.

Mr Hodgson thanked Mrs Malin for her update and offered his congratulations to her and her team for the completion of the CFC.

Professor Fairhurst requested that Directors note the progress made by the NHP in Q1, as well as the development of the products needed to support the development approach of the associated business cases. She extended her thanks to Mrs Malin for attending and providing her update.

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

TB/2021/112 PENNINE LANCASHIRE ICP UPDATE AND PARTNERSHIP AGREEMENT FOR 2021-22

Mr Hodgson provided a brief introduction to the item and explained that Mrs Cross was in attendance in her role as Head of ICP Development for Healthier Pennine Lancashire to update Directors further.

Mrs Cross stated that partnership working had been in place for many years across Pennine Lancashire and that the Trust had been a significant driving force behind local partnership arrangements. She explained that the Government had now set out draft legislation following the publication of the NHS Long Term Plan in 2019 which, when passed, would result in the formal establishment of the Pennine Lancashire ICB. Mrs Cross confirmed that this draft legislation was intended to allow decisions to be made as close to communities as possible and made frequent reference to place-based partnerships. She also confirmed that the legislation was clear around the need for budget decisions to be devolved to specific areas and that she and other ICP leads had been working over recent years to ensure clarity around the overall direction of travel, including the development of a strategic narrative.

Mrs Cross confirmed that the ICP would continue to work collaboratively around a number of key priorities and explained that its Partnership Agreement had now been revised to more accurately reflect this way of working. She informed Directors that the ICP was currently asking for its stakeholders to endorse this revised agreement and stated that she hoped the Board would also feel comfortable to do so. Mrs Cross acknowledged that there was still a lack of clarity in some areas but stated that the ICP was in a strong position to shape future developments. She concluded by confirming that she was intending to provide regular updates to the Board regarding any further changes or agreements made.

Mr Wedgeworth noted that the paper referred to engagement with local communities and enquired as to whether patients and staff were fully aware of the developments taking place around the ICP and whether they had been given the opportunity to express their views. Mrs Cross explained that the ICP was working collectively with communication and engagement leads for LSC system, as well its own leads within Pennine Lancashire, to plan timescales and activities around resident engagement. She advised that these activities were expected to take place either in December 2021 or January 2022.

Mrs Gilligan stated that she supported the comments made by Mrs Cross around how closely organisations in the ICP were working together and that she was pleased to see things moving forward with a truly collaborative approach.

Mr Hodgson stated that references had been made in his CEO report around the preparation for delegation to place level and noted that Mrs Cross had presented some of the detailed architecture by which this would be achieved in her report.

Professor Fairhurst requested confirmation from Directors that they were content to endorse the direction of travel presented by Mrs Cross. Directors confirmed that they were content to do so. Professor Fairhurst stated that she looked forward to the next update from Mrs Cross later in the year.

RESOLVED: **A further update on the Pennine Lancashire IPC will be provided at a future meeting.**

TB/2021/113 EMERGENCY PREPAREDNESS RESILIENCE RESPONSE (SUMMARY)

Mr McDonald clarified that the purpose of this item was for delegated authority to be requested to submit the year's Emergency Preparedness Resilience Response (EPRR) core standards annual assurance statement on behalf of the Trust. He advised that this would be submitted, along with the Trust's statement of compliance, to lead commissioners on the 8 October 2021 after which it would then feed into regional and national statements of compliance. Mr McDonald stated that this would be presented to Directors at the next meeting for information. Directors confirmed they were content to approve this request

RESOLVED: **Directors approved the request for delegated authority to be granted for the submission of the EPRR core standards annual assurance statement and statement of compliance.**

TB/2021/114 FINANCE AND PERFORMANCE COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

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

TB/2021/115 QUALITY COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

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

TB/2021/116 AUDIT COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

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

TB/2021/117 **TRUST CHARITABLE FUNDS COMMITTEE INFORMATION REPORT**

The report was presented to the Board for information.

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

TB/2021/118 **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/2021/119 **REMUNERATION COMMITTEE INFORMATION REPORT**

The report was presented to the Board for information.

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

TB/2021/120 **ANY OTHER BUSINESS**

No items were raised for discussion

TB/2021/121 **OPEN FORUM**

No queries were raised by members of the public prior to the meeting.

TB/2021/122 **BOARD PERFORMANCE AND REFLECTION**

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

Mr Hodgson stated that he felt the meeting had demonstrated a good balance between the complex pressures and priorities the Trust was managing, as well as how it was performing against them, but had also shown tangible evidence of how this was being done at both a place-based and ICS level.

Mrs Gilligan also stated that she felt the meeting had been a good one and that she had felt the challenges raised by Professor Fairhurst around the risk of not engaging with partners had been fair.

Professor Fairhurst thanked Directors for their comments and their attendance. She reminded them that the Trust's Annual General Meeting would be taking place the following day at 3.00pm.

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

TB/2021/123 **DATE AND TIME OF NEXT MEETING**

The next Trust Board meeting will take place on Wednesday, 10 November 2021 at 13:00, via MS Teams.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 129

10 November 2021

Purpose Information

Title	Action Matrix
Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Professor E Fairhurst, 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

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 Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. 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

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2021/107: Corporate Risk Register	The wording used to describe the controls in place for Risk ID 8221 will be revised for the next iteration of the Corporate Risk Register report.	Executive Medical Director	November 2021	Complete: The wording used to describe the controls in place for Risk ID 8221 been revised.
TB/2021/108: Board Assurance Framework	Directors to consider revising the score assigned to risk 3 on the BAF to more accurately reflect the current levels of partnership working.	Executive Directors	November 2021	Update: The Audit Committee is undertaking its annual review of the BAF after which the scoring assigned to reach risk will be reviewed on a wholesale basis.
TB/2021/109: Serious Incidents Requiring Assurance Report	An update on the Patient Safety Incident Response Framework (PSIRF) will be provided at the next meeting. An update on the integration of the Trust's Datix system with its new Electronic Patient Record (EPR) system will be provided at the next meeting.	Executive Medical Director Executive Medical Director	November 2021 November 2021	Agenda Item: November 2021 Update: This item will be addressed under the Serious Incidents Requiring Assurance section at the November Trust Board meeting.

Item Number	Action	Assigned To	Deadline	Status
TB/2021/110: Integrated Performance Report	An update will be provided on the E.coli outbreak on the NICU. An update on the Trust's appraisal process will be provided at the next meeting.	Executive Medical Director Executive Director of HR & OD	November 2021 November 2021	Update: This item will be addressed under the Safe section of the Integrated Performance Report. Update: This item will be addressed under the Well-led section of the Integrated Performance Report.
TB/2021/112: Pennine Lancashire ICP Update and Partnership Agreement for 2021-22	A further update on the Pennine Lancashire IPC will be provided at a future meeting.	Interim Chief Executive	TBC	Agenda Item: March 2022

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item

10 November 2021

Purpose Information

Title	Chief Executive's Report
Author	Mrs E-L Cooke, Joint Deputy Director Communications and Engagement
Executive sponsor	Mr M Hodgson, Chief Executive

Summary: A summary of national, health economy and internal developments is provided for information.

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

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 Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

(Item Number) Chief Executive's Report

CEO Report

November 2021

This report is divided into five sections. Section one details major national headlines, section two reports news from across Lancashire and South Cumbria, and section three notes Trust news and initiatives which are aligned to the Trust's values. The fourth section shows the external communications and engagement interactions with the final section summarising the Chief Executive's diary.

An additional section has been included in this report to provide an update on nosocomial infections.

One - National Headlines

Top news reports gathered from NHS England, NHS Improvement, NHS Providers and other reputable news sources.

UK COVID-19 vaccine programme update

Almost 50 million people have had a first vaccine dose - about 86% of over-12s. More than 45 million - about 79% of over-12s - have had both doses and just under 8 million have received their booster or third dose.

The number of first doses administered each day is now averaging about 44,000 - far below a peak of some 500,000 in mid-March. An average of about 23,000 second doses are now being given a day. Two in five people aged 50 and over, who are eligible, have already coming forward for their extra jab. More than a third of eligible health and care workers have also had their booster vaccine.

Progress made in the UK so far means the country continues to be among those with the highest vaccination rates globally. Currently reporting shows 68% of the population to be fully vaccinated.

Vaccination rates have now levelled off in every age group in England apart from 16 and 17-year-olds. The highest rates of vaccination can be seen in the oldest age groups - among the first to be vaccinated. The roll out the vaccine for school children aged 12 to 15 has also begun, with almost three million children in this age group eligible for one dose of the Pfizer vaccine.

Office for National Statistics (ONS) data suggests more than nine in 10 UK adults now have coronavirus antibodies - which is evidence of a past Covid infection or having received at least one dose of a vaccine.

Recent reports show unvaccinated people in England were 32 times more likely to die of COVID-19 than those who have been fully vaccinated. Analysis of weekly age-adjusted risk of death between 2 January and 24 September 2021 showed the age-standardised mortality rates (ASMRs) for deaths involving

COVID-19 were consistently lower for people who had received two vaccinations compared to one or no vaccinations.

Heavy toll of Covid

People seeking NHS help to lose weight during the pandemic are on average five pounds heavier than those starting the programme during the previous three years, new NHS research has revealed.

Extra weight, gained as people lived through the COVID pandemic, means people are at higher risk of developing Type 2 diabetes.

The study, published in The Lancet Diabetes and Endocrinology, showed that people aged under 40 enrolling on the NHS Diabetes Prevention Programme have seen the greatest differences in weight and are an average of eight pounds heavier than those enrolling before. It is estimated that weight gain of one kilogram, or 2.2 pounds, can increase someone's risk of diabetes by around 8%.

More than 405,000 have been helped by the Programme since it was established in 2016 and have been provided with bespoke advice on healthy eating, physical exercise and weight management. Latest NHS data show that people completing the programme typically achieve an average weight loss of 3.3 kilograms, and 3.6 kilograms for those who are overweight or obese, reducing their risk of Type 2 diabetes significantly.

The NHS has fast-tracked access to the Programme after research found that people are twice as likely to die from COVID-19 if they have Type 2 Diabetes.

New NHS clinical leadership to support post-COVID challenges

Leading clinicians from across the health service have been appointed to new national clinical roles to help lead action on post-COVID challenges facing patients and staff.

The five new clinical leads – covering urgent and emergency care, elective care and long COVID – will provide expert advice to the NHS Medical Director, Professor Stephen Powis, and to the programme teams working to support local NHS teams improve services for patients in these areas.

The NHS's first ever national specialty adviser roles for long COVID have also been created to help the NHS meet new demand for ongoing care from people suffering long-term effects from the virus.

New NHS England senior appointments

Sir Jim Mackey, the Chief Executive of Northumbria Healthcare NHS Foundation Trust, has been appointed to spend two days a week supporting the national NHSE/I team to find new ways to address the elective backlog. He previously led NHS Improvement.

His appointment comes after the Government announced additional funding for the NHS to cover COVID costs and provide millions more health checks, treatments, procedures and operations over the next few years. The NHS is already pulling out all the stops to help as many patients as possible with many benefitting from accessing millions more health checks, operations and procedures this summer than the same time last year.

Tom Cahill has been appointed as the national director for learning disability and autism. Tom, who has been Chief Executive of Hertfordshire Partnership University NHS Foundation Trust since 2009, will join NHS England to build on progress already made in providing people with a learning disability or autism with care in the community, rather than in inpatient settings.

The number of inpatients with a learning disability has fallen by around a third since 2015, and with the establishment of integrated care systems, local NHS groups are now working with councils to drive this number down further.

NHS England and NHS Improvement will be undertaking a review, working with commissioners, of every single inpatient with a learning disability, autism or both in a mental health inpatient care setting to ensure that each person has a clear care and treatment plan and discharge date in place. If these are not in place, the review will explore why not.

New landmark strategy to improve the lives of autistic people

Improving the lives of autistic people is the focus of a new multi-million pound strategy launched by the government.

Backed by nearly £75 million in the first year, it aims to speed up diagnosis and improve support and care for autistic people. The funding includes £40 million through the NHS Long Term Plan to improve capacity in crisis services and support children with complex needs in inpatient care.

Autistic people face multiple disadvantages throughout their lives, with too many struggling to get support that is tailored to their needs at an early enough stage and facing stigma and misunderstanding, often leaving them lonely or isolated. Through this new strategy, steps will be taken to improve diagnosis, which is crucial to help people get the support they need and improve society's understanding of autism.

The 5-year strategy was developed following engagement with autistic people, their family and carers. It will support autistic children and adults through better access to education, more help to get into work, preventing avoidable admissions to healthcare settings, and training for prison staff to better support prisoners with complex needs.

NHS staff experience busiest September on record

NHS staff are continuing to increase the amount of non-urgent care provided to patients, despite experiencing the busiest September on record.

Major A&Es treated over 1.39 million people during September – the highest ever for the month and all while staff cared for thousands of COVID patients. The figures also showed that staff carried out 1.1 million elective procedures in August – up by one third compared to the same period last year. This was despite the health service admitting 23,000 COVID patients in August – 14 times as many patients compared to the same month last year.

NHS figures also show a reduction in the number of patients waiting for a diagnostic scan for the first time this year, meaning more people are now getting the checks they need. This follows the rollout of NHS diagnostic centres last month which were backed by fresh funding to help the NHS to tackle the backlog.

Ambulances responded to a record 76,000 life threatening call-outs, an increase of more than 20,000 on the previous high for September, while 999 took nearly one million calls in September. NHS 111 also saw record demand taking a call every 7 seconds and over 1.9 million calls across August. The NHS has invested an additional £23 million into NHS 111 to help the service meet the rise in demand.

Figures released showed GPs were also facing record demand with 24 million appointments taking place – above pre-pandemic levels. The NHS announced a £250 million winter access fund to support GP practices to improve availability so that patients who need care can get it, often on the same day if needed.

NHS sets out blueprint for improving patient access to GP appointments

The NHS has published a new plan that it hopes will help improve patient access to GP appointments, as well as support practitioners and primary care teams. The blueprint – Our plan for improving access for patients and supporting general practice - was worked on in collaboration with the Department of Health and Social Care.

GP surgeries will be provided with additional funding to boost their capacity to increase the proportion of appointments delivered face to face. This is part of a major drive to support general practice and level up performance, including additional efforts to tackle abuse against staff.

The measures, including a £250 million winter access fund from NHS England, will enable GP practices to improve availability so that patients who need care can get it, often on the same day if needed. The investment will fund locums and support from other health professionals such as physiotherapists and podiatrists, with a focus on increasing capacity to boost urgent same-day care. This is in addition to £270 million invested over the previous 11 months to expand capacity and support GPs.

NHS launches world's first trial for new cancer test

The NHS launched the world's largest trial of a revolutionary new blood test that can detect more than 50 types of cancer before symptoms appear. The first people to take part will have blood samples taken at mobile testing clinics in retail parks and other convenient community locations.

The Galleri(tm) test checks for the earliest signs of cancer in the blood and the NHS-Galleri trial, the first of its kind, aims to recruit 140,000 volunteers in eight areas of England to see how well the test works.

Cholesterol-busting jab to save thousands of lives

A new drug to lower cholesterol will be made available to hundreds of thousands of NHS patients, thanks to a world-leading deal announced by the head of the health service today.

The revolutionary new treatment, Inclisiran, is delivered as an injection twice a year and can be used alongside statins, adding to the options available to patients to help control their cholesterol levels.

This first NHS 'population health agreement', between the NHS and Novartis, will enable 300,000 patients with high cholesterol and a history of cardiovascular disease to benefit from the lifesaving drug over the next three years, a figure that could rise to nearly half a million people beyond that initial period.

More than two in five people in England have high cholesterol which puts them at significant risk of developing heart disease, and around 6.5 million adults in England are currently taking lipid-lowering drugs such as statins. It has been estimated that Inclisiran could prevent 55,000 heart attacks and strokes, saving 30,000 lives within the next decade.

NHS supports mental health patients return to work

Thousands of people with mental health problems have been supported into employment during the pandemic, thanks to the NHS Long Term Plan**.**

The plan committed to helping tens of thousands of patients with severe mental illness into work through the Individual Placement and Support (IPS) scheme by 2023. Over the last year, more than 4,000 people were employed in a range of roles including in retail and digital marketing as part of the employment support scheme run by the health service.

Based on over 20 years of research the IPS employment model is internationally recognised as the most effective way to support people with mental health problems to gain and keep paid employment.

Those supported by IPS work significantly more hours per month and have higher earnings and better job tenure than participants in other forms of vocational services. Some of the participants experienced demonstrate reduced rates of hospital admission and less time spent in hospital.

We are the NHS campaign launched

NHS England and NHS Improvement, in partnership with NHS Health Education England, has launched its annual workforce recruitment campaign, 'We are the NHS'. Now in its fourth consecutive year, the campaign aims to increase positive perceptions of, and pride in, working for the NHS across a diverse range of roles.

Building on the successes of previous years, it aims to motivate target audiences to undertake a career in the NHS including in nursing, the Allied Health Professions and as Healthcare Support Workers (HCSWs).

Two - Lancashire and South Cumbria Headlines

Important updates and information reflecting work being carried out across Healthier Lancashire and South Cumbria and Healthier Pennine Lancashire.

COVID-19 update

Across the North West, more than 10.2 million vaccines have been administered, which includes over 5.1 million first doses. The North West case rate is now higher than the national figure but is increasing less quickly. Case rates are highest in secondary school age children.

Across Lancashire and South Cumbria, case rates have been rising with high pockets of prevalence in the Ribble Valley, Blackpool and Central Lancashire.

As the community prevalence increases, more patients are requiring treatment in our hospitals and intensive care units. Thankfully, those patients who are being hospitalised are recovering quicker and spending less time in hospital. However, the number of people with Covid being treated in critical care and on hospitals wards is having an impact on the delivery of elective care and primary care. The situation is being monitored closely to minimise the need to delay or cancel operations or treatments.

Our hospital acquired infection cases remain low enabling visiting to continue.

It remains, and will continue to be, incredibly important to continue to follow the protective measures learnt over the last year, and encourage our staff, patients, and communities to do the same. This will support our work to reduce waiting lists and minimise the risk of the rising infection rates.

Vaccination programme update

Almost 2.4 million Covid vaccinations have been handed out in Lancashire and South Cumbria with uptake continuing to increase amongst the 18-29 year-old cohort, with 72% now having received their first dose.

The National Booking System (NBS) is now open for those aged 16-17.75 to book their Covid-19 vaccination. This significantly increases the number of vaccination services available to this group of patients and no longer relies on walk-in clinics.

The NHS has now begun vaccinating all 12-15-year-olds in schools. Those aged 12-15 who are not already covered by existing Joint Committee on Vaccination and Immunisation (JCVI) advice, receive a single dose of the Pfizer vaccine. Government resources for schools and for parents and children are available, and further guidance is expected to follow in coming weeks on any secondary offer, and the evergreen offer for those turning 12.

The latest Public Health England figures indicate that most Covid-19 cases are in 10-19 year olds, so vaccinating children is a key step to keeping communities protected from this virus.

Following the JCVI decision on providing booster jabs to cohorts 1-9 the Covid-19 booster programme (Phase 3) has begun and over 1 million people across the country have already booked their booster on the National Booking System. People will be offered a booster dose no earlier than six months after completion of their primary vaccine course.

The Covid-19 vaccination programme has already substantially reduced the risk from severe illness in the UK population. The latest national coronavirus Covid-19 vaccine surveillance report from Public Health England, estimates that the Covid-19 vaccination programme in England has averted approximately 230,800 hospitalisations in those aged 45 years and over, prevented almost 25 million infections and between 108,600 and 116,200 deaths.

Elective Care Recovery

Recovery continues to be a primary focus of our work and it is vital we stand back up as much of our elective care programme as possible, while at the same time working to ensure those who have already waited for considerable time for care are treated as soon as possible. Mutual aid is proving an invaluable tool to ensure the sickest patients are treated as quickly as possible in the most appropriate place, including cancer patients who, where necessary are being treated through our surgical hubs.

To date, NHS organisations across the North West have responded well to the challenge of recovering services, with significant gains made already in diagnostic services notable, but also in general electives and outpatients.

Where appropriate, online outpatient appointments and innovative ways of delivering surgery are helping to ensure people get the care they need in a timely way.

In addition to working as one NHS across the North West to provide mutual aid to deliver vital services, we continue to work with the private sector to provide resource to address the backlog in our elective care programme and get patients treated as quickly as possible.

Some services are already back up and operating at more than 120% in comparison to the 2018/2019 baseline numbers which means we are not just back up and operational in those areas, but also starting to make some inroads into the backlog and those patients who have waited for some time for care.

As we continue the work of restoring services impacted by the pandemic, it is vital that we ensure this is balanced with the recovery and resilience of our staff. Supporting staff who have been going above and beyond the call of duty now for more than a year is a crucial piece of the jigsaw and putting all our efforts into that principle is the only way we will prepare the NHS for the work we will need to do as we start to move away from the most intense moments of the pandemic.

The NHS is open and caring for patients, with many previously paused services staring back up again, and we must do all we can to encourage the public to seek care when they need it and ensure they know

they will be safe when they come into hospital because of the significant measures undertaken around infection prevention and control. We should encourage the public to contact NHS 111 first where they have urgent medical needs and are considering attending A&E, either online at 111.nhs.uk or by phone to make sure they are getting the right care in the right place.

NHS System Oversight Framework

NHSEI recently consulted on the new System Oversight Framework (SOF) 2021/2022, which introduced a fresh approach to the oversight of integrated care systems (ICSs), Trusts and CCGs, and reinforces the system-led delivery of integrated care. The document reflected the vision set out in the NHS Long Term Plan, NHSE/I's paper Integrating care: next steps to building strong and effective integrated care systems across England, the NHS White Paper, and the 2021/22 Operational Planning Guidance.

Following feedback from local leaders and others, this new SOF is now being implemented. The purpose of the NHS System Oversight Framework is to:

- align the priorities of ICSs and the NHS organisations within them
- identify where ICSs and organisations may benefit from or require support to meet the standards required of them in a sustainable way, and deliver the overall objectives for the sector in line with the priorities set out in the 2021/22 Operational Planning Guidance, the NHS Long Term Plan and the NHS People Plan
- provide an objective basis for decisions about when and how NHS England and NHS Improvement will intervene in cases where there are serious problems or risks to the quality of care

The approach to its use is based on the following key principles:

- a greater emphasis on system performance and quality of care outcomes, alongside the contributions of individual healthcare providers and commissioners to system goals
- matching accountability for results with improvement support, as appropriate
- greater autonomy for ICSs and organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access
- compassionate leadership behaviours, that underpin all oversight interactions.

There are six themes to the framework: quality of care, access, and outcomes; preventing ill-health and reducing inequalities; finance and use of resources; people; leadership and capability; local strategic priorities. The information reviewed will include annual plans and reports, regular financial and operational information; quality insight, risks, and issues; and other exceptional or significant data, including relevant third-party material. Depending on the type of information, data might be reviewed in year (using monthly or quarterly collections), annually (using annual submissions) or by exception (where

material events occur). The new framework retains the familiar four segments (1-4) but sets out ICS, CCG and Trust descriptions for each segment.

	Segment description			Scale and nature of support needs
	ICS	CCG	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver the ICS four fundamental purposes is well developed	Consistently high performing across the six oversight themes Streamlined commissioning arrangements are in place or on track to be achieved	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and overall ICS priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective, self-standing ICS Plans that have the support of system partners in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England and NHS Improvement universal support offer (eg GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in building the capability and capacity required to deliver on the ICS four fundamental purposes	Significant support needs against one or more of the six oversight themes No agreed plans to achieve streamlined commissioning arrangements by April 2022	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)	Bespoke mandated support through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

There will be a phased approached to segmentation across 2021/22 and by default ICSs, Trusts and CCGs will be allocated to segment 2 – unless the criteria to move into another segment is met.

For systems, Trusts and CCG allocated to segment 4, the new national Recovery Support Programme (RSP) will provide focused and integrated support. RSP replaces the separate quality and finance special measures programme

New Hospitals Programme update

Case for Change

The local NHS in Lancashire and South Cumbria has published a new report explaining why funding for new hospital facilities is essential for the health of local people. The New Hospitals Programme Case for Change report outlines the critical need for investment in Royal Lancaster Infirmary, Royal Preston Hospital and Furness General Hospital. It describes the impact that the current issues with these buildings have on patient and staff experience, local people's health and the ability to deliver hospital services productively and efficiently.

Following the publication of the Case for Change report, the Lancashire and South Cumbria New Hospitals Programme has entered an important phase.

After collecting a host of information, the team has started to narrow down the possible scenarios for what they might do.

The team has now developed a longlist of possible solutions for hospital facilities in Preston, Lancaster and Barrow-in-Furness that are feasible in terms of addressing some or all of the main challenges. As established through the Case for Change process, these hospitals are the priority for investment.

To help narrow down the longlist of solutions, the next step is to work with a panel of experts made up of clinical leaders and hospital construction, financial and logistics specialists, as well as local NHS leaders, stakeholders and patient representatives. They have the essential, but challenging, task of putting each possibility to the test against a set of criteria, designed to meet the requirements of the NHS and the Government. This will produce a shortlist of proposals that will be subject to much more detailed analysis and appraisal to determine a preferred option or options.

The team is still relatively early in this journey and no decisions have yet been made. They will continue to keep people updated as they progress.

More information on the programme can be found on its dedicated website here.

System Reform Programme update

The System Development Programme is progressing at pace, overseen by the ICS development Oversight Group, with significant work being undertaken across all workstreams.

A report (10a System Reform Programme – General Update – page 46) was laid at the recent ICS Board and provides a high-level update focussing specifically on the following key areas of work:

- National guidance
- Readiness to Operate Statement and System Development Plan
- ICB Governance
- Provider Collaboration
- Communications and Engagement

Specific recommendations in relation to naming conventions and the use of the Lancashire and South Cumbria Health and Care Partnership identity were also included for approval.

Place-Based Partnerships

In November 2020 the NHS published Integrating care: Next steps to building strong and effective integrated care systems across England about how ICSs could be embedded in legislation or guidance, followed in February 2021 by recommendations to Government to establish ICSs on a statutory basis.

In December 2020, the ICS Board approved a common strategic narrative for placebased partnerships (then referred to as integrated care partnerships), along with an approach to working across the five places that was used to shape a development programme for 2021/22. This development programme was approved by the ICS Board in May 2021 and focused on three key areas:

- Overarching themes and success measures for places

- How we will organise ourselves to work together as partners
- Place Based Leadership and Implementation

The Integrated Care Systems: design framework was published by NHS England in June 2021. The guidance sets out five place-based governance arrangements that could be established by the NHS ICS body in partnership with local authorities and other partners to jointly drive and oversee local integration.

Further national guidance was published in September 2021, entitled: "Thriving places: Guidance on the development of place-based partnerships as part of statutory integrated care systems". This additional guidance provided further detail beyond that contained in the ICS design framework.

A paper, 10b Place-Based Partnerships: Proposed Governance and Leadership Arrangements for 2022/23 (page 54) was laid at the recent ICS Board set out a summary of the approach, together with proposals on future ways of working for place-based partnerships.

Framework Model of Care

A draft Framework Model of Care (FMOC) has been created to outline our aspirations for what future care should look like within our hospitals. It provides a frame against which detailed models of care can be developed as the Lancashire and South Cumbria New Hospital Programme (NHP) progresses and is clear on the potential options for hospital facilities and the configuration of our future hospital services.

Whilst hospital care is the focus, the FMOC has been developed based around the concept of an integrated health and social care system in Lancashire and South Cumbria. It is also recognised that the New Hospital Programme is one part of our system and the FMOC is therefore based on the wider ICS clinical strategy, which will determine the clinical model across Lancashire and South Cumbria.

The FMOC has been developed in collaboration with our clinical and operational staff from across the Lancashire and South Cumbria ICS footprint, who have participated in a number of workshops. These workshops have been complemented by a series of working groups focused on the development of the FMOC in the following categories:

- Urgent and Emergency Care
- Planned Care
- Women's and Children's services
- Specialist services
- Community interface/Diagnostic services

It is set out as follows:

Part one: provides the strategic context and describes:

- An overview of current arrangements
- A summary of the case for change
- The approach by which the Framework Model of Care has been developed

- The key principles agreed with stakeholders
- The vision for the future
- The key enablers that need to be in place for the implementation of the FMOC digital/ workforce/out of hospital

Part two: takes each of the main areas of acute activity (Urgent and Emergency Care, Planned care, Women's and Children's services and Specialist services) and considers:

- The scope of services
- The system vision, for this area
- Current strengths and challenges
- A high-level patient flow diagram describing the future model of care; and
- A summary of alignment of this with the key principles agreed with stakeholders.

The FMOC is an iterative document which will continue to be developed by our clinical and operational teams based on any feedback from the Senate to meet the requirements of the PCBC/SOC, depending on the preferred NHP option(s). Whilst service reconfiguration and other transformation programmes sit within the ICS and Provider Collaborative Board remit, they are a vital consideration for the Programme as the NHP capital requirements need to be aligned. Furthermore, the submission of the Outline Business Case (Jan 24) is a key milestone for inclusion of the any estate capacity requirements in the NHP.

Lancashire and South Cumbria Estates and Infrastructure Strategy

Our health infrastructure is fundamental to both the delivery of our health services and to improving population health. It is so much more than 'bricks and mortar'; it is an ecosystem that includes everything from the accommodation we use, our technology, our digital systems, the places we influence, our environmental footprint, the decisions we make, the way we use our land, the innovation we adopt, the way we work collaboratively and beyond. We need so much more than an 'Estates Strategy' and today, we will look at our health infrastructure more holistically than we have ever done before.

Lancashire and South Cumbria has changed significantly in the three years since we first developed our 2018 Estates Strategy. We need to review and refresh our thinking as our plans for future clinical services emerge and continue to develop and we become clearer about the impact of having the right infrastructure to support these in a way that is effective, efficient and sustainable.

In February 2021 the ICS held a capital prioritisation and strategy workshop with colleagues from Trusts (Directors of Operations, Estates, Finance, IMT) and the Strategic Estates Group Chairs (representing ICPs/CCGs.) An Infrastructure Strategy has been developed from the output of this workshop and over the following months. It is structured into five guiding principles:

- Digital
- Green
- Sustainable

- the Right Accommodation
- Healthier Places

In this draft Infrastructure Strategy, we set out our long-term vision and a five year strategy for how we will begin to deliver our vision to create a network of public assets supporting good health; where our health infrastructure helps us in reducing health inequalities, actively contributes to creating healthy communities and supports people to live longer, healthier lives across Lancashire and South Cumbria.

We have been working collectively over the past year to understand the impact of the Covid pandemic and to start to reflect the current and future world in our emerging service and infrastructure plans. Through this collaborative work, we have developed shared ambitions that are relevant for today and tomorrow; we know we need to have an infrastructure that is digital, green, sustainable, provides the right accommodation and that shapes healthy places for local populations and our staff.

We know that to achieve this we will need to be creative; we will need to connect the dots in new ways and will need to work together with each other and wider partners. There will be big challenges and even bigger opportunities (and limitations) as we plan and develop our services. We also know our strategy will pose as many questions as it answers. We cannot attempt to answer many of these questions today, but over the next five years, we will work together to address questions identified in this strategy (and ask ourselves many more along the way).

Some things we need to do will be straightforward, and we will get on with these. Other things will be more difficult and we know that sometimes we will need to do complex work, make brave decisions and do things a little differently – and this might not always be easy. But with the right attitude, leadership and investment, we are confident we can achieve our 2036 vision.

Winter plans

The NHS published its 2021/22 priorities and operational planning guidance: October 2021 to March 2022 report, which contains six areas of priority:

1. Supporting the health and wellbeing of staff and taking action on recruitment and retention.
2. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19.
3. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.
4. Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
5. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (EDs), improve timely admission to hospital for ED patients and reduce length of stay.
6. Working collaboratively across systems to deliver on these priorities.

In response and preparation for the delivery of health services over the winter period the annual local Winter Plan for 2020/2 has been by the ICS Local A&E Delivery Board. Assurances and agreement of the plan has been received by all partner organisations. The plan contains the agreed strategic response for seven areas. These are:

- Supporting 999 and 111 Services
- Supporting Primary Care to help manage the demand for urgent and emergency care services
- Supporting greater use of Urgent Treatment Centres (UTCs)
- Using communications to support the public to choose services wisely
- Improving in-hospital flow and discharge
- Supporting adult and children's mental health needs
- Ensuring a sustainable urgent and emergency care workforce

The plan has now been submitted to NHSE/I for approval. It has been recognised by NHS England that due to the nature of system resilience, rising Covid prevalence and elective recovery pressures, this is an iterative document, and so provides future opportunities to update and remodel as plans progress.

Lancashire and South Cumbria Health Equity Commission

Lancashire and South Cumbria is set to have its very own Health Equity Commission, chaired by international expert in health equity, Professor Sir Michael Marmot. This follows an agreement by Health and Community Leaders to form a regional Lancashire and South Cumbria Health Equity Commission (HEC) to improve health inequalities and help transform the health and wellbeing of people living in the region.

Lancashire and South Cumbria is home to a growing population of 1.8 million people. More of us are getting older and experiencing long-term health problems. Some of this disease could be avoided or the ill-effects slowed down if we took positive action to prevent it.

Living long, healthy and happy lives is a goal that everyone aspires to. Unfortunately, this is not the same for everyone and there remain persistent and widening gaps between those with the best and worst health and well-being. This difference is unfair, unjust and avoidable. Health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on their social and economic circumstances.

With Professor Sir Michael Marmot as the Chair, the Health Equity Commission will consist of regional health, community, business and public sector leaders and influencers, as well as independent experts. The Commission will aim to provide local leaders, organisations and partnerships with the support they need to make health inequalities and the 'prevention agenda' a joint priority and provide a loud and clear voice in the region. The initial scope of the HEC is to influence all partners to mobilise health and care to reduce health inequalities and its role in the economy.

Community diagnostic centres open in Lancashire and South Cumbria

Four new community diagnostic centres have already opened across Lancashire and South Cumbria, working to boost the number of checks, scans, and tests which were delayed by the COVID-19 pandemic.

To help work through the backlog, Lancashire and South Cumbria has received a share of £350 million funding from the government for the centres at Westmorland General Hospital, Rossendale Primary Health Care Centre, Preston Healthport and Whitegate Drive Health Centre in Blackpool, which act as 'one-stop shops' in convenient locations for people who have been waiting for these services.

People urged to share their views on plans to improve stroke services

Stroke is one of the main causes of death and disability in the UK and the eight Clinical Commissioning Groups who are responsible for commissioning health services within the Lancashire and South Cumbria Health and Care Partnership have approved an unparalleled investment to enhance acute stroke and rehabilitation services across the region.

The business case, which identified the areas where the region's acute stroke centres needed developing to bring them up to the level of the best acute stroke services in the country, called for an investment of £19.5 million (£13.8 million of which is year on year expenditure) and was supported by stroke survivors and their carers, the Stoke Association and stroke specialists at local and national levels.

Health and care partners are keen to hear people's views on the enhancements in facilities, equipment, specialist staff and processes which will take three years to implement and will contribute significantly to a reduction in patients dying or having severe disabilities from a stroke.

A period of public engagement on enhancing acute stroke care services in Lancashire and South Cumbria has been launched to inform the wider public of the enhanced services that will be put in place and to ask for feedback on any issues or concerns that people may have about its implementation.

Lancashire Resilience Hub launched

The Lancashire and South Cumbria Resilience Hub was created in response to the pandemic to help support public sector workers psychologically affected by Covid-19.

The Resilience Hub team is dedicated to supporting those who work in the emergency services, health and social care, teachers, carers, local authority staff and volunteers as well as their immediate family members too. The Resilience Hub motto is: 'You're here for us, we're here for you.'

Since its launch at the start of the Covid-19 pandemic, the Resilience Hub has helped people get back to doing the things they love most. This includes those who have worked on the frontline of the pandemic, those who struggled with the shift to working from home and the changing demand of their jobs and sadly, to those who have lost loved ones.

The new campaign urges all public sector workers to ‘check in’ on how they’re feeling using the Resilience Hub self-assessment tool. With around 75% of referrals currently being from the NHS, the campaign will specifically target all groups that the team can support.

Pennine Lancashire Covid service wins top national award

A team of ELHT colleagues working in partnership with other health and social care organisations, including the voluntary sector within Pennine Lancashire have achieved national recognition and a top award for their response to the covid pandemic. The top team created a new service called the Pennine Lancashire Virtual Covid Ward.

The virtual covid ward was quickly established when local health professionals from both primary and secondary care services worked together to create it as the covid pandemic began to take hold. It has so far helped over 2,000 people from becoming seriously ill or hospitalised with severe COVID-19 or worse.

The Pennine Lancashire CCGs, local GPs, East Lancashire Medical Services (ELMS), Burnley, Pendle and Rossendale CVS, East Lancashire Hospital NHS Trust and Lancashire and South Cumbria Care Foundation NHS Trust worked together at breakneck speed to deliver the “at home” service to respond to the big numbers of people seriously affected by COVID-19.

Three - ELHT Headlines

Important news and information from around the Trust which supports our vision, values and objects.

Use of the Trust Seal

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

- On **1 October 2021** the seal was applied in relation to a pre-emption agreement between East Lancashire Hospitals NHS Trust and Lancashire Teaching Hospitals NHS Foundation Trust relating to land on Old Bank Lane Road. The documents were signed by Mr Jawad Husain, Executive Medical Director, and Mrs Christine Pearson, Executive Director of Nursing.
- On **11 October 2021** the seal was applied in relation to a Deed of Covenant between East Lancashire Hospitals NHS Trust and Park Homes (UK) Limited relating to land at Blackburn Royal Infirmary. The documents were signed by Mr Martin Hodgson, Interim Chief Executive and Mrs Michelle Brown, Executive Director of Finance.

SPEC Award Recommendation

Ward C18b achieved a third consecutive green NAPF inspection and attended their fourth SPEC panel on 5 October.

The ward provided a portfolio of evidence and delivered a presentation to the SPEC panel to demonstrate how they have maintained consistently high standards of care delivery. Colleagues on the Ward also described their journey throughout COVID and quality improvement initiatives that have been undertaken.

The panel agreed that the ward should be recommended for this prestigious status following the review. Approval is therefore required from the Trust Board to award is area SILVER for always delivering Safe, Personal and Effective Care.

Financial planning

The Trust is working closely with all partners in the ICS to develop plans to meet the requirements of the national ‘H2’ (second half of 2021/22) planning process.

Specifically this entails development of:

- Elective recovery plans
- Winter plans by A&E Delivery Boards
- Supporting workforce plans

- Financial plans
- Supporting narrative plan outlining key assumptions and risks

The plans are in final draft and will be shared with the Board once finalised.

A&E is “high performing” in challenging circumstances

The Trust’s A&E Department at Royal Blackburn Teaching Hospital has been highly praised by the Royal College of Emergency Medicine for its performance, whilst managing extremely high attendances and challenges caused by the COVID 19 pandemic.

The A&E Department has been given an average experience score of 8.2 out of 10 in the Urgent and Emergency Care Survey, an improvement on the score of 7.3 the department received in 2018. Respondents also gave the department an average score of 8.9 for cleanliness, and an average of 9.3 out of 10 for treatment with respect and dignity.

The results were collected from 217 patients surveyed in September 2020 by the Care Quality Commission (CQC).

ELHT honours 'stars' with virtual staff award ceremony

The Trust hosted its Staff Thank you and Recognition (STAR) Awards in September after plans were put on hold due to the pandemic. Normally an evening black tie event, this year’s celebration was a more inclusive virtual celebration hosted by the CEO with awards being announced by the Executive Team.

The winners were:

- Clinical Worker of the Year – Donna Butler, Baby Friendly Team Specialist
- Compassionate Care Award – Marsden Rehabilitation Stroke Unit
- Non-Clinical Worker of the Year – David Anderson, Hospital Chaplain and Counsellor
- Employee of the Year – Tracey Smith
- Quality, Innovation and Research – Sarah Carter, Lead Midwife in Diabetes
- Patients Choice – Adele Ormerod, Health Care Assistant
- Volunteer of the Year - Lewis Baker-Vose, Main Reception Royal Blackburn volunteer
- Outstanding Achievement Award - Anne Livesey Enhanced Recovery Lead Nurse
- Leadership Award – Carmel Wiseman, Assistant Director of Nursing, Macmillan
- Rising Star Award – Scott Smith, Clinical Pharmacist
- Role Model of the Year Award – Paula Beech, Team Leader
- Unsung Hero Award – Anne Wilson, Staff Nurse
- Non-Clinical Team of the Year – Occupational Health Team
- Clinical Team of the Year – Head and Neck Robotic Team

The winners from all 14 categories were awarded with their trophies and certificates at a special ‘Star Awards Day’ following the virtual ceremony. Executive Directors met and celebrated with the winners in small groups.

New 'Inclusion Wall' unveiled

The Trust has asked patients and the local community to join in their message of inclusivity and firm opposition to discrimination, by unveiling their new ‘Inclusion Wall’.

The montage of photos and statements displayed at the Royal Blackburn Teaching Hospital site showcases the diversity of colleagues across the Trust and their views on what inclusion means to them.

Alongside the display, the overarching statement from the Trust is clear: “We are proud that our #ELHTFamily is made up of colleagues with such diverse backgrounds, experiences and beliefs as this ensures that we are able to provide Safe, Personal and Effective care to all across our communities.”

It continues: “Please take a moment to read some of our colleagues’ stories about what inclusion means to them. We are ELHT – everyone is welcome here, everyone belongs.”

The montage was unveiled during the Trust’s Festival of Inclusion week, an annual week where colleagues come together to celebrate the work done to create a fairer and more inclusive ELHT. As well as the Inclusion wall there were also talks from keynote speakers from organisations such as Euro Garages and discussions on mental health and disability and how it is viewed across the Trust.

Therapy dog Jasper receives national award

ELHT’s therapy dog Jasper has been recognised with a special award from the International Fund for Animal Welfare (IFAW) presented at the House of Lords.

Jasper, a Six-year-old cockapoo, along with owner David Anderson, who is a Hospital Chaplain and Counsellor at ELHT, support more than 9,000 staff across the Trust’s acute and community hospitals, including Royal Blackburn Teaching Hospital and Burnley General Teaching Hospital.

When COVID-19 hit, David and Jasper were no longer able to visit the wards, with Jasper initially having to stay at home and David carrying out counselling sessions for end-of-life patients and goodbye calls for family members via Zoom. However, with the huge strain placed on staff working through the darkest days of the pandemic, David soon realised there was a need for Jasper, as well as himself, to provide in-person support to the Trust’s workforce.

Jasper is trained to go to people showing distress or crying and is very perceptive to the emotions around him. David explained that although the peak of the pandemic has passed, it was at this point for some staff that the trauma of the previous months hit home and many have continued to struggle as the next wave of COVID patients has been markedly younger.

When he is not at work, Jasper enjoys going for walks with David and playing with the many toys he receives from his hospital friends.

Hip-Hip hurray!

The Trust has performed its first ever day case hip replacement surgery. An exciting new development as the Trust progresses in its aim to reduce patients' length of stay following an operation.

Prior to his surgery, Andrew Cook, 53, from Burnley served in the Armed Forces for 22 years. The intense and demanding job took its toll on his hips to the point where he needed both of them replacing. As a young, fit and motivated patient undergoing hip replacement surgery, Mr Cook was identified as an ideal candidate to trial the Trust's first ever day case.

ELHT's Orthopaedic team have been focussing on reducing length of stay for hip and knee arthroplasty patients and the majority of patients are now staying in hospital for less than 3 days.

Mr Cook arrived at Burnley General Teaching Hospital at 7.30am for his surgery and following input from a multidisciplinary team, he was able to leave by 6.30pm the same day and continue his recovery at home.

Junior Doctor Chanelle is a storybook star!

Chanelle Smith, an FY1 currently based in the Ophthalmology Department at the Trust, has been featured in "One Hundred Reasons to Hope", a book written by the late Captain Sir Tom Moore.

The book has been curated by double Paralympic gold medallist Danielle Brown MBE, illustrated by Adam Larkum and begins with a foreword from Captain Sir Tom Moore's daughter, Hannah Ingram-Moore. It was written to celebrate the contribution of 'COVID heroes' during the pandemic.

Chanelle told us more her clinical background and her experience of being featured in the book.

Caring medical student rewarded with scholarship at ELHT

A University of Central Lancashire (UCLan) student who has been inspired to train as a doctor after caring for her disabled sister has won a medical scholarship at the Trust.

Halima Adam is the primary carer for her younger sister Zafirah, who has cerebral palsy, and she has been chosen as the 2021/22 recipient of the Mackenzie Scholarship. Jointly funded by East Lancashire Hospitals NHS Trust and UCLan, it is open to all Bachelor Medicine Bachelor Surgery (MBBS) applicants from East Lancashire and covers the recipient's tuition fees for the duration of the five-year course.

Emergency Department refurbished cubicles

Two new custom designed cubicles for those who need mental health inpatient treatment have been opened within the Emergency Department at Royal Blackburn Teaching Hospital.

The new cubicles will provide a calmer, safer environment for patients in mental health crisis and allows staff to look after them in the right place. Patients will be able to stay there for up to 12 hours whilst waiting for an appropriate mental health bed. The rooms are also ligature proof (as mental health patients have a higher risk of self-harm) and have panic alarms to keep staff safe.

Update on the PWE Healthcare collaborative

PWE Healthcare is currently a primary care collaborative between ELHT, Padiham Group Practice and Waterfoot Medical Practice who have worked together as PWE Healthcare since forming in 2017.

The Waterfoot Medical Practice and Padiham Group Practices have now taken the difficult decision to withdraw from the PWE collaboration to concentrate on their own practices. However, all parties are keen that PWE Healthcare remains operating seamlessly for the continued benefit of all registered patients.

It was therefore proposed that ELHT take sole responsibility of the PWE contract to maintain provision of safe and effective primary care services for the registered patients, particularly noting the current strains put upon General Practice in the Covid/Post-Covid era.

This has been through a robust assurance process with the Clinical Commissioning Group and the Primary Care Committee and the Trust can now confirm that the contract variation has been approved. The Trust welcomes the PWE colleagues and will begin working to mobilise the changes required to commence the new contract.

Four – Communications and Engagement

A summary of the external communications and engagement activity.

September 2021

Communications and Engagement

Monthly Media Update

Top Stories...

- Rise in children's respiratory infections across East Lancashire
- Minor injuries unit in Accrington reopens
- Trust welcomes new Chief Executive
- First patients welcomed in to the new Fairhurst Building
- ELHT honours 'stars' at virtual staff awards ceremony

Trust welcomes new Chief Executive

Press and Media Relations...

29 mentions in all media

10 Media enquiries handled

8 media releases issued this month

83% of stories were positive or neutral

Projects the Communications Department has supported...

- Inclusion
- Restoration
- Health and wellbeing
- ED Pressures
- RSV
- Maternity
- EPR
- Surgery School

Website...

Our website got **148,831** page views by **55,170** people.

The most viewed webpage was – Waiting times

Social media and digital...

Followers on social media:

18,348 ↓

9,034 ↑

3,093 ↑

25,133 ↓
Avg Weekly Facebook Reach

139,000 ↓
Twitter Impressions

910 ↑
Twitter mentions

The most talked about issues on our social networks..

- Rise in cases of RSV (Respiratory Syncytial Virus) in East Lancashire (33.6k)
- Trial of Streamer Tool in the Emergency Department (24.9k)
- Launch of staff vaccination campaign (9.7k)
- Virtual COVID ward wins HSJ Award (7.8k)
- ELHT's virtual Star Awards (4.1k)

Posts of the month...

East Lancashire Hospitals NHS Trust
13 September at 16:07 ·

We've been seeing a rise in cases of Respiratory Syncytial Virus (RSV), which can cause bronchiolitis in infants and children, particularly now schools and nurseries have reopened.

Know the signs and symptoms and keep your child safe 👉 https://orlo.uk/K1NuJ

East Lancashire Hospitals NHS Trust
@ELHT_NHS

"It is a real honour to be asked to lead an organisation that I feel so passionately about and where I am so proud to work."

ELHT are pleased to welcome our new Interim Chief Executive, Martin Hodgson.

Click here to read: orlo.uk/oewni

Routine activity:

Weekly staff bulletin
COVID briefing
Stakeholder Briefing
Other News

Website updates
Sharepoint/OLI updates
Facebook Group

October 2021

Communications and Engagement

Monthly Media Update

Top Stories...

- ELHT unveils new 'Inclusion Wall'
- Jasper the Therapy Dog receives national award
- ELHT performs first ever day case hip replacement surgery
- Junior Doctor Chanelle is a storybook star
- New digital record system to revolutionise maternity care
- Medical student wins scholarship

Our new 'Inclusion Wall'

Press and Media Relations...

29 mentions in all media ↑

10 Media enquiries handled ↓

8 media releases issued this month ↑

79% of stories were positive or neutral ↓

Projects the Communications Department has supported...

- Inclusion
- Restoration
- Health and wellbeing
- ED Pressures
- Rollout of Badgernet
- Supervision of filming on-site
- EPR (E-Lancs)
- Surgery School

Website...

Our website got **149,376** page views by **116,976** people. ↑

The most viewed webpage was – Waiting times

Social media and digital...

Followers on social media:

18,930 ↑

9,183 ↑

3,116 ↑

48,165 ↑
Avg Weekly Facebook Reach

174,000 ↑
Twitter Impressions

690 ↓
Twitter mentions

The most talked about issues on our social networks..

- Our Therapy Dog is off to the House of Lords! (21k impressions)
- The #WaveofLight on display outside Lancashire Women and Newborn Centre (82k impressions)
- Launch of the Inclusion Wall (15k impressions)
- Junior Doctor Chanelle is a storybook star! (9k impressions)

Posts of the month...

East Lancashire Hospitals NHS Trust
15 October ·

Tonight, a #WaveofLight is on display at Lancashire Women's and Newborn Centre, in memory of babies that have passed away, marking the end of #BabyLossAwarenessWeek

Families have visited the Centre today to place the names of their babies on our Memory Tree, in remembrance of them

East Lancashire Hospitals NHS Trust
@ELHT_NHS

Our therapy dog is off to the House of Lords!
ELHT's therapy dog Jasper is being recognised with a special award from @IFAWUK at the House of Lords this week for his vital support to colleagues during the pandemic. Read more orlo.uk/TDodM

@NHSNW @NHSEngland

Routine activity:

Weekly staff bulletin
COVID briefing
Stakeholder Briefing
Other News

Website updates
Sharepoint/OLI updates
Facebook Group

Five - Chief Executive's Meetings

Below are a summary of the meetings the Chief Executive has chaired or attended since the last board meeting.

October 2021 Meetings

Date/Frequency	Meeting
Weekly – Tuesday	Executive Team
Weekly – Tuesday	Senior Leadership Group
Weekly – Tuesday	Chairman/Chief Executive Briefing
5 October	Specialised Commissioning Leadership
5 October	H2 Planning
6 October	LSC ICS Board
6 October	Joint Local Negotiating Committee
11 October	Employee of the Month
11 October	LSC and Wigan Vascular Network Board
12 October	EPR meeting
12 October	PL Chairs and Chief Officers
12 October	Team Brief
13 October	LSC Chief Executive Briefing
14 October	HIVE Business Awards
18 October	LSC Stakeholder interviews
20 October	LSC System Leaders Executive
26 October	LSC Pathology Board Development session
27 October	LSC CEO Chief Executive Briefing
29 October	LSC Pathology Service Board

29 October	H2 Planning
29 October	Provider Collaboration Board

November 2021 Meetings

Date/Frequency	Meeting
Weekly – Tuesday	Executive Team
Weekly – Tuesday	Senior Leadership Group
Weekly – Tuesday	Chairman/Chief Executive Briefing
2 November	NW System Leaders and Chairs
2 November	NHS Providers virtual visit
3 November	LSC ICS Board
3 November	Joint Local Negotiating Committee
4 November	Lancashire Cumbria HEC Chief Execs/Leadership Workshop with Sir Michael Marmot
8 November	Blackburn with Darwen Health and Wellbeing Board
9 November	PL Chairs and Chief Officers Advisory Group
10 November	Trust Board
11 November	Task and Finish Group
11 November	NHS Providers NW Regional Meeting
15 November	NHP Programme Management Group
16/17 November	NHS Providers Annual Conference (virtual)
17 November	LSC System Leaders
17 November	PL Partnership Leaders Forum
18 November	Joint Quality, Finance and Performance Meeting Finance and Performance Section

22 November	NHS Quest CEO network
24 November	Back to the Floor (ED)
24 November	LSC CEO Briefing
26 November	LSC Pathology Service Board
26 November	Provider Collaboration Board
30 November	NW System Leaders and Chairs

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 133

10 November 2021

Purpose Monitoring

Title	Corporate Risk Register
Author	Mrs J Hardacre, Assistant Director of Patient Safety and Effectiveness
Executive sponsor	Mr J Husain, Executive Medical Director

Summary: This report presents an overview of the Corporate Risk Register (CRR) as of the 22/10/2021 these risks have been reviewed at RAM on the 24/09/2021 and will be reviewed in the next meeting on the 29/10/2021.

Recommendation: Members are requested to receive, review, note and approve this report and to gain assurance that the Trust Corporate Risk Register is robustly reviewed, scrutinised and managed in line with best practice.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Work with key stakeholders to develop effective partnerships
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. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. 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	Yes	Financial	Yes
Equality	No	Confidentiality	Yes

Changes to the report since last updated;

1. A controls review has taken place across all Corporate Register risks and there is now only one risk which is listed as having 'Inadequate' controls in place
2. All other risks have controls in place and these are regularly reviewed, those that are 'Limited' in controls may have active controls that are working but may have some GAPS within those controls which are stopping them from being fully effective. Further work to review these is underway. A lack of 'Adequate' controls may stop the risk from bringing the likelihood of the risk occurring, down.
3. One risk has increased from 15 to 20 since the last update. This is due to current prolonged increased demand on our Emergency Department which is no impacting on performance. This will be further impacted by ED withdrawing from its current expansion into Fracture Clinic (an agreed action to manage Risk 8543). The senior team in ED plan to review triage arrangements to support flow and minimise the impact. Divisional Clinical Director to present risk to Board to articulate the reasons for increase and risk would be fully reviewed and re-written.

Risk Performance information;

1. **1709** risks are currently open. **20** of which are on the Corporate Risk register.
2. **1342** risks are live, 257 on the Tolerated Register, 56 are new risks identified, 26 currently being reviewed and challenged. 25 are awaiting report to Divisional groups for approval.
3. **162** of these risks are currently **OVERDUE**, down from 181 last month.
4. Training has been made available across the whole organisation with regular face to face sessions and e-learning sessions being taken, this has improved the compliance of managing risks and some quality improvements have been seen. **217 staff members** have taken the risk e-learning or training since April 2021.
5. The Head of Risk Management post has been vacant since mid-August 2021. This role has been reviewed and upgraded to enable more senior oversight and clear links to exec portfolios. An Assistant Director for Health & Safety and Risk Management post has been banded and is currently being short listed for interview.
6. Currently the Risk Assurance Meeting (RAM) is being chaired by the Associate Director for Quality and Safety.

Table 1: List of Corporate Risks

No	ID	Where is this risk being managed?	Title	Impact score	Likelihood score	Rating (current)	Effectiveness of Controls (taken from Datix)
1	8441	Corporate Services	Coronavirus (COVID-19) Outbreak	5	4	20	Adequate
2	8126	Corporate Services	Aggregated Risk - Potential to compromise patient care due to lack of Trust-wide advanced Electronic Patient Record (EPR) System	4	5	20	Limited
3	7762	Family Care (FC)	Risks associated with providing HDU care in DGH with no funding for HDU provision	4	5	20	Limited
4	8061	Corporate Services	Management of Holding List	4	4	16	Limited
5	8221	Family Care (FC)	Lack of recurrent investment and review of CNP services resulting in service at risk	4	4	16	Inadequate
6	6190	Surgical and Anaesthetic Services (SAS)	Insufficient Capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescale.	4	4	16	Limited
7	7067	Medicine and Emergency Care (MEC)	Aggregated Risk - Failure to obtain timely MH treatment impacts adversely on patient care, safety and quality	3	5	15	Adequate
8	1810	Medicine and Emergency Care (MEC)	Aggregated Risk - Failure to adequately manage the Emergency Capacity and Flow system	4	5	20	Limited
9	5791	Corporate Services	Aggregated Risk-Failure to adequately recruit to substantive nursing & midwifery posts may adversely impact on patient care.	3	5	15	Adequate
10	7008	Surgical and Anaesthetic Services (SAS)	Failure to comply with the 62 day cancer waiting time target	3	5	15	Limited
11	8257	Diagnostic and Clinical Support (DCS)	Loss of Transfusion Service.	5	3	15	Limited
12	8243	Family Care (FC)	Absence of an end to end IT maternity system	3	5	15	Limited
13	8652	Corporate Services	Failure to meet internal & external financial targets for 2021-22	5	3	15	Adequate
14	8543	Surgical and Anaesthetic Services (SAS)	Fracture Clinic Capacity & Demand	3	5	15	Limited
15	8839	Surgical and Anaesthetic Services (SAS)	Failure to achieve performance targets (SAS)	3	5	15	Limited
16	8914	Diagnostic and Clinical Support (DCS)	Potential interruption of high-flow oxygen therapy to critically ill patients across RBTH	5	3	15	Limited
17	8808	Corporate Services	BGTH - Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke	5	3	15	Adequate
18	7764	Corporate Services	RBTH- Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke	5	3	15	Adequate
19	8960	Family Care (FC)	Risk of undetected foetal growth restriction and possible preventable stillbirth given non-compliance with national US guidelines	5	3	15	Limited
20	4932	Corporate	Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained.	3	5	15	Limited

Table 2: Detailed risk information

No	ID	Title					
1	8441	**Coronavirus (COVID-19) Outbreak**					
Lead		Tony McDonald	**Current score**	**20**	**Score Movement**	⟷	
Description		This risk is to capture the risk to our patients and staff in the event of further infection rates across the UK from the coronavirus (COVID-19) outbreak.		**Actions**	1. Continuous actions managed and monitored through the ICC meetings and regular OCC meetings throughout the trust. 2. Mass Vaccination rollout	**All actions managed by Tony McDonald (Continued actions under development as pandemic progresses through the appropriate meetings)**	
Top Controls		1. Co-ordination centre set up Trust HQ to enable the management and implementation of plans, processes and procedures, with daily update meetings taking place. 2. ICC meetings currently once a week with a Senior Leadership meeting once a week for key decision making and escalation. 3. Increased staffing during core hours to alleviate pressures - including current winter pressures measures. 4. Regular communications about next steps/working group outcomes to keep staff and patients informed 5. Social Distancing Group in place within the EPRR meeting (Monthly) to review key issues and escalations. 6. Established executive oversight group which will support A) Asymptomatic staff testing B) Mass staff vaccination C) Mass Vaccination. 7. Mass vaccination programme underway and launched 18/01/2021 8. Enhanced monitoring of Oxygen flow and capacity. Regularly reported on and discussed in Patient Flow meetings/ICC. 9. Increased activity within mass vaccinations to roll out vaccinations to younger age groups due to the variants of concern.					
Update since the last report		**27/09/2021 –** vaccination programme rolled out, lockdown restrictions lifted, social distancing and mask wearing no longer required in public. Numbers levelling off (around 40 covid +ve patients, inc approx. 5 in critical care) No reduction to score as we continue to be in a pandemic with an uncertain picture as we head into winter. There has been no change in this risk status since June.		**Date Last reviewed**	**27/09/2021**		
				Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
					20	**20**	**X**	**X**
				8 week score projection	**20**			
				Current issues	**Impacted by COVID-19. Indian variant causing higher numbers of infections locally.**			

No	ID	Title					
2	8126	**Aggregated Risk - Potential to compromise patient care due to lack of Trust-wide advanced Electronic Patient Record (EPR) System**					
Lead		Mark Johnson	**Current score**	**20**	**Score Movement**	⟷	
Description		The absence of a Trust Wide Electronic Patient System, the reliance on paper case notes, assessments, prescriptions and the multiple minimally interconnected electronic systems in the Trust.		**Actions**	**All actions completed – awaiting new update for the risk as this has now become a project risk expected to last until September 2022.**		
Top Controls		1. Stable PAS system (albeit 25+ years old) 2. ICE system 3. EMIS system 4. Improved infrastructure (including storage) to maintain and manage existing systems. 5. Register of non-core systems capturing patient information in					
Update since the last report		**21/07/2021 –** Discussed with Mark Johnson – this risk will be reviewed as EPR has now moved into project stage. **22/07/2021 -** New Emergency Funding application submitted. Awaiting feedback from NHSI.		**Date Last reviewed**	**16/09/2021**		
				Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
					20	**20**	**X**	**X**
				8 week score	**15**			

	16/09/2021 Awaiting feedback from ePR project group re confirmation of the transfer of this risk into wider project management.	**projection**	
		Current issues	The risk is currently moving into a Project so further discussions will take place about the future management of this.

No	ID	Title					
3	7762	**Risks associated with providing HDU (High Dependency Unit) care in DGH with no funding for HDU provision (Family Care)**					
Lead		Neil Berry	**Current score**	**20**	**Score Movement**		
Description		ELHT provides HDU (High Dependency Unit) care as does most District General Hospitals with the tertiary centres providing formal HDU In recent years with increasing demand and limited tertiary capacity the provision for HDU care is increasing. We have received no funding to manage this provision and yet provide an estimated 1404 HDU days per year (70 % being Level 2 HDU).		**Actions**	1. STP leading review of DGH HDU care	1. Vanessa Holme	1. 26/06/2021 **(Was 09/03/2021 and 28/03/2021)**
Top Controls		1. Safer staffing is reviewed for nursing on a daily basis at Matron and Trust Director of nursing level. Staffing is managed according to acuity and therefore managed in a safe manner. 2. Medical staffing actions have been taken to mitigate risk of medical cover to HDU activity in winter months -specific winter planning takes place. 3. HDU competencies and training completed and co-ordinated in the Directorate to ensure suitable skills. 4. Safer staffing for nursing completed on a daily basis and acuity of patients managed at Matron/Trust level. 5. Medical staffing support monitored and winter planning actions put in place to support increased HDU activity.					
Update since the last report		**23/06/2021-** Demand is higher than the current amount of commissioned beds in the unit. There is a review underway with the ICS to look at funding the additional surge demand which is expected to take through past winter 2021. The original part of this risk is not resolved by this additional funding. **28/08/2021** - Recent GIRFT report (2021) for paediatric critical care has highlighted gaps in ability as a network to achieve PCC standards for education, training and workforce due to commissioning arrangements. No robust data for network to evidence numbers of level 1,2,3 patients. This information is collected locally on a paper based system.		**Date last reviewed**	**22/10/2021**		
				Risk by Quarter 2021	**Q1**	**Q2**	**Q3** / **Q4**
					20	**20**	X / X
				8 week score projection	**20**		
				Current Issues	CCG currently not funding L2 Critical care activity. Awaiting decision from the ICS. Surge in HDU use expected past winter 2021.		

No	ID	Title					
4	8061	**Aggregated Risk - Management of Holding List**					
Lead		Victoria Bateman	**Current score**	**16**	**Score Movement**		
Description		Patients waiting past their intended date for review appointment and subsequently coming to harm due to a deteriorating condition or suffering complications due to delayed decision making or clinical intervention.		**Actions**	1. Weekly review of the holding list	1. Victoria Bateman	1. 02/08/2021
Top Controls		1. There is a process in place to ensure all follow up patients are assigned a RAG rating at time of putting them on the holding list. This process is for outpatients predominantly. A process forward is currently being developed. 2. There is an automated daily report to provide oversight of the holding lists by speciality. 3. Underlying demand and capacity gaps must be quantified and plans put in place to support these specialities in improving the current position and reduce the reliance on holding lists in the future. 4. Report being provided weekly to the Executive Team. 5. Holding List performance is discussed as part of the weekly performance meetings.					

Update since the last report	28/9/21 The issues surrounding the holding list still remain challenging. We have a lack of capacity to date our holding list patients which is compounded by longer backlogs since COVID and higher volumes of cancer and urgent patients requiring treatment. Each speciality is working on their highest risk and clinically urgent first.	**Date last reviewed**	**28/09/2021**			
		Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
			16	**16**	**X**	**X**
		8 week score projection	**16**			
		Current issues	**Impacted by COVID-19**			

No	**ID**	**Title**				
5	8221	**Lack of recurrent investment and review of CNP (Community Neuro developmental Paediatrics) services resulting in service at risk (Family Care)**				
Lead		Debbie Mawson	**Current score**	**16**	**Score Movement**	⟷
Description		CNP is currently undergoing a service review which has stalled due to lack of resource from a CCG perspective. This is due to the service working under a block contract which has not been reviewed for a number of years. A number of roles and services are being funded non recurrently and this funding stops in march 2020 but has been continued at present due to COVID.	**Actions**	1. Conduct CNP Service review post COVID measures	1. Debbie Mawson	1. 12/07/2021 **(was 30/11/2020 and 22/03/2021)**
Top Controls		1. Review meetings with our commissioner monthly. 2. Escalated through CNP spec board and DMB (Divisional Management Board) also SMWRG (Senior Management Group) with DGM (Divisional General Manager) and Lead for Children and Young People Pennine CCG. 3. Risk assessment completed. 4. Funding continuing throughout review period but capacity issues remain the same.				

Update since the last report	**18/10/21** Continuing to deliver capacity clinics to support the restoration plans. Concern re ELCAS not delivering the 11+ ASD pathway due to non re-current funding ending in Mar 22. Referrals are now being redirected to CNP. CNP are not able to deliver this service without a service spec and funding. CCG have submitted a BC to their board awaiting outcome.	**Date last reviewed**	**18/10/2021**			
		Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
			16	**16**	**X**	**X**
		8 week score projection	**15**			
		Current Issues	Funding has been extended because of COVID but that does not mitigate the risk as we still provide the service with no additional funding and uncertainty post COVID.			

No	**ID**	**Title**				
6	6190	**Insufficient Capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescale (Ophthalmology)**				
Lead		Victoria Bateman	**Current score**	**16**	**Score Movement**	⟷
Description		Insufficient clinic capacity for patients to be seen in outpatient clinics resulting in unbooked new patients and a very large holding list of overdue patients. In some cases there is significant delay and therefore risk to patients The demand far outweighs capacity, and this has been exacerbated since the covid pandemic, with the requirement for social distancing meaning less patients can be accommodated in waiting areas. All patients are risk stratified (red, amber, green), however still cannot be seen within timescales and additional risk that amber patients could become red over time etc.	**Actions**	1. Community stable Glaucoma 2. Outsourcing of OCT & Visual Fields	1. Vikas Shankar 2. Vikas Shankar	1. 01/09/2021 (was 16/04/2021) 2. 31/101/2021 (was 02/08/2021)

Top Controls	**1.** Failsafe Officer in place - focuses on appointing the red patients and the longest waiters. Validates the holding list. **2.** Capacity sessions where doctors willing and available. **3.** Used locums previously - however not currently in place due to (i) lack of available space, (ii) calibre of personnel is questionable, (iii) specialised areas of expertise, and (iv) in practice they do not tend to discharge and it therefore adds to holding list concerns at a later date. **4.** Flexibility of staff **5.** Integrated Eye Care Service in place for specific pathways, keeping relevant patients out of hospital eye services where possible.					
Update since the last report	24/09/2021 additional clinics provided during the previous 3 months which has helped reduce the holding list, however the risk remains the same as those clinics aren't forthcoming going forward.	**Date last reviewed**	**24/09/2021**			
		Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
			16	**16**	**X**	**X**
		8 week score projection	**16**			
		Current Issues	**Impacted by COVID-19**			

No	**ID**	**Title**					
7	7067	**Aggregated Risk** - **Failure to obtain timely mental health (MH) treatment impacts adversely on patient care, safety and quality**					
Lead		David Simpson	**Current score**	**15**	**Score Movement**		
Description		ELHT is not a specialist provider or equipped to provide inpatient mental health services. Patients with mental health need do present to the Trust and they may require both physical and mental health assessments, treatment and referral to specialist services. Due to lack of specialist knowledge, this may cause deterioration of the patient.	**Actions**	1. ELHT to audit the number of patients admitted to the MHUAC from 1st of april on a monthly basis 2. Review impact of MH service provision with opening of MHUAC 3. To establish and embed clinical model of review times from MHLT 4. RCEM 2019-2020 Audit action plan completetion	**1.** Rafia Naser **2.** David Simpson **3.** David Simpson **4.** David Simpson	**1.** 30/07/2021 **(was 30/04/2021, 30/06/2021)** **2.** 30/07/2021 **(was 03/06/2021)** **3.** 06/08/2021 **4.** 03/09/2021
Top Controls		**1.** Daily system mental health teleconference, attended by ELHT Clinical Site Managers. **2.** Discussion and review at four times daily clinical flow meeting **3.** Expanded mental health liaison team service based in emergency department. **4.** Treat as one group established to oversee the response to physical and mental health needs of patients. This group is chaired by the director of nursing and includes representatives from ELHT and LSCFT, LCC, BWDBC,CCG, Police. TAO group currently stood down but multiple meetings across the trust still cover core essentials. Multi agency oversight group also in place. **5.** Mental Health Shared Care Policy including out of hours escalation process for MH patients.					
Update since the last report		**29/09/2020** - continue to have weekly meetings with LSCFT to address ongoing issues and to plan for the new MH unit being launched in December. risk updated. no change. **18/10/2021** – risk reviewed remains same.	**Date last reviewed**	**18/10/2021**			
			Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
				15	**15**	**X**	**X**
			8 week score projection	**15**			
			Current issues	Clinical model to be embedded, this has been added as a new action this month.			

No	ID	Title
8	1810	**Aggregated Risk - Failure to adequately manage the Emergency Capacity and Flow system**

Lead	David Simpson	**Current score**	**15**	**Score Movement**	⟷

Description	Lack of capacity across the Trust can lead to extreme pressure resulting in a delayed delivery of the optimal standard of care across departments. At times of extreme pressure this increase in the numbers of patients within the emergency pathway makes medical/nursing care difficult and impacts on clinical flow	**Actions**	1. Nursing Assurances to be provided regarding care delivery to patient in ED 2. Review impact of NWAs direct streaming to AECU 3. To have an automated DTA validation list via Powerbi	1. Zoe Lewis 2. David Simpson 3. Shane Platt	1. 02/08/2021 (was 31/03/2021) 2. 27/08/2021 3. 03/09/2021
Top Controls	1. Further in-reach to department to help to decrease admission 2. Workforce redesign aligned to demands in ED 3. Review of processes across Acute / Emergency medicine in line with Coronial process and incidents. 4. Work with CCG on attendance avoidance 5. Phase 6 build commenced - completion Nov 2020 6. Business plan in place to review the footprint of ED and urgent care.				

Update since the last report	**06.10.2021:** Risk reviewed, risk was discussed at RAM and approved/agreed that due to current system pressures the risk should remain as a 20. Ambulance delays/triage has now improved due to new embedded systems and processes (cubicles 1-7 now dedicated for triage). This does impact the department as 7 cubicles are used solely for triage. Neutropenic sepsis was 52% for August, this has improved to 80% for September 2021. Department overcrowding remains a risk due to the number of patients in the department waiting for a bed, this has been around 30 patients each day, continue to see surges in patients presenting to UCC- often 25+ waiting for triage.	**Date Last reviewed**	**06/10/2021**		
		Risk by Quarter 2021	**Q1**	**Q2**	**Q3** / **Q4**
			15	**20**	X / X
		8 week score projection	**20**		
		Current issues	**Impacted by COVID-19**		

No	ID	Title
9	5791	**Aggregated Risk - Failure to adequately recruit to substantive nursing and midwifery posts may adversely impact on patient care and finance.**

Lead	Julie Molyneux/Chris Pearson	**Current score**	**15**	**Score Movement**	⟷

Description	Use of agency staff is costly in terms of finance and levels of care provided to patients	**Actions**	1. Twice yearly professional judgment review of nurse and midwifery staffing requirements 2. Ongoing recruitment ,, locally, nationally, and internationally	1. All actions owned and managed by Julie Molyneux	1. 31/01/2022 **(was 01/03/2021)** 2. On-going
Top Controls	1. Daily staffing teleconference, chaired by Divisional Director of Nursing, who balances and mitigates risks based on professional judgment, debate and acuity and dependency. 2. The use of the Safe Care Tool within Allocate to support decisions regarding acuity an dependency 3. E rostering - Planned and actual nurse staffing numbers recorded daily and formally reported monthly following quality assurance processes; 4. Dashboard review of good rostering compliance 5. Monitor red flags, IR1s, complaints and other patient experience data				

Update since the last report	**21/06/2021**- No change in risk score - we have engaged with an agency called Jane Lewis on international recruits however due to pandemic the Indian nurses we usually recruit has been temporarily suspended.	**Date Last reviewed**	**06/09/2021**			
		Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
			15	**15**	X	X

	06/09/2021 – NO change in risk score. Nurse staffing remains extremely challenging	**8 week score projection**	**15**
		Current issues	Some impact from COVID but risk has been in place for a while and recruitment nationally is still an issue.

No	ID	Title					
10	7008	**Failure to comply with the 62 day cancer waiting time.**					
Lead		Caroline Rogers	**Current score**	**15**	**Score Movement**	⟷	
Description		Cancer treatment delayed. Potential to cause clinical harm to a patient if the treatment is delayed.	**Actions**	1. Creation of comprehensive Cancer PT and automated Hot list 2. Implementation of Rapid cancer diagnostic and assessment pathways 3. Capacity & Demand Review 4. Investment of Alliance Funding in pathway to improve processes.	**All actions managed by William Wood**	**1.** 30/06/2021 (**was 31/03/2021)** **2.** 31/09/2021 **(Was 31/12/2020 and 30/03/2021)** **3.** 31/03/2022 **(was 30/03/2021)** **4.** 31/03/2022**(was 30/03/2021)**
Top Controls		1. CNS engagement with virtual PTL 2. Cancer escalation process modified and re-issued 3. Cancer Hot List issued twice weekly 4. Additional theatre capacity with additional capacity being attained throughout other hospital services. 5. Lancashire Cancer Tactical Group, Trust and CCG colleagues discuss performance, progress, and ideas for improvement. 6. Cancer Performance Improvement group has been established and is chaired by the Lancashire/South Cumbria Alliance.				
Update since the last report		**31/08/2021** – 62 day performance shows no signs of recovery to date, however, performance is consistent and not deteriorating further. The trust continues to maintain its cancer performance framework with performance information and meetings being shared and held weekly. Recent discussions held with the Deputy COO regarding performance data and the recovery plan. The 62 and 104 day backlogs continue to grow, still in the majority being caused by the FDS backlog. The Cancer Alliance have set a "6 week challenge" aimed at delivering week on week improvement in the numbers in the FDS backlog **16/09/2021** – Risk Lead changed to C Rogers due to staffing changes No further update on system	**Date Last reviewed**	**15/10/2021**		
			Risk By Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
				15	**15**	**X**	**X**
			8 week score projection	**15**			
			Current issues	**Impacted by COVID-19**			

No	ID	Title				
11	8257	**Loss of Transfusion Service**				
Lead		Lee Carter	**Current score**	**15**	**Score Movement**	⟷
Description		Denial of the laboratory premises at RBH, especially blood transfusion, due to: 1. Planned evacuation due to fire alarm test. 2. Unplanned evacuation, in response to local fire alarm activation 3. Evacuation due to actual fire within the laboratory.	**Actions**	**All actions have been completed. The risk is being reviewed and should reduce in score and move to the 'Trust Wide' Risk register. Awaiting further updates.**		

Top Controls	**1.** Emergency bloods can be stored in temporary insulted boxes for a period of time **2.** The BMS (Bio Medical Scientist) would either station themselves outside the entrance to the laboratory, where they could issue emergency units out **3.** If level 0 was out of bounds, clinical flow room would be point of contact skilled staff. **4.** Hospital Transfusion Committee in place and review of meeting still underway.		
Update since the last report	**22/06/2021 –**The electronic blood banks have arrived on site and are awaiting installation. Installation on the RBTH site requires building works to alter a room, to specifically serve as the blood bank room. BGTH site involves a co-ordinate effort with Obs & Gyn to remove and re-site existing blood bank in theatres (also to be retrofitted with an electronic kiosk, to seamlessly link with the new electronic system). Once agreement has been reached to fund the change, this can go ahead. The new blood bank is to be placed in the existing area, but alteration works (data points) are required. Liaising with estates for work to be progressed, but also to see if there are temporary areas, across the Trust where we can start the validation work. **14/09/2021 –** No change, awaiting the siting of the fridges. Once sited this will be removed from CRR	**Date Last reviewed**	**18/10/2021**
		Risk by Quarter 2021	Q1: **15** / Q2: **15** / Q3: **X** / Q4: **X**
		8 week score projection	**10**
		Current issues	The siting of the fridges is being discussed and when in place they will need to go through change control.

No	ID	Title				
12	8243	**Absence of an end to end IT maternity system (Family Care)**				
Lead		Neil Berry/Tracy Thompson	**Current score**	**15**	**Score Movement**	⟷
Description		Inability to have an end to end IT record of a woman's care throughout her antenatal, intrapartum and postnatal care. Impact on midwives work load as data capture will be manual, time consuming with an inconsistent approach to collect, no additional resources are available to collate this data manually which would equal at a minimum a full time post. Potential gaps and risks of inaccurate data capture		**Actions**	**All actions completed, awaiting further actions as risk is close to mitigation.**	
Top Controls		**1.** The ICS procurement process is nearing its conclusion and the supplier for the new maternity system should be decided by the 30st September 2020. A divisional, multidisciplinary maternity system steering group has been formed and will meet every fortnight from the 14th October. The group will begin by discussing and developing the business case for the new system, discuss and look at setting up the project team once the chosen supplier is known and then discussing the choice and purchase of new IT infrastructure, again once the chosen supplier known. **2.** Review of equipment used by midwives in the community for accessing systems is underway				
Update since the last report		**31/08/2021** - Work continues towards go-live 9/11/2021. Training to commence 1/9/2021 and environment configured. Staffing pressure continue. PAS interfaces almost ready and ICE/Viewpoint next week. **18/10/2021** Staff training continues although serious staffing issues are causing problems. This was raised at the project board. Interfacing has been challenging and continues to be tested. Clinical UAT has begun and so far successful however until interfacing correct not able to be finished. Go live approaching for antenatal bookings and preparation continues with support and business continuity.		**Date Last reviewed**	**18/10//2021**		
			Risk by Quarter 2021	Q1: **15** / Q2: **15** / Q3: **X** / Q4: **X**		
			8 week score projection	**12**		
			Current issues	Roll out has been delayed which has paused some of the training.		

No	ID	Title						
13	8652	**Failure to meet internal & external financial targets for 2021-22**						
Lead		Michelle Brown	**Current score**	**15**	**Score Movement**			
Description		Failure to meet financial targets is likely to lead to the imposition of special measures and limit the ability of the Trust to invest in the services it provides. Continued failure to meet financial targets may lead to the Trust being taken over by another provider.		Actions	1. Submit monthly financial monitoring returns to NHSEI 2. To ensure we have a financial training programme in place to support the wider organisation and network 3. To work across the Trust with non-financial colleagues	All actions managed by Charlotte Henson	**1.** Ongoing	
Top Controls		**1.** Robust financial planning arrangements, to ensure financial targets are achievable and agreed based on accurate financial forecasts; **2.** Financial performance reports distributed across the organisation to allow service managers and senior managers to monitor financial performance against financial plans, supported by the Finance Department; **3.** Enforcement of Standing Financial Instructions through financial controls to ensure expenditure commitments to incur expenditure are made in accordance with delegated limits; **5.** Arrangements to monitor and improve delivery of the Waste Reduction Programme **6.** Enforcement of Standing Financial Instructions through financial controls to ensure expenditure commitments to incur expenditure are made in accordance with delegated limits						
Update since the last report		**. 05/10/21** The Trust has met its H1 financial obligations. H2 planning guidance was issued in the last few days and is currently being modelled this is showing that H2 will be extremely pressured with a reduction in income and a shortfall of funding to cover the pay award. A mid year review is being carried out with each divisional management team of the Trust to look at current pressures and mitigation's that need implementing. The meetings are planned for Late October and November 2021		**Date Last reviewed**	**05/10/2021**			
				Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
					15	**15**	**X**	**X**
				8 week score projection	**15**			
				Current issues	Deficit under review with NHSI			

No	ID	Title						
14	8543	**Fracture Clinic, Capacity & Demand**						
Lead		Michelle Turton/Victoria Hampson	**Current score**	**15**	**Score Movement**			
Description		Accommodation is currently being shared with UCC to support COVID green pathway for E/D. Inability to social distance in Fracture clinic due to it being used by 2 different departments. To support social distancing the main waiting room can only safely accommodate 17 patients. The numbers of patients attending both UCC and fracture clinic are increasing month on month. UCC use the waiting room to return patients to while they are waiting for investigations/results. Fracture clinic patients are having to wait on chairs on the corridor Medical students and trainee ACP's are unable to be accommodated due to lack of space so will impact on learning. ACP's are being moved to the BGH site so will not have the direct supervision they may require. Fracture clinic would be used for training but due to lack of space but is no longer an option.		**Actions**	**1.** Regular management meetings with Medicine	**1.** Victoria Hampson	**1.** On-going	
Top Controls		**1.** Fracture clinic staff have worked on flow through the department so that patients are seen as promptly as possible and are moved from the main wait. **2.** A member of staff are placed at the front door to advise patients about infection control measures, advised where to wait and to support waiting patients. **3.** Spacing of Fracture clinic appointments to try to prevent over capacity.						

	4. Fracture clinic making non face to face appointments as much as possible. **5.** Patient seating made available of hospital corridor. Move what can be moved to BGH fracture clinic.					
Update since the last report	**15/07/2021-** UCC (Urgent care) relocation in AM not yet assessed and will update risk once this change is embedded. **11/08/2021** - Risk remains in afternoon periods. Reduction to be discussed at Divisional Patient Safety meeting in September **22/10/21** – email sent to Division to request update on approval of reduction in risk level.	**Date Last reviewed**	**11/08/2021**			
		Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
			15	**15**	**X**	**X**
		8 week score projection	**15**			
		Current issues	**Impacted by COVID-19**			

No	**ID**	**Title**				
15	8839	**Failure to meet performance targets (SAS)**				
Lead		Victoria Bateman	**Current score**	**15**	**Score Movement**	⇔
Description		The concern is the Division's ability to meet the national performance targets set for referral to treatment times. Non achievement on the standards ultimately impacts and causes delays in patient treatment. Due to covid 19 all surgical specialities are currently significantly challenged for meeting RTT. Failure of the standard means that individual patient care is impacted upon as patients have to wait an extended length of time for treatment. Impact on patient experience and patient treatment plan. Patients may deteriorate waiting for treatment for extended lengths of time. As this standard is monitored externally, failure to meet this standard has reputational issues for the Trust and patients may choose to not be treated at ELHT.				
Top Controls		1. Strong monitoring at Trust, Divisional and Directorate Level. 2. Weekly PTL meeting within division to ensure awareness of current position and to ensure controls are continuously put in place to focus on achievement of the standard. 3. Bi-weekly performance meeting with Directorate Managers led by the Director of Operations. 4. Planning & information produced for trajectories. 5. Monitoring at directorate and divisional level at Directorate meetings and DMB. 6. Recovery plans being updated weekly by Directorate Managers. 7. Attendance of divisional information manager at directorate meetings to provide information regarding current position. 8. Strong management of standard at DMB and performance meeting with exec team. 9. Exception reports provided by divisional information manager for all specialities where the 28DR standard is not met. 10. Monthly performance meeting with exec team and DMB where divisional position is reported discussed and challenged. 11. Regular meetings with CCG colleagues to work together on demand management	**Actions**	**1.** Utilise independent sector	**1.** Victoria Bateman	**1.** 01/07/2021
Update since the last report		**28/09/21** Due to the introduction of national P codes this also means that the most clinically urgent patients are treated first leaving a bigger backlog of even longer waiters behind due to lack of capacity. We currently have 6 patients that have waited over 104 weeks which has never happened before. We also have a proportion of patient choice patient that we are trying to work through and re offer dates to in their specified time frame. The risk is still very much valid and a constant challenge for the services across the trust to achieve performance standards.	**Date Last reviewed**	**28/09/2021**		
		Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
			15	**15**	**X**	**X**
		8 week score projection	**15**			
		Current issues	**Impacted by COVID-19**			

No	ID	Title					
16	8914	**Potential interruption of high-flow oxygen therapy to critically ill patients across RBTH**					
Lead		Susan Chapman/Andrew Appiah	**Current score**	**15**	**Score Movement**		
Description		Risks to continuity of medical oxygen supply from the VIE due to inadequate resilience in current infrastructure. The designed maximum oxygen flow limits of the current VIE tank and vaporisers has been near enough exceeded during this pandemic. This could have potentially led to an interruption of essential treatment of critically ill patients, such as invasive ventilation and low- and high-flow oxygen therapies. When the total oxygen draw from the patients and devices exceed the designed limit of the vaporisers, the system would not be able to turn liquid oxygen into gas quickly enough; hence it could start drawing liquid oxygen into the system potentially damaging it.		**Actions**	1. Review outcome of funding	1. Andrew Appiah	1. 30/04/2021
Top Controls		**1.** Protocols for the Management of Oxygen during periods of High Demand have been developed. **2.** Elevated clinical demand for oxygen is monitored throughout the day and escalated. **3.** Appropriate escalation measures have been allocated to various departments to avoid interruption of supply for patient's clinical care					
Update since the last report		**23/06/2021-** During the 16th June Capital planning board meeting the Exec Finance Director shared the Finance proposal to grant Estates a budget for high risk items which will allow an upgrade of the current VIE system to deliver an increased maximum flow capacity from 2400L/min to 5000L/min to address any surges/potential breaches in winter. The breaches during the last winter occurred at 3600L/min. Air Products will need at least 14 weeks lead time to order the upgrade equipment, hence the funds to procure this needs to be approved by the end of June. **14/10/2**1– No change		**Date Last reviewed**	**14/10/2021**		
				Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
					15	**15**	**X**	**X**
				8 week score projection	**15**			
				Current issues	**Impacted by COVID-19**			

No	ID	Title					
17	8808	**Burnley Hospital (BGTH) - Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke.**					
Lead		Tony McDonald/Michelle Brown	**Current score**	**15**	**Score Movement**		
Description		Deficiencies in provision of fire barriers in external cavity walls in Area 7 Phase 5, BGTH. This is a PFI building, not owned by the Trust. Excess gaps around fire doors have been identified, with inadequate fire stopping. Additionally issues have been identified within the Fascial Cavity Barrier & External Wall survey. Kingspan render/insulation is present but no test evidence to show fire resistance properties have been provided by Project Co or Kingspan. This has been requested by the Trust. The Trust has currently suspended fire stopping work internally due to COVID.		**Actions**	**There are a list of actions actively monitored in the Fire Stopping cell group which is led by the Executive Director of Finance and the Executive Director of Integrated Care, Partnerships and Resilience. These actions are regularly monitored whilst the Trust starts restoration on previous Fire Stopping works.**		
Top Controls		**1.** Fire alarm system throughout the building to provide early warning in case of fire. Tested, serviced and maintained. **2.** External monitoring of fire alarm and connected to RBTH switchboard. **3.** Staff completes fire safety training. **4.** Fire Policy in place. **5.** Engie Fire Risk Assessments for non-Trust locations, these include Plant Room areas which are not occupied by the Trust. **6.** Contractual arrangements in place between PFI and the Trust for maintenance of systems and PPM's. **7.** Monthly meeting between lead execs and support team to					

	review this risk and outstanding fire stopping issues. Meeting will review the trust position on fire stopping each month and all parties aware of contractual agreements.		
Update since the last report	**13/09/2021** - Meetings continue between the Trust, Capita and Project Co to determine the restoration and remedial works required to the building. 14 new or reviewed FRA's have been carried out in Phase 5. **11-10-21** Regular meetings being carried out between Project co and Trust, also attended by capita. Rectifications still need confirming.	**Date Last reviewed**	**11/10/2021**
		Risk by Quarter 2021	**Q1**: 15 / **Q2**: 15 / **Q3**: X / **Q4**: X
		8 week score projection	**15**
		Current issues	**Impacted by COVID-19**

No	**ID**	**Title**				
18	7764	**Royal Blackburn Hospital (RBTH) Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke**				
Lead		Tony McDonald/Michelle Brown	**Current score**	**15**	**Score Movement**	⟷
Description		There has been a Covid suspension of planned fire stopping works on site from March 20 but this will be reviewed in a regular monthly meeting with the Exec Director of Finance, PFI Partners, H&S (Fire) and Estates. The exception is for capital and restore and restoration work only. Additional issues have been identified in a recent 3rd party sample survey -Fascial Cavity Barrier & External Wall Internal lining Investigations. The decision to stop such works transfers the risk of fire on the main site at Blackburn to the Trust. Project Co (PFI) cannot be held responsible until the Trust decides to reinstate such works which is being reviewed monthly.		**Actions**	**There are a list of actions actively monitored in the Fire Stopping cell group which is led by the Executive Director of Finance and the Executive Director of Integrated Care, Partnerships and Resilience. These actions are regularly monitored whilst the Trust starts restoration on previous Fire Stopping works.**	
Top Controls		**1.** Fire alarm system throughout building providing early warning of fire **2.** Evacuation procedures in place **3.** Fire Wardens in most areas **4.** All staff trained in awareness of alarm and evacuation methods **5.** Fire policy in place **6.** On site fire team response **7.** Total Fire Safety Ltd have also started the programme of works on phases 1-4 **8.** Balfour Beatty carrying out work in Phase 5. **9.** Monthly meeting in place with executives and senior management to review the trust position on the works being stopped and deal with escalations. First meeting 23/11/2020. The trust will review the position of this each month. **10.** Contractual arrangements in place between PFI and the Trust for maintenance of systems and PPM's.				
Update since the last report		**13/09/2021** - Meetings continue between the Trust, Capita and Project Co to agree on progressing restorative and remedial work. Reviewing of the existing fire evacuation strategy is being undertaken currently. **11/10/21** Information continues to be exchanged between all parties. Mechanical Riser 1 and 2 reports added.		**Date Last reviewed**	**11/10/2021**	
				Risk by Quarter 2021	**Q1**: 15 / **Q2**: 15 / **Q3**: X / **Q4**: X	
				8 week score projection	**15**	
				Current issues	**Impacted by COVID-19**	

No	ID	Title						
19	8960	Risk of undetected foetal growth restriction and possible preventable stillbirth given non-compliance with national Ultrasound guidelines						
Lead		Helen Collier	Current score	15	Score Movement			
Description		Diagnosis of intrauterine growth restriction could be missed some due to inability to report/action Pulsatility Index on uterine artery doppler measurement. The introduction of national/international recommendations will require investment of resources including the introduction of Viewpoint as the obstetric reporting package, an increase in sonography hours and midwife sonography hours currently allocated and updated ultrasound machines within maternity services.	Actions	1. To complete a business case for additional staffing	1. Charlotte Aspden	1. 25/06/2021 **(was 30/04/2021) awaiting new date**		
Top Controls		1. We have an additional ultrasound machine funded and due to arrive in the department in the next couple of weeks. 2. We have staff within the department trained in measuring and interpreting pulsatility index. 3. We have Viewpoint reporting software which allows us to interpret and report pulsatility index. 4. At present we are reporting umbilical artery end diastolic flow as present, absent or reversed with no measurement of the pulatility index. This will identify some babies with foetal growth restriction but is less sensitive than the recommended pulsatility index. Those babies that we feel demonstrate foetal growth restriction is referred to placenta clinic for further management. 5. Currently only women at very high risk of early-onset growth restriction are seen within Placenta clinic.						
Update since the last report		**15/09/2021** - Risk Assessment reviewed between HOM and DM. Pending Ockenden monies, midwifery sonography staffing model and service provision to be implemented once received. Meeting organised with consultant lead for the 06.10.21 to agree plans for progressing and operationlising the model. **07.10.21** - RA reviewed at the meeting between HOM, Clinical Lead and DM. All staff are now trained. Viewpoint will be in place from the 9th November 2021. Agreed that an audit tol be undertaken through November to ascertain the potential demand for the service going forward.	Date Last reviewed	07/10/2021			
			Risk by Quarter	Q1	Q2	Q3	Q4	
				15	15	X	X	
			8 week score projection	15				
			Current issues	Business case for sonographer hours is being reviewed, awaiting update on approval of this.				

No	ID	Title						
20	4932	Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained.						
Lead		Howard Stanley	Current score	15	Score Movement			
Description		Patients referred to Lancashire County Council and Blackburn with Darwen Council (Supervisory Body) for a Deprivation of Liberty Safeguards (DOLS) authorisation are not being assessed by these agencies within the statutory timescales or at all, which means the DOL is in effect unauthorised. The Local Authority (Supervisory Body) is aware but has not been able to process the assessments within the statutory timescales.	Actions	**New risk added – action plan being developed.**				

Top Controls	1. The Mental Capacity Act Policy (C82v5) and DOLS procedure is being adhered to by wards and applications are being made in a timely manner. They are being supported by the Adult Safeguarding Team. 2. The policy was updated and agreed at Policy Council and includes up to date information regarding the 2014 Supreme Court Judgement. 3. Non mandatory MCA/DOLS Training Programme is available to all Trust employees. 4. Additional support and training to ward based staff has been provided by the Mental Capacity Act Lead and other members of the Adult Safeguarding Team. 5. Applications are tracked by the Adult Safeguarding Team and changes in patient status are relayed to the local authority (Supervisory Body). 6. Ability to extend the Urgent Authorisation for all patients up to 14 days in total, which provides some defence to ELHT. 7. Legal advice and support available to the Trust 8. Despite the legal framework issues, it is anticipated that the patients will not suffer any adverse consequences or delays in treatment etc, and Principles of the Mental Capacity Act will still apply.		
Update since the last report	07/09/2021 - Whilst this risk continues to exist, the Trust have now mandated additional training to all clinical professional staff from 1st October 2021, in relation to the MCA and DoLS. In addition a new Named Professional has been recruited who will focus on continued improvement of the MCA in practice 12/10/21 - no changes to risk. Update on replacement LPS awaited from DoH.	**Date Last reviewed**	**12/10/2021**
		Risk by Quarter 2021	**Q1**: **15** / **Q2**: **15** / **Q3**: **X** / **Q4**: **X**
		8 week score projection	**15**
		Current issues	

East Lancashire Hospitals NHS Trust
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TRUST BOARD REPORT

10 November 2021

Item 134

Purpose Assurance
Approval

Title	Board Assurance Framework (BAF) Review
Authors	Mrs A Bosnjak-Szekeres, Director of Corporate Governance/Company Secretary Miss K Ingham, Acting Head of Corporate Governance
Executive Sponsor	Mr J Husain, Executive Medical Director

Summary: The Executive Directors have revised the BAF and examined the controls and assurances, together with any gaps, to establish whether they have changed since the September 2021 Trust Board meeting.

The cover report has been reviewed to summarise the key changes, specifically to the key controls, sources of assurance, actions and any gaps in assurance or control. All new items added are indicated in green within the document and any out of date information has been removed.

Recommendation: Directors are asked to discuss and approve the content as per the recommendations from the Committees.

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 Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

(134) Board Assurance Framework Review

1. The Board Assurance Framework (BAF) brings together in one document all of the relevant information on the risks to the Trust's strategic objectives. By regularly reviewing it, the Trust is in a position to identify whether the BAF remains fit for purpose and whether it provides the Board with real confidence that it is having a thorough oversight of the strategic risks.
2. The effective application of assurance processes in producing and maintaining the BAF is enabling the Board to consider the process of securing the necessary assurance using formal procedures that promote good governance and accountability, whilst gaining a clear and comprehensive understanding of the risks faced by the Trust in pursuing its strategic objectives.
3. The BAF informs the Board about the types of assurance currently obtained, so consideration can be given whether they are effective and efficient and enables the Board to identify areas where the existing controls might be failing and the risks that are more likely to occur as a consequence. The BAF also gives the Board the ability to better focus the existing assurance resources.
4. Some of the BAF risks are considered by both the Quality Committee and Finance and Performance Committee (risks 1, 2, 3 and 5) due to their overarching nature, however each Committee only discusses the risk elements under their specific remits and are aligned to their Terms of Reference.
5. Please note that where sources of assurance have been removed, this is to enable the document to be more streamlined/high-level and does not mean that the assurance is no longer in place.

Risk 1: Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care.

6. It is proposed that the **risk score remains at 16 (**likelihood **4** x consequence **4)**.
7. The key controls section has been updated to confirm that the deployment of the strategic framework is in development to ensure robust Trust, divisional and directorate plans are in place as part of the annual planning process.
8. The assurances section has been updated as follows:
   a) work is taking place to align improvement approaches and deliver training across the ICP to upskill individuals where necessary.
   b) A model for improvement was also approved at PCB in September 2021.

9. Gaps in control have been updated with two items and are included in green text in full BAF below.
10. Mitigating actions have been revised to include:
    a) Additional executive oversight through the executive leadership wall to be developed and strengthened (quarter 4 2021/22).
    b) Ongoing alignment of Trust improvement approach to ICP and ICS (quarter 3/4 2021/22).

Risk 2: Recruitment and workforce planning fail to deliver the Trust objectives

11. It is proposed that the risk descriptor be revised slightly to the following: *Recruitment, retention, and workforce planning fail to deliver the Trust's objectives*
12. It is proposed that the **risk score remains at 20 (**likelihood **4** x consequence **5).**
13. Internal and external assurances have been updated to add further information and clarification to existing items. In addition, one new source of assurance has been included, as follows:
    a) Extended health and wellbeing offer introduced across the organisation and ICS Enhancing Health and Wellbeing projects to support staff and reduce sickness absence/associated bank and agency usage.

Risk 3: Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities.

14. The **risk score remains at 16** (likelihood **4** x consequence **4**) and will be revised, along with the rest of the BAF risks following the Audit Committee's annual review of the BAF.
15. Key controls have been updated with minor revisions for clarification and readability purposes. In addition, there has been one new control added:
    a) Work is almost complete on the clinical harms review across the ICS (one policy and guidance).
16. The sources of assurance section have been updated to reflect minor changes for clarification. In addition, there has been one new source of assurance added:

a) Haematology services at ELHT are under significant pressure as a consequence of partnership working with UHMB and BTH is resulting in advice and guidance service and clinicians from BTH are providing mutual aid.

17. The gaps in control section had been updated to include the following:
    a) Availability of the workforce will be a limiting factor in delivering objectives across the ICS.

Risk 4: The Trust fails to achieve a recurrent sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to achieve H1 financial balance, with a further risk associated with lack of clear guidance for H2 planning.

18. There is a recommendation to revise the risk descriptor to the following: *The Trust fails to achieve a recurrent sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to achieve ~~H1~~ financial balance, at the end of H2.*
19. The **risk score remains at 20** (likelihood **5** x consequence **4**).
20. The key controls section has been updated with minor revisions for clarification and readability purposes and a small number of points have been removed as they are out of date.
21. The mitigating actions have been updated with revised timelines and to confirm the completion of the restructure to support capacity requirements.

Risk 5: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

22. The **risk score remains at 16** (likelihood **4** x consequences **4**).
23. Key controls have been updated with one new addition and minor updates for clarification which are shown in the BAF in green text.
24. The sources of assurance section have been updated with a small number of minor updates. There has also been one new addition as follows:
    a) Mortality Steering Group which meets on a monthly basis and reviews the HSMR, SHMI and related mortality indicators.
25. The gaps in control section has been updated to add further information and clarification to existing items. In addition, three new items have been added, as follows:

a) An extension to the additional CT Scanner has been mobilised via the ICS Diagnostics Programme for a further 6 months until 31st March 2022 to support diagnostic and elective recovery. This operates 7 days a week for patients under the care of ELHT (4 days a week) and LTH (3 days a week).

b) Mobilisation of Community Diagnostic Centres (CDC) led by the ICS Diagnostic Programme have commenced across Lancashire and South Cumbria including one in Pennine Lancashire based at Rossendale Primary Health Centre. This will enable expanded diagnostic provision to be provided closer to home rather than hospital settings where clinically appropriate, to be undertaken sooner, tackle health inequalities and improve health outcomes and support reducing diagnostic and elective backlog in line with national planning guidance, ICS and ICP priorities.

c) Provider Collaboration Board has approved the establishment of the Diagnostic Imaging Network for Lancashire and South Cumbria using collaborative model and will be hosted by ELHT.

East Lancashire Hospitals NHS Trust
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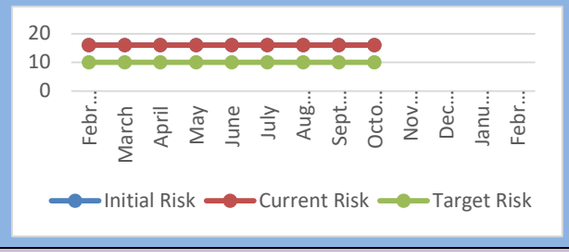
Appendix – Board Assurance Framework (Full)

BAF Risk 1

Objective theme: Quality, Delivery, Workforce and Finance	**Executive Director Lead**: Deputy Chief Executive, Director of Finance and Medical Director, Director of HR and OD and Director of Nursing
Risk Description: Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care.	**Date of last review:** October 2021
Risk Rating (Consequence x likelihood): Initial Risk Score: 4 x 4 = 16 Current Risk Score: 4 x 4 = 16 Target Risk Score: 2 x 5 = 10 	**Effectiveness of controls and assurances:** Effective X Partially Effective Insufficient **Risk Appetite:** The Trust has **Low** risk appetite for any risk which has the potential to compromise our reduction of cost base and the Waste Management Programme.

Controls:
• The programme is monitored through the Improvement Practice Office reporting to the Senior Leadership Group (SLG), Finance and Performance Committee, Quality Committee.
• The 4 elements of Quality, Delivery, Morale and Finance are monitored through internal governance groups.
• Divisional improvement is monitored through the Divisional Governance structures.
• Improvement Practice Priorities and development strategy – three-year plan. 12-month plan in development.
• Patient Participation Panel involvement in transformation projects delayed due to ongoing pandemic response.
• Trust involvement in ICS restoration and recovery programmes including Adapt and Adopt Improvement Programmes.
• Work to review and revise the Trust's Quality Strategy and Quality Priorities for the next 12 months, through engagement with Senior Leadership Group, Quality Committee, all staff representatives, patients and other partners.
• Trust's Strategic Framework has been reviewed and agreed the strategy deployment process is now in development to ensure robust Trust, divisional and directorate plans are in place as part of the annual planning process.
	Assurances:
	Internal Assurances
	• The Trust planning process has identified a single set of key work programmes and improvement priorities for the Trust in conjunction with ICP Partners. The priorities identified are aligned to the Trust's Clinical Strategy, the ICP priorities as outlined in the Pennine Plan, key ICS and national restoration priorities and to the NHS Long-Term Plan.
	• Ownership and embedding of the improvement plans across the Pennine Lancashire ICP.
	• The Trust has adopted and is implementing a consistent improvement approach (improving Safe Personal and Effective Care Plus (SPE+) based on Lean and is a founder Trust of the Vital Signs programme.
	• The Trust has invested in dedicated improvement capacity through the development of the Improvement Hub Office and seeks, through the planning round, to align capacity across the organisation to the delivery of a single plan. The improvement hub has developing a revised training and capability programme, the first phase of which has commenced.
	• Operational and Executive oversight is provided via:
	  • Executive Visibility Wall (virtual in development)
	  • Executive Team meeting- weekly
	  • Senior Leadership Group
	  • Monthly Clinical Leaders Forum and bi-monthly Joint Clinical Leaders Forum
	  • Weekly Medical Director meetings

Appendix – Board Assurance Framework (Full)

BAF Risk 1

	• Monthly Board assurance is provided via reporting to:
	  • Finance and Performance
	  • Quality Committee
	  • Trust Board (bi-monthly reporting)
	
	<u>External Assurances</u>
	• Work is on-going to align improvement approaches and deliver associated training to upskill across the ICP and ICS with a model for improvement approved at PCB in September 2021.
	• Reporting of improvement activities to the Trust Quality Review meetings with the CCG.
	• There has been good participation by system partners in several system-agreed improvement events.
	• There is ongoing alignment of improvement resources across the ICP including commissioning portfolios.
	• System-wide Programme Boards have been developed to focus on delivery of system priorities and dovetail to Trust's information and transformation plans. These Boards cover Urgent and Emergency Care, Scheduled Care, Integrated Community Care and Mental Health. A Programme Co-ordination Group, consisting of senior responsible officers and delivery leads, established to oversee delivery.
	• New Hospitals programme.
	• The Trust is part of the ICS level Elective Cell Recovery Group.

Gaps in controls and assurance: • Additional executive oversight through the executive leadership wall to be developed and strengthened. • Capacity and resilience building in relation to improvement is in early phase but being addressed through development of capability and training programme. • Dependency on stakeholders to deliver key pieces of transformation • Financial constraints • Transformation priorities not yet fully aligned to appraisal and objective setting	**Mitigating actions:** **Action** / **Target Date** Additional executive oversight through the executive leadership wall to be developed and strengthened — Q4 2021/22 Ongoing alignment of Trust improvement approach to ICP and ICS — Q3/4 2021/22 Refresh of the Trust's Quality Strategy and Quality Priorities. — Q3 2021/22

Appendix – Board Assurance Framework (Full)

BAF Risk 1

• Capacity and time to release staff to attend training related to improvement in order to build improvement capability across the organisation. • Adequate assurance mechanism that the service integration plans are on track together with the rigour of governance arrangements/lack of delegation from the sovereign bodies to the system. • Impact of ICP/ICS governance changes on improvement plans. • Ongoing effect of COVID-19 on restoration, staff wellbeing and morale. • Electronic Patient Record is a key enabler to support delivery of improvement work streams.	Trust Wide Electronic Patient System approval and implementation	November 2022

East Lancashire Hospitals NHS Trust
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Appendix – Board Assurance Framework (Full)

BAF Risk 2

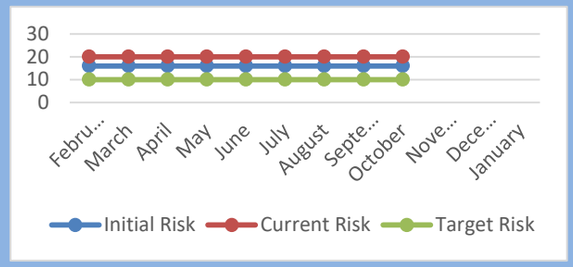
Objective theme: Workforce	**Executive Director Lead**: Director of HR and OD
Risk Description: Recruitment, retention and workforce planning fail to deliver the Trust objectives.	**Date of last review**: October 2021

Risk Rating (Consequence x likelihood):

Initial Risk Score: 4 x 4 = 16

Current Risk Score: 4 x 5 = 20

Target Risk Score: 2 x 5 = 10



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: The Trust has **NO** risk appetite for any risk surrounding NICE guidance which has the potential to cause harm to patients and staff.

The Trust has a **Low** risk appetite to any risk that could affect patients, staff, contractors, public and Trust assets.

Controls:

- Workforce transformation is being worked into the Trust's improvement methodology.
- Divisional Workforce Plans aligned to Business & Financial Plans through the planning process.
- SLG monitor on-going performance, actions and risks.
- Regular reports to Finance & Performance Committee and Board on delivering the People Strategy.
- Trust is in the process of reviewing and revising the Workforce Controls process to review all vacancies and support the Workforce Transformation strategy.
- Pennine Lancashire ICP Workforce Strategy agreed, and ICP People Board established.
- ICS People Board established and complementary workforce strategy developed to enable collaboration.
- People Strategy aligned to deliver National ICS, ICP and Trust workforce objectives and is cognisant of the NHS People Plan.
- Increased staffing during core hours to alleviate pressures.
- As a result of COVID pressures the Trust continually monitors opportunities to offer escalation rates to ensure safe staffing to avoid the need to use agency staff.

Assurances:

Internal Assurances

- On-going monitoring of vacancies and bank/agency usage via Trust IPR, performance measures, time limited focus groups with action plans, Board and Committee reports, regulatory and inspection agencies, stakeholders, internal audit.
- WRES and WDES action plans with timelines in place. Regular reporting to the Board on progress. Ongoing monitoring of workforce diversity through the re-establishment of the Diversity and Inclusion Steering Group and Trust staff networks. Establishment of a strategic BAME oversight group (including Board members and BAME Network Chairs to provide oversight).
- Joint Medical and Non-Medical Agency Group in place. Dashboard giving overview of bank/agency usage presented monthly. Additional scrutiny from a nursing perspective.
- Integrated Performance Report, Performance Assurance Framework, Workforce Dashboard reporting key performance indicators within Divisions on a monthly basis, Details of these reported on a quarterly basis to the Finance & Performance Committee.
- Lean Programme (Vital Signs) overall linking into workforce transformation. Improvement priorities are now being identified as part of the delivery of the People Strategy, working to embed in culture.

Appendix – Board Assurance Framework (Full)

BAF Risk 2

• Staff upskilling across the Trust to support in other areas of the Trust during increased demand. • Workforce tools such as Safe Care, e-rostering and dashboards to monitor safe staffing levels, revised in light of winter and COVID-19 • International, band 5 nurse and HCA recruitment • Vaccinations and LAMP testing of staff groups • Mutual aid arrangements in place across ICS • Job planning in light of service demands • Medical Training Initiative Scheme • COVID-19 implemented agile working schemes • Daily medical and workforce huddles to identify gaps in staffing levels • Work is ongoing to appoint clinical (medical, nursing and AHP) staff via targeted recruitment activity.	• Completion rates of the annual staff survey and low rates of turnover. • Uptake of flu vaccine and COVID booster across the workforce. • Workforce dashboard developed and showing on Power BI (Business Intelligence System). • Extended health and wellbeing offer introduced across the organisation and ICS Enhancing Health and Wellbeing projects to support staff and reduce sickness absence/associated bank and agency usage. • A Senior Medical Staffing Performance Review Group established - responsibility for reviewing all consultant job plans, consultant vacancies etc. adding further rigor on our appropriate use of resource. • Revised appraisal process linked to talent management and succession planning with plans to increase compliance post-COVID-19. Activity underway to increase compliance and incorporate wellbeing conversations post COVID. • E&D Action Plan. • Development of a Trust-wide leadership development offer to align values and behaviours with the aspiration to create a culture of inclusion and compassion. • The Equality and Inclusion Group has been established to consider the wider diversity agenda. A number of staff networks established (BAME, LGBTQ, Mental Health and Disability, women's network). • First Shadow Board cohort completed, with participants being offered Talent Conversations and a second cohort planned (awaiting further details from leadership academy). • Partners programme participation (NHSLA/ NHSI) senior leadership representation on the programme. • Nurse Recruitment Strategy Group and Action Plan. • Reverse mentoring scheme commenced and will be a perpetual scheme (first cohort completed; second cohort being determined). • Occupational Health team supporting testing and isolation advice. • Ongoing international and domestic recruitment. • Commitment to achieving ICP priority of recruitment of 1,000 local people into Health and Social Care roles. • Trust's Behaviour Framework launched at the Festival of Inclusion in September 2021.

Appendix – Board Assurance Framework (Full)

BAF Risk 2

	• Launch of the flexible working manifesto and a number of flexible working pilots to support recruitment and retention. External Assurances • Staff Friends and family test (further detail in BAF risk 5). • Benchmarking of agency spend is available through the Model Hospital data. • Collaboration across the ICS on agency usage. Participation in ICS Bank and Agency Collaborative to manage agency rates across the region. ICS collaboration on Careers, International Recruitment and Workforce mobility. ICS wide People Board - looking at nurse recruitment across the whole system. • Joint work taking place across the ICS to consider implications and options to mitigate the impact on pensions. The Trust has agreed a range of measures with ICS colleagues to help address the pensions challenges along with implementation of NHSE's interim solution for financial year 2019/20. • Establishment of a Pennine Lancashire and a Lancashire and South Cumbria People Board. • Improving staff survey completion rate. • WRES/WDES results. • Ongoing development of national performance dashboard to support delivery of the people plan. • £1.5m secured for the ICS to develop an enhanced health and wellbeing offer.
Gaps in controls and assurance: • National recruitment shortages, capacity for delivery of transformation programmes, financial restrictions. Reduction of CPD monies from HEE (could be offset by the apprenticeship levy).	**Mitigating actions:**

Appendix – Board Assurance Framework (Full)

BAF Risk 2

Varying incentive schemes/packages across provider sector.

- Additional gap in relation to the unknown impact of COVID on long term travel plans, which may affect international recruitment.
- The impact of the changes to the pension rules and taxation has resulted in a significant reduction in capacity and additional work being undertaken by senior medical staff. This has resulted in a reduction in clinical capacity.
- Inability to control external factors (COVID-19, Brexit, visas etc).
- Regulators stance on safe staffing and substitution of roles in place of registered workforce.
- Lack of data/intelligence regarding the number of nurses and clinical staff in the 55+ age category and the related risk of 'brain drain' in the coming years. Work has been done by ICS across the system but it does not contain the level of detail needed for each Trust. Efforts need to be made to understand and refine the workforce data in order to address the issues in the Trust.
- Risk of staff leaving the NHS due to post COVID burnout
- Potential ongoing staff sickness from COVID-19
- COVID-19 impact on appraisals
- COVID-19 impact on Black and Minority Ethnic (BAME) population

Action	Target Date
HCA recruitment continues, contributing to the reduction in HCA bank shift requests adding further stability and flexibility to our support workforce. 100 HCA applicants being processed following recent campaign and are currently in pre-employment stages with envisaged start dates in Q1 2021/22 First phase complete, with a second cohort to commence shortly.	Ongoing
AHP job planning project underway across the ICS.	Ongoing

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Appendix – Board Assurance Framework (Full)

BAF Risk 3

Objective theme: Quality, Delivery, Workforce and Finance

Executive Director Lead: Deputy Chief Executive, Director of Finance, Director of Service Development and Medical Director

Risk Description: Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities.

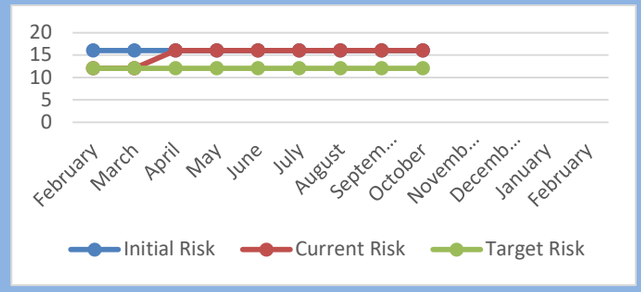
Date of last review: October 2021

Risk Rating (Consequence x likelihood):

Initial Risk Rating: 4 x 4 = 16

Current Risk Rating: 4 x 4 = 16

Target Risk Rating: 3 x 4 = 12



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: The Trust has a **Moderate** risk appetite for opportunities which enable achievement of the Trust's strategic objectives, and collaboration with system partners in the Integrated Care System (ICS) and Integrated Care Partnership (ICP) within the available resources.

The Trust has a **Low** risk appetite for risk, which may affect the reputation of the organisation.

Controls:

- CEO are members of the ICS Board and System Leaders Executive. The Chairman, CEO and Deputy CEO are members of the ICS PCB.
- PCB guidance released
- Number of senior clinicians involved with ICS work groups. Professional Leadership Committee (PLC) has ELHT representation.
- The ELHT Accountable Officer is the senior responsible officer (SRO) for the Pennine Lancashire Transformation Programme, sits on the System Leaders Forum and on the Integrated Care System for Lancashire and South Cumbria (ICS) Programme Board.
- Working relationships with stakeholders in relation to mental health services including shared policies.
- Multiple COVID-19 initiatives at ICP level.
- Strategic planning – planning guidance received (regional and ICS planning groups established, Deputy CEO on both and COO on ICS level group).

Assurances:

Internal Assurances

- 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. Standing agenda item at Executive meetings.
- Potential gains in strengthened reputation with regulators and across the ICS and region.
- Early stage discussions being undertaken for creating single teams across the system, e.g., 'one workforce' with timelines for implementation. Progress covered under BAF risk 2.
- Board CEO report including updates on system developments and engagement.
- Refreshed Clinical Strategy is closely linked to the ICS clinical strategy

Internal/External Assurances

- The Pennine Lancashire and ICS Cases for Change have been published.

Appendix – Board Assurance Framework (Full)

BAF Risk 3

• ICP level – relationships between partners have developed in strength, particularly between the P care, PCNs and Trust, based on the COVID working that has taken place over the last 12 months. Agreed set of priorities developed for future working. • Agreed co-chairs of the A&E Delivery Board (Executive Director of Integrated Care, Partnerships and Resilience, Medical Director for East Lancashire CCG). • Each Executive lead is involved in their associated specialist group, eg Director of Finance is involved in Financial Assurance Committee at ICS level. • Pathology collaboration programme. • ICS Clinical strategy. • Long COVID clinics in partnership with the local CCGs and Lancashire and South Cumbria Care NHS Foundation Trust. • Strategic / Annual Planning Process. • Socialisation of the refreshed Clinical Strategy which has a system focus. • ELHT input into the ICP maturity matrix report and subsequent task and finish group (Deputy Chief Executive) and development plan. An agreed set of priorities for the ICP now developed. • Chairman / Chief Executive / Deputy Chief Executive input to ICS Board / Provider Collaboration Board / System Leaders Executive and New Hospitals Programme. • Hospital cell led by the Chief Executive with ELHT represented by Deputy Chief Executive • ICP Providers meeting on a regular basis • Provider Chief Operating Officer (COO) / Director of Operations group led by ELHT COO • Diagnostic Programme Board. • Appointment process being undertaken for consultant interface medicine (this post will be the link between Primary Care and Secondary Care). • Close to completion of the clinical harms review across the ICS (one policy and guidance)	• Fostering good relationships with GP practices through Primary Care Network development and wider out of hospital working. • Pennine Lancashire ICP MoU agreed by stakeholders workplan in place after Tripartite Board session. Revised governance and delivery standards. Programme Boards established with good ELHT representation. • ELHT hosting the Providers Programme Director for the ICS Provider Board who reports to the Chief Executive of ELHT. Interim CEO leading on the construction of the work programme with the Directors of Strategy from all the providers. Component business cases at Pennine Lancashire level forming a draft overarching ICP plan. Plan on a page for the ICP, connecting to the Plan on a page for ELHT completed and shared with the Commissioners. CEO of ELHT and Accountable Officer of East Lancashire CCG jointly chairing the Pennine Lancashire ICP Programme. Cultural development programme for system level leadership established with involvement of all senior leaders across the ICP. • ICS architecture on clinical services is developing (e.g. pathology, stroke and frailty). Positive feedback from service reviews (stroke and endoscopy). Structures in place for the Out of Hospital stream with the Trust significantly contributing to the workstream. Across the ICS footprint the Medical Directors of the four Trusts agreed to focus on urology, vascular services, stroke, emergency department, interventional radiology and gastrointestinal bleed, and neonatology. Meetings are ongoing regarding the acute Programme and more focused work is taking place in Stroke, Vascular, Head and Neck and Diagnostics. At ICS level all providers met to formulate work programme - 3 categories of services agreed: – services that are fragile now – services where there is no immediate risk but possible in the not too distant future – services that need to be managed across the whole footprint. Agreement on the way of taking this forward to be agreed. Prioritisation of diagnostics, pathology and cancer work streams agreed. • Haematology services at ELHT are under significant pressure as a consequence of partnership working with UHMB and BTH is resulting in advice and guidance service and clinicians from BTH are providing mutual aid. • Developed work programme discussed by the Provider Collaboration Board at ICS level. and work on developing future configuration continues, no timelines for completion set at this stage. Revised set of governance arrangements in place. • Clinical leadership through the Professional Leadership Committee (PLC) at Pennine Lancashire ICP level giving consistent message about the importance of working as a

Appendix – Board Assurance Framework (Full)

BAF Risk 3

system. Strengthening the relationship with primary care networks' leadership.

- Vital Signs is a system wide transformation programme across the Pennine Lancashire ICP. Patient experience strategy envisages good patient and public involvement to support the collaborative transformation. Progress with work covered under BAF risk 1. A system financial and investment group for the ICP looking into the priorities and aligning them with the financial envelope for the local system.
- Underpinning governance of the ICS Provider Collaboration Board (PCB) recently reviewed with a view to expedite decision making for improved provider collaboration. Strategic Co-ordination Group established, comprising Executives from across the 5 NHS Trusts. Role of the group is to be the engine room of the PCB. The group is under the chairmanship of the PCB Director.
- Regular communication with NHS England, NHS subsidiaries, Commissioners and Senior/Exec Management between teams. (BAF 5)
- New Hospitals Programme (NHP)
- Elective Care Recovery Group (ECRG) leading on recovery and restoration planning.
- Financial Assurance Board (FAB)
- There are a number of service areas being assessed in terms of clinical priorities across the ICS area. This work is undertaken by the Medical Directors and Chief Operating Officers within the ICS area.

Gaps in controls and assurance:

- The capacity of the Trust Directors and others to continue to work at Trust level and also at ICP and ICS level to the degree that is required.
- There is a need for consistent leadership across the system. in order to ensure that we continue prioritising in line with system affordability.
- Building trust and confidence and agreeing collaborative approaches to service provision.
- Lack of clarity regarding the investment priorities across the ICP have the potential to destabilise acute services.
- Lack of unified approach in relation to procurement by Commissioners.
- Ensuring consistent capacity to work externally as well as internally by building system collaboration into the leadership roles and having good joined leadership programmes.

Mitigating actions:

Action	Target Date
Developing relationships with the ICP and ICS	Ongoing work
Refresh of the Trust's strategic framework, particularly the strategic goals of the Trust. This work is being done in conjunction with David Fillingham, Executive Sensei for the Vital Signs Programme in the context of the White paper and system working and the ICS system design framework.	End July 2021

Appendix – Board Assurance Framework (Full)

BAF Risk 3

• Adequate assurance mechanism that the service integration plans are on track together with the rigour of governance arrangements/lack of delegation from the sovereign bodies to the system. • It is unclear what the impact of the changes in senior leadership in partner organisations will be. • Understanding what is happening to providers with regard to financial milestones in the ICS. • Understanding the ramifications of system working on the Trust, particularly the role of NEDs. • Costs associated with the ICP/ICS 5-year plan may have an effect on Trust finances. • Agreed at ICP that the interim leadership arrangements will remain as they currently are, (no interim place-based leader). This is not a sustainable position for the medium term and is a holding position for the time being. • ICS level – design framework, alongside national guidance about the structuring of the ICS's and PCB guidance (technical) is expected to follow. The make-up of the PCB is likely to be similar to the LSC makeup. • Availability of the workforce will be a limiting factor in delivering objectives across the ICS.	

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Appendix – Board Assurance Framework (Full)

BAF Risk 4

Objective theme: Finance

Executive Director Lead: Director of Finance

Risk Description: The Trust fails to achieve a recurrent sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to achieve financial balance, at the end of H2.

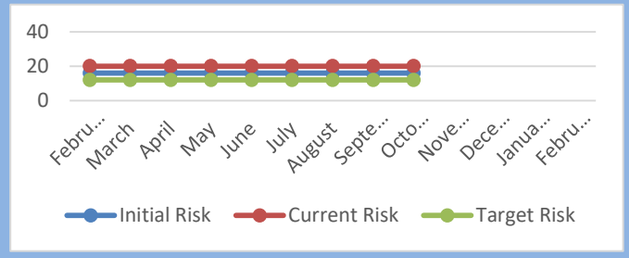
Date of last review: October 2021

Risk Rating (Consequence x likelihood):

Initial Risk Rating: 4 x 4 = 16

Current Risk Rating: 5 x 4 = 20

Target Risk Rating: 3 x 4 = 12



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: The Trust has a **Low** risk appetite to financial risk which could threaten the financial stability of the Trust.

The Trust has **NO** risk appetite for any risk which has the potential to compromise data security.

The Trust has **Low** risk appetite for any risk which has the potential to compromise our reduction of cost base and the Waste Reduction Programme.

Controls:

- Budgetary controls (income & expenditure) in place including virement authorisation, workforce control and variance analysis.
- Measures to mitigate financial risk overseen by the Finance Assurance Board reporting to the Finance and Performance Committee.
- Financial Assurance Board in operation, which reviews the financial position, making recommendations for improvement.
- Financial investment/recovery strategy is in development.
- Robust financial planning arrangements supported by financial reporting
- Standing Financial Instructions enforcement
- Waste Reduction Programme
- National block contract in place to continue for H1 and likely H2
- Robust costing systems to support block contract monitoring

Assurances:

Internal Assurances

- Regular reporting to Finance and Performance Committee and the Board to reflect financial position.
- Financial objective included in individual appraisals.
- Robust financial forecasting
- Use of data sources (e.g. model hospital and PLICS data) to drive improvement and mitigate deterioration. Evidencing the routine use of benchmarking data to drive positive change.
- Alignment and involvement in all ICS collaborative working opportunities including agency group, pathology etc.
- Full alignment to the ICS Finance Assurance Committee
- Counter fraud updates, including new Counter Fraud Champion (Deputy Director of Finance)

Appendix – Board Assurance Framework (Full)

BAF Risk 4

- Capital programme overseen by Capital Planning Board
- Director of Finance is the lead for the Elective Care Recovery fund.
- MIAA commissioned to carry out a review of acute provider accelerator cost to allow peer to peer review.

- Representation on ICS Financial Sustainability Group.

External Assurances

- External audit view on value for money.
- Model Hospital benchmarking (including cost per Weighted Activity Unit).
- ICS Led benchmarking
- Getting It Right First Time (GIRFT) Programme
- Shared Cost Improvement Programme (CIP) and Quality, Innovation, Productivity and Prevention (QIPP) group established with the CCGs.

Gaps in controls and assurance:

- Uncertainty of Financial envelope for H2 2021-22
- Deterioration in the underlying financial position outside of NHSE/I request requiring additional improvement schemes in 2021/22.
- Workforce policies and procedures may require amendments.
- Controls around improvement schemes and WRP to be monitored by the FAB.
- Lack of standardisation in applying rostering controls.
- Weaknesses in discretionary non-pay spend.
- Officers operating outside the scheme of delegation.
- Inadequate funding assumptions applied by external bodies (pay awards).
- Hidden costs of additional regulatory requirements - highlighted with NHSE/I.
- Cost shunting of public sector partners increasingly managed through ICS and ICP.
- Significant external pressures which may intensify internal financial pressure.
- Ensuring consistent capacity to work externally as well as internally by building system collaboration into the leadership roles and having good joined leadership programmes.
- Impact of COVID-19 wave three and restoration could impact the forecast position.

Mitigating actions:

Action	Target Date
Review funding with CCG on level 2 critical care and CNP	End of March 2022
Greener NHS Campaign Trust Strategy draft to Trust Board in November for sign off in January 2022	Q4 2021/22
ELHT DOF is the lead for ERF/accelerator Finances in the ICS	Q1/2 2021/22
Non-pay control review underway	Q2 2021/22
Pay control review underway	Q2 2021/22
Senior Finance Team restructure to support capacity requirements, currently being implemented - complete	Q2 2021/22

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Appendix – Board Assurance Framework (Full)

BAF Risk 5

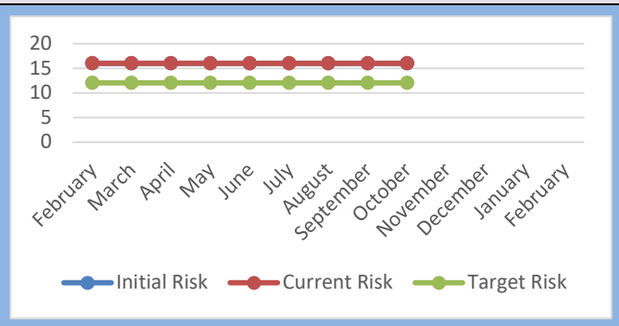
Objective theme: Quality, Delivery and Finance	**Executive Director Lead:** Chief Operating Officer, Director of Nursing and Medical Director
Risk Description: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil the regulatory requirements defined in the NHS Constitution and relevant legislation.	**Date of last review:** October 2021

Risk Rating (Consequence x likelihood):

Initial Risk Rating: 4 x 4 = 16

Current Risk Rating: 4 x 4 = 16

Target Risk Rating: 3 x 4 = 12



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: The Trust has **Low** risk appetite for risks which are non-clinical but affecting the day-to-day services the Trust provides.

The Trust has a **Low** risk appetite for risk, which may potentially slightly affect the delivery of services without compromising the quality of those services.

Controls:

- Weekly operational performance meeting covering RTT, holding lists and key operational indicators. Separate dedicated weekly cancer performance meetings. Weekly performance is reviewed at SLG and operational update provided to the Executive Team.
- Engagement meetings with CQC in place monitoring performance against the CQC standards. Work is being undertaken to prepare for the transitional monitoring approach (virtual visit) – 7 core services to be reviewed between July 2021 and Feb 2022. Three services have been reviewed by the CQC as part of the TMA work. No concerns have been raised about the services visited or the Trust in general. CQC have decided to step down the remaining TMA's and have reverted to quarterly engagement meetings.
- Quality and safety compliance assessed by each division and assurance through the Divisional Quality and Safety Boards (DQSB) reporting into the TWQG. Pre-Covid meeting structure to be re-introduced in April 2021. A revised version is being implemented. Eg patient safety, patient experience and clinical effectiveness committees have been realigned into two committees.
- Divisional Assurance Boards feeding into the operational sub-committees and the Quality Committee.

Assurances:

Internal Assurances

- IPR reporting to the SLG and at Board/Committee level, also presented to JNCC for information.
- Regular deep dive into the IPR through Quality and Finance and Performance Committees including RTT, all cancer standards and the emergency care standards.
- Performance monitoring provided through the weekly operational meeting, Scheduled Care Board (joint Board with CCG).
- Regular reporting from the divisions into the operational sub-committees and the Quality Committee. Alignment with national priorities through the quality and safety governance mechanisms.
- Silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments continues.
- Rolling programme of assessments under the framework planned for all inpatient wards and departments including Community Services.
- Independent Complaints Review Panel being established with Non-Executive Director

Appendix – Board Assurance Framework (Full)

BAF Risk 5

• Nursing Assessment Performance Framework reporting through to the Quality Committee and involvement of NEDs on the SPEC Panels. Board approval for the award of SPEC awards. • A&E Delivery Board (co-chaired by the Executive Director of Integrated Care, Partnerships and Resilience and the Medical Director for East Lancashire CCG) with Emergency Care Pathway assurance feeding into it. • Elective, Diagnostic and Cancer Board with elective pathway assurance feeding into it. • Elective Care Recovery Group set up across the ICS (Chief Operating Officer, Executive Medical Director and Director of Finance attend). • Daily nurse staffing review using safe care/allocate Nursing and Midwifery. • Medical Staffing Group held weekly to review rotas and address gaps. • Weekly Medical Staffing Review - Nursing and Midwifery staffing review feeding into the annual professional judgement review for all wards. Professional Judgement Review deferred until October 2021 due to COVID-19 response. • Daily operational flow meetings at 08.30, 12.30, 15.30 and 19.30. Site walkaround carried out by COO/Deputy COO at around 18.00 instead of the meeting. • Everyday matters meeting held daily to assist patient flow, discharge and long Length of Stay improvement. • Incident Management Team (for COVID-19) has been re-established currently on a weekly basis to manage the increasing numbers of patients. • Critical Care meetings with Executive Directors and the Management Team of the division and department to ensure management of COVID-19 and non-COVID patients. • Process implemented to ensure elective smoothing for patients requiring critical care post-op to ensure cancellations are reduced/removed. • Weekly ED / urgent care performance and improvement meeting. • Deputy Medical Director will work with Clinical Leads to create and monitor improvement plans for the RTT and holding list positions. • NHS 111 referral measures - including home testing and support to alleviate UCC/ED (Urgent Care and Emergency Department) pressures. • Cancer performance improvement group chaired by the ICS Cancer Alliance • Extended ED and plans for restoration. Performance and restoration update provided weekly	representation. • Quality walkrounds are to be reinstated in October due to COVID IPC measures we may have a mixture of virtual and in person quality walkrounds. • Quality Committee oversee the CQC action plan. • Reduction in use of nursing agency staff continues. The Trust is also part of the ICS-wide agency staffing collaborative. • Staffing escalation process for nursing including forecast gaps in staffing and senior decision making. Standard Operating Procedure (SOP) developed and monitoring through Nursing and Midwifery Leaders' Forum reported to Quality Committee. • Maternity Floor to Board report presented to the Quality Committee at each meeting. The Trust also has named Maternity Champions, one Executive Director and one Non-Executive Board member. • Infection Prevention and Control (IPC) feeds into the Quality Committee. • CEC is recommencing and feeds into TWGC. • Director of Nursing and the Executive Medical Director are working on enhanced SIRI processes. • Weekly monitoring of complaints at the Executive Team and reporting to the Patient Safety and Experience Committee and End of Life Care Group, focusing on reducing any 50+ day complaints (non-currently in the system). Complaint reviews are being undertaken with both Exec and NED leads following conclusion of a complaint. • NAPF - operational monitoring through the Nursing and Midwifery Leaders' Forum monthly, receiving assurance from the Assistant Director of Nursing and NAPF team and monitoring by matrons at ward level where they carry out mini-NAPFs on a weekly basis to keep up the improvement work and report to Quality Committee (every other meeting). • Trust response to Ockenden Review of Maternity Services covering the seven immediate and 12 urgent clinical priorities and monitored through the Trust's Quality Committee. • Assessment against GIRFT, NICE and national audits. • Single points of contact being set up across all divisions/directorates to ensure smoother communication and delivery (operational co-ordination centres). • Mortality Steering Group which meets on a monthly basis and reviews the HSMR, SHMI and related mortality indicators. <u>External Assurances</u>

Appendix – Board Assurance Framework (Full)

BAF Risk 5

to Executive team and SLG as well as monthly to Finance and Performance Committee and each Trust Board. • Insourcing supporting endoscopy, pain management and oral surgery. • Weekly Medical and Clinical Directors meetings. • Joint Leadership Clinical Forum. • ICS been selected as an accelerator system aiming to deliver 120% of the activity based on 2019/20 figures from July 2021. • Job Planning Scrutiny Panel for delivery of service, including policy review. • RSV (paediatric respiratory) Contingency plan in place overseen by RSV Cell which feeds into ICP and ICS groups. • Via the ICC there is work taking place on paediatric RSV because of the pandemic. This work includes primary care, secondary care and community and tertiary services. There are also additional paediatric ambulance transfers available as part of this work • Vascular Board has been stood up to establish the delivery of services across the ICS. • COVID-19 related harms are being reviewed across the ICS by Medical Directors and Chief Operating Officers.	• Trust rated 'Good' by CQC in 2018 with improvements in various areas and some outstanding services. • Nurse staffing review as part of the IPR. Staff Care Allocate and daily monitoring of allocation for staff and three times daily matrons' meetings to monitor. Audit carried out by MIAA for nurse staffing received significant assurance. • MIAA have carried out an emergency care risk assessment audit which gained an assurance rating of 'Significant Assurance'. • Cancer Alliance commissioned a review of internal processes for cancer performance management and patient tracking. Highly commended with strong processes in place. • Guardian of Safe Working Hours reporting to Quality Committee. • COO is the lead for restoration across the ICS region. <u>Internal / External Assurances</u> • System wide approach to Emergency Care Pathway, as part of monthly A&E Delivery Board. • PLACE assessments - percentage improved in all areas and monitoring continues. Annual PLACE report presented to the Quality Committee for assurance. Nursing and Midwifery Leaders' Forum also monitor. Patient Experience Committee receives minutes of the PLACE Steering Group. NAPF Team also monitors environmental issues linking to PLACE Assessments. No dates for when the PLACE assessments will recommence. • Positive responses to Friends and Family Test and patient surveys with improvement areas identified. Monitoring at ward level, local divisions prepare monthly patient experience action plans that feed into the Patient Experience Committee that reports to the Quality Committee. Monthly monitoring is provided by the Nursing and Midwifery Leaders' Forum. • Positive response and results from the 2020 National Staff Survey. • Incident reporting from the central governance team - updates and analysis sent through to the ICC (Incident Co-ordination centre) who collate and share this information on a weekly basis. • Nosocomial Infections Report highlighting patients who have died following COVID-19 and requiring a structured judgement review. • A report is being prepared for submission to the Board regarding lessons learned from the pandemic, particularly nosocomial infections, and duty of candour. All duty of candour requirements has been carried out with all the affected patients/families. The report will go to

Appendix – Board Assurance Framework (Full)

BAF Risk 5

the Quality Committee in October then to the Board in November 2021.

- Mental Health Urgent Assessment Unit opened.

Gaps in controls and assurance:

- Restrictions in the supply of medical, nursing, midwifery and other staff groups to meet demand. Reference in BAF risk 2.
- Risk of mental health providers not being able to ensure sufficient assessment and treatment capacity although work is taking place to address this.
- Restrictions in the primary care system to ensure sufficient capacity.
- Insufficient capacity to deliver comprehensive seven-day services across all areas.
- Insufficient capacity in the ED and Urgent Care workforce to manage the demands and surges in attendance (unpredictable pressure on A&E with increased attendances on previous years).
- Pathology industrial action remains ongoing, therefore potential impact on service provision. Mitigation is in place to minimise impact. Exploring conciliation with ACAS to help bring resolution to the dispute.
- Insufficient bed capacity to ensure there are no delays from decision to point of admission.
- Histopathology pressures affecting cancer performance. Outsourcing in place but external firms are unable to deliver within the required timeframes. This is being addressed through the pathology collaborative
- Lack of unified approach in relation to procurement by Commissioners.
- Priorities of CCGs starting to be aligned with priorities for pathway redesign (e.g. stroke) but this work is still in the early phases.
- Future role of NHSE/NHSI merged teams to be determined.
- Ensuring consistent capacity to work externally as well as internally by building system collaboration into the leadership roles and having good joined leadership programmes.
- Adequate assurance mechanism that the service integration plans are on track together with the rigour of governance arrangements/lack of delegation from the sovereign bodies to the system.
- Understanding what is happening to providers with regard to financial milestones in the ICS.

Mitigating actions:

Action	Target Date
Systems are in place to monitor audits to provide ongoing assurance in relation to the CQC action plan. The Action Plan is monitored by the CQC and through the Quality Committee.	Ongoing
Elective Recovery Cell Group work in progress to ensure equity of access across the ICS and address long waiters	Ongoing
Utilisation of independent sector for planned surgical capacity	In place and ongoing
Mini mock-CQC visits regularly carried out and focussing on all areas with regular reporting back to the Quality Committee. The next round will be scheduled to take place in Q2 of 2021/22	Q2 2021/22
PLACE assessments oversight of the reports will be provided by the Quality Committee and summary updates as part of the committee updates to the committee to the Board. Training for key members of the inspection teams was completed by the Trust's Estates and Facilities team prior. Results will be included in the PLACE Annual Report to the Quality Committee.	TBC – Deferred as a result of COVID-19

Appendix – Board Assurance Framework (Full)

BAF Risk 5

• Costs associated with the ICP and ICS 5-year plan may have an effect on Trust finances. • Capacity to manage COVID patients. • Capacity in critical care beds/staffing. • Staff exhaustion, resilience, sickness and availability as a result of the ongoing pandemic response. • New guidance on self-isolation for NHS staff is affecting the availability of staff and is open to interpretation • Similar to the above point, there is an unavailability of staff within care home which has a negative effect on the discharge of patients, therefore affecting patient flow in the Trust. • Secured an extension to the additional CT Scanner mobilised via the ICS Diagnostics Programme for a further 6 months until 31st March 2022 to support diagnostic and elective recovery. This operates 7 days a week for patients under the care of ELHT (4 days a week) and LTH (3 days a week). • Mobilisation of Community Diagnostic Centres (CDC) led by the ICS Diagnostic Programme have commenced across Lancashire and South Cumbria including one in Pennine Lancashire based at Rossendale Primary Health Centre. This will enable expanded diagnostic provision to be provided closer to home rather than hospital settings where clinically appropriate, to be undertaken sooner, tackle health inequalities and improve health outcomes and support reducing diagnostic and elective backlog in line with national planning guidance, ICS and ICP priorities. • Provider Collaboration Board has approved the establishment of the Diagnostic Imaging Network for Lancashire and South Cumbria using collaborative model and will be hosted by ELHT.	

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 135

10 November 2021

Purpose Information
Decision

Title	Serious Incident Assurance Report
Author	Mr L Wilkinson, Incident and Policy Manager
Executive sponsor	Mr J Husain, Executive Medical Director

Summary: The Trust Board is asked to receive the paper as a summary update on the serious incidents reported to CCG and as assurance that any themes identified have been appropriately escalated and responded to within the Trust.

The Board is asked to receive the included update on the implementation of PSIRF and to receive a full report on PSIRF at the next meeting following full adoption.

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

1. Serious Incidents Reported from 1st September to 31st October 2021

1.1 From 1st September 2021 to 31st October 2021 the Trust reported 25 Serious Incidents to our commissioners. The top 2 categories:

- 17 Pressures Ulcers (PUs) (increase of 12 on the previous two months)
- 4 Slips/Trips/Falls

1.2 Reports for all 4 never events have been shared with the CCG for the review and whether they agree to the de-escalation of the never event status. At the time of writing no feedback has yet been received from the CCG, however it is understood that the CCG also need to discuss the reports with NHS England and Improvement.

1.3 There have been no breaches of duty of candour reported in September and October 2021.

2. CCG Assurance Dashboard (Appendix A)

2.1 The East Lancashire Clinical Commissioning Group (CCG) provides a serious incident dashboard each month to the Trust (see appendix A). At the time of the Dashboard being produced the Trust had 124 Serious Incidents open for investigation and learning with the local CCG.

- 57 are under investigation
- 31 investigations have been completed and awaiting closure or de-escalation by the CCG
- 32 investigation reports have had further information requested from divisions before closure can be agreed
- 4 are HSIB investigations

2.2 The CCG dashboard highlights that 21 reported StEIS incidents have been de-escalated on completion of the investigations to date for 2021.

2.3 The three top externally reported incident categories:

- Pressure Ulcers
- Slips/trips/falls
- Maternity (baby only)
-

3 SIRI Panel Overview (September and October)

3.1 SIRI Panel(s) including PU SIRI Panel a total of 29 investigation reports were discussed:

- 16 reports were approved with learning
- 8 reports approved and de-escalation requested
- 5 not approved as further work required

3.2 A summary of themes is conducted at each Serious Incidents Requiring Investigation Panel (SIRI), at the September and October meetings the following themes were identified:

- Escalation routes for deteriorating patients in community hospitals
- Assessment and self-management of risk in pregnancy
- Decision making for escalation of end-of-life patients
- Management of vulnerable patients e.g., hard of hearing
- Capacity assessments for people with variable capacity
- SSKIN bundle compliance and use of Waterlow scores, related to staff turnover, bank/agency staff.
- The prolonged pressure within the organisation and the ability to maintain safety in busy clinical areas.
- Intentional rounding
- TVN referrals
- Accuracy of documentation

4 Patient Safety Incident Response Framework (PSIRF)– Early Adoption Update

4.1. Progress towards preparing the Trust to adopt the PSIRF approach has continued.

- Three senior patient safety incident investigators have been appointed and are due to start in post December and January. The fourth post has been out for advert again and shortlisting is taking place.
- The Trusts Patient Safety Incident Response Plan (PSIRP) has been drafted with the five local priorities identified:
    i. Nutrition and Hydration in vulnerable adults (NMB)
    ii. Slips, Trips and Falls leading to fracture neck femur

iii. Communication – DNACPR with patient and family
iv. Internal transfer and handover of patients from ED
v. 104 Day Cancer – delay has caused moderate or above harm

- PSIRP and local priorities have been approved by:
  i. ELHT Quality Committee
  ii. CCG Quality Committee
- PSIRP has been sent to and waiting for approval by:
  i. ELHT Trust Board (10th November)
  ii. NHS England / Improvement

4.2. The Trust is on track for full adoption of PSIRF by end of November 2021.

Lewis Wilkinson – Incident and Policy Manager
2nd November 2021

Appendix A: Serious Incident Dashboard produced by East Lancashire CCG on 20th Ocotber 2021

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Provider: ELHT | 20/10/2021

Dashboard developed and produced by Lewis Wilkinson, Quality & Performance Support Officer,MLCSU (Embedded)

Total number of incidents			
665			
2021/22	2020/21	2019/20	
74	108	68	
2018/19	2017/18	2016/17	2015/16
54	64	66	76

Total number of incidents closed			
541			
2021/22	2020/21	2019/20	
5	53	68	
2018/19	2017/18	2016/17	2015/16
54	64	66	76

Total number of incidents open			
124			
2021/22	2020/21	2019/20	
69	55	0	
2018/19	2017/18	2016/17	2015/16
0	0	0	0

ELHT extension requests: September 2021	
0	
Difference from rolling 12 month mean	Rank
-8.6	10

Month	Count	Difference from rolling 12 month mean	Rank
Aug-21	1	-7.6	3
Jul-21	1	-7.6	3
Jun-21	1	-7.6	3
May-21	1	-7.6	3
Apr-21	0	-8.6	10
Mar-21	1	-7.6	3
Feb-21	1	-7.6	3
Jan-21	59	50.4	1
Dec-20	1	-7.6	3
Nov-20	0	-8.6	10
Oct-20	37	28.4	2

Overdue from initial date	
0-10	2
11-20	3
21-30	5
31-40	4
41-50	3
51-60	2
61-70	3
71-80	1
81-90	0
91-100	1
>100	32

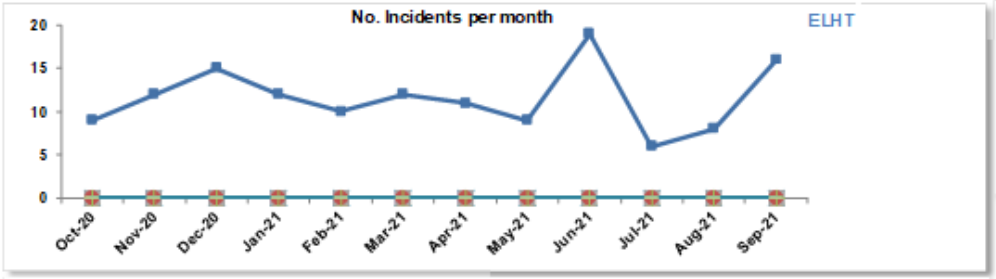
Top 5 Incident Types (12 month rolling) 20 October 2020 - 20 October 2021	
Pressure ulcer (grade unknown)	58
Slips/Trips/Falls	15
Maternity/Obstetric incident meeting SI criteria: baby only (this includes foetus, neonate and infant)	14
Diagnostic incident including delay (including failure to act on test results)	11
Surgical/invasive procedure incident	9

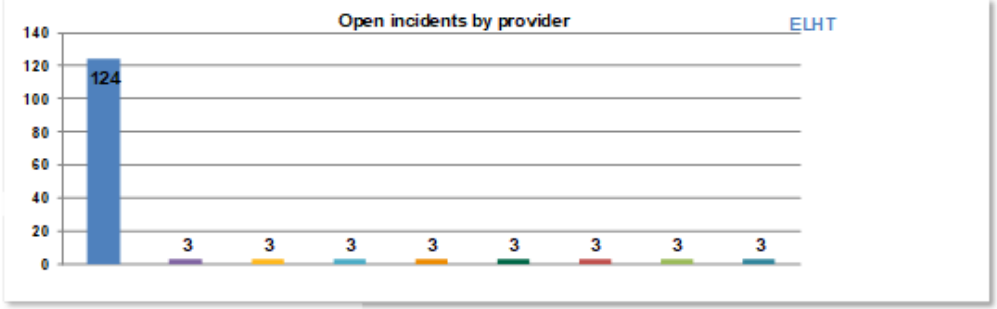
Reported in 2 working days of SI identified: 2020/21			
Yes	154	No	22

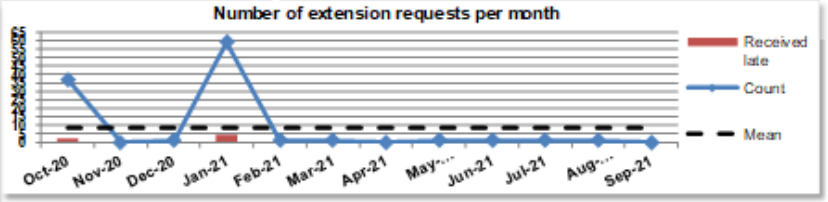
Status of all open StEIS incidents	
Awaiting additional information	32
Awaiting closure	31
Under HSIB investigation	4
Awaiting RCA	57
LAT Managed	0
Total	124

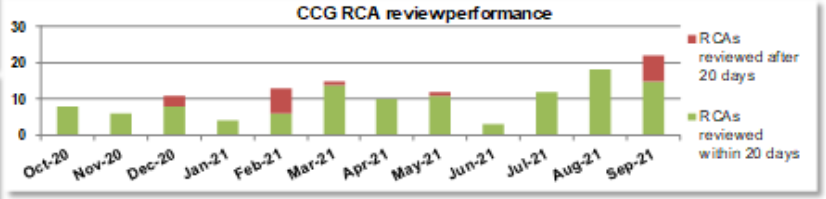
RCAs due (all years)	
More than 14 days till due	29
Due within 14 days	3
Stop the clock in place	0
Overdue	31
Total	63

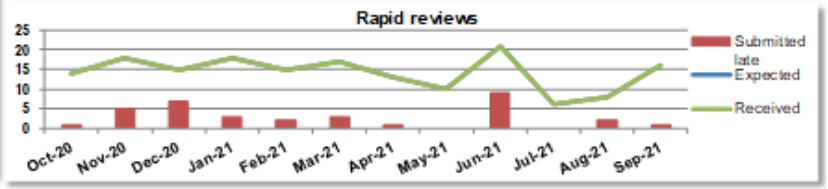
Never Events				
2020/21	2019/20	2018/19	2017/18	2016/17
3	5	1	7	1











East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 136

10 November 2021

Purpose Information
Action
Monitoring

Title	Integrated Performance Report
Author	Mr M Johnson, Associate Director of Performance and Informatics
Executive sponsor	Mrs S Gilligan, Chief Operating Officer

Summary: This paper presents the corporate performance data at September 2021

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

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 Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. 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	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

Board of Directors, Update

Corporate Report

Executive Overview Summary

Positive News

- There were no confirmed post 2 day MRSA bacteraemia in month.
- There were no medication errors causing serious harm.
- There were no never events reported in month.
- There were no maternal deaths in month.
- Average fill rates for registered nurses/ midwives and care staff remain above threshold, although continue to be extremely challenging.
- The complaints rate remains below threshold.
- The Trust vacancy rate is below threshold at 3.0%
- The Trust is reporting an adjusted deficit of £0.7 million in month 6, but a breakeven position for the year to date, in line with the H1 plan.

Areas of Challenge

- There were 2 healthcare associated clostridium difficile infections detected in month ('Hospital onset healthcare associated (HOHA)'
- There were 16 steis reportable incidents in month.
- The Hospital Standardised Mortality Ratio (HSMR) is 'within expected levels'.
- Friends & family scores have deteriorated in all areas. A&E is below threshold.
- The 'Emergency Care 4 hour standard' (Pennine A&E Delivery Board) was not achieved in September at 73.1%
- There were 23 breaches of the 12 hour trolley wait standard (13 mental health and 10 physical health)
- There were 433 ambulance handovers > 30 minutes and 15 > 60 minutes. Following validation, 3 of the 21 were ELHT breaches. The trend is showing significant improvement.
- The cancer 62 day standard was not met in August at 74.8%.
- There were 11 breaches of the 104 day cancer wait standard.
- The 6wk diagnostic target was not met at 18.84% in September.
- The Referral to Treatment (RTT) number of total ongoing pathways has increased on last month to 36,240, however the number over 40 weeks has reduced to 1156.
- There were 679 breaches of the RTT >52 weeks standard due to COVID-19, which is below the monthly trajectory.
- There was 1 breach of the 28 day standard for operations cancelled on the day.

- Sickness rates are above threshold at 6.1% (August)
- Trust turnover rate is showing a significant increase, but remains below threshold.
- Compliance against the Appraisal (AFC staff) remains below threshold. Appraisals were on hold until March 21.
- Compliance against the Information Governance Toolkit remains below the 95% target at 92%
- Temporary costs as % of total pay bill remains above threshold at 12%.
- All areas of core skills training are above threshold, with the exception of information governance and basic life support.

No Change

- The Summary Hospital-level Mortality Indicator (SHMI) has remained as expected at 1.09.
- Venous Thromboembolism (VTE) risk assessment performance remains above threshold.
- The emergency readmission rate is showing no change
- Length of stay is within normal levels.
- There were 82 operations cancelled on the day (non-clinical). This has returned to pre-covid levels.
- CQUIN schemes are on hold until March 22.

Introduction

This report presents an update on the performance for September 2021 and follows the NHS Oversight Framework. The narrative provides details on specific indicators under the five areas; Safe, Caring, Effective, Responsive, Well Led

Key to Scorecard Symbols

Variation

	No significant variation or change in the performance data (Common cause variation)
	Significant improvement in the performance data that is not due to normal variation (Special case variation)
	Significant deterioration in the performance data that is not due to nornal variation (Special case variation)

Assurance

	The indicator may or may not meet the target - the variation in data sometimes meets the target and sometimes not
	The indicator will consistently meet the target. The variation in the data always falls within the target
	The indicator will consistently fail the target. The variation in the data always falls outside the target

Safe					
	Indicator	Target	Actual	Variation	Assurance
M64	Clostriduim difficile (C.diff) - 'Hospital onset healthcare associated (HOHA)'	n/a	2		No target set to provide assurance against
M64.3	Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)'	n/a	0		
M64.4	Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA)	67	30		
M65	MRSA	0	0		
M124	E-Coli (post 2 days)	n/a	9		
M155	P. aeruginosa bacteraemia (total post 2 days)	n/a	0		
M157	Klebsiella species bacteraemia (total post 2 days)	n/a	2		
M66	Never Event Incidence	0	0		
M67	Medication errors causing serious harm (Steis reported date)	0	0		
M68	Maternal deaths	0	0		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)	No Threshold Set	7.5		
M69	Serious Incidents (Steis)	No Threshold Set	16		
M70	Central Alerting System (CAS) Alerts - non compliance	0	0		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	98%		

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	37%		
C40	Maternity Friends and Family - % who would recommend	90%	91%		
C42	A&E Friends and Family - % who would recommend	90%	66%		
C32	NHS England A&E response rate from Friends and Family Test	No Threshold Set	8%		
C44	Community Friends and Family - % who would recommend	90%	91%		
C38.5	Outpatient Friends and Family - % who would recommend	90%	93%		
C15	Complaints – rate per 1000 contacts	0.40	0.20		
M52	Mixed Sex Breaches	0			

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Within Expected Levels	1.09		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at Jun-21)	Within Expected Levels	100.4		
M74	Hospital Standardised Mortality Ratio - Weekday (as at Jun-21)	Within Expected Levels	99.4		
M75	Hospital Standardised Mortality Ratio - Weekend (as at Jun-21)	Within Expected Levels	103.1		
M73	Deaths in Low Risk Conditions (as at Jun-21)	Within Expected Levels	n/a		
M159	Stillbirths	<5	2		
M160	Stillbirths - Improvements in care that impacted on the outcome	No Threshold Set	n/a		
M89	CQUIN schemes at risk	CQUIN Suspended for 2021/22			

Responsive

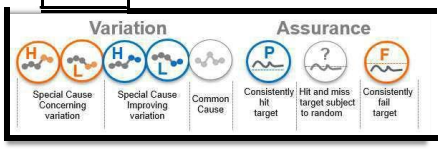
	Indicator	Target	Actual	Variation	Assurance
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95.0%	71.5%		
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95.0%	73.1%		
M62	12 hour trolley waits in A&E	0	23		
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	433		
M84	Handovers > 60 mins (Arrival to handover)	0	15		
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	54.1%		
C3	Referral to Treatment (RTT) non- admitted pathways: percentage within 18 weeks	No Threshold Set	83.9%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	No Threshold Set	36,240		
C4.2	Referral to Treatment (RTT) waiting times Incomplete pathways -over 40 wks	No Threshold Set	1156		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	861	679		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1.0%	18.8%		
C18	Cancer - Treatment within 62 days of referral from GP	85.0%	74.8%		
C19	Cancer - Treatment within 62 days of referral from screening	90.0%	66.7%		
C20	Cancer - Treatment within 31 days of decision to treat	96.0%	94.2%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98.0%	100.0%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94.0%	87.9%		
C36	Cancer 62 Day Consultant Upgrade	85.0%	89.0%		
C25.1	Cancer - Patients treated > day 104	0	11		
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	1		
M138	No.Cancelled operations on day	No Threshold Set	82		
M55	Proportion of delayed discharges attributable to the NHS	New reporting in development			
C16	Emergency re-admissions within 30 days	No Threshold Set	12.9%		
M90	Average length of stay elective (excl daycase)	No Threshold Set	3.4		
M91	Average length of stay non-elective	No Threshold Set	5.1		

Well Led

	Indicator	Target	Actual	Variation	Assurance
M77	Trust turnover rate	12.0%	8.8%		P
M78	Trust level total sickness rate	4.5%	6.1%		?
M79	Total Trust vacancy rate	5.0%	3.0%		F
M80.3	Appraisal (Agenda for Change Staff)	90.0%	57.0%		F
M80.35	Appraisal (Consultant)	90.0%	97.0%		?
M80.4	Appraisal (Other Medical)	90.0%	97.0%		?
M80.2	Safeguarding Children	90.0%	94.0%		P
M80.21	Information Governance Toolkit Compliance	95.0%	92.0%		?
F8	Temporary costs as % of total paybill	4%	12.0%		F
F9	Overtime as % of total paybill	0%	0%		
F1	Variance to H1 financial performance surplus / (deficit) (£m)	£0.0	£0.0		
F2	Variance to H1 Waste Reduction Programme (WRP) achieved (£m)	£0.0	£0.00		
F3	Liquidity days	>(7)	(8.8)		
F4	Capital spend v plan	85.0%	100.0%		
F18a	Capital service capacity	>1.25	1.8		
F19a	H1 Income & Expenditure margin	>(2.5%)	0.0%		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	97.4%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	96.6%		
F14	Better Payment Practice Code (BPPC) NHS No of Invoices	95.0%	96.1%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	97.3%		

NB: Finance Metrics are reported year to date.

KEY



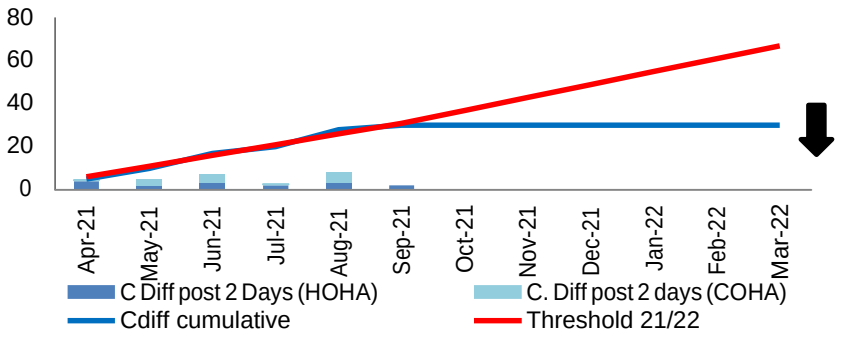
SPC Control Limits

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

PRIVATE BOARD ONLY					
	Indicator	Target	Actual	Variation	Assurance
C46	Cancer - 28 Day faster diagnosis standard	75.0%	75.1%		
C24	Cancer - seen within 14 days of urgent GP referral	93.0%	90.1%		
C25	Cancer - breast symptoms seen within 14 days of GP referral	93.0%	97.2%		
C4.3	Referral to Treatment (RTT) waiting times Incomplete pathways - Average Wait	8.7	11.9		
C4	Referral to Treatment (RTT) waiting times Incomplete pathways %	92.0%	78.1%		

SAFE

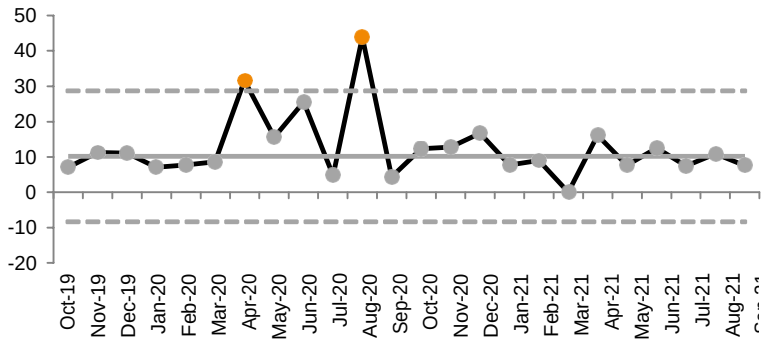
C Difficile



There were no post 2 day MRSA infection reported in September. So far this year there has been 1 case attributed to the Trust.

The objective for 2021/22 is to have no more than 67 cases of 'Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)' . The final figure for cases reported in 2020/21 was 69.

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

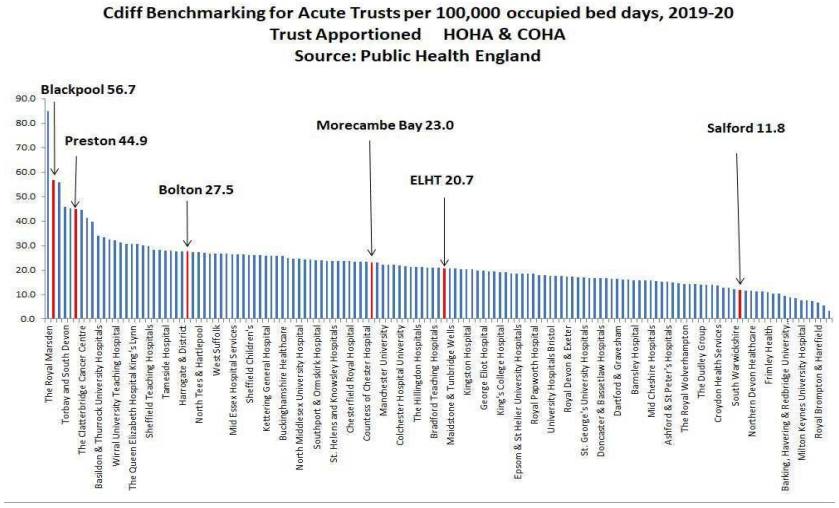


There were 2 healthcare associated Clostridium difficile toxin positive isolates identified in the laboratory in September, post 2 days of admission, both of which were 'Hospital onset healthcare associated (HOHA)'. There wre no 'Community onset healthcare associated (COHA)' cases.

The year to date cumulative figure is 30 (HOHA & COHA). The detailed infection control report will be reviewed through the Quality Committee.

The rate of HOHA infection per 100,000 bed days has remained at similar levels levels in September.

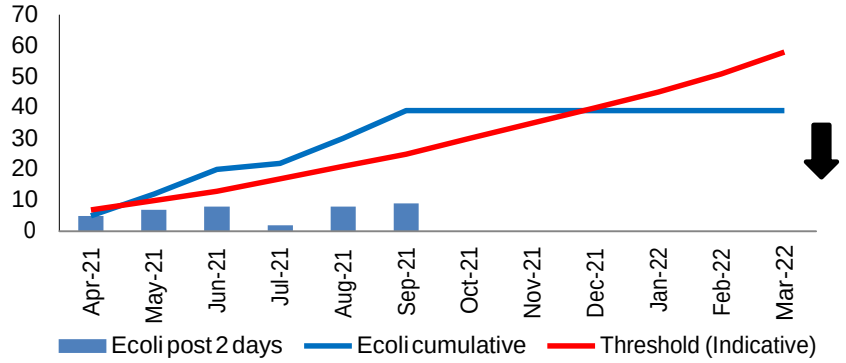
C Difficile benchmarking



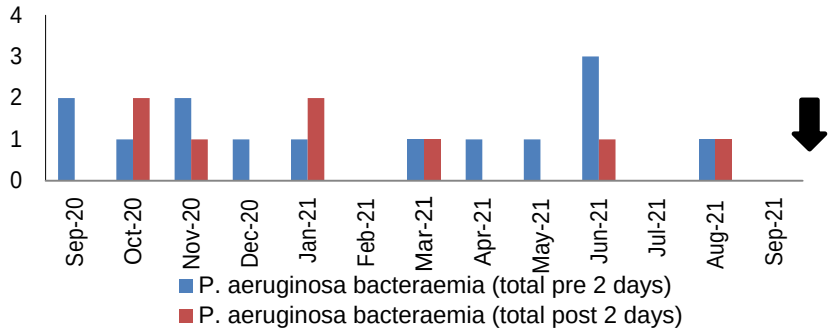
ELHT ranked 75th out of 146 trusts in 2019-20 with 20.7 HOHA & COHA clostridium infections per 100,000 bed days. The best performing trust had 0 and the worst performer had 85.0 infections per 100,000 bed days.

SAFE

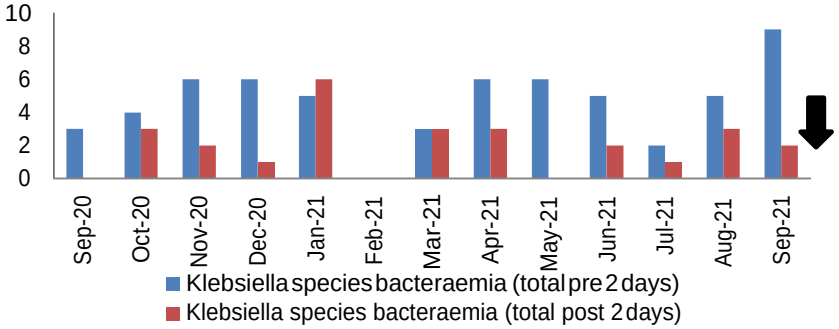
E. Coli (HOHA)



P.aeruginosa



Klebsiella



The Government initiative to reduce Gram-negative bloodstream infections by 50% by 2021 has been revised and now is to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

This year's trajectory for reduction of E.coli is 142 which includes both HOHA & COHA.

There were 9 post 2 day E.coli bacteraemia (HOHA) detected in September and 5 COHA cases.

From April 2017, NHS Trusts must report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa to Public Health England.

From 21/22 the a trajectory has been introduced for Klebsiella and Pseudomonas. The Trust should have no more than 35 cases this year for Klebsiella and 8 cases for Pseudomonas.

So far this year, there have been 24 Klebsiella cases and 3 Pseudomonas

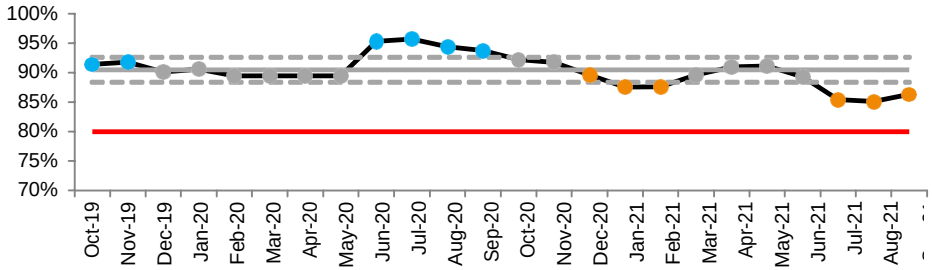
Surveillance will be undertaken in line with current requirements (e.g. E. coli bacteraemia). This surveillance will be carried out by the Infection Prevention and Control Team.

The work on catheter care, prevention of line infections, sepsis and improving hydration will help prevent healthcare associated bloodstream infections

SAFE

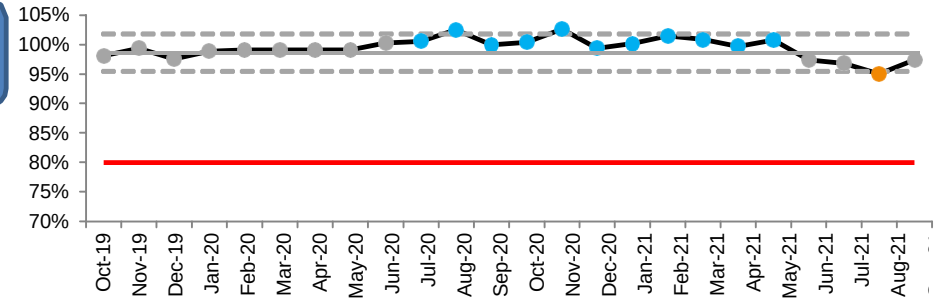
NB: Mar - May 20 figures were not collected due to COVID 19, so are estimated here for purposes of calculating the Statistical Process Control (SPC) limits

Registered Nurses/ Midwives - Day



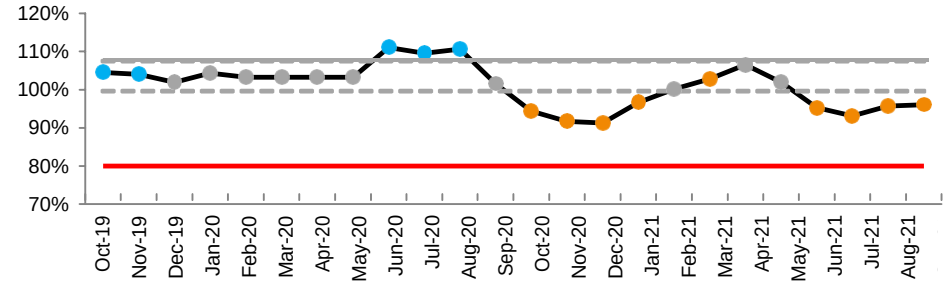
The average fill rate for registered nurses/ midwives during the day is showing a reduction in the last 3 months, however based on current variation will consistently be above threshold.

Registered Nurses/ Midwives - Night



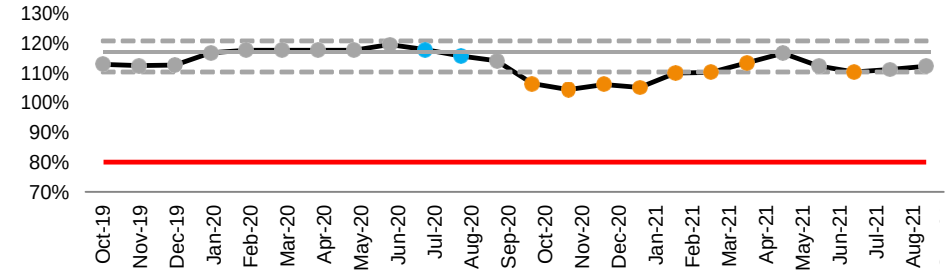
The average fill rate for registered nurses/ midwives at night is showing a return to normal levels in September, however based on current variation will consistently be above threshold.

Care Staff - Day



The average fill rate for care staff during the day is showing a significant reduction however based on current variation will consistently be above the threshold.

Care Staff - Night



The average fill rate for care staff at night is within normal range and based on current variation will consistently be above threshold.

SAFE

Staffing in September 2021 has continued to be extremely challenging. Restoration and recovery plans are well underway, however there has been a requirement to maintain one COVID ward. The already established vacancies, impact of acuity, shielding and staff sickness remains very challenging. Lots of cross cover between wards and the high use of bank and agency staffing continues.

6 wards fell below the 80% for Registered Nurses/ Midwives in September for the day shift. The filling of Health Care Support Worker shifts remains challenging

5 wards below 80% for Registered Nurses during day shifts:

Medicine & Emergency Care (MEC)

OPU – lack of shift coordinators. No patient harm in relation to staffing identified
C5 - lack of shift coordinators. No patient harm in relation to staffing identified
C7 - lack of shift coordinators. No patient harm in relation to staffing identified
C9 - lack of shift coordinators and reduced patient occupancy. No patient harm in relation to staffing identified

Community & Integrated Care (CIC)

Rakehead- This was due to a lack of shift co-ordinators. No patient harm in relation to staffing identified

Surgical & Anaesthetic Services (SAS)

None

It should be noted that actual and planned staffing does not denote acuity, dependency, the number of women in labour or bed occupancy. The divisions consistently risk assess and flex staffing resources to support staffing.

SAFE

Red Flags

Datix received by staff regarding staffing reviewed, not all constituted a red flag.

In line with the NICE Safe Staffing guidance there were 6 adult inpatient red flags for the month of September

Medicine & Emergency Care (MEC)

D3 – high acuity on the ward, delays in undertaking intentional rounding , no patient harms reported.
C2 – delays in administering medications due to staffing levels and acuity, no patient harms reported.
C2 - delays in administering medications due to staffing levels and acuity, no patient harms reported.
OPU - delays in undertaking patient vital signs as per policy, no harms reported

Community & Integrated Care (CIC)

No red flags

Surgical & Anaesthetic Services (SAS)

Ward 15 – less than 2 registered nurses on a night duty. This was a risk based decision made to support another area as only one patient on ward 15 that night. No patient harm. Acute care team made aware for support.
B22 – less than 2 registered nurses on a night duty for a time period of 2 hrs due to sickness. Delays in administering control drugs pain relief. No harm identified

Anecdotally staff resilience is low and some remain affected by the pandemic against a backdrop of high acuity, usage of a high proportion of agency staff, junior skill mix, shielding and the constant moving of staff to support other areas.

SAFE

Actions taken to mitigate risk

Safe staffing conference at 10:00 am followed up with meetings throughout the day where required to ensure safe staffing, with contingencies agreed for weekends and out of hours, utilising the acuity and dependency tool (Safe Care)

Extra health care assistant shifts are used to support registered nurse gaps if available

Relaunch of recruitment strategy, this will now be an internal QI project

Nurse recruitment lead working closely with divisions demonstrating recruitment data dashboard to enable and empower divisions to proactively manage recruitment

On and off framework agencies constantly engaged to with looking for block bookings

Professional judgement reviews taking place across all divisions

Financial incentive offered to staff to support staffing levels and identified gaps in rotas

Temporary Staffing Team have created a bank shift option for Nursing Associates and monitoring fill rates

Imminent Health Care Support Worker Recruitment drive to recruit 30 with no Health and Social Care experience

The COVID-19 situation continues to improve. The Philippines has now been removed from the red list with a reduced quarantine time. ELHT. 14

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-21	86.3%	96.0%	97.4%	112.0%	26,615	8.96	6	4	1	2

SAFE

Monthly Trend

	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 (%)
Jan-21	87.6%	96.6%	100.2%	105.0%	25,962	9.74	12	3	0	2
Feb-21	87.6%	100.1%	101.5%	109.8%	22,251	10.28	13	5	0	1
Mar-21	89.6%	102.9%	100.9%	110.0%	24,868	10.31	9	1	0	1
Apr-21	91.0%	106.5%	99.7%	113.3%	24,821	10.15	7	1	0	2
May-21	91.2%	101.9%	100.8%	116.4%	26,351	9.71	1	1	0	0
Jun-21	89.3%	95.2%	97.4%	112.2%	23,966	10.05	3	3	0	0
Jul-21	85.5%	93.1%	96.8%	110.1%	26,936	9.08	8	3	0	1
Aug-21	85.1%	95.7%	95.1%	111.0%	27,582	8.81	10	4	0	2
Sep-21	86.3%	96.0%	97.4%	112.0%	26,615	8.96	6	4	1	2

SAFE

Family Care

1 Family Care Ward , Blackburn Birth Centre fell below the 80% for Registered Midwives – this is reflective of closure and reduced activity to relocate midwives to support other areas

1 red flags on Central Birth Suite- Inability to provide 1:1 care during labour. 1:1 care was provided as soon as a midwife from antenatal was able to attend within the hour. No harm identified

Maternity (Midwife to Birth Ratio)

Month	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Staffed to full Establishment	01:26	01:25	01:26	01:27	01:26	01:27	01:27	01:28	01:27	01:26	01:26	01:28
Excluding mat leave	01:27	1:26.71	01:27	01:28	01:27	01:28	01:28	01:29	01:27	01:27	01:27	01:29
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	Bank Usage	Bank Usage
Per week	13.15wte	10.52wte	8.03wte	18.82wte	18.90wte	19.53wte	11.25wte	24.14wte	17.98wte	17.40wte	18.54wte	21.84wte

SAFE

Maternity- The September bank filled hours covering vacancies/ pregnancy shielding, short, long-term sickness is 21.84 wte.

In view of the increase with self-isolation/sickness/ substantive gaps the enhanced hourly rate of pay for bank or overtime has been extended to then end of October when 19.76 whole time equivalents are due to start in post.

The specialist midwife rota cover for clinical areas has continued in the month of September. This is to support with cover to any potential staffing gaps Monday to Friday, Primarily Antenatal clinic (ANC).

Intrapartum births at Blackburn centre remain redirected to Burnley General Birth Centre to support midwifery gaps at the Lancashire Women's Newborn Centre. Weekly staffing risk assessments remain in place to support decision to open or close the facility.

Daily safe midwifery staffing levels reviewed at each safety huddle on Central Birth Suite (CBS) . Midwives are redeployed to other areas to support acuity and activity as and when required. Staffing huddle frequency is increased during times of pressure. Daily and weekend staffing plans are summarised with a further review of skillset and experience for each midwife prior to redeployment. The CBS coordinator will receive the staffing plan at the onset of duty with a view to redirect if deemed appropriate at handover

Badgernet training was scheduled for the month of September for a large cohort of midwives alongside monthly MDT training scheduled to aid 90% in line with CNST. Training for badger on a number of occasions did require cancellation on the day to cover clinical shifts; these were rescheduled to October with no impact on go live date in November.

Neonatology – All Nursing duties covered to safe staffing levels in September. Some periods of closure to external admissions continued in view of Intensive Care acuity. Additional Bank and agency duties have been requested in general where required to achieve safe staffing levels and to cover 121 care with regard to IPC isolation as directed by IPC team in line with guidance.

Paediatrics - There is currently a programme of lifecycle works closing between 3-7 beds for upgrade of patient environment at any one time throughout September. With the current vacancies this has enabled safe staffing levels and the care hours per patient has not been compromised. The peaks and troughs in activity and acuity has also allowed for lower than required care hours therefore maintaining safety at all times. No nursing red flags reported within the month of September. 11 paediatric staff nurses have been recruited, 5 commence in October and 6 in November. In addition to this, workforce plans were presented to Chief Nurse Executive Director of Nursing and Director of Finance to review the pending Respiratory Syncytial Virus (RSV) surge. A further x3 nurses will be recruited to support this.

Gynaecology – Staff shielding, absences, specialist posts all covered with bank/additional clinics where required to maintain services and the service provision of hot clinics, this remains as safe with relevant contingency plans in place. No nursing red flags reported. (No changes from August to note)

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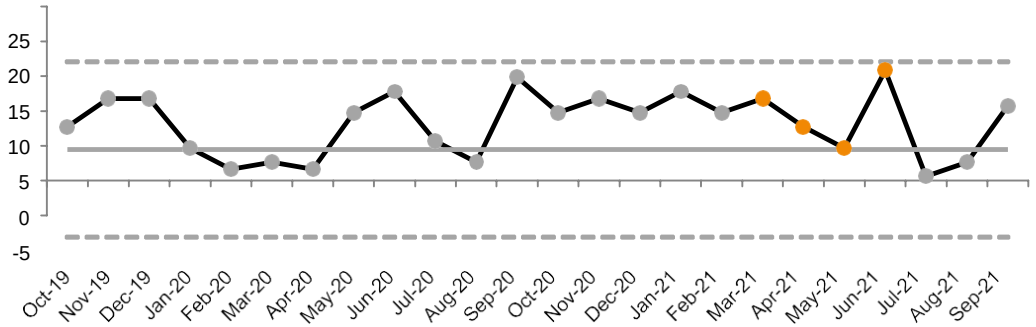
SAFE

Serious Incidents



There were no never events reported in September.

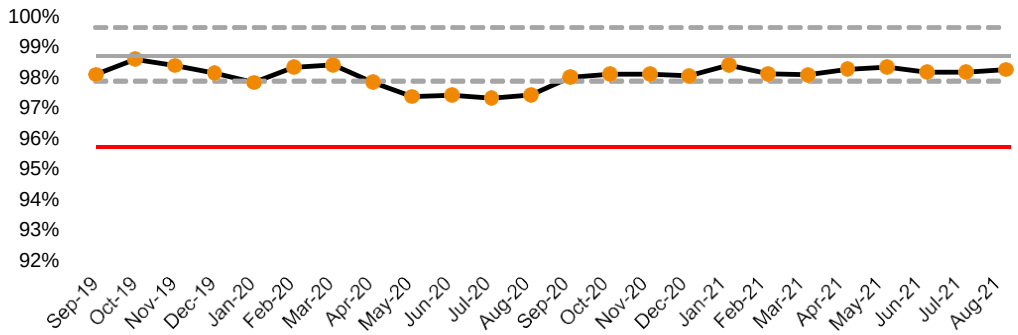
The Trust unverified position for incidents reported to the Strategic Executive Information System (StEIS) in September was 16 incidents.

The trend is showing a return to normal variation.

Strategic Executive Information System (StEIS) Category	No. Incidents
Pressure ulcer	10
Maternity/ Obstetrics	3
Slips, trips & falls	2
Diagnosis failure/ problem	1

A detailed report providing assurance on the management of each of the STEIS reported incidents is submitted monthly to the Patient Safety and Risk Assurance Committee.

VTE assessment



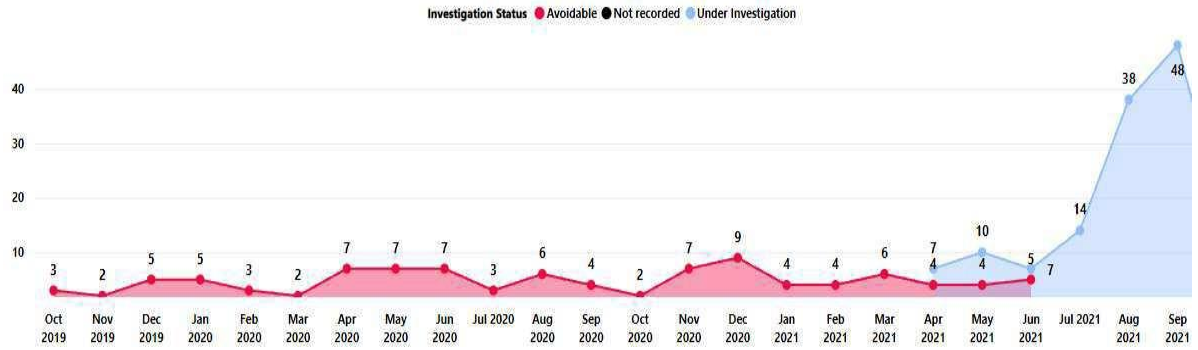
The Venous Thromboembolism (VTE) assessment trend continues to be below previous levels and is showing a significantly lower performance in September than previous months, however is still above the threshold.

SAFE

Pressure Ulcers

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

Developed/ Deteriorated (Avoidable, Under Investigation & Not Recorded) Pressure Ulcers by Reported Date and Investigation Status - Last 2 Years



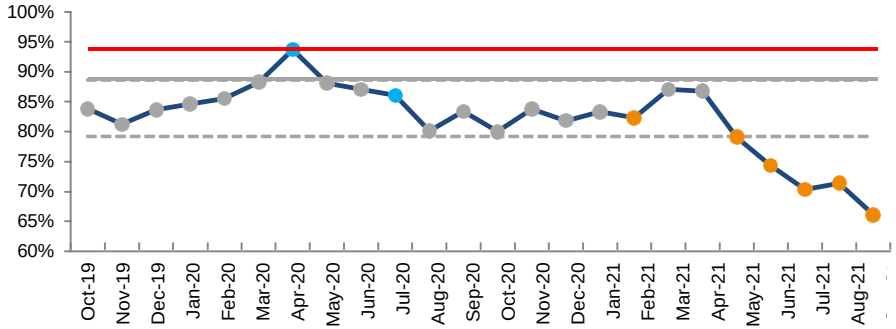
The pressure damage SIRI group supported by the pressure damage/ moisture lesion steering group continues to maintain a high level of focus on all incidents to ensure every learning opportunity is maximised.

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.

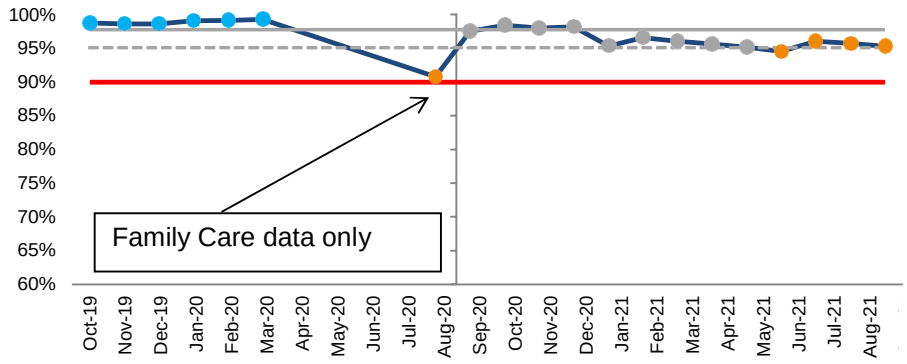
Inpatient data collection was suspended April 20 - Sep 20 due to COVID

Friends & Family A&E



A&E scores are showing a significant deterioration in the last 5 months. Based on current variation this indicator is not capable of hitting the target routinely.

Friends & Family Inpatient

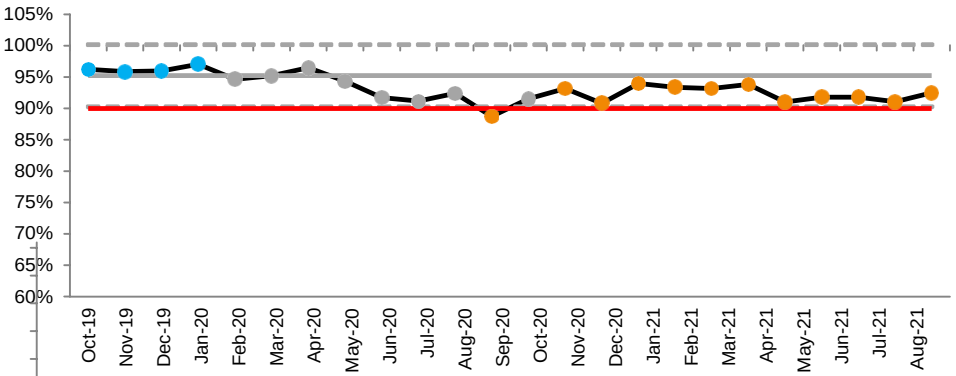


Inpatient data was suspended April - September 20 due to the COVID pandemic. Paper surverys were resumed in Family Care from 1st August 20 and across all areas from 1st September 20.

The trend is showing significant deterioration, however based on recent performance will consistently be above threshold.

CARING

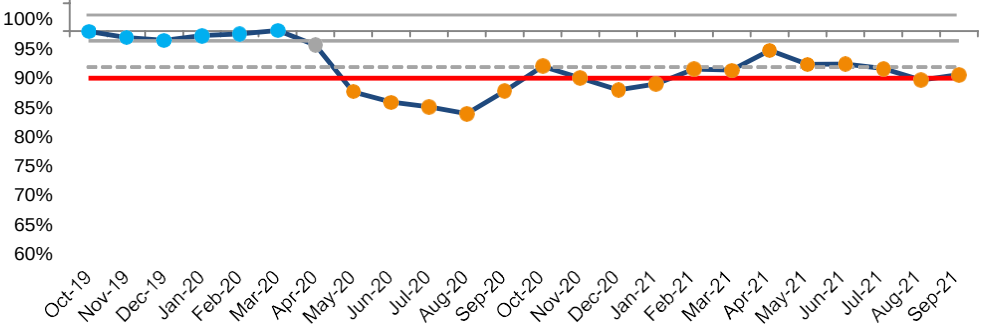
Friends & Family Outpatients



Outpatient scores continue to be below usual levels, however remain above target.

Based on current variation this indicator should consistently hit the target.

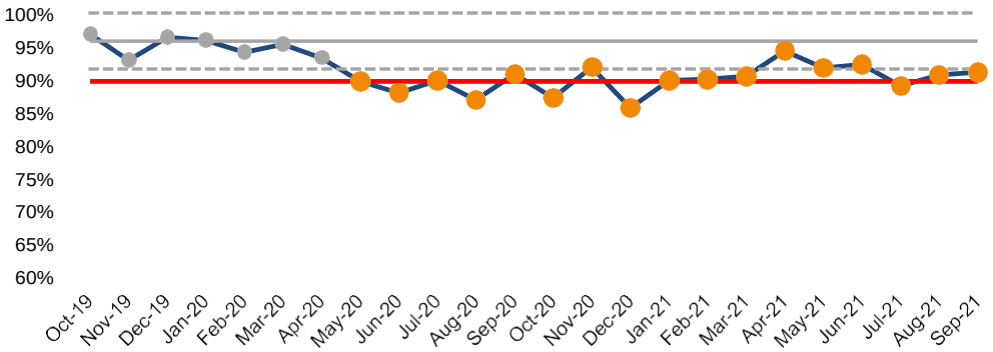
Friends & Family Community



Community scores are just above target this month and are showing continued deterioration, which is significantly lower than usual variation.

Based on normal variation this indicator should consistently hit the target.

Friends & Family Maternity

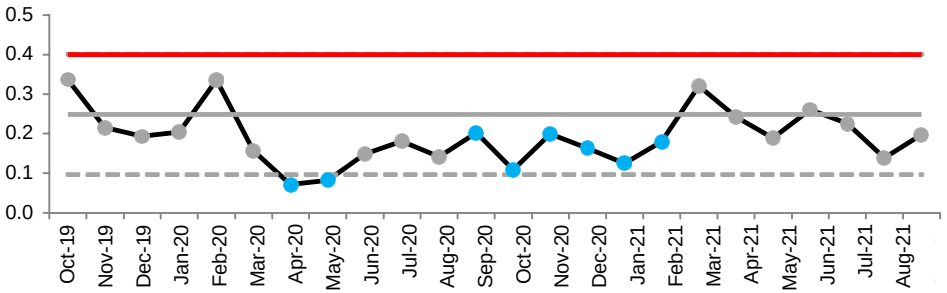


Maternity scores continue to show a reduction, which is significantly lower than usual variation, however are above threshold this month.

Based on normal variation this indicator would consistently hit the target.

CARING

Complaints per 1000 contacts



The Trust opened 25 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 0.20 Per 1,000 patient contacts.

The trend is showing normal variation and based on current variation will remain below the threshold.

Patient Experience

		Dignity	Information	Involvement	Quality	Overall
Type	Division	Average Score	Average Score	Average Score	Average Score	Average Score
Antenatal	Family Care	100.00	100.00	100.00	100.00	100.00
Community	Community and Intermediate Care Services	97.53	96.47	96.32	97.74	96.83
Community	Diagnostic and Clinical Support	100.00	81.25	100.00	-	94.34
Community	Surgery	100.00	80.00	-	-	85.71
Delivery	Family Care	100.00	-	100.00	100.00	100.00
ED_UC	Surgery	86.22	78.95	80.77	82.14	82.08
Inpatients	Community and Intermediate Care Services	100.00	100.00	93.75	100.00	98.21
Inpatients	Diagnostic and Clinical Support	100.00	85.57	88.15	95.31	91.42
Inpatients	Family Care	97.50	90.00	98.11	93.00	95.26
Inpatients	Medicine and Emergency Care	89.76	72.70	74.85	78.13	77.31
Inpatients	Surgery	95.18	85.63	89.57	86.30	89.38
OPD	Diagnostic and Clinical Support	100.00	100.00	96.43	91.67	94.83
OPD	Family Care	94.23	90.63	88.24	86.76	89.55
OPD	Medicine and Emergency Care	100.00	88.46	100.00	99.39	96.29
OPD	Surgery	100.00	90.91	100.00	-	95.24
Paediatric	Family Care	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	95.83	94.57	91.67	94.12	93.87
	Total	96.68	88.92	92.19	93.90	92.92

From 1st May 2020 the Trust moved to a new system, CIVICA to manage the Friends & Family Test (FFT) and patient experience surveys.

The new reports have now been configured and the table demonstrates divisional performance from the range of patient experience surveys in September 2021.

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 is above the threshold of 90% for 3 of the 4 competencies. Performance against the Information competency fell slightly below at 89%

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

EFFECTIVE

SHMI Published Trend

The latest Trust Summary Hospital -level Mortality Indicator (SHMI) value as reported by the Health and Social Care Information Centre and Care Quality Commission for the period May 20 to April 21 has remained within expected levels at 1.09, as published in September 21.

Dr Foster HSMR rolling 12 month

	HSMR Rebased on latest month July 20 – June 21
	ALL
TOTAL	100.4
Weekday	99.4
Weekend	103.2
Deaths in Low Risk Diagnosis Groups	Not Available

The latest indicative 12 month rolling Hospital Standardised Mortality Ratio (HSMR), (July 20 – June 21) has improved from last month and is 'within expected levels' at 100.4 against the monthly rebased risk model.

The benchmark model has been adjusted this month to account for data upto Mar 21, meaning risk scores are increasingly adjusted for changes seen during the pandemic. This has resulted in a general positive shift in HSMR scores nationally.

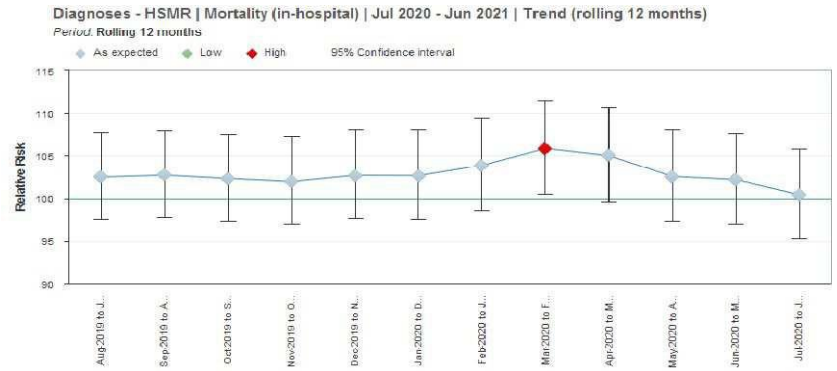
There is currently one HSMR diagnostic groups with a significantly high relative risk score: Pneumonia.

Cancer of bronchus, lung is also currently also alerting on the nationally monitored SHMI groups.

These are being investigated through the mortality steering group and each have a nominated clinical lead and associated action plan.

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.

Dr. Foster HSMR



Learning Disability Mortality Reviews (LeDeR)

No update provided in September

EFFECTIVE

Structured Judgement Review Summary

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 below 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.

	Month of Death											
Stage 1	pre Oct 17	Oct 17 - Mar 18	Apr 18 - Mar 19	Apr 19 - Mar 20	Apr 20 - Mar 21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	TOTAL
Deaths requiring SJR (Stage 1)	46	212	250	261	214	15	19	14	28	19	14	95
Allocated for review	46	212	250	260	212	12	15	9	15	7	4	58
SJR Complete	46	212	250	260	192	9	13	9	13	5	1	49
1 - Very Poor Care	1	1	0	0	0	0	0	0	0	0	0	0
2 - Poor Care	8	19	22	34	29	0	3	1	1	1	1	6
3 - Adequate Care	14	68	70	68	60	0	4	2	1	1	0	8
4 - Good Care	20	106	133	129	94	7	6	5	10	3	0	31
5 - Excellent Care	3	18	25	29	9	2	0	1	1	0	0	4
Stage 2												
Deaths requiring SJR (Stage 2)	9	20	22	34	29	0	3	1	1	1	1	6
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	1	4	1	0	0	0	0	0	0	0
Allocated for review	6	18	21	30	28	0	3	1	1	1	1	6
SJR-2 Complete	6	18	21	30	28	0	3	1	0	0	0	4
1 - Very Poor Care	1	1	1	2	0	0	0	0	0	0	0	0
2 - Poor Care	3	6	7	13	11	0	2	0	0	0	0	2
3 - Adequate Care	2	10	13	13	16	0	1	1	0	0	0	2
4 - Good Care	0	1	0	2	1	0	0	0	0	0	0	0
5 - Excellent Care	0	0	0	0	0	0	0	0	0	0	0	0

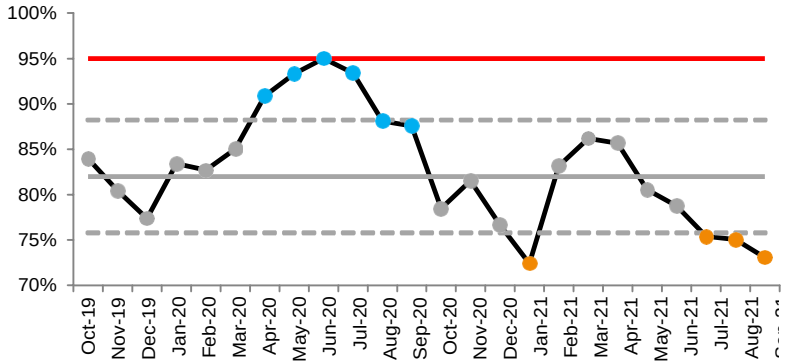
EFFECTIVE

Commissioning for Quality and Innovation (CQUIN)

As per the guidance on finance and contracting arrangements for H2 2021/22, the block payments approach for arrangements between NHS commissioners and NHS providers in England will now remain in place for remainder of the 2021/22 financial year. Block payments to NHS providers are deemed to include CQUIN, and there will be no 2021/22 CQUIN scheme (either Clinical Commissioning Group or specialised) published at this stage.

RESPONSIVE

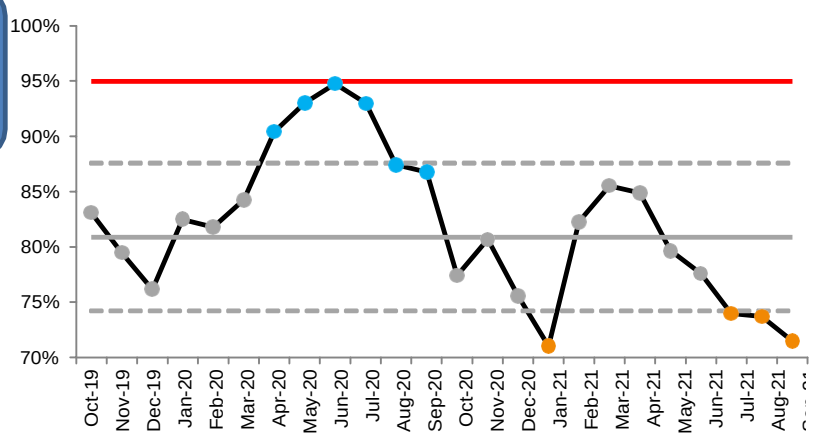
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 73.1% in September, which is below the 95% threshold and the Trust trajectory (87%)

The trend is showing deterioration this month and based on current variation is not capable of hitting the target routinely.

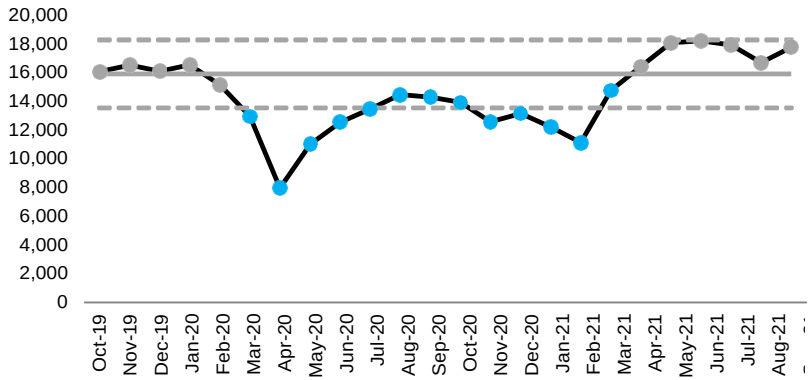
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 71.5% in September.

The national performance was 75.2% in September (All types) with none of the 112 reporting trusts with type 1 departments achieving the 95% standard.

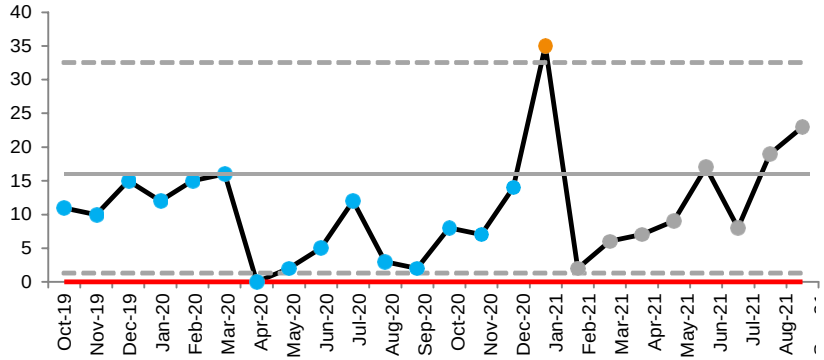
A&E Attendances - Trust



The number of attendances during September was 17,758, which is within the normal range, however continues to be above average.

RESPONSIVE

12 Hr Trolley Waits

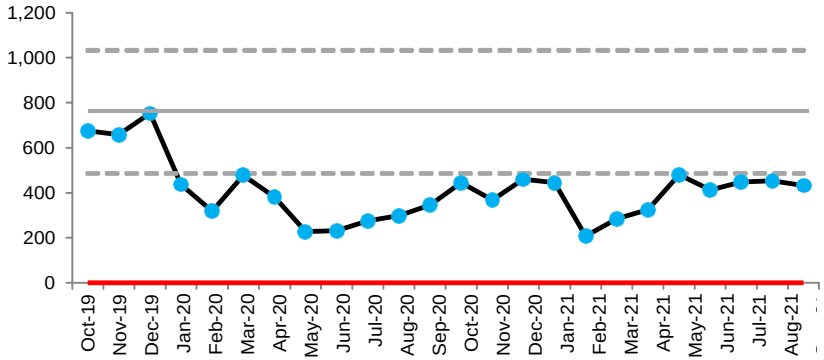


There were 23 reported breaches of the 12 hour trolley wait standard from decision to admit during September. 13 were mental health breaches and 10 were physical health.

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	13	10
Average Wait from Decision to Admit	24hr 23 min	15hr 18 min
Longest Wait from Decision to Admit	48hr 49 min	20hr 58 min

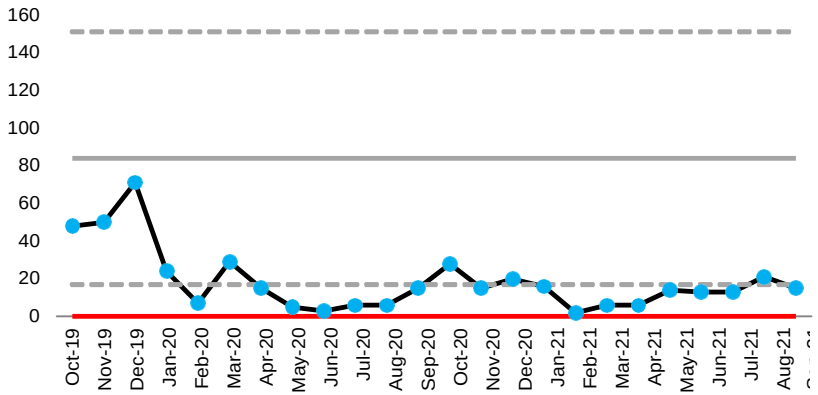
Ambulance Handovers - >30Minutes



Following a review of North West Ambulance Service data and reporting, the ambulance handover metrics have been amended and now show the arrival to handover time, having previously shown the notification to handover.

There were 433 ambulance handovers > 30 minutes in September. The trend is still showing significant improvement from previous levels.

Ambulance Handovers - >60 Minutes

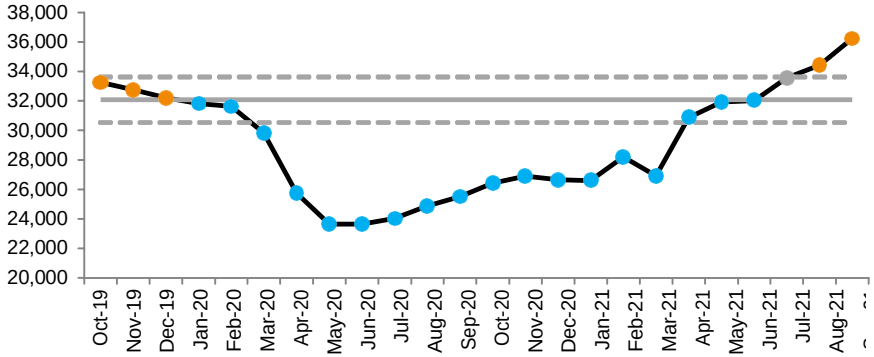


There were 15 ambulance handovers > 60 minutes in September, which continues to demonstrate a signifcant improvement. Following validation, 3 of the 15 were actual ELHT breaches and 12 were due to non-compliance with the handover screen.

The average handover time was 21 minutes in September and the longest handover was 1hr 13 minutes.

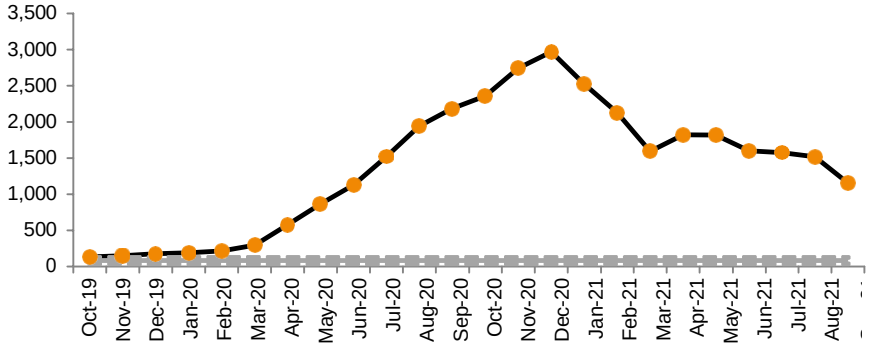
RESPONSIVE

Referral to Treatment (RTT) Total Ongoing



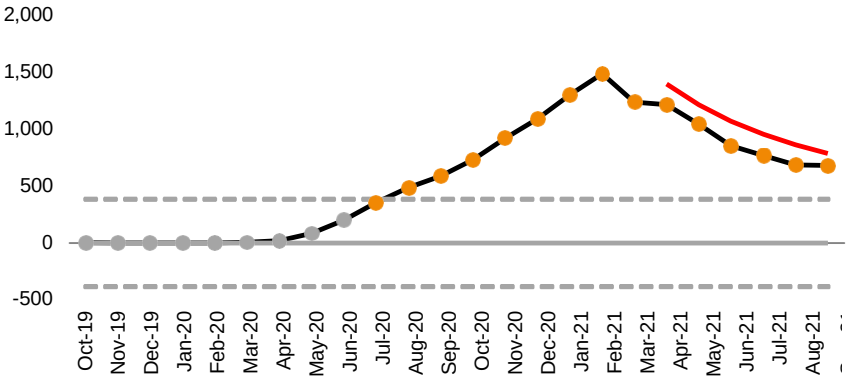
At the end of September, there were 36,240 ongoing pathways, which has increased on last month and is now above pre-COVID levels.

RTT Total Over 40 wks



The number of pathways over 40wks decreased in September with 1156 patients waiting over 40 wks at month end.

RTT Total Over 52 wks

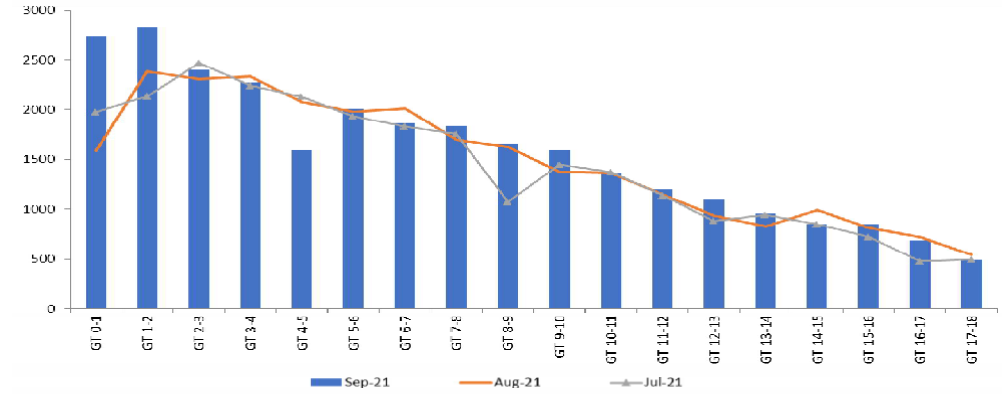


There were 679 patients waiting over 52 weeks at the end of September, due to the COVID-19 pandemic, which was below the month end trajectory (786).

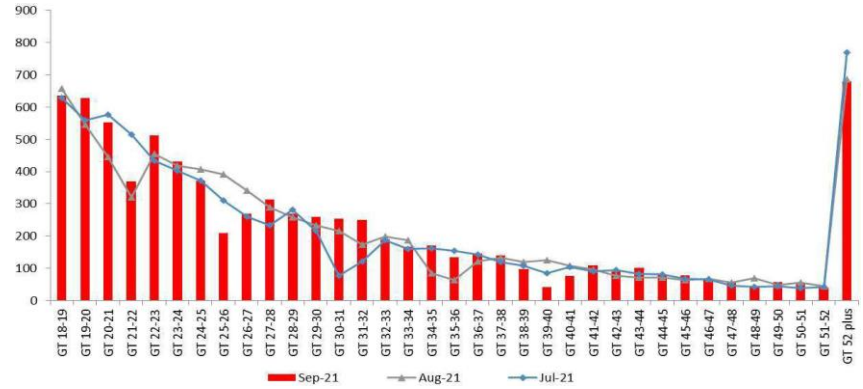
There were 6 patients waiting over 104 weeks.

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

RTT Ongoing 0-18 Weeks

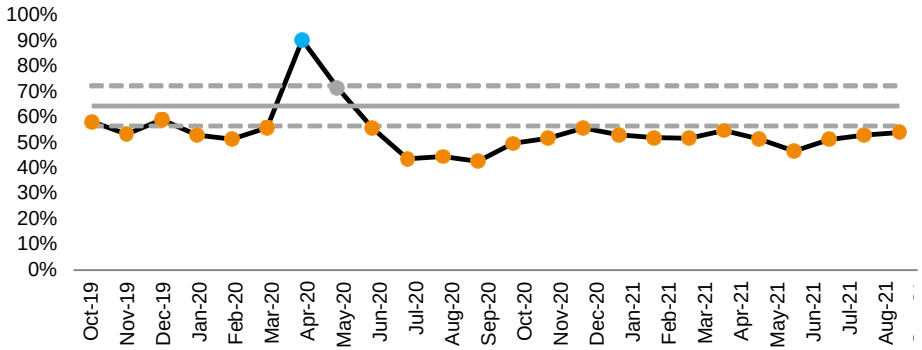


RTT Over 18 weeks

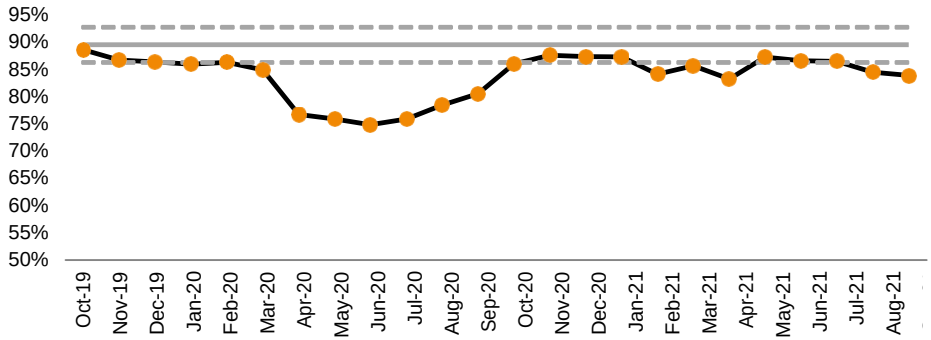


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.
During April 20 and May 20, only priority and urgent patients were admitted.

RTT Admitted



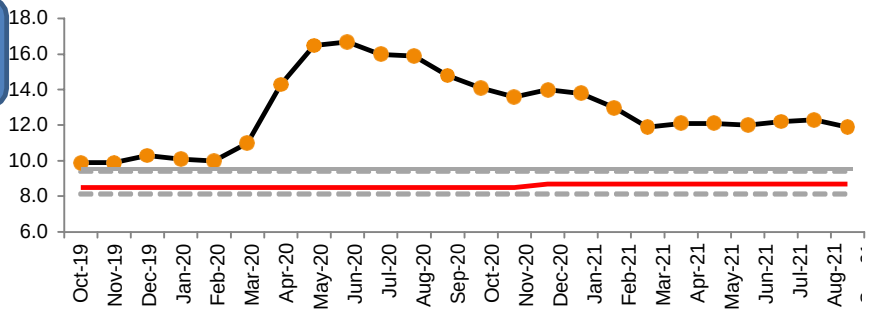
RTT Non-Admitted



RESPONSIVE

PRIVATE BOARD ONLY - RTT Average Wait & % Within 18 Weeks

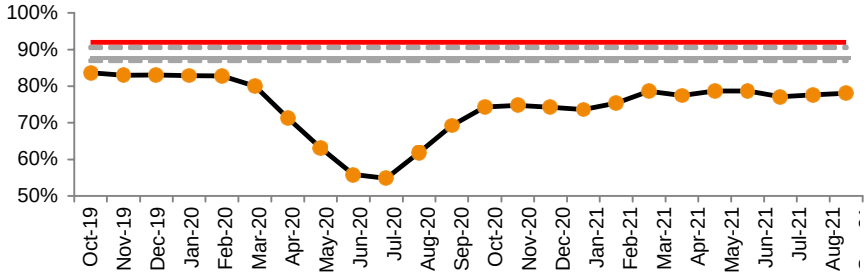
RTT Average Wait (Weeks)



The Trust commenced field testing of the new Referral to Treatment (RTT) average wait standard in August 2019, with a local target of 8.7 weeks.

The performance in September was above target at 11.9 weeks. The trend remains significantly higher than previous levels and based on current performance the indicator remains at risk of failing.

RTT Ongoing %



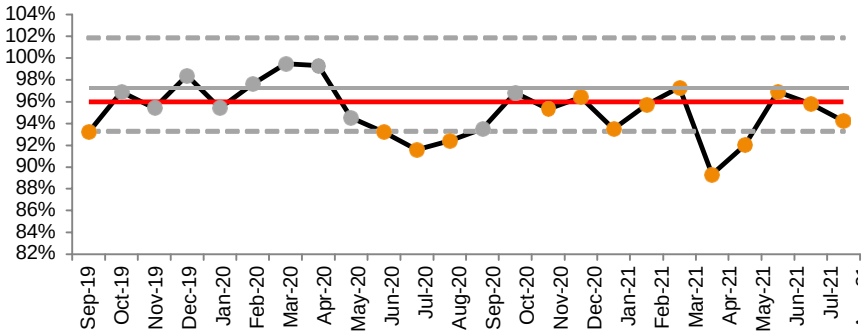
The 18 week referral to treatment (RTT) % ongoing position was not achieved in August with 78.1% patients, waiting less than 18 weeks to start treatment at month end.

The trend remains significantly lower than previous levels and based on current variation this indicator remains at risk of failing the target.

The latest published figures from NHS England show continued failure of the ongoing standard nationally (reported 1 month behind), with 67.6% of patients waiting less than 18 weeks to start treatment in August.

RESPONSIVE

Cancer 31 day

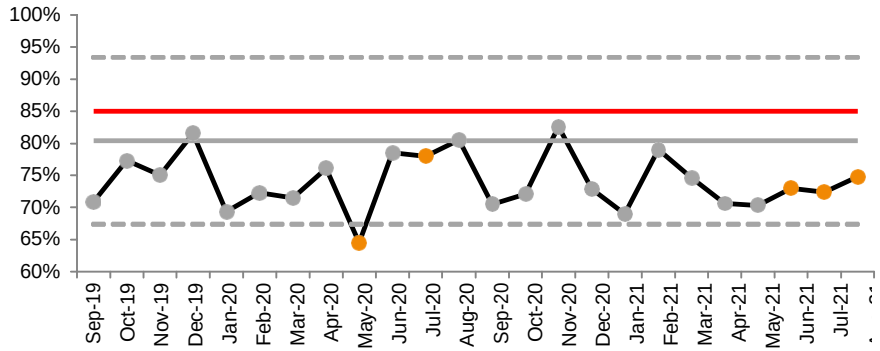


The 31 day standard was not achieved in August at 94.2%, below the 96% threshold.

Q1 was not achieved at 93.1%

The trend is showing deteriorating performance and based on current variation, the indicator is at risk of not meeting the standard.

Cancer 62 Day

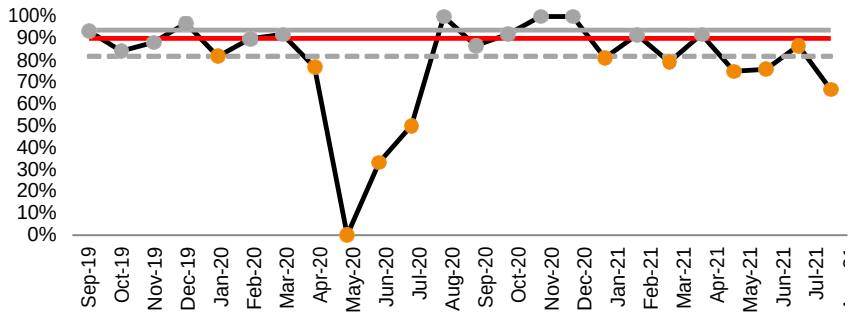


The 62 day cancer standard was not achieved in August at 74.8% below the 85% threshold.

Q1 was not achieved at 71.6%

The trend is showing deteriorating performance and based on the current variation, the indicator remains at risk of not meeting the standard.

Cancer 62 Day Screening



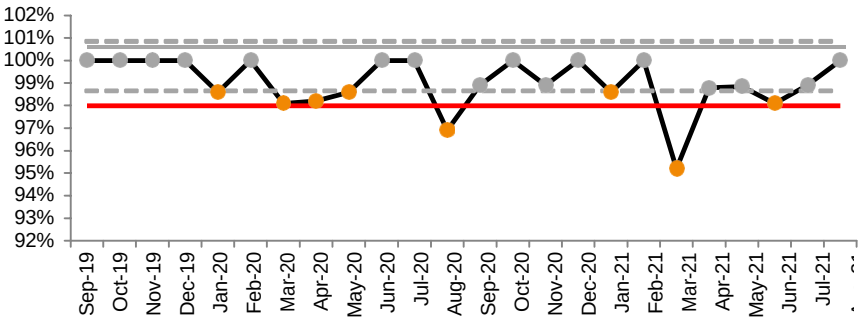
The 62 day screening standard was not achieved in August at 66.7%, below the 90% threshold.

Q1 was achieved at 82.2%

The trend is showing deteriorating performance and based on the current variation, the indicator remains at risk of not meeting the standard.

RESPONSIVE

Cancer - Subsequent treatment within 31 days (Drug)



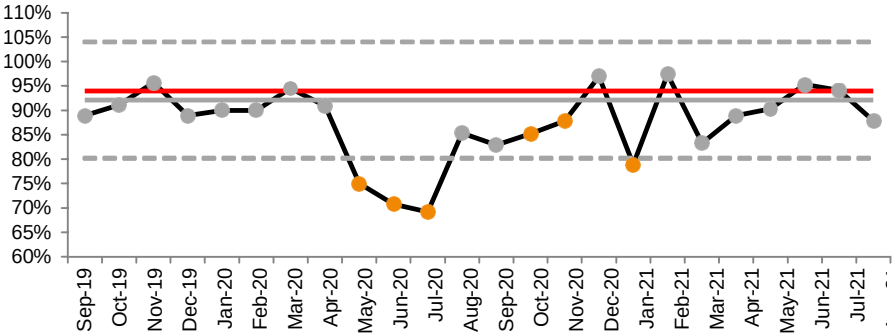
The subsequent treatment - drug standard was met in August at 100%, above the 98% threshold.

Q1 was achieved at 98.5%*

* Following further validation, June 21 performance has been revised up to 98.1% from the nationally submitted position of 95.6%. This will be resubmitted in November 21.

The trend is showing normal variation this month and based on the usual variation, the indicator should consistently achieve the standard.

Cancer - Subsequent treatment within 31 days (Surgery)

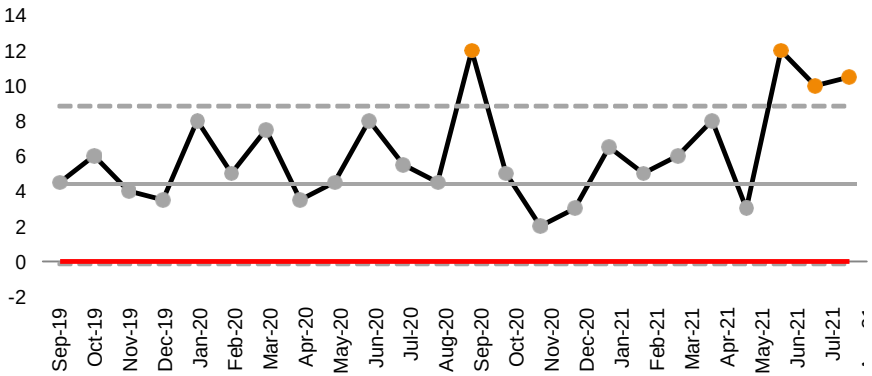


The subsequent treatment - surgery standard was not acieved in August at 87.9%, below the 94% standard.

Q1 was not achieved at 91.6%

The trend is showing normal variation this month and based on the current variation, the indicator is at risk of falling below threshold.

Cancer Patients Treated > Day 104



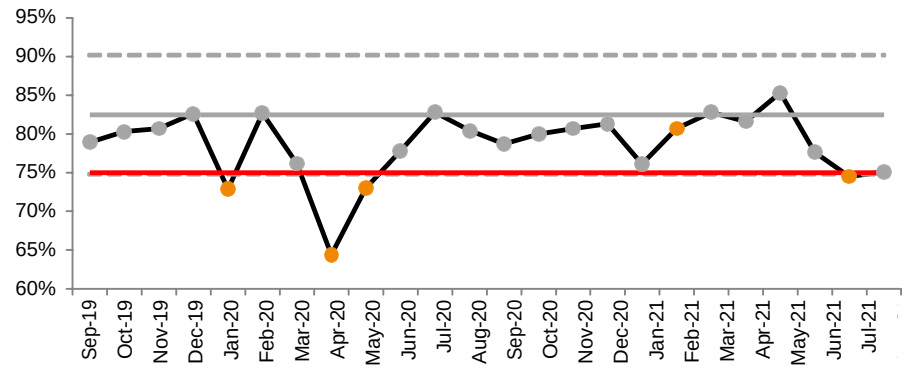
There were 11 breaches allocated to the Trust, treated after day 104 in August and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the consultants involved in the pathway as required.

The trend is showing a significant increase this month.

RESPONSIVE

PRIVATE BOARD ONLY - Cancer 2 week wait & 28 day faster diagnosis

Cancer 28 Day faster diagnosis



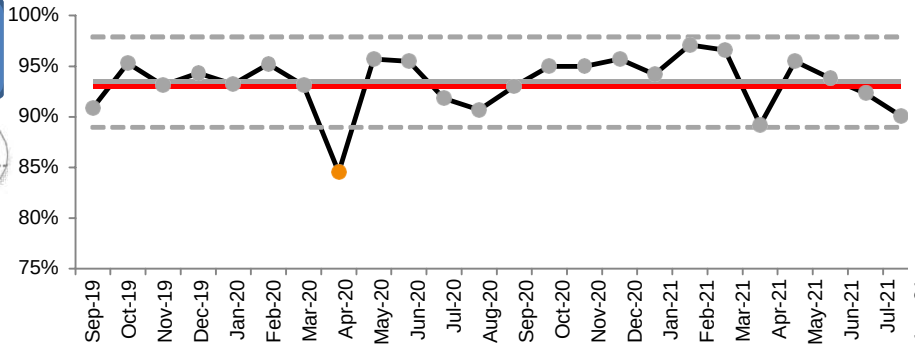
The Trust commenced testing of the new 28 day faster diagnosis standard from August 2020, which has been shadow monitored in previous months.

The Trust will be monitored against a baseline target of 75%. The performance in August was above target at 75.1%

Q1 was achieved at 81.5%

The trend is showing normal variation this month.

Cancer 2 Week



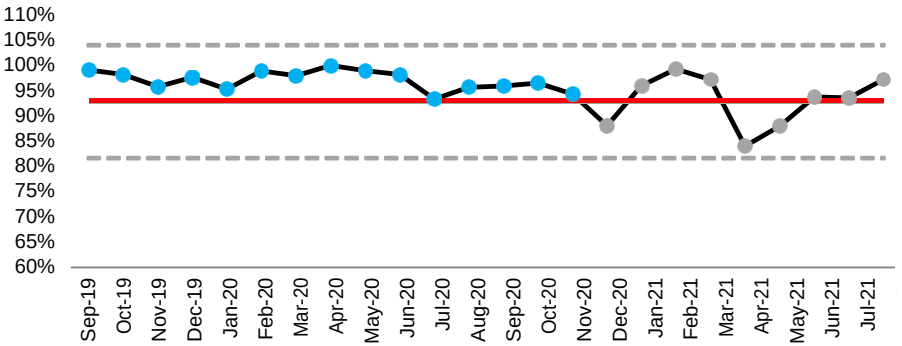
During the field test, the 2 week wait standard will be removed and is shown here for information only.

The cancer 2 week wait for GP referrals standard was not achieved in August at 90.1%, below the 93% threshold.

Q1 was not achieved at 92.8%

The trend is showing normal variation, however based on current variation, the indicator is at risk of failing the standard.

Cancer 2 Week - breast



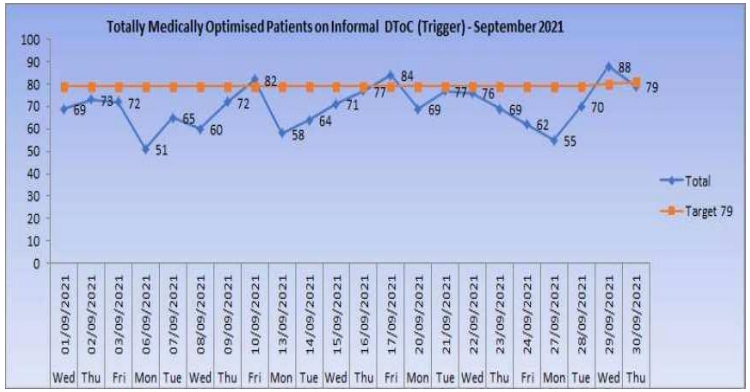
The 2 week breast symptomatic standard was achieved in August at 97.2%, above the 93% threshold.

Q1 was not achieved at 90.2%

The trend shows normal variation, and based on current variation this indicator is at risk of failing the standard.

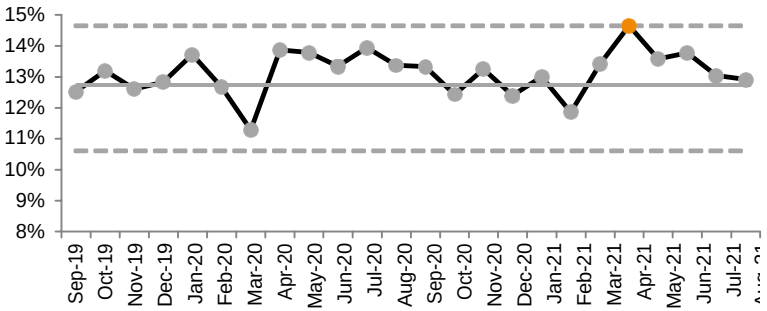
RESPONSIVE

Delayed Discharges



The formal reporting has now stopped as performance around discharge is being monitored regionally and nationally by the Discharge Patient Tracking List. The aim is to have fewer than 79 patients delayed in hospital and this is monitored daily. The delayed transfer of care work is now monitored locally and on a daily basis with a case management focus of the MFFD list. (Medically fit for discharge).

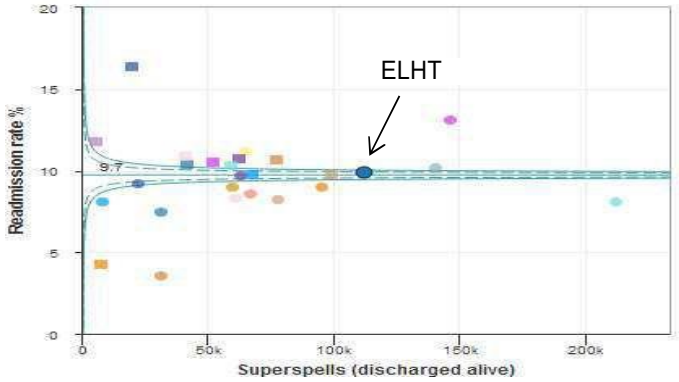
Emergency Readmissions



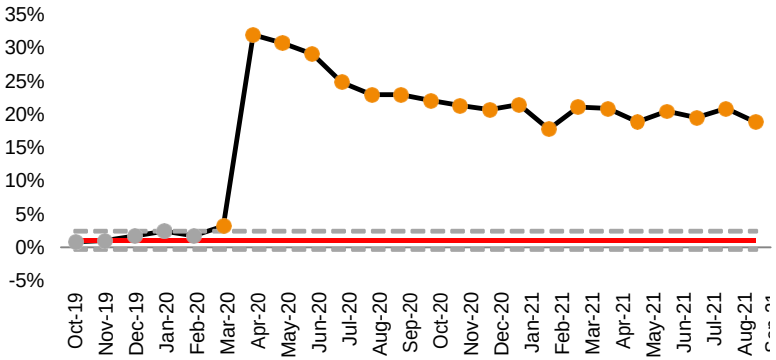
The emergency readmission rate trend is within the 'normal' range.

Dr Foster benchmarking shows the ELHT readmission rate is below the North West average.

Readmissions within 30 days vs North West - Dr Foster
January 2020 - December 2020



Diagnostic Waits



In September 18.84% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is above the 1% threshold.

The trend remains significantly higher than normal and based on current variation this indicator is at risk of failing the target.

Nationally, the performance is failing the 1% target at 27.1% in August (reported 1 month behind).

RESPONSIVE

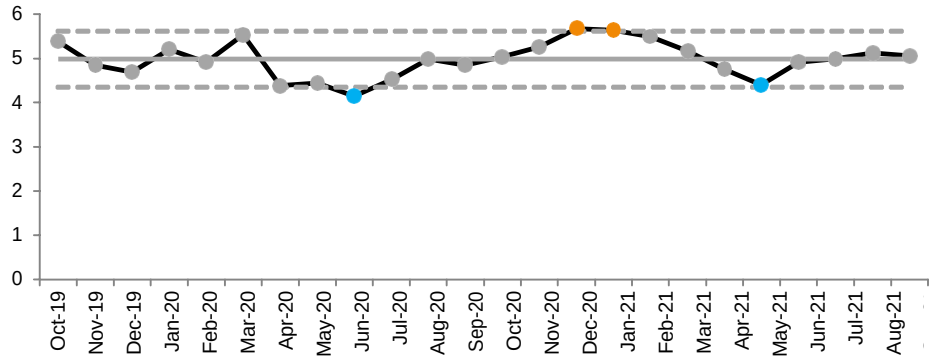
Average length of stay benchmarking

Dr Foster Benchmarking July 20 - June 21

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	54,816	8,527	46,289	3.2	2.6	-0.7
Emergency	59,019	59,019	0	4.3	4.2	0.0
Maternity/ Birth	12,773	12,773	0	2.1	2.2	0.1
Transfer	181	181	0	8.9	24.3	15.4

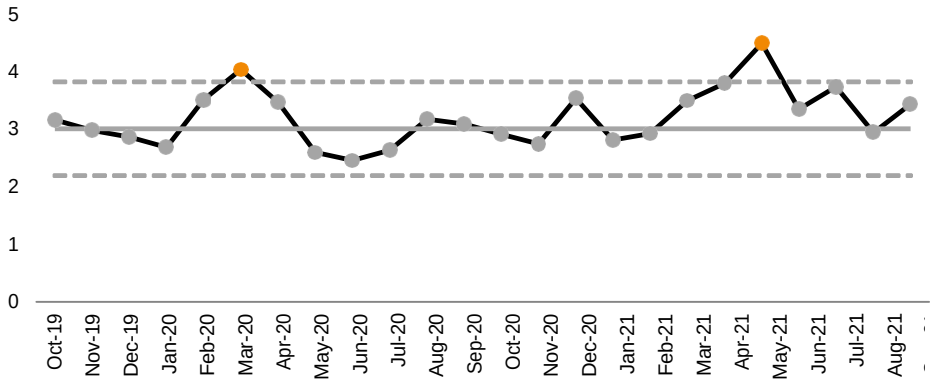
Dr Foster benchmarking shows the Trust length of stay to be below expected for non-elective and for elective when compared to national case mix adjusted, for the period July 20 - June 21.

Average length of stay - non elective



The Trust non-elective average length of stay is showing normal variation this month.

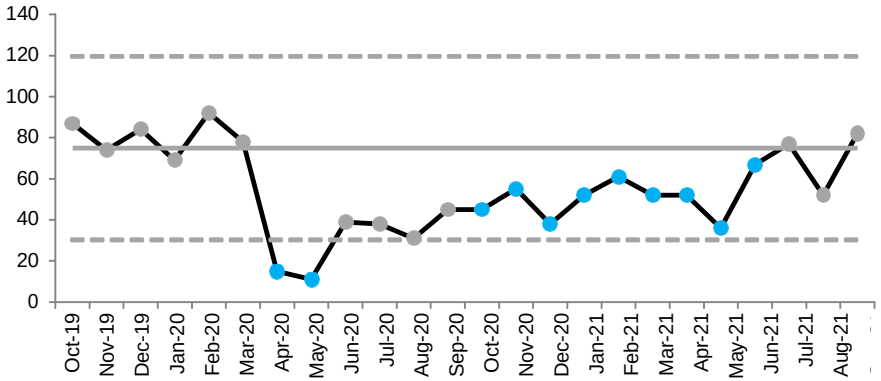
Average length of stay - elective



The Trust elective average length of stay is showing normal variation.

RESPONSIVE

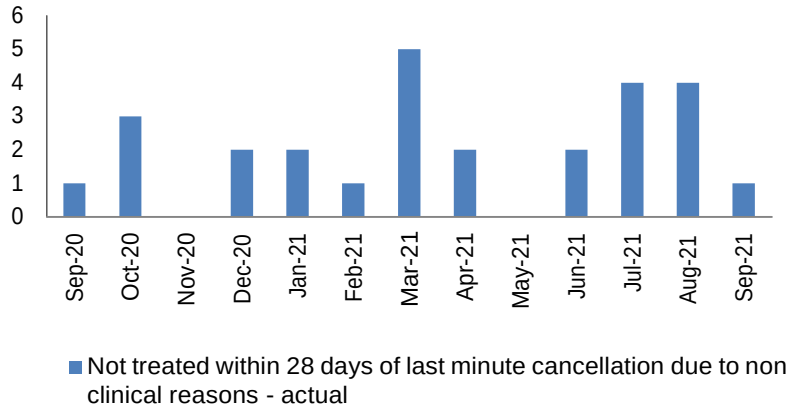
Operations cancelled on day



There were 82 operations cancelled on the day of operation - non clinical reasons, in September.

The trend is showing a return to normal variation.

Operations cancelled on day - breaches of 28 day standard

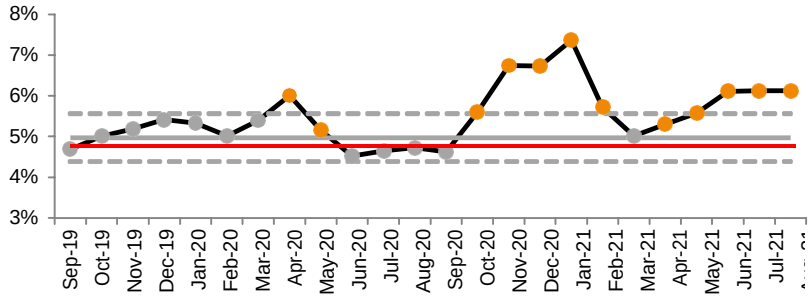


There was 1 'on the day' cancelled operations not rebooked within 28 days in September.

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.

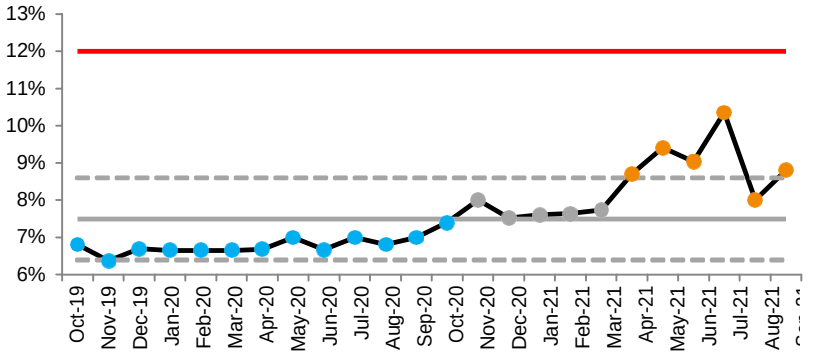
WELL LED

Sickness



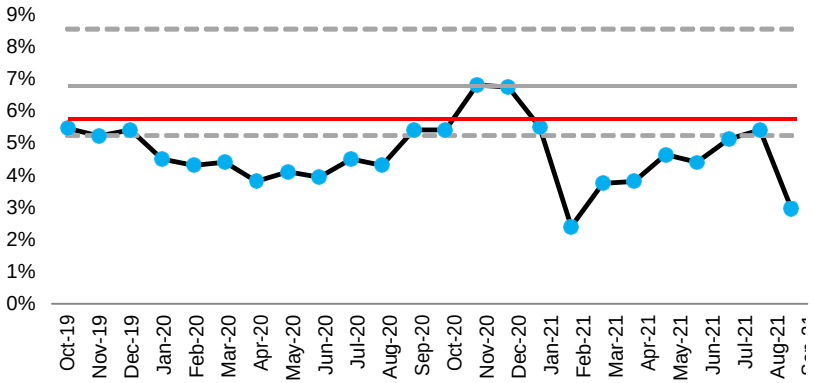
The sickness absence rate was 6.1% for August which is above the threshold of 4.5%. The trend is showing a significant increase and based on the current level of variaton, remains unlikely to acheive the target.

Turnover Rate



The trust turnover rate continues to be higher than normal at 8.8% in September, however remains below threshold. Based on current variation, the indicator will consistently be below the threshold.

Vacancy Rate



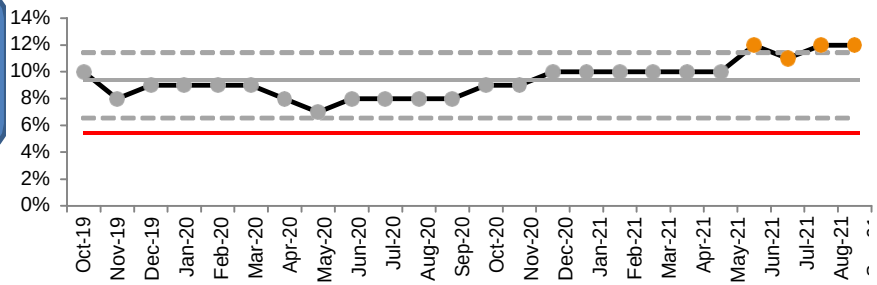
The vacancy rate is 3.0% for September which is below the 5% threshold.

This continues to be a significant reduction on previous levels.

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

WELL LED

Temporary costs and overtime as % total pay bill

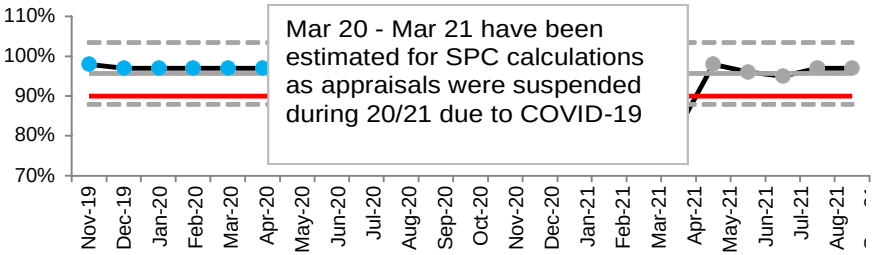


In Sept 2021, £5.0 million was spent on temporary staff, consisting of £2.1 million on agency staff and £2.9 million on bank staff.

Whole Time Equivalent (WTE) staff worked (9,315 WTE) was 118 WTE more than is funded substantively (9,197 WTE).

Pay costs are £0.1 million more than budgeted establishment in September.

Appraisals, Consultant

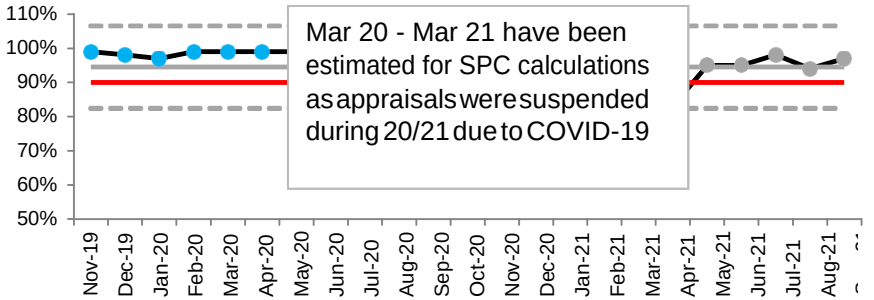


At the end of September 21 there were 256 vacancies

The temporary staffing cost trend shows a significant increase and is not capable of hitting the target.

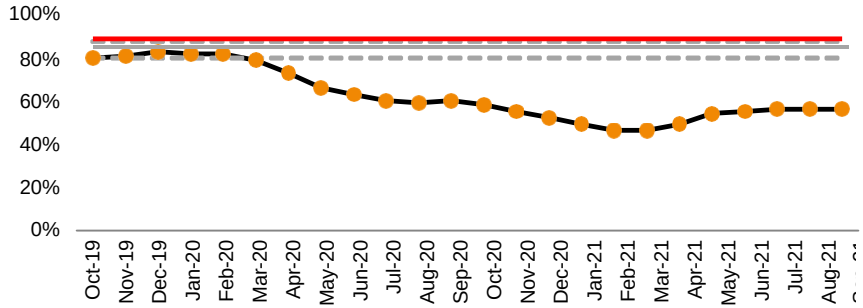
Appraisal and revalidation was suspended during 20/21 due to COVID-19.

Appraisals, Other Medical



The appraisal rates for consultants and career grade doctors are reported cumulative year to date to September 21 and reflect the number of reviews completed that were due in this period.

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 showing significant deterioration 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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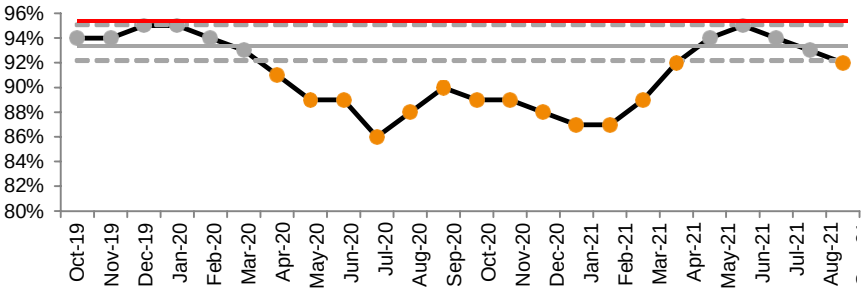
Job Plans

Stage	Consultant	SAS Doctor
Not Published	0	0
Draft	6	6
In discussion with 1st stage manager	197	37
Mediation	0	0
Appeal	0	0
1st stage sign off by consultant	43	6
1st stage sign off by manager	37	2
2nd stage sign off	30	7
Signed off	34	2
Locked Down	0	0

As at September 2021, there were 347 Consultants and 60 Specialty Doctor/ Associate Specialist (SAS) doctors registered with a job plan on Allocate. The table shows the numbers in each stage of the job planning process.

Information Governance Toolkit Compliance



Information governance toolkit compliance is 92% in September which is below the 95% threshold. The trend is showing deterioration and based on current variation, the indicator is not capable of achieving the target routinely.

Core Skills Training % Compliance

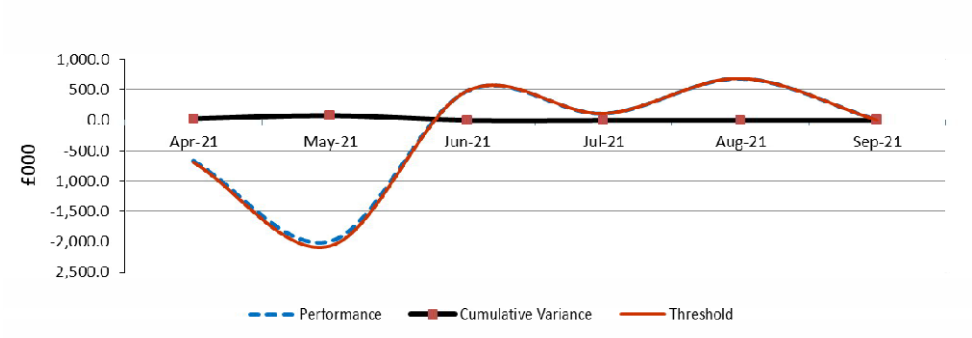
	Target	Compliance at end September
Basic Life Support	90%	86%
Conflict Resolution Training Level 1	90%	96%
Equality, Diversity and Human Rights	90%	96%
Fire Safety	90%	94%
Health, Safety and Welfare Level 1	90%	97%
Infection Prevention L1	90%	96%
Infection Prevention L2	90%	90%
Information Governance	95%	92%
Prevent Healthwrap	90%	95%
Safeguarding Adults	90%	95%
Safeguarding Children	90%	94%
Safer Handling Theory	90%	95%

The core skills framework consists of eleven mandatory training subjects. 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 which has a threshold of 95%

Two core training modules are below threshold; Basic Life Support and Information Governance.

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.

Finance & Use of Resource metrics



Adjusted financial performance suplus

WELL LED

Efficiency Savings

The Trust is reporting an adjusted deficit of £0.7 million in month 6, but a breakeven position for the year to date, in line with the H1 plan.

The cash balance as at 30th September 2021 was £47.1 million, an increase of £1.9 million on the position at the end of the previous month.

The 2021-22 capital programme remains at £27.4 million, of which £1.9 million has been spent in Month 6, and £9.6 million for the year to date.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 137

10 November 2021

Purpose Information / Action / Monitoring

Title	Workforce Race Equality Standard (WRES) Action Plan Update
Author	Mr N Makda, Inclusion Lead
Executive sponsor	Mr K Moynes, Executive Director of HR and OD

Summary: The minutes of the previous Trust Board meeting held on 8 September 2021 are presented for approval or amendment as appropriate.

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 Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	No

Maintenance of accurate corporate records

Safe | Personal | Effective

Equality	No	Confidentiality	No

Previously considered by: NA

WRES Action Plan Update

1. The WRES is designed to help NHS organisations understand and actively address differences in the experience between Black, Asian and Minority Ethnic (BAME) and white employees and provides a framework to address and close any gaps through the development and implementation of action plans for improvement.

2. Appendix 1 on page 4 provides an update on key milestones on all actions from the Race Equality WRES Action Plan.

3. Action status categorisation is as follows;

   G Green = being delivered

   AG Amber Green = on schedule to be delivered but more work to be done

   AR Amber red = in progress but needs more focus

   R Red = not on track to deliver

4. Some of the timescales have slipped due to Covid and other clinical pressures. Much of the work reflected in the action plan is long-term in nature and continues beyond the end of the timescales.

Recommendation

5. The Board is asked to note the WRES action plan update outlined within ***Appendix 1 on page 4*** and be assured of its implementation over the coming months, with a full review in June 2022.

Appendix 1 – RACE EQUALITY (WRES) ACTION PLAN 2021-2023

Description of Objective Recommendation	Accountable Lead	Progress	Actions	Timescales	RAG
	Green = being delivered Amber Green = on schedule to be delivered but more work to be done Amber red = in progress but needs more focus Red = not on track to deliver				
1.LEADERSHIP					
Executive, Senior Management and Board buy-in. Unified approval from the Trust Board to examine and initiate change, plus extending this to other executives and senior management colleagues sharing an interest in the subject for their input and involvement in formulating a strategy.	Operational Director of HR/OD	• Reverse Mentoring, • Exec Panel with BAME • Kevin McGee BAME network Sponsor, • Board approval of WRES and • People Plan Strategies in place • Improved BAME representation on Board • Strategic BAME Committee	**1.** Buy-in from other senior and middle managers 8a and above by engaging in the BAME staff network, Inclusion group and other initiatives like festival of inclusion **2**.Board Development session **3.** At least 90% of Trust Board members to be reverse mentored by BAME staff **4**. All manager's bands 8a and all clinical directors to engage in reverse mentoring by BAME staff	Sep-21 Sep- 21 Oct-21 Mar-23	AG
Embedding Race Equality within vison and values. Adding terminology around 'equity' and 'inclusivity' (at all levels), would really transmit a high-level sense of belonging.	Operational Director of HR/OD	Inclusion Statement of intent published	**5.** Embed Inclusive and Compassionate within Trust culture and practices	Apr-23	AG

Description of Objective Recommendation	Accountable Lead	Progress	Actions	Timescales	RAG
	Green = being delivered Amber Green = on schedule to be delivered but more work to be done Amber red = in progress but needs more focus Red = not on track to deliver				
Boards must embed accountability. Start by setting clear measurable time limited goals, ensuring managers and staff understand why, and then holding themselves (and their managers) to account. There should be consequences and/or incentives when agreed diversity goals are not met as for any other key performance indicator (KPI) helping build their capacity and confidence at every level, recognising that requires investment of time and determination by leaders.	Divisional Directors Divisional General Managers	Not in place	**6.** Divisional improvements in all WRES metrics **7.** WRES data to be quarterly standing agenda item within all DMB's	Dec-21 and then quarterly	R
Increase the number of executive and non-executive board members from a BAME background in ELHT	Operational Director of HR/OD	• 1 x Medical Director • 3xNed's • Shadow Board	**8.** Talent management and succession for BAME staff to progress to Executive Director positions	Dec-21	AR
Board and senior leaders to be mentored on Race Equality	Operational Director of HR/OD	Not in place	**9**. Source a mentor(s) for Board	Sep-21	R
Create a new Star Award - Leadership for Inclusion	Operational Director of HR/OD	Award category included	**10**. To start at the next Star awards in 2022	2022	AG

Description of Objective Recommendation	Accountable Lead	Progress	Actions	Timescales	RAG
	Green = being delivered Amber Green = on schedule to be delivered but more work to be done Amber red = in progress but needs more focus Red = not on track to deliver				
BAME network is going to be really crucial is supporting Board members learn about Race equality so plan more panel sessions with the Exec team	Operational Director of HR/OD	Meeting held 23rd June	**11.** Quarterly meetings to invite exec team to BAME network meetings	Sep-21 & then quarterly	G
Implement the actions arising from the WRES Race Disparity ratio (RDR)	Operational Director of HR/OD	Baseline has been worked out by the WRES team	**12.** Deliver Race Disparity Ratio actions	June-23	R
2. RECRUITMENT					
Equality, Diversity and Inclusion (EDI) to have the appropriate resources to support the delivery of the Inclusion agenda	Operational Director of HR/OD	Funding for festival of inclusion	**13**. Additional resources to support the Equality, Diversity and Inclusion agenda.	April-23	R
NHSEI WRES Model Employer action to improvements in recruitment of additional ethnic minority people in senior leadership positions over the next 4 years to reach equity for bands 6 and above. Model Employer target is to reflect representation of ethnic minority staff at equal proportions in all AfC pay scales by 2025.	Operational Director of HR/OD DGM's Divisional Directors	Recent Improvements ○ 2 x band 8d ○ 1 x Medical Director ○ 2x Ned's	**14.** WRES Model Employer Goal / target is 19% for bands 6 and above roles, **Band** / **Current position** / **Additional required** / **Target for 2025** 6 / 232 / 119 / 351 7 / 70 / 60 / 130 8a / 24 / 28 / 52 8b / 2 / 11 / 13 8c / 3 / 4 / 7 8d / 2 / 2 / 4 9 / 1 / 2 / 3	Year on year improvements until Dec-25	R

Description of Objective Recommendation	Accountable Lead	Progress	Actions	Timescales	RAG
	Green = being delivered Amber Green = on schedule to be delivered but more work to be done Amber red = in progress but needs more focus Red = not on track to deliver				
			VSM 3 2 5		
Review and audit the whole recruitment cycle, getting the basics right by ensuring fair and consistent recruitment and selection processes – including formal and soft promotion and development activities Implementation of the NHSEI's 6 key actions on overhaul of recruitment and promotion I. Ensure ESMs own the agenda, as part of culture changes in organisations, with improvements in BAME representation (and other under-represented groups) as part of objectives and appraisal by: a) Setting specific KPIs and targets linked to recruitment. b) KPIs and targets must be time limited, specific and linked to incentives or sanctions	Operational Director of HR/OD Head of Education Deputy Director of HR Head of Resourcing Head of Medical Staffing EDI Lead (supported by staff network members)	• Recruitment process mapping exercise with staff networks completed • Action plan in place	**15.** Complete the recruitment audit against the organisational policies and processes **16.** Ensure all senior posts within the organisation include a BAME member as part of the interview panel **17.** Introduce a system of 'comply or explain' to ensure fairness during interviews. This system includes requirements for diverse interview panels, and the presence of an equality representative who has authority to stop the selection process, if it was deemed unfair. **18**.Train organisations and HR policy teams on how to complete robust / effective Equality Impact Assessments of recruitment and promotion policies **19**. Ensure that for Bands 8a roles and above, hiring managers include requirement for candidates to demonstrate EDI work / legacy during interviews.	Mar-22	AR

Description of Objective Recommendation	Accountable Lead	Progress	Actions	Timescales	RAG
	Green = being delivered Amber Green = on schedule to be delivered but more work to be done Amber red = in progress but needs more focus Red = not on track to deliver				
			20. Overhaul interview processes to incorporate: a) Training on good practice with instructions to hiring managers to ensure fair and inclusive practices are used. b) Ensure adoption of values based shortlisting and interview approach c) Consider skills-based assessment such as using scenarios d) Adopt resources, guides and tools to help leaders and individuals have productive conversations about race		
3. EDUCATION / DEVELOPMENT / TALENT MANAGEMENT					
Talent Management of BAME staff	Operational Director of HR/OD Head of Education	• Review of leadership and management development programmes • Talent Management strategy	**21**. Develop talent management pathway for BAME staff to include acting up opportunities, stretch assignments, secondments, coaching & mentoring, etc. **22**. Organise talent panels to:	Mar-22	AR

Description of Objective Recommendation	Accountable Lead	Progress	Actions	Timescales	RAG
	Green = being delivered Amber Green = on schedule to be delivered but more work to be done Amber red = in progress but needs more focus Red = not on track to deliver				
	Associate Director of Wellbeing & OD		a) Create a 'database' of individuals by system who are eligible for promotion and development opportunities such as Stretch and Acting Up assignments must be advertised to all staff b) Agree positive action approaches to filling roles for under-represented groups c) Set transparent minimum criteria for candidate selection into talent pools		
Developing future leaders via workforce planning Adopt a 'hire for attitude, train for skills' approach and fulfil the equity and inclusion agenda. Targeting schools and colleges	Operational Director of HR/OD Head of Education DGM's	• Work experience • Step into the NHS • Apprenticeships	**23**. Review the workforce planning exercise undertaken by HR for upcoming positions within each division or directorate over the next 5-years develop a bespoke undergraduate learning and development pathway	Mar-22	**R**
Enhanced EDI training for managers at all levels	Head of Education		**24**. Strengthening the Cultural & Religious Awareness, Unconscious Bias training and	Starting	

Description of Objective Recommendation	Accountable Lead	Progress	Actions	Timescales	RAG
	Green = being delivered Amber Green = on schedule to be delivered but more work to be done Amber red = in progress but needs more focus Red = not on track to deliver				
Training and development, Improve both cultural awareness and managerial training. Elaborate on the existing unconscious bias training and/or (as literature suggests) develop a bespoke cultural awareness training package (either in-house or with UCLan), structured through lived experiences of ELHT staff.	EDI Lead	• Part of Core Mandatory training • Bespoke sessions on unconscious bias being delivered	launch new mandatory 'Becoming Race Confident' training to include a series of hard-hitting scenarios acted out by BAME staff sharing their stories and tips to encourage behavioural and mind-set change for Race confident line management **25**. Produce a manager's best practice guide with links to outside best practice to support an anti-racist culture	Mar-22 Apr-22	AG
Bespoke Leadership development programme to develop staff who are bands 7 and below to help them with their progression Targeted programmes that can help to address historic imbalances in access to development and career progression for ethnic minority staff.	Head of Education EDI Lead	• Diverse Leaders • Engaging managers • NHS leadership programmes e.g. stepping up • Shadow Board	**26** Develop a bespoke leadership development programme for bands 4-7 to include career coaching for BAME staff so that they can learn the skills to enhance their prospects for progression and support leadership development of BAME staff both internal and external	Mar-22	AR
4. COMMUNICATION & ENGAGEMENT					
Through a regular drum beat of communications raise the profile and visibility of BAME staff in many of our publications, channels, events and web resources	Director of Communication	• Festival of Inclusion • Risk Assessments	**27**. Develop Communications Plan for Race equality	Mar-21 & then monthly	G

Description of Objective Recommendation	Accountable Lead	Progress	Actions	Timescales	RAG
	Green = being delivered Amber Green = on schedule to be delivered but more work to be done Amber red = in progress but needs more focus Red = not on track to deliver				
Proactive communication Before, during and after any implementations, an effective communication sub-strategy is imperative. In this instance formulating a 'campaign' type approach using social media, staff bulletins and the intranet could be advantageous.		• Awareness days • Inclusion Wall • Events e.g. Pride, Black History Month, etc.			
A committee with a voice, reviewing the remit, makeup, leadership and objectives of the BAME network. Consider proportionately representing peer groups and renaming to Race Equality Committee. Also, enable an opt in/out option for all BAME staff i.e. the BAME network and revise methods of communication in line with the new sub-strategy.	BAME Co-Chairs	• TOR • Meetings well attended • Progress is tracked • Current arrangements working well • Good engagement, good mix of makeup of network • Shortlisted for the HSJ award 2021	**28.** Monitor progress on race equality WRES actions providing assurance and scrutiny **29**. Improve awareness of BAME staff network to increase membership and attendance	Ongoing	G
EDI Statement of Intent and visible pledge is displayed across all sites	Director of Communication	Published in Other News	**30.** Physical, Virtual and Visible display across all areas	July-21	G
Include staff stories to be shared at Trust Board to highlight the lived experience of BAME staff	Operational Director of HR/OD	Not in place	**31**. BAME staff to share stories at board meeting	From Oct-21	R

Description of Objective Recommendation	Accountable Lead	Progress	Actions	Timescales	RAG
	Green = being delivered Amber Green = on schedule to be delivered but more work to be done Amber red = in progress but needs more focus Red = not on track to deliver				
Workshops and discussions. Participants should be empowered to discuss their experiences, good, bad or indifferent without the fear of repercussion.	Operational Director of HR/OD DGM's BAME Co-Chairs	Let's talk about Race delivered during FOI David Knight from UCLAN Guest speaker	**32** Plan more Let's Talk About Race sessions within divisions 33 Commission expertise of David Knight from UCLAN to support the Trust in improving Race equality	Sep 2021 & then monthly	AG
Undertaking regular and independent survey/ consultation and feedback from all BAME staff across the trust and the staff group to direct this with appropriate access to resources	Non-Exec Director EDI Board Lead Champion	Staff Survey Inclusion Continuum	**34** Send out quarterly surveys to all BAME staff	May-21 & then quarterly	AG
5. EMPLOYEE RELATIONS					

Description of Objective Recommendation	Accountable Lead	Progress	Actions	Timescales	RAG
	Green = being delivered Amber Green = on schedule to be delivered but more work to be done Amber red = in progress but needs more focus Red = not on track to deliver				
Integrated support infrastructure, empower divisional and/or profession specific, BAME champions to work alongside and support the Staff Guardian (including the newly appointed BAME champions). Eliminating the ethnicity gap in relation to numbers of staff entering formal disciplinary processes - introduction of Employee Relations Review Panel	BAME Co-Chairs Employee relations Case Review Group Head of HR	Employee Relations Case Review Group in place Employee Relations Review Group have met 6 times 3 BAME FTSUP staff champions recruited	**35.** Recruit BAME FTSUP staff champions **36**.HR to share current live employee relations cases by ethnicity with BAME network **37**.Seek clearer and measurable mechanisms (informal/formal) to enforce action addressing those involved in discriminatory behaviour or not adhering to Trust EDI policies	Completed Sep-21 Nov-21	G R
Amendments to the Trust's policy framework to ensure policies support the removal of racism from the workplace and allow for positive action to be taken where it can be objectively justified i.e. Zero Tolerance against all forms of discrimination Seek clearer and measurable mechanisms (informal/formal) to enforce action addressing those involved in discriminatory behaviour or not adhering to trust EDI policies.	Deputy Director of HR	A sub-group has been set up to look at micro-aggressions, etc	**38** A positive first step will be the explicit definition of racial abuse as a specific gross misconduct (in addition to discrimination) in the Disciplinary policy. Social media policies to be amended to define that the publishing, sharing, encouraging or promoting of racist material will be treated as a gross misconduct	Dec-21	AR
6. EMPLOYEE WELLBEING					

Description of Objective Recommendation	Accountable Lead	Progress	Actions	Timescales	RAG
	Green = being delivered Amber Green = on schedule to be delivered but more work to be done Amber red = in progress but needs more focus Red = not on track to deliver				
Adopt the Mayo Clinic Wellbeing Index to support staff wellbeing and resilience	Operational Director of HR/OD Consultant Gynaecologist	Data collected from ICS to support with business case	**39**.Awaiting feedback from Occupational Health **40**.Quotation from Mayo Clinic **41**.Business case approval	Aug-21	AR
Risk assessment of all BAME staff	Deputy Director of HR/OD	All BAME staff risk assessed	**42**.External audit of risk assessments **43**. Appropriate support in place to mitigate background risk **44.** The Covid vaccination programme will need to ensure every effort is made to get good coverage in black, Asian and minority ethnic (BAME) staff.	Completed Ongoing	G
BAME staff needs to be supported with protected time to attend network meetings similar to staff side to support with the EDI agenda	Operational Director of HR/OD	Working with ICS/NHS England to develop a paper	**45**. Protected time for network members to attend meetings and events	Aug-21	R
7. SERVICE DELIVER / PATIENT EXPERIENCE					

Description of Objective Recommendation	Accountable Lead	Progress	Actions	Timescales	RAG
	Green = being delivered Amber Green = on schedule to be delivered but more work to be done Amber red = in progress but needs more focus Red = not on track to deliver				
Prayer room at Burnley site needs to be renovated as it's in a very poor condition with no access to washing facilities	Deputy Chief Nurse DGM Estates Chaplaincy Manager	• 5 daily prayers • Friday Prayer • Catering for genders • Individual meditation	**46**. Major improvements required to wash facilities and renovation of the prayer facilities	Sep-21	R
Explore options for enabling accessible prayer rooms at Accrington and Clitheroe sites.	Deputy Chief Nurse DGM Estates Chaplaincy Manager	Not in Place	**47**. Find suitable sites across satellite hospitals	Sep-21	R
Appointment of a woman spiritual counsellor predominantly for Burnley women and new born centre. Support the workload of the current Muslim Chaplin with appointment of another colleague at least as part time to provide cover for the unmet additional demand and as cover when the chaplain is away on leave or holidays.	Deputy Chief Nurse Chaplaincy Manager	2 part time Muslim females recruited.	**48.** Recruit a woman spiritual care staff to support BGTH & new born centre **49.** Recruit more staff to support the Imam	Aug-21	G

Description of Objective Recommendation	Accountable Lead	Progress	Actions	Timescales	RAG
	Green = being delivered Amber Green = on schedule to be delivered but more work to be done Amber red = in progress but needs more focus Red = not on track to deliver				
Catering for BAME staff spiritual and cultural needs whilst at work	Line managers	Ad Hoc	**50.** Guidance for managers to support staff to observe their religious rituals whilst at work	Mar-22	R
Work to be undertaken to explore/validate that clinical and patient care interventions are based on best practice, up to date and appropriate for local BAME communities.	Director of Operations Director of Quality & Safety Director of Nursing	Not in Place	**51.** Implement Goals 1&2 of the Equality Delivery system focussing on Race and ethnicity **52**. Equality Impact assessments for all policies, practices, events, decision-making processes and functions	Dec-21	R

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

10 November 2021

Item 138

Purpose Information
Action
Monitoring

Title	Behavioural Framework Launch
Author	Mrs J Hargreaves, Senior HR Business Partner Mrs E Schofield, Deputy Director of HR & OD
Executive sponsor	Mr J Husain, Medical Director Mrs K Quinn, Operational Director of HR&OD

Summary: The purpose of this report is to update the Trust Board following the design and launch of our Behaviour Framework, outline the reasons why embedding our behaviours is critical and what our intended next steps are. The Trust Board is asked to note the contents of the report and help play a part in creating our desired culture and leading by example in displaying these behaviours. The Behaviour Framework is attached at Appendix 1.

Recommendations: The Trust Board are asked to:

- Fully embrace, support and role model our 5 Behaviours
- Help to embed the Behaviour Framework by taking every opportunity to raise awareness and discuss behaviours, their impact and importance
- Encourage colleagues to make it the norm to talk about behaviours as part of everyday conversations, recognising and rewarding when behaviours are good and challenging appropriately, when they are not.
- Support the recommendation for a further progress report in 6-9 months' time.

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
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. Recruitment and workforce planning fail to deliver the Trust objectives The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single

Oversight Framework.

Impact

Legal	No	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by: Exec

1. Purpose

1.1 The purpose of this report is to update the Trust Board following the design and launch of our Behaviour Framework, outline the reasons why embedding our behaviours is critical and what our intended next steps are. The Trust Board is asked to note the contents of the report and help play a part in creating our desired culture, and leading by example, in displaying these behaviours. The Behaviour Framework is attached at appendix 1.

1.2 Our Behaviour Framework was launched at the Festival of Inclusion on 27th September 2021.

2. Our Aim

2.1 The overall aim of this programme is to '*design a bespoke behaviour framework and embed our ELHT behaviours throughout each stage of the employment lifecycle, from recruitment and on boarding to exit. Over time these behaviours will become part of our DNA, enabling us to live our values and consistently deliver Safe, Personal and Effective care to our patients and customers'*.

2.2 Whilst our strategy and objectives describe what we will do as ELHT, our behaviour framework describes 'how' we will behave and interact, and therefore underpins our strategies to support implementation.

2.3 Our Behaviour Framework also underpins our ELHT People Strategy aim to *'enable ELHT to recruit the best people, with the right skills and values, to an organisation that supports staff to be the best they can be in a culture of community, compassion, inclusion, innovation and improvement, to deliver Safe, Personal and Effective care'*.

2.4 A key consideration during the design phase was to ensure that our behaviours reflected the needed to succeed in a digital healthcare system, where an improvement mind-set is at the heart of everything we do, and that the way in which we behave helps to create an inclusive and diverse workforce. Therefore all of these priorities were considered in the design phase and have been built into the Behaviour Framework.

2.5 Ownership of the Behaviour Framework will be critical to ensure there is the desired cultural impact in time, and therefore the approach taken from the offset has been one of collaboration and co-design with all professional groups contributing to the design and overall programme.

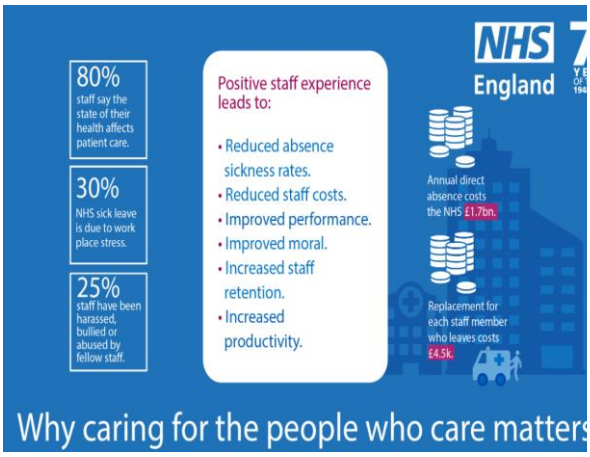
2.6 The success of this programme is really down to the next phase of work, over the next 18 months, to fully embed these behaviours in everything we do. The intension is to re-run the cultural survey at 6 months and 12 months post implementation to assess the impact.

3. Benefits

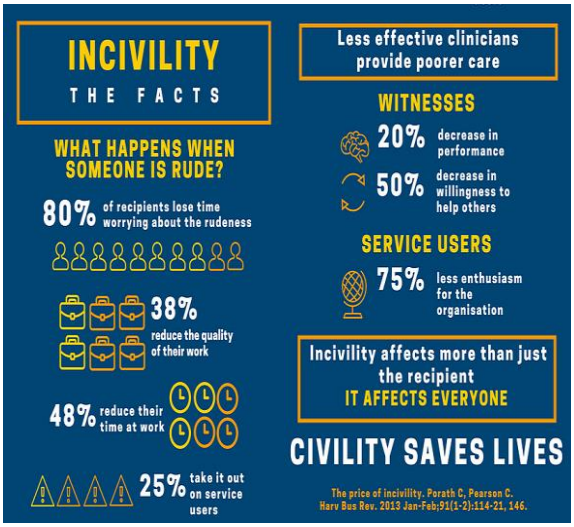
3.1 It's been proven that the way we behave, speak and act at work has a huge impact on colleagues and this in turn directly affects the care our patients receive. We want to be an

employer that prioritises compassion, civility and improving behaviours because this is essential to providing **Safe, Personal and Effective** Care to our patients.

3.2 The following infographics set out some of the widely recognised benefits of focusing on behaviour and culture change to improve patient and colleague experience:



Why caring for people who care matters. *NHS England. Oct 2018*



The price of incivility. Porath C, Pearson C. Harvard Business Rev. 2013 Jan-Feb; 91(1-2); 114-21, 146.

3.3 We also know that having a consistent, widespread compassionate and inclusive culture is one of the main components of what makes an 'outstanding' organisation. The CQC Inspection Framework asks *"are there cooperative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?"* The CQC framework also asks '*are poor behaviours challenged to ensure that action is taken to address behaviour and performance that is inconsistent with visions and values, regardless of seniority, encouraging openness and honesty at all levels within the organisation*'.

3.4 Therefore this programme of work will have a pivotal impact in creating our desired culture and in journey to becoming an 'outstanding organisation.

Below are the key Staff Survey and Behavioural Survey responses we hope to see an improvement in the next 18 months:

Staff Survey Question	Result in 2020	Result in 2019	Result in 2018
I am able to make improvements happen in my	44% disagreed	40% disagreed	38% disagreed

area of work			
Relationships at work are not strained	53% disagreed	49% disagreed	52% disagreed
Look forward to going to work	41% disagreed	38% disagreed	38% disagreed
I receive the respect I deserve from my colleagues at work	28% disagreed	26% disagreed	26% disagreed

Behavioural Survey Question	***Result in 2021***
ELHT leaders and managers resolve conflict and disagreements quickly and professionally	39.3% disagreed
At ELHT we reflect on our own behaviour and ask for feedback	29.9% disagreed
At ELHT we appropriately challenge unhelpful behaviours	34.9% disagreed
At ELHT we are respectful and considerate in language and action	23.5% disagreed
At ELHT we reflect on our own behaviours and how they may impact on others	32.8% disagreed
At ELHT we respond positively to feedback and challenge and are open to try new ways of working	22.6% disagreed

**682 respondents*

4. Progress to Date

4.1 In June 2021, an Executive Sponsor was selected (Jawad Husain), a strategic working group was set up (chaired by Emma Schofield) and 20 Trust wide Champions were handpicked to come together and engage colleagues to help design a our Behavioural Framework. The results of last year's staff survey, our first ELHT behavioural colleague survey, patient feedback and qualitative data from HR, the Staff Guardian and Behavioural Framework Champions were used to complete a thematic analysis, identifying key themes, strengths and weaknesses. Our Framework was then created to describe the expected behaviours of all colleagues regardless of profession or level of responsibility. The Behavioural Framework was designed to positively shape our culture and therefore enable our vision to provide Safe, Personal and Effective care.

4.2 The Framework was launched at the Festival of Inclusion on 27th September 2021, where our Executive Sponsor Jawad Husain revealed the Behaviour Framework in his opening address to the Trust. Three further sessions were held to talk about it in more detail and over 300 colleagues attended and positively engaged in the conversation. Our five behaviours were also used to underpin all sessions delivered during the week.

4.3 A Behavioural Framework Resource Hub was designed and launched providing information and resources to help colleagues and managers in using the Framework, and will continue to be developed over the coming 18 months.

4.4 The clear ask of all colleagues as part of the initial launch was a) to personally review the Behaviour Framework and self-reflect. B) To use the framework to support 1:1 conversations with colleagues in holding each other to account. C) To use it as the basis for team conversations to identify strengths as a team and where there is a need for action to ensure each team is working in line with the 5 behaviours. Feedback so far is that the Framework is being used to start conversations and colleagues have welcomed having direction which enables them to hold their peers to account to create a more compassionate and inclusive working environment.

4.4 The working group members and our Behavioural Framework Champions along with HR colleagues are attending Directorate and Divisional meetings to ensure the above ask is being progressed and to provide further support to raise awareness.

5. Next steps

5.1 The following activities are prioritised for the next 6 months, at which point the cultural survey will be re-run to evaluate progress and determine next steps. It should be noted that this programme will span over the next 18 months as a minimum.

- A Trust wide communications campaign is being designed for roll out over the next 12-18 months including promotional materials to ensure the Framework remains visible and continues to be at the forefront of colleagues mind.
- Behaviour Framework Hubs organised across Trust sites to encourage engagement and understanding on our behaviours.
- Embed the Behavioural Framework into the Trust's Induction, Appraisal and Performance Management method, policy and training, continuing to design support materials/training to support colleagues.
- A patient leaflet will be designed to articulate our behaviours, why this is important to us, how this impacts the quality of care they receive and what they can expect to see.
- A 60 second survey tool will be designed for teams to use, to seek customer feedback on their experience, based on our behaviours.
- Reward and recognition approaches will be reviewed and we will embed recognition for displaying our behaviours with colleagues, patients and customers
- Review 2021 Staff Survey results to identify impact (although this is unlikely until the 2022 survey)
- Patient complaints and complements will be analysed again to determine any change in patient experience.

6. Measures of Success

As with all culture change measuring the specific impact of the Behaviour Framework is multifaceted and so a number of specific methods will be used to measure overall impact:

- 6 monthly culture assessments to measure impact against our baseline
- Annual staff survey results
- Patient complaints and complements to measure against our baseline

The table below captures the high level benefits we expect to realise over time:

Delivery

1. ELHT performance KPIs improved
2. Our service agility and flexibility has increased.
3. More colleagues feel able to make improvements happen in their area of work, contributing directly to patient/colleague experience.

Quality

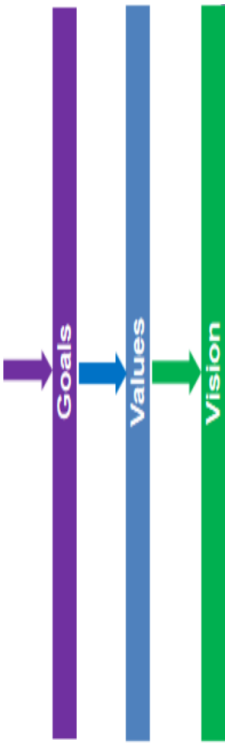
1. Quality of care and Patient outcomes have improved
2. An increased number of colleagues reporting they have been involved in deciding on changes introduced that improved their work area
3. Increased numbers of colleagues feel that their role makes a difference to patients

Cost

1. Litigation costs reduced
2. Complaint levels are lower and the time to deal with complaints has reduced
3. Cost of staff sickness has reduced
4. Number of behaviour related requests for Resolution have reduced
5. Reduced turnover of staff, contributing to lower recruitment costs.

People

1. Improved patient experience feedback
2. Reduced sickness absence relating to stress at work.
3. Fewer patient complaints received regarding staff behaviour
4. Fewer incidents occurring
5. More people report feeling happy working with the colleagues in their team
6. More disagreements being dealt with constructively within teams
7. Improved colleague wellbeing



7. Recommendation

7.1 The Trust Board are asked to:

- Fully embrace, support and role model our 5 Behaviours

- Help to embed the Behaviour Framework by taking every opportunity to raise awareness and discuss behaviours, their impact and importance
- Encourage colleagues to make it the norm to talk about behaviours as part of everyday conversations, recognising and rewarding when behaviours are good and challenging appropriately, when they are not.
- Support the recommendation for a further progress report in 6-9 months' time.

Jo Hargreaves, Senior HR Business Partner

Emma Schofield, Deputy Director HR & OD

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

OUR NEW

Behavioural Framework

Safe | Personal | Effective

Introduction

This Framework defines **how** we can all contribute to the success of our organisation and to our own successes as individuals and as a team. Adopting and embracing these behaviours will help to achieve our Trust's ambition to deliver **Safe, Personal and Effective** care and continue to make ELHT a great place for everyone.

What is the behaviour framework?

It is a set of core behaviours which define **how** we are expected to approach our work and sits alongside **what** we do.

It details the behaviours and attitudes required by all of our ELHT colleagues and it supports the delivery of our strategic priorities, values and culture.

What does the term behaviour mean?

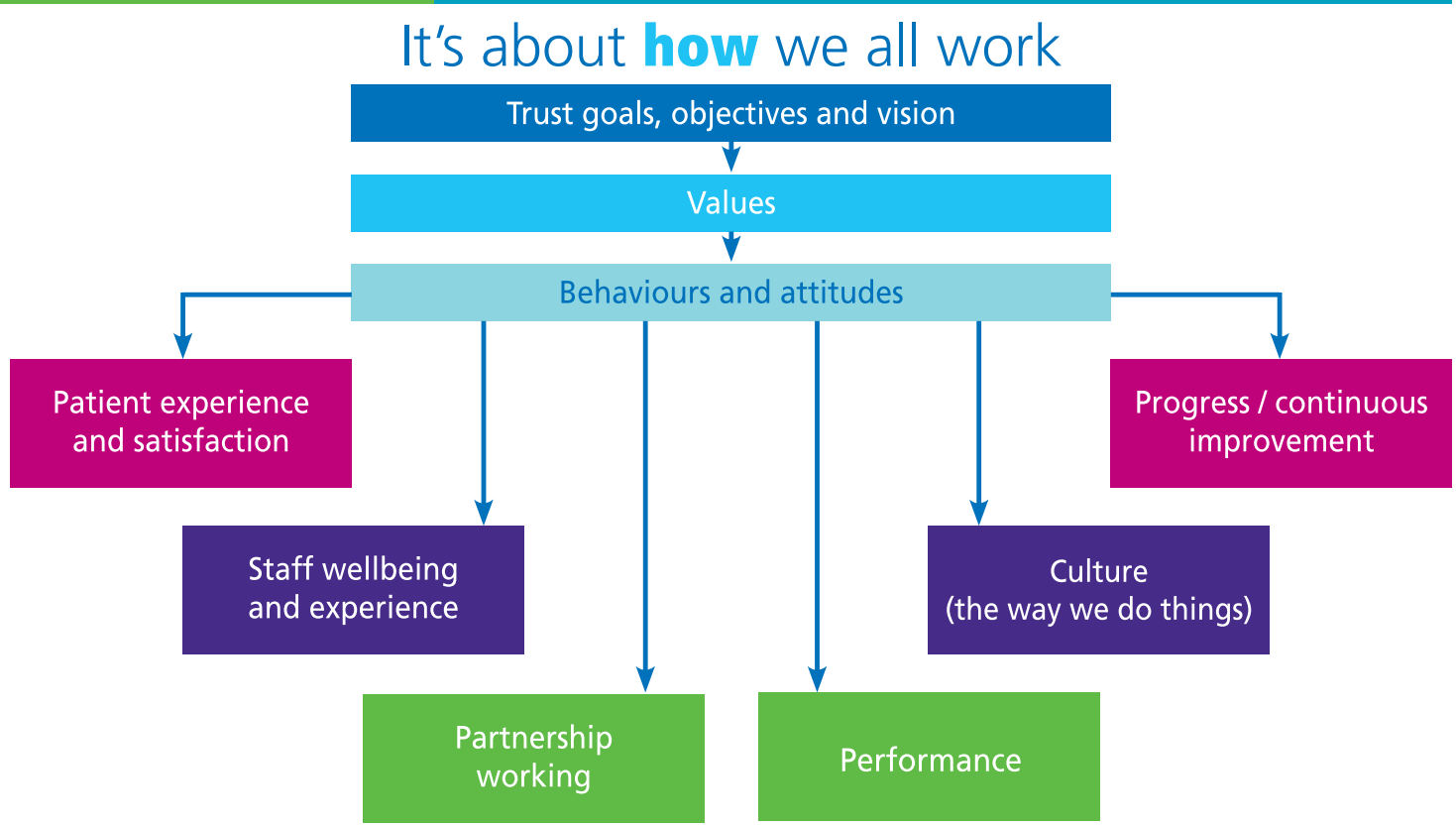
Behaviours demonstrate the attitude and approach we all bring to our work and encompass how we do things, what we say and how we say it, how we treat others and how we expect to be treated.

Why is this important to me?

This behaviour framework sets out the expectations of each individual at ELHT. It is embedded into the whole employment lifecycle from recruitment and selection and induction, through appraisals and development conversations.

This sets the standard by which we can identify our talented individuals, enabling our organisation to develop its workforce and plan for the future.

By demonstrating the behaviours within this framework, colleagues will contribute to make ELHT an effective, positive and rewarding place to work.



Safe | Personal | Effective

Behaviour Definitions

Taking Responsibility

Take ownership of your work and use initiative to deliver your objectives and role expectations. Be accountable for your own performance and development by taking responsibility for your own actions and decisions.

Building Trust and Respect

Recognise the importance of self awareness and the impact you have on others. Value difference, diversity and inclusion, ensuring fairness and opportunity for all. Be open and listen carefully to the views and opinions of others. Build relationships based on trust, respect, compassion and kindness.

Keeping it Simple

Communicate clearly and concisely, to ensure the message is understood by all. Actively work to prevent over-complication or confusion, demonstrating a clear, simple, non-bureaucratic approach to work.

Working Together

Form effective partnerships and relationships with people internally and externally from a range of diverse backgrounds. Strive to work with others to reach a common goal; sharing information, supporting colleagues and seeking expertise, ideas and solutions from others where needed. Actively listen and take on board the views and opinions of others.

Excellence

Seek out opportunities to create effective change and suggest innovative ideas for improvement. Review your ways of working, including seeking and providing feedback to improve services. Demonstrate a **can-do** and professional attitude.

Safe | Personal | Effective

How do you use the Framework?

The framework is designed to set out the behaviours we should all be striving to demonstrate in all of our activities. It should be used as an **easy to use** tool for our working relationships as well as using it alongside key people activities, such as recruitment, training, performance and development reviews.

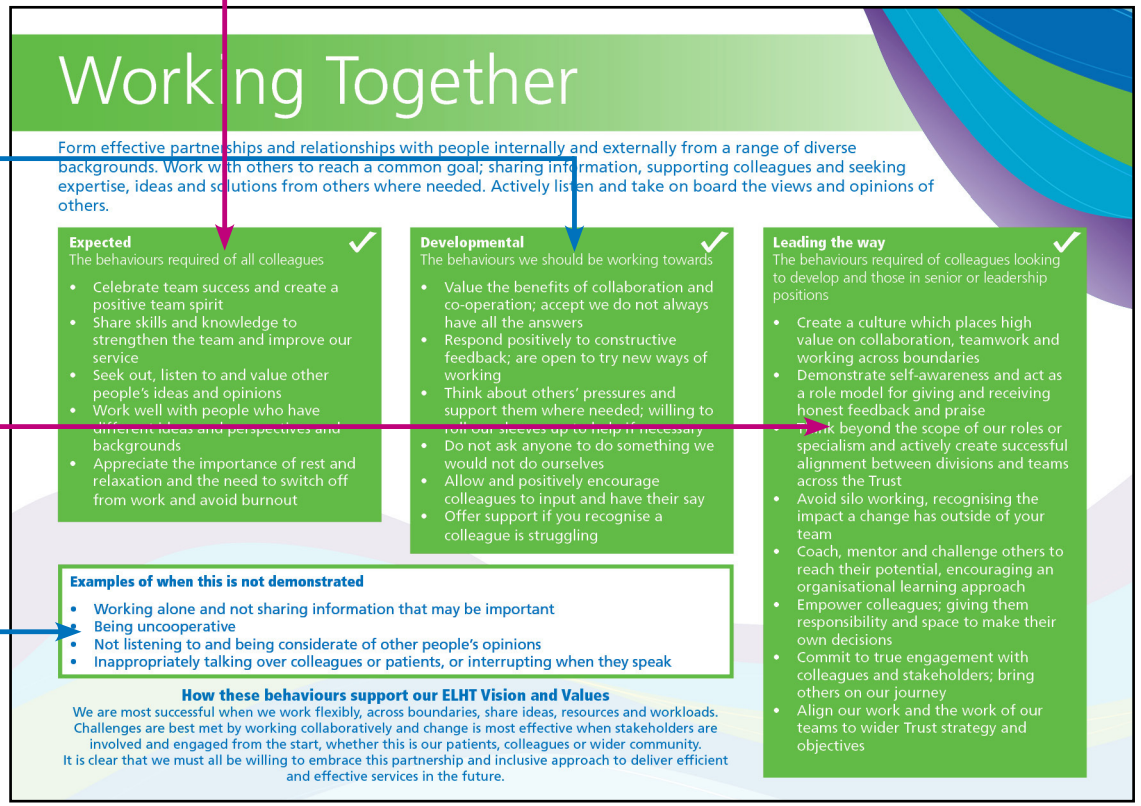
The framework is made up of five elements.

Each element outlines the behaviours that ***we expect*** at ELHT from all of our colleagues.

Each element also outlines behaviours that many colleagues will already demonstrate and that we should all be working towards. Training and support may be needed to help colleagues develop.

Additional behaviours that are expected of people managers, senior leaders and those colleagues looking to develop further are also detailed for each element.

Examples of unhelpful behaviours are also provided. These can negatively affect our colleagues and the care or service we provide.



Working Together

Form effective partnerships and relationships with people internally and externally from a range of diverse backgrounds. Work with others to reach a common goal; sharing information, supporting colleagues and seeking expertise, ideas and solutions from others where needed. Actively listen and take on board the views and opinions of others.

Expected
The behaviours required of all colleagues

- Celebrate team success and create a positive team spirit
- Share skills and knowledge to strengthen the team and improve our service
- Seek out, listen to and value other people's ideas and opinions
- Work well with people who have different ideas and perspectives and backgrounds
- Appreciate the importance of rest and relaxation and the need to switch off from work and avoid burnout

Developmental
The behaviours we should be working towards

- Value the benefits of collaboration and co-operation; accept we do not always have all the answers
- Respond positively to constructive feedback; are open to try new ways of working
- Think about others' pressures and support them where needed; willing to roll our sleeves up to help if necessary
- Do not ask anyone to do something we would not do ourselves
- Allow and positively encourage colleagues to input and have their say
- Offer support if you recognise a colleague is struggling

Leading the way
The behaviours required of colleagues looking to develop and those in senior or leadership positions

- Create a culture which places high value on collaboration, teamwork and working across boundaries
- Demonstrate self-awareness and act as a role model for giving and receiving honest feedback and praise
- Think beyond the scope of our roles or specialism and actively create successful alignment between divisions and teams across the Trust
- Avoid silo working, recognising the impact a change has outside of your team
- Coach, mentor and challenge others to reach their potential, encouraging an organisational learning approach
- Empower colleagues; giving them responsibility and space to make their own decisions
- Commit to true engagement with colleagues and stakeholders; bring others on our journey
- Align our work and the work of our teams to wider Trust strategy and objectives

Examples of when this is not demonstrated

- Working alone and not sharing information that may be important
- Being uncooperative
- Not listening to and being considerate of other people's opinions
- Inappropriately talking over colleagues or patients, or interrupting when they speak

How these behaviours support our ELHT Vision and Values

We are most successful when we work flexibly, across boundaries, share ideas, resources and workloads. Challenges are best met by working collaboratively and change is most effective when stakeholders are involved and engaged from the start, whether this is our patients, colleagues or wider community. It is clear that we must all be willing to embrace this partnership and inclusive approach to deliver efficient and effective services in the future.

Taking Responsibility

Take ownership of your work and use your initiative to deliver your objectives and role expectations.
Be accountable for your own performance and development by taking responsibility for your actions and decisions.

Expected
The behaviours required of all colleagues

- Reflect on your own performance and behaviour and ask for feedback
- Take responsibility and accountability for your own work
- Acknowledge when mistakes are made and take responsibility for addressing and correcting them
- Have a flexible approach and be adaptable to change
- Aim to resolve issues informally before escalating
- Always speak to someone if we see or hear unhelpful behaviours
- Deliver what you promise and to be honest if you are unable to fulfil
- Work safely following instructions and within working practices and guidelines

Developmental
The behaviours you should be working towards

- Empower others and encourage them to suggest improvements
- Appropriately challenge unhelpful behaviours
- Respond positively to constructive feedback; be open to try new ways of working
- Make suggestions rather than complaints
- Resolve conflict and disagreements quickly and professionally

Examples of when this is not demonstrated

- Seeking to find blame when things don't go as expected
- Not taking responsibility for your own actions and the part you have played
- Missing a deadline with no explanation
- Uses phrases such as "that's not my responsibility" as a reason not to do something when asked.
- Excusing negative and unhelpful behaviours as a personality trait and leaving them unchallenged as it may be difficult to address

Leading the way
The behaviours required of colleagues looking to develop and those in senior or leadership positions

- Establish what is important and communicate expectations clearly across the organisation
- Create a culture where colleagues take personal accountability for their actions and hold each other to account
- Balance risk against benefit and make courageous decisions where and when needed
- Set expectation that change; transformation and improvement are a constant across the Trust and wider system
- Promote a Just Culture, where professionals can learn from mistakes without fear or blame
- Address performance and behavioural issues even if this may be controversial and difficult; support people to improve
- Balance own ambition with acting for the greater good

How these behaviours support our ELHT Vision and Values

Taking responsibility and being proactive avoids a blame culture and allows us all to focus on continually improving the way we work and the services we offer.
By taking responsibility, our patients, community and colleagues gain confidence and therefore take reassurance about the quality of our service.

Building Trust and Respect

Recognise the importance of self awareness and the impact you have on others. Value difference, diversity and inclusion, ensuring fairness and opportunity for all. Be open and listen carefully to the views and opinions of others. Build relationships based on trust, respect, compassion and kindness.

Expected ✓
The behaviours required of all colleagues

- Compassionate, inclusive, caring and empathetic towards colleagues, patients and their families
- Respectful and considerate in language and action
- Recognise and value others; give praise, say thank you
- Support each other when things are challenging
- Open and honest in everything you do

Developmental ✓
The behaviours you should be working towards

- Reflect on your behaviours and how this might impact on others
- Challenge disrespectful or discriminatory behaviour or language
- Recognise where there is a need to compromise
- Make decisions about people based on facts rather than favouritism, opinion or any kind of discrimination

Leading the way ✓
The behaviours required of colleagues looking to develop and those in senior or leadership positions

- Lead a culture of honesty, respect, fairness and trust by being inclusive in approach – recognise and celebrate the diversity and individual talents of your colleagues
- Listen to patients, colleagues and stakeholders in order to understand the impact that decisions have on them
- Ensure that inclusion is at the heart of everything
- Show a role models integrity; be seen as an inspirational figurehead by colleagues and stakeholders
- Lead by example and role model our Trust values
- Be self aware; understand and reflect that how you act can impact on your team and other colleagues

Examples of when this is not demonstrated

- Reacting negatively or rudely when asked to do something different by a colleague or manager
- Being unhelpful and/or obstructive
- Being rude or impolite
- Lack of consideration for others
- Use of discriminatory language or displaying discriminatory behaviours towards others

How these behaviours support our ELHT Vision and Values

Respecting the diversity and opinions of our patients, colleagues and communities is key to ensuring we are a truly inclusive organisation.
It improves our patient experience, colleague relationships, creates mutual trust and removes barriers.
It creates a better place to work and in turn impacts positively on our communities and the services we provide.

Working Together

Form effective partnerships and relationships with people internally and externally from a range of diverse backgrounds. Work with others to reach a common goal; sharing information, supporting colleagues and seeking expertise, ideas and solutions from others where needed. Actively listen and take on board the views and opinions of others.

Expected

The behaviours required of all colleagues

- Celebrate team successes and create a positive team spirit
- Share skills and knowledge to strengthen your team and improve our services
- Seek out, listen to and value others ideas and opinions
- Work well with people who have different ideas, perspectives and backgrounds
- Appreciate the importance of rest and relaxation and the need to switch off from work and avoid burnout

Developmental

The behaviours you should be working towards

- Value the benefits of collaboration and co-operation; accept we do not always have all the answers
- Respond positively to constructive feedback; be open to try new ways of working
- Think about others' pressures and support them where needed; be willing to help
- Do not ask someone to do something you would not do yourself
- Allow and positively encourage your colleagues to input and have a say
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Leading the way

The behaviours required of colleagues looking to develop and those in senior or leadership positions

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How these behaviours support our ELHT Vision and Values

We are most successful when we work flexibly, across boundaries, share ideas, resources and workloads. Challenges are best met by working collaboratively and change is most effective when stakeholders are involved and engaged from the start, whether this is our patients, colleagues or wider community. It is clear that we must all be willing to embrace this partnership and inclusive approach to deliver efficient and effective services in the future.

Excellence

Seek out opportunities to harness diverse views, talents and ways of thinking among staff and stakeholder groups to create effective change and suggest innovative ideas for improvement. Review ways of working, including seeking and providing feedback to improve services. Demonstrate a **can-do** and professional attitude.

Expected

The behaviours required of all colleagues

- Have a 'can do' attitude and are willing to go the extra mile for patients and colleagues
- Work with patients, community and colleagues to ensure we are able to meet their expectations
- Focus on solutions and not problems
- Take responsibility for developing your own skills for the future
- Open to and recognise the need for change and improvement
- Positive, polite, professional and friendly approach to all colleagues, patients and visitors to our Trust

Examples of when this is not demonstrated

- Actively obstructing the delivery of excellence and improvement
- Showing lack of concern in the quality of your own work
- Sticking to outdated models of working; "We've always done it that way"
- Unwilling to be exposed to change or uncertainty

Developmental

The behaviours you should be working towards

- Open to, promote and drive continuous improvement by asking 'How could we do this better?'
- Adopt an improvement mindset and by challenging 'why' we do things the way we do.
- Plan and anticipate changes in working practices and don't just do things the way they have always been done
- Recognise potential barriers or fear of change and identify ways in which these might be minimised
- Recognise and share positive outcomes and experiences
- Make full and best use of digital technologies and resources
- Respond positively to constructive feedback; be open to try new ways of working
- Recognise the need for agile and flexible responses to challenges and barriers

Leading the way

The behaviours required of colleagues looking to develop and those in senior or leadership positions

- Promote a culture of professionalism and excellence when dealing with others whether internal or external at all levels
- Promote an agile and flexible working culture of innovation and creativity, encourage new ways of thinking and eliminate barriers
- Build excitement and inspire others to invest in their own development, so that they can become the best version of themselves
- Create an inclusive environment which values and celebrates diversity and encourages colleagues to freely and openly share their thoughts and opinions
- Lead the transformation agenda towards using digital technologies to improve our services; ensuring full consideration of the diverse range of end users
- Be clear about our expectations and purpose by providing clear objectives
- Lead and enable teams to shift from 'fire fighting' to 'process improver'

How these behaviours support our ELHT Vision and Values

We at ELHT pride ourselves on the quality of our services, of putting safety and quality at the heart of everything we do and in looking to the future for new, better and more innovative ways of working. Encouraging feedback, embracing change and striving for improvement as individuals, teams and services will ensure we continue to meet the high expectations of our communities.

Keeping it Simple

Communicate clearly and concisely, to ensure the message is understood by all. Actively work to prevent over-complication or confusion, demonstrating a clear, simple, non-bureaucratic approach to work.

Expected ✓
The behaviours required of all colleagues

- Understand and make best use of Trust systems and procedures to support the work we do at ELHT
- Make sure your communication style suits our audience and consider how it will be received
- Communicate openly and regularly to keep colleagues, managers, patients and our community informed
- Limit use of jargon, abbreviations, terminology and language which all may not understand
- Ensure services and processes are designed with the user in mind

Developmental ✓
The behaviours you should be working towards

- Summarise or simplify complex information to make sure it is widely understood
- Think through in advance how you can best communicate with your colleagues
- Provide instructions and briefings clearly and concisely using appropriate language
- Make informed decisions based on data, research or best practice where appropriate

Leading the way ✓
The behaviours required of colleagues looking to develop and those in senior or leadership positions

- Promote colleague and stakeholder confidence through relevant, effective and an engaging approach to communication
- Commit to the reduction of unnecessary bureaucracy and barriers to efficiency
- Champion creativity and innovation, including new technology, to improve service delivery and the experience of our patients and community
- Focus on our key Trust priorities; challenge activity or behaviours that distract or detract from delivering these priorities
- Avoid silo working; recognise the impact a change has outside of your team

Examples of when this is not demonstrated

- Overcomplicating approaches to work and creating unnecessary bureaucracy
- Choosing and using ways of communicating that lead to confusion and are not appropriate for the audience
- Including people in communications such as emails unnecessarily
- Working in a way that may put self or others at risk e.g. not wearing PPE when advised to

How these behaviours support our ELHT Vision and Values

Being inclusive and taking a simple, focussed approach to our service delivery and the way we all communicate improves access, understanding and removes barriers. Using the systems we have not only helps us work efficiently, but provides consistency of approach, openness, transparency and helps us to maintain quality and compliance.

What do you need to do next?

This Framework defines how we can all contribute to the success of our organisation and to our own successes as individuals and as a team. Adopting and embracing these behaviours will help to achieve our Trust's ambition to deliver **Safe, Personal and Effective** care and continue to make ELHT a great place to work.

Everyone

Actively engage with colleagues to understand the framework and how it will work in your area

Reflect on our own behaviours – this means **ALL OF US**

- What kind of language do you use? Is it appropriate, professional and friendly?
- Think about your body language - How do you come across to others?
- How do you make people feel when you are around?
- How do you respond to constructive feedback if someone gives it to you?

Don't immediately react, remember to...

STOP - REFLECT - CONSIDER

People and culture sharepoint

Manager's resource

Team agreement

Real conversations

Reflecting on feedback

How to have a coaching conversation

People Managers

- Share this **Behaviour Framework** with your team to ensure understanding
- Agree as a Team what you need to do to make it work
- Agree what you are going to do if someone isn't displaying our ELHT behaviours
- Document and display what you agree in your work areas
- Always take a coaching approach to addressing any unhelpful behaviours

BE CLEAR – BE KIND

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

10 November 2021

Item: **139**

Purpose: **Information**
Action
Monitoring

Title	North West Staff Health and Wellbeing Programme and Pledges
Author	Mrs L Barnes, Associate Director Staff Wellbeing & Engagement ELHT and BTH
Executive sponsor	Kevin Moynes, Executive Director of Human Resources and Organisational Development

Summary: Board members are asked to note the information regarding the North West staff health and wellbeing programme and pledges. Members are also asked to discuss, support and approve the outlined recommendations.

Report linkages

Related strategic aim and corporate objective	Provide high quality, safe and effective care. To achieve this in a financially sustainable way, through our skilled and motivated workforce
Related to key risks identified on assurance framework (Delete as appropriate)	Failure to attract, recruit and sustain appropriately skilled and representative workforce Failure to foster, grow and continuously nurture the right culture where everyone feels they belong, safe, healthy and well Failure to deliver high quality clinical services

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by:

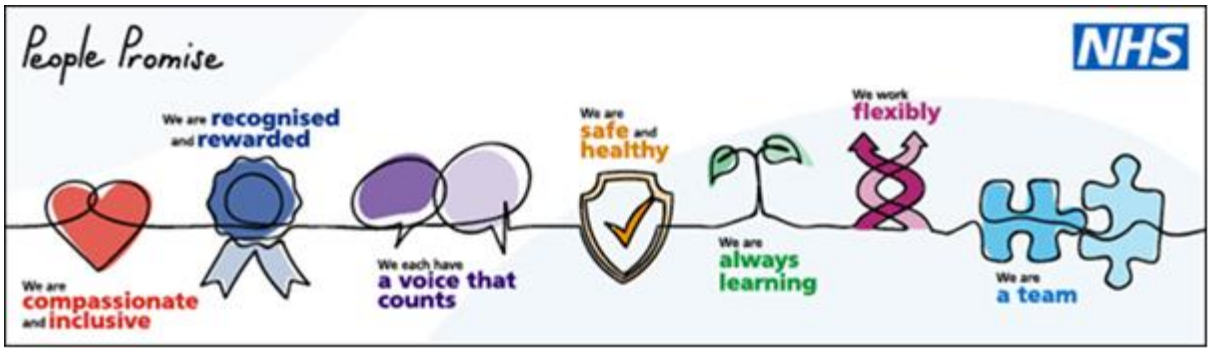
Executive summary

1. In September 2021, Chief Executives, Chairs, Wellbeing Guardians and Staff Side Chairs were invited to a North West workshop to discuss staff health and wellbeing. Attendees were asked to commit to organisational actions to enhance and enable holistic health and wellbeing. This report provides Board members with an overview of the pledges and the next steps to support implementation.

Introduction

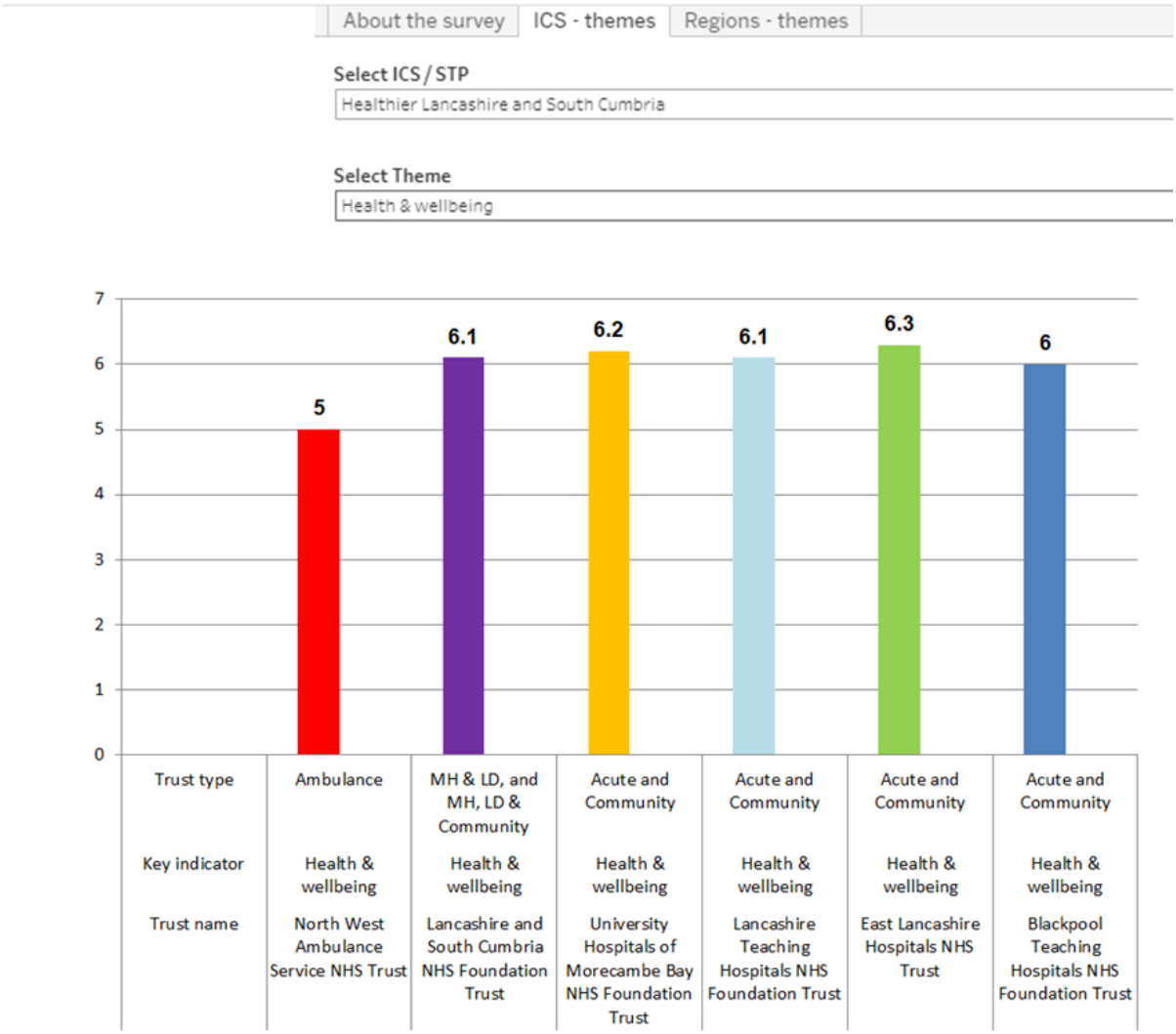
2. The NHS People Plan and People Promise set out actions to support transformation across the whole NHS. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care. The actions are organised around four pillars:
    - Looking after our people- with quality health and wellbeing support for everyone.
    - Belonging in the NHS- with a particular focus on tackling the discrimination that some staff face.
    - New ways of working and delivering care- making effective use of the full range of our people's skills and experience.
    - Growing for the future- how we recruit and keep our people, and welcome back colleagues who want to return.

3. The NHS People Promise has come from those who work in the NHS. People in different healthcare roles and organisations have made it clear what matters most to them, and what would make the greatest difference in improving their experience in the workplace. The below infographic depicts what we should all be able to say about working at ELHT and across the NHS, by 2024:



4. The National Staff Survey has been identified as the principal way to measure progress across the 7 People Promise themes. Our National Staff Survey Health and Wellbeing indicator benchmarking position across Healthier Lancashire and South Cumbria can be seen below:

NHS Staff Survey 2020 regional dashboards by NHS Staff Survey Coordination Centre



5. It can be seen from the above that ELHT continues to have the best health and wellbeing indicator scores across our ICS. However to support our continuous improvement approach to staff health and wellbeing it would be of benefit to go further with our efforts and sign up to the North West staff wellbeing programme.

Programme and pledges overview

6. In September 2021, Chief Executives, Chairs, Wellbeing Guardians and Staff Side Chairs were invited to a North West workshop to discuss staff health and wellbeing. During the North West wellbeing workshop it was emphasised that across the NHS the historic predominant focus has been on reducing sickness absence which is focusing on the 5% not the 95% of our people. The workshop also highlighted it is imperative we re-focus and apply a holistic evidence based health and wellbeing approach to have both a proactive preventative approach to keep our people safe and healthy along with a compassionate and inclusive reactive restorative approach if colleagues become unwell.

7. During the workshop each organisation was asked to commit to a set of pledges and actions to help shift the emphasis to holistic health and wellbeing by:

a) Preparing our Board for the change:

- Why presenteeism is of at least equal importance to sickness absence.
- Significant policy shift - from a focus on sickness absence to holistic well-being and from rigid attendance management to a more person centred & flexible approach.
- Considerations for ethics, equality, diversity and inclusion - moving away from treating everyone the same to more individualised and person-centred approaches.
- How the approach aligns with embedding a just culture.

b) Evidencing that well-being is a priority at our Board by:

- Understanding the well-being of our people and how we are meeting their needs, giving staff a safe voice.
- Showing how a well-being lens is applied to all decisions.
- Understanding our organisation's culture, including what has been normalised, taking positive action to address the issues and support our People.

c) Committing to the three NW themes of enabling work:

- Well-being services that support the 95%.
- A new person-centred well-being and attendance management policy framework.
- Leadership development that supports managers in our new approach.

Timescales and next steps

8. The timescales and next steps for signing up to the programme are:

- By the end of November 2021 - Pledges and reflections discussed at Trust Board with the recommendation of a commitment for the organisation to sign up to the pledges and programme.
- By the end of December 2021 - Agree our organisation's enabling health and wellbeing action plan via a participative approach with key stakeholders.
- At the January 2022 Trust Board members sign off the enabling health and wellbeing action plan.
- Monitor progress at Board and sub-committees on a quarterly basis.

Recommendations

9. It is recommended that the Trust Board:

- Note that ELHT continues to have the best health and wellbeing indicator scores across our ICS following the implementation of our staff health and wellbeing approach.
- Support the sign up to the North West wellbeing programme and ethos.
- Commit the organisation to this programme, pledges and actions within the outlined timescales.
- Individually commit to participate in the programme by role modelling healthy leadership behaviours and demonstrating that an enhancing staff health and well-being lens is applied to all decisions.
- Agree to receive a draft enhancing staff health and wellbeing enabling plan for sign off at the Trust Board meeting in Jan 2022.

Conclusion

31. ELHT has made progress with our staff health and wellbeing approach to embed a holistic evidence based health and wellbeing approach. Further organisational commitment and support aligned to the North West health and wellbeing programme will help ELHT to continue our improvement journey and ambition to meet the people promise for all of our staff.

Lee Barnes

Associate Director Staff Wellbeing & Engagement ELHT and BTH 21.10.2021

Our pledge for the **wellbeing of our NHS people**

Insert organisation logo

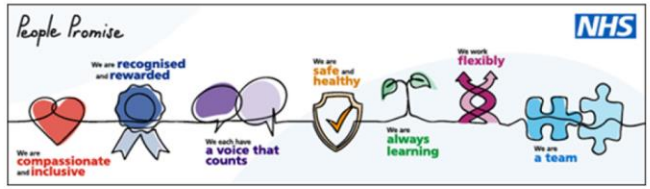
Signed……

Name……

We pledge to commit to shifting the wellbeing focus from the 5% to the 95% by:

- **preparing our board for the change** to take a more holistic, person-centred individual and flexible approach, which is driven through policy and aligns with embedding a just culture.
- **evidencing that wellbeing is a priority with our board by** understanding the wellbeing of our people, giving them a voice, making sure all decisions have a wellbeing lens applied and addressing any issues.
- **committing to the three North West's themes of enabling work**
  - wellbeing services that support the 95%
  - a new person-centred wellbeing approach and an attendance management policy framework
  - leadership development that supports managers in our new approach.

NHS Employers in association with NHS RAND EUROPE social partnership forum



East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item **140**

10 November 2021

Purpose Information
Action
Monitoring

Title	Patient Safety Incident Response Plan (PSIRP)
Author / Investigators	Mrs J Hardacre, Assistant Director of Safety and Effectiveness
Executive sponsor	Mr J Husain, Medical Director

Summary: The plan provides how the Trust will move away from reporting and investigating incident under the National Serious Incident Framework to working in line with the New Patient Safety Incident Response Framework.

Recommendation: The Trust Board are asked to review and approve the plan so a go live date can be set with the CCG and NHSE from moving from the Serious Incident Framework (SIF) to the new Patient Safety Incident Response Framework.

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 Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objective Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to 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	Yes/No	Financial	Yes/No
Equality	Yes/No	Confidentiality	Yes/No

Previously considered by:

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Patient safety incident response plan 2021/23

Finalised date: [ ]

Estimated refresh date: 01/04/2023

Safe | Personal | Effective

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1. Introduction, Purpose, scope, aims and objectives

1.1. Introduction and Purpose

The NHS Patient Safety Strategy was published in July 2019 and describes the Patients Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we have done at East Lancashire University Teaching Hospital NHS Trust (ELHT) to prepare for "go live" with PSIRF.

The Serious Incident Framework provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents.

One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

This Patient Safety Incident Response Plan (PSIRP) sets out how ELHT will respond to patient safety incidents reported by staff and patients, their families and carers as part of work to continually improve patient safety incident investigations (PSIIs) by:

- Refocusing PSII towards a system analysis approach and the rigorous identification of interconnected causal factors and system issues
- Focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents
- Transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents
- Demonstrating the added value from the above approach.

1.2. Scope

There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of system learning and improvement.

There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

This plan explains the scope for a systems-based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this document.

Responses covered in this Plan include:

- Patient Safety Reviews (PSRs)
- Patient Safety Incident Investigations (PSIIs)

Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners' inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this Plan.

To be effective in meeting their specific intended purposes, responses that are not conducted for patient safety learning and improvement are separate entities and will be appropriately referred as follows:

- human resource (employee relations) teams for professional conduct/competence issues and if appropriate, for referral to professional regulators
- legal teams for clinical negligence claims
- medical examiners and if appropriate local coroners for issues related to the cause of a death
- the police for concerns about criminal activity.

1.3. Aims and objectives

The implementation of PSIRF will see both the four strategic aims of the Patient Safety Incident Response Framework (PSIRF) upon which this plan is based, the overarching aims

and how these will be achieved through specific objectives (Table 1) and our Trust visions embodied in our work.

"To be widely recognized for providing Safe, Personal and Effective care"

Table 1. Overarching aims and specific objectives of the Patient Safety Incident Response Framework

Overarching aims	Specific objectives
1. Improve the safety of the care we provide to our patients.	• Develop a climate that supports a just culture[1] and an effective learning response to patient safety incidents. • Respond to patient safety incidents purely from a patient safety perspective • Reduce the number of duplicate PSIIs into the same type of incident to reduce waste, enable more resource to be focused on effective learning and so enable more rigorous investigations that identify systemic contributory factors • Aggregate and confirm validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents • Consider the safety issues that contribute to similar types of incident • Develop system improvement plans across aggregated incident response data to produce systems-based improvements • Better measurement of improvement initiatives based on learning from incident response
2. Improve the experience for patients, their families and carers wherever a patient safety incident or the need for a PSII is identified.	• Act on feedback from patients, families, carers and staff about their concerns with patient safety incident responses in the NHS. • Support and involve patients, families and carers in incident response, for better understanding of the issues and contributory factors
3. Improve the use of	• Transfer the emphasis from quantity of investigations

[1] A culture in which people are not punished for actions, omissions or decisions commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated. Eurocontrol (2019) Just culture.

valuable healthcare resources.	completed with an arbitrary deadline to a higher quality response to patient safety incidents, and the implementation of meaningful actions that lead to demonstrable change and improvement • Develop a local board-led, commissioner and integrated care system (ICS)/sustainability and transformation partnership (STP) assured architecture around response to patient safety incidents, which promotes ownership, accountability, rigour, expertise and efficacy
4. Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.	• Act on feedback from staff about their concerns with patient safety incident responses in the NHS. • Support and involve staff in patient safety incident response, for better understanding of the issues and contributory factors

2. Resource analysis

A review of the PSII resource and activity (associated with patient safety incident investigation) for the period January 2017 to December 2020 has been undertaken to determine how many PSIIs can be supported during December 2021 to March 2023. This review has been undertaken alongside the Patient Safety Incident Standards to ensure that all future PSIIs are compliant with these standards.

This review has been undertaken by the Trust's Quality and Safety team with support and involvement from the Quality Improvement Team in identify the Trusts local priorities.

In summary East Lancashire Teaching Hospitals has identified that it is able to undertake 60 PSIIs across the Trust per annum. Each lead investigator will be supported by the Patient Safety Investigator administrator and subject matter experts as appropriate. Further support in terms of a family liaison officer will be provided by clinical staff within Divisions to ensure patient/family/carers are involved and kept informed of progress.

To improve our ability to deliver against PSII standards the trust plan to:

- Assign a team of appropriately trained Patient Safety Incident investigators who have received system based training on incident investigation methodologies.
- Assign an appropriately trained board member to oversee delivery of PSII standards and support the sign off of all PSIIs
- Develop an incident investigation toolkit to support other trust staff so they can review patient safety incidents where a PSII is not indicated but learning can still be identified.

2.1. Background

There are many ways an organisation can respond to a patient safety incident to learn and improve.

Patient Safety Reviews (PSRs) include several techniques to identify areas for improvement, immediate safety actions and to respond to any concerns raised by the affected patient, family or carer. Different PSR techniques can be adopted depending on the intended aim and required outcome. All PSRs are conducted locally by our organisation.

There are four broad categories of PSRs (see Appendix B. Patient Safety Review Types for more information):

- Incident recovery
- Team reviews
- Systematic reviews
- Monitoring

Patient Safety Incident Investigations (PSIIs) are distinct from PSRs and include a range of techniques (such as interviews and observations) to systematically identify the circumstances surrounding incidents.

While most PSIIs are conducted locally by our organisation, some are conducted independently. Independent PSIIs can be funded by our organisation or regionally / nationally.

Some types of patient safety incidents have been identified as national priorities and require a specific response. See Appendix A for a full list of national priorities, and what response is required to them.

All patient safety incidents leading to moderate harm or above and all incidents for which a patient safety incident investigation is undertaken trigger the Duty of Candour. (Trust Policy: C075 Openness and Honesty policy inc. Duty of Candour)

Understanding our capacity to respond to incidents enables us to be strategic in proactively allocating resources to responding to patient safety incidents that are not included in the list of national priorities.

This section outlines our approach to understanding our available resources, it describes how we are ensuring our resources meet standards required in the National PSII standards and details how much resource we have available to proactively plan how we will respond to key risks that fall outside national priorities.

2.1. Understanding patient safety incident response activity

The Trust completed a review of three years data which included:

- National priorities:
    - Never Events
    - Learning from Deaths

    - All other national priorities covered in appendix A
- Patient safety incident investigations conducted locally for example:
    - Independent investigations conducted locally but including/requiring a funded independent specialist
    - Incidents reported to StEIS 'coroner initiated' patient safety investigations
    - Patient safety reviews (non StEIS incidents meeting the requirements of Duty of Candour which are currently investigated by divisional teams including concise reports completed for learning).

Table 2. Average annual response activity for 2018-2020

Response type	Category	Average annual number of responses
National priorities requiring patient safety incident investigation	Patient safety incident investigation into Never Events	4
	Patient safety incident investigation into deaths thought more likely than not to be due to problems in care.	10
	All other StEIS incidents figure does not included incidents de-escalated (Pressure Ulcers)	62 (16)
Patient safety incident investigations conducted locally	Manage within Division full incident investigation (Including moderate harm incidents meeting the requirement for statutory Duty of Candour, but not meeting Serious Incident Framework criteria)	72
	Manage within Division concise reviews (Including moderate or lower harm incidents requiring validation at divisional level	49
Patient safety reviews	LeDeR	14
	SJR 1	90
	SJR 2	15
	PMRTs	40

2.2. Patient safety incident response skills - gap analysis

A review of the PSII resource and activity associated with existing Serious Incident Investigations for the period 2018 - 2020 has been undertaken to determine how many PSIIs can be supported during 2021/23. This review was carried out alongside the Patient Safety Incident Standards to ensure that all future PSIIs are compliant with these standards.

In addition, a review has been completed to determine the current level of resource for non-PSII related activity. This supports planning of appropriate responses using different review techniques where PSII is not indicated.

Under the Serious Incident Framework ELHT have over 200 investigators who have completed patient safety incident investigation training but have limited time and resources to complete these. The Trust has also trained clinical staff to completed SJR and LeDeR reviews and has set up a multi-disciplinary panel to complete PMRTs.

- LeDeR trained reviewers x 3
- SJR 1 trained reviewers x 22 (plus 1 being trained)
- SJR 2 trained reviewers x 2 (currently managing demand)

2.3. Resources for proactive planning

Under the new PSIRF the Trust have commissioned a Patient Safety Incident Investigation Team who will be responsible for completing all National and Local priorities, ad hoc complex investigations provide investigation skills training for staff across the trust and disseminate lessons learnt. The team will consist of:

- 2 x permanent WTE PSII Leads – Band 8a
- 2 x 12 month fix term WTE PSII Leads– Band 8a
- 1 x permanent WTE PSII Administrator – Band 4

Team resources will be reviewed at 6 months and 12 months to gain an understanding for funding for the following 5 years.

Each investigator lead will be supported by an investigation team comprising: medical/clinical expert, family liaison officer and the PSII administrator. This team will be responsible for leading on all National, five local priority investigations and ad hoc complex investigations where a full PSII is required. Executive leads will be identified as and when required.

To improve our ability to deliver against PSII standards and completion of other investigation covered by PSRs and local non StEIS incidents the trust plan to:

- Assign an appropriately trained member of the Executive Team to oversee delivery of the PSII standards and support the sign off of all PSIIs.
- Invest in SEIPS training for the PSII Team and update training as and when required.
- Provide incident investigation training for all staff completing PSR investigation in specific areas. This could include for example:
    - Application of updated analytical tools to support PSR
    - Training in identifying and understanding human factors including unconscious bias
    - Development of safety improvement plans using QI methodology and improvement science approaches

Table 3. Proactive response planning: overview of estimated resource allocation for patient safety incidents that fall outside national priorities

Response type	Category	Total number of responses
PSII	Locally defined PSIIs	30
	Unanticipated incidents	12
PSRs	All types (LeDer, PMRTs, SJRs 1 and 2)	159
	Incidents resulting in moderate or severe harm to patient (not including Pressure Ulcers)	33

3. Risk analysis

3.1. Risk stakeholders and data inputs

The Trust used a thematic analysis approach to determine which areas of patient safety activity it should focus its local patient safety priorities. Our analysis used a number of data sources and safety insights from key stakeholders.

The patient safety risk process was a collaborative process to enable us to define the top 20 patient safety risks from incident reporting and then cross reference these from a number of other data source including key stakeholders.

Key stakeholders included:

- Senior Managers within the Trust
- Staff from all levels and areas
- Commissioners
- Patient Participation Groups and Health Watch

The Trust reviewed three years of data from January 2018 to December 2020. Data sources included:

- patient safety incident reports
- complaints
- mortality reviews
- claims and outcome of inquests
- risk assessments
- safety insights from key stakeholders held at 4 Quality Workshops

3.2. Local patient safety risk profile

Through our analysis of patient safety insights, based on both the original incident review, safety insights provided by key stakeholders and using the criteria in table 4, the trust have determined its 5 local patient safety priorities it will focus on to March 2023 in table 5.

Table 4. Criteria for defining top local patient safety risks

Criteria	Considerations
Potential for harm	• People: physical, psychological, loss of trust (patients, family, caregivers) • Service delivery: impact on quality and delivery of healthcare services; impact on capacity • Public confidence: including political attention and media coverage
Likelihood of occurrence	• Persistence of the risk • Frequency • Potential to escalate

Table 5. Top local patient safety risks

	Incident type	Description	Specialty
1	**Nutrition and Hydration**	Vulnerable adults - nil by mouth	Trust wide
2	**Slips, Trips and Falls**	Inpatient fall leading to Fracture Neck femur	Trust wide
3	**Communication**	DNACPR with patient / family	Trust wide
4	**Transfer/Handover**	Internal transfer/handover of patients from ED to other areas of the Trust	ED
5	**104 Day Cancer (Trauma cases)**	Delay in cancer treatment which caused moderate or above harm to a patient	Cancer

3.3. Locally defined responses

Through our analysis of patient safety insights, potential for learning and improvement, systemic risk and resources available to complete PSII investigations the trust will completed 6 PSIIs on each of the local patient safety priorities in table 7.

All other patient safety incidents/risks will be triaged and allocated a PSR response. For further details on PSRs see appendix B.

Table 6. Criteria for selecting risks for PSII response

Criteria	Considerations
Potential for learning and improvement	• Increased knowledge: potential to generate new information, novel insights, or bridge a gap in current understanding • Likelihood of influencing: healthcare systems, professional practice, safety culture. • Feasibility: practicality of conducting an appropriately rigorous PSII • Value: extent of overlap with other improvement work[2]; adequacy of past actions
Systemic risk	• Complexity of interactions between different parts of the healthcare system

Table 7. Planned responses for top local patient safety risks

	Incident type	Description	Response type	Number of responses (if PSII)
1	**Nutrition and Hydration (NBM)**	Nil by mouth – vulnerable adults	Full PSI Investigation	6
2	**Slips, Trips and Falls**	Fracture Neck femur	Full PSI Investigation	6
3	**Communication (DNACPR)**	DNACPR with patient / family	Full PSI Investigation	6
4	**ED Transfer/Handover**	Internal transfer of patients from ED	Full PSI Investigation	6
5	**104 Day Cancer breach**	All Trauma cases	Full PSI Investigation	6

3.4. Approach to Patient Safety Incidents

Deciding what to investigate through a Patient Safety Incident Investigation (PSII) process will be a flexible approach, informed by the national and local priorities. Our objective is to facilitate an approach that involves decision making through a triage process to identify National and local priorities and potential for learning and improvement and system risks.

2

Table 8: Planned responses to Patient Safety Incidents (see appendix A for full list of national priorities and appendix B for a list of PSR tools)

			Event	Approach	Improvement
Patient Safety Event Occurs	Patient Safety Incident Investigation	National Priorities	Incidents meeting each baby counts criteria	Referred to Healthcare Safety Investigation Branch (HSIB)	Respond to recommendations from external referred agency / organisation as required.
			Incidents meeting maternal death criteria		
			Child Death	Initiate child death review process	
			Death of person with learning disabilities	Reported and reviewed by Learning Disabilities Mortality Review (LeDeR) programme	
			Safeguarding incidents meeting criteria	Reported to ELHT named safeguarding Lead	
			Incidents in screening programmes	Reported to Public Health England (PHE)	
			Deaths of patients in custody, in prison or on probation	Reorted to Prison and Probation Ombudsman (PPO)	
			Incidents meeting the Never Event criteria	Patient Safety Incident Investigation Team	Create local organisational recommendations and safety improvement plans.
			Incidents resulting in death	Patient Safety Incident Investigation Team	
		Trust Priorities	• Nutrition and Hydration NBM • Slips, Trips and Falls • DNACPR communication • ED Transfer / Handover • 104 Day Cancer Breach • Emergent area of risk	Patient Safety Incident Investigation Team	Create local organisational recommendations and safety improvement plans feeding into Quality Improvement Strategy
	Patient Safety Review	Local Level	Incident resulting in moderate or severe harm to patient	Statutory duty of candour and appropriate PSR tool	Inform thematic analysis of ongoing patient safety risks at teams, speciality, directorate, divisional and trust level
			No / Low Harm Patient Safety Incidents	Validation of facts at local level recorded on DATIX	

3.5. Timescales for PSIIs

Where a PSII is required (as defined in this Plan for both local and national priorities), the investigation will start as soon as possible after the patient safety incident is identified.

PSIIs will ordinarily be completed within one to three months of their start date.

In exceptional circumstances, a longer timeframe may be required for completion of a PSII. In this case, any extended timeframe will be agreed between the ELHT and the patient/family/carer.

No PSII should take longer than six months. A balance will be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

4. Aggregating learning from incident responses

Findings from PSIIs and PSRs provide key insights and learning opportunities, but they are not the end of the story.

Findings will be translated into effective improvement design and implementation.

If a single response reveals significant risk(s) that require(s) immediate safety actions to improve patient safety, these actions will be made as soon as possible.

All other recommendation development will consider aggregated findings across all or a subset of responses into a single risk.

To aggregate learning, findings from each individual response linked to a specific risk will be collated to identify common contributory factors and any common interconnections or associations upon which effective improvements can be designed. Associated recommendations and monitoring arrangements will be summarised in a System Improvement Plan.

Consideration will be given to the timeframe taken to complete a System Improvement Plan and the impact of extended timescales on those involved in the incident.

System Improvement Plans will be shared with those involved in the incident including patients, families, carers and staff.

5. Roles and responsibilities

This organisation describes clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents.

5.1 **Chief Executive and the Board of Directors**

The Chief Executive and Trust Board has the ultimately responsibility for all aspects of risk management and safety, including the management of incidents. This includes ensuring that suitable arrangements are in place for the systematic investigation, analysis and improvements, both locally and corporately including resources are available to comply fully with this plan.

5.2 **Executive Directors**

All Executive Directors have responsibility for ensuring incidents are investigated in a timely manner and responded to in accordance with this plan. Oversees the development and review of the organisations PSIRP, ensuring sufficient resources to support the delivery of the PSIRP (including support for those affected, such as staff, patients, families and carers where required) and Duty of Candour is upheld.

5.3 **Executive Medical Director**

The Executive Medical Director has day to day responsibility for managing the strategic development and implementation of risk management in the areas of quality, patient safety and effectiveness. They are responsible for ensuring an adequate system is in place for incident management, including reporting at all levels up to Trust Board, and to inform the Board of serious incidents as they occur including immediate actions taken.

5.4 **Associate Director of Quality and Safety**

The Associate Director of Quality & Safety supports the Executive and Non-Executive Directors in carrying out their responsibilities for risk and incident management and takes the management lead within the Trust for developing and implementing the Board Assurance Framework. They have overall responsibility as lead manager for the Trust's risk, patient safety, health & safety, complaints and litigation functions and has overall responsibility for ensuring the development, planning and implementation of these aspects of the Trust's governance programme.

5.5 **Assistant Director of Patient Safety and Effectiveness**

Has the responsibility for ensuring that the Trust has robust incident management systems and processes in place that meet the requirement of the Patient Safety Incident Reporting Framework and the plan, that they are utilised effectively to identify learning and change to prevent recurrence. They are also responsible for providing assurance on Patient Safety incident management processes and overseeing the functionality of the Trust's Patient Safety Incident panels.

5.6 **Divisional / Directorate Managers, Clinical Leads, Lead Matrons/Matrons/Senior Nurses and Service Managers**

Ensure that appropriate experts are available to support the Patient Safety Incident Investigation Leads to carry out investigations within the relevant divisions. They ensure that all investigations are completed in a timely manner by releasing all staff involved within an incident to attend any investigation discussions. The Divisional Directors of Nursing and/or Clinical Director agree risk reduction action plans and ensure that all relevant risks identified from incident reports are included on the divisional risk registers. They also ensure the completion of any action plans arising from incidents and report as necessary to professional bodies e.g. Nursing Midwifery Council (NMC), General Medical Council (GMC) if staff conduct or performance is proven to be deficient.

5.7 **Divisional Quality and Safety Leads**

The Quality and Safety Leads support the Trust's Divisional and Directorate teams in ensuring that the Divisions / Directorates review, manage, investigate and monitor learning from incidents. They work closely with the Patient Safety Incident Reporting and Investigation Teams in supporting the timely and appropriate reporting, recording, investigating and co-ordinating of all incidents. The Quality and Safety Leads are responsible for ensuring that risks and trends from incidents are escalated through the risk management process. Any learning is included within the Divisional Patient Safety and Risk Reports (DPS&R) or Divisional Quality Safety Board (DQSB) and reported to Divisional Managers Boards (DMB) so learning can be cascaded through the Quality and Safety processes within the division/directorates.

5.8 **Patient Safety Incident Reporting Team**

The Patient Safety Team are responsible for reviewing all incidents reported on the DATIX incident management system, obtaining additional information and amending incident details as necessary. They will manage and co-ordinate the triage of all incidents assigning the correct level of investigation in conjunction with the Divisional Quality and Safety Leads. The Team are required to report incidents to relevant external Stakeholders in accordance with their reporting requirements and timely

submission of investigation reports to Patient Safety Incident Panels for final sign off and onward reporting to other external bodies as required.

5.9 **Patient Safety Incident Investigation Leads**

The Patient Safety Incident Investigation Lead is responsible for undertaking a full investigation into patient safety that meet the criteria within the plan, that are conducted in accordance with the plan and working closely with the family liaison officer to ensure patient/family/carers are given an opportunity to provide relevant information that will support the investigation, that they are kept informed of the process and outcome of the investigation.

5.10 **Family Liaison Officer**

They are responsible for ensuring appropriate support is offered to the patient/family/carers and confirming any questions of concern the family/patient/carer would like including as part of the key lines of enquiry of an investigation being the link person for patient/carer/family and ensuring that they are given the opportunity to provide relevant information that may inform the outcome of the investigation and linking in with the Patient Safety Incident investigation Lead.

5.11 **All Staff**

All staff are required to provide information either/both verbal or written reports for any investigation for an unexpected event or incident in a culture of being open and honest, supporting colleagues with a view to learning lessons in a just culture. Line managers have a responsibility to ensure staff are released from duty to attend debriefings, round table discussions, interviews regarding any incident.

5.15 **Trust Board**

Trust Boards have a clear duty to ensure investigation of patient safety incidents and satisfy themselves that all reasonable steps have been taken to prevent a recurrence. This has to be done, at the earliest opportunity, openly, and within a culture that seeks to learn from the event. The Trust Board are responsible for the final approval of all outcome reports, actions and quality improvements.

5.16 **Quality Committee**

Receive bi-monthly reports regarding all patient safety incidents meeting the national or local reporting criteria and will review any trends or clusters of incidents to ensure appropriate action is taken.

5.17 **Patient Safety and Risk Group (PSARG)**

Receive bi-monthly reports regarding all patient safety incidents meeting the national or local reporting criteria and will review any trends or clusters of incidents to ensure appropriate action is taken and escalated to Quality Committee as required. Review and monitor safety improvement plans to ensure they are fully implemented and reduce the likely hood of a similar incidents happening again within the Trust.

5.18 **Patient Safety Incident Requiring Investigation (PSIRI) Panel**

Receive national and local priority incident investigation reports at a Trust level to review and approve the quality of the investigations carried out by the investigator which includes the learning from incidents, lessons to be shared and agree appropriate safety improvement plan to be taken to reduce the likely hood of a similar incident happening again. This has to be done, openly, and within a culture that seeks to learn from the event. To identify any trends, clusters or risks which cannot be actioned and take appropriate action, escalating when required to appropriate committee.

3.19 **Divisional Patient Safety Incident Reporting Group (DPSIRG)**

Receive National, Local and Divisional incident investigation reports at a divisional and trust level to review and approve the quality of the investigations carried out by either the Patient Safety Incident investigator Lead or named divisional lead which includes the learning from incidents, lessons to be shared and agree appropriate safety improvement plan to be taken to reduce the likely hood of a similar incident happening again. This has to be done, openly, and within a culture that seeks to learn from the event. To identify any trends, clusters or risks which cannot be actioned and take appropriate actions and escalate if required to PSIRI and / or Patients Safety and Risk Group.

6. Patient Safety Incident reporting arrangements

This section should be read in conjunction with Incident Reporting Policy C003 and Openness and Honesty inc. Duty of Candour policy C075.

6.1 Immediate responses required

In all instances, the first priority for the Trust is to ensure the needs of individuals affected by an incident are attended to, including any urgent clinical care which may reduce the harmful impact.

A safe environment should be re-established with all equipment/consumables or medication retained and isolated and all relevant documentation copied and secured to preserve evidence to facilitate the investigation and learning. If there is a suggestion that a criminal offence has been committed, the organisation should contact the police. If regard staff may need to refer to vulnerable adult or children's safeguarding if required.

Steps must be taken to ensure members of staff, visitors and the service users are not put at further risk by the after effects of the incident. It is the responsibility of the person in charge or manager to ensure that the team takes necessary steps needed to make the situation safe as quickly as possible and to consider the needs of the service users, visitors and staff in doing this.

If the incident is a possible Never Event or major incident staff most escalate details of the incident to senior manager within directorate/division and agree any further immediate action that may be required.

Staff should be provided the opportunity for debrief and support (it may be deemed appropriate to stand staff down until further notice). If a possible never event happens within a theatre, the reminding theatre list ceases and does not proceed until Divisional Director, Medical Director or Director of Nursing has agreed.

6.2 Reporting the Incident

All staff have a contractual responsibility to report incidents immediately to their line manager and within 24 hours or as reasonably practicable on to the Trust's incident reporting system DATIX which can be found on the Trust's intranet Oli. The reporter must ensure the incident is recorded correctly on DATIX is factual and objective. This information may be needed for a range of reasons including legal processes, complaints and incident investigations and analysis.

National Patient Safety Agency level of harm criteria is utilised within the Trust to help determine level of harm caused as a result of the incident. When grading an incident, the reporter should select an appropriate grade that reflects the perceived level of harm caused by the incident. The documented level of harm may change through triage and/or the investigation.

6.3 Reporting of RIDDOR Incidents

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 is a legally enforceable piece of legislation that required employers, and other people who are in control of work premises, to report to the Health and Safety Executive, and keep records of any:

- Deaths as a result of, or in connection with, a work activity
- Serious or Major Injuries such as fractures (except fingers, thumbs or toes), amputation, dislocations, loss of sight (temporary or permanent) etc.
- Injuries to staff, arising out of or in connection with a work activity, which results in absence for continuous periods of seven days or more (including weekends or days off following shift work).
- Injuries to persons who are not at work if it results from an accident arising out of or in connection with a work activity and hospitalisation.
- Service user falls where the fall has resulted in a fracture and they were identified as being at risk of falls requiring special observations or falls protection equipment etc.
- SHARPS or needle stick injuries where an employee is injured by sharps known to be contaminated with a blood borne virus such as Hepatitis B, C or HIV etc.

- Certain dangerous occurrences such as the collapse, overturning or failure of load bearing parts of lifts and or lifting equipment.

- Cases of diagnosed industrial disease, infections and ill health such as occupational dermatitis, occupational asthma, carpel tunnel syndrome or hand arm vibration syndrome and infections such as legionellosis etc.

A ‘responsible person/s’ has the duty to notify RIDDOR reportable incidents to the HSE. The ‘responsible person/s’ for East Lancashire Hospitals NHS Trust is the Health and Safety Team.

6.4 Incident Hotline

The Patient Safety Team has a dedicated e-mail address for corresponding with the Patient Safety Team in relation to any incident or query regarding incident management: incidents@elht.nhs.uk

6.5 External reporting requirements

All patient safety incidents are routinely reported to NHS England through the National Reporting and Learning System (NRLS) via the Trusts Incident Management system DATIX by the Patient Safety Team. These are reported onwards to the Care Quality Commission (CQC).

National and Local priorities must be reported to the relevant commissioning body who then inform NHS England. This is carried out via the Strategic Executive Information System (STEIS) within 48 hours of identification of the incident.

There are a number of other incidents that need to be reported externally and staff should follow appropriate Trust policies for these:

- IRMER– Procedure for management of radiation incidents

- All near misses or potential incidents relating to NHS Screening

- Information Security Incidents

- Infection Control Incidents

- Safeguarding Vulnerable Adults and Children

- Public Health/Environmental Health

The requirement to report all patient safety incidents to the NRLS remains unchanged. When the NRLS is replaced by the new Learning from Patient Safety Events (LFPSE), further guidance will be issued.

Under the PSIRF, the StEIS reporting platform will change from a system enabling commissioners to monitor the process and progress relating to individual investigations, to a reporting and monitoring system for providers.

Commissioners should advance to using StEIS to conduct a single, annual audit of progress against each local provider's PSIRP. In line with these changes:

- Reporting incidents previously defined as 'Serious Incidents' to StEIS will halt and providers will instead use StEIS to log and monitor **all** patient safety incidents identified as requiring a patient safety investigation (in line with national and locally identified priorities in their local patient safety incident response plans).
- Management and monitoring of individual investigations should be picked up immediately by providers.

7. Procedures to support patients, families and carers affected by PSIs

It is the principle of the Trust to be open and honest whenever there is a concern that mistakes have happened. Being open about what happened and discussing the safety incidents promptly, fully and compassionately can help patients, carers and families and professionals to cope better with the after effects. Speaking with patients and families openly and honestly should take place regardless of the level of harm caused by an incident and is a requirement of professional registration.

All patient safety incidents that are graded as moderate or above level of harm are subject to Duty of Candour regulation. Verbal Duty of Candour most be carried out within 10 working days of the occurrence of such an incident and must be evidenced on the relevant incident report on the DATIX system and in the patient's clinical notes. This should then be followed up with written notification to the relevant person following the face to face apology. Further information on Duty of Candour can be found in the Trusts Openness and Honesty when things go wrong – incorporating requirements of Duty of Candour C75.

All incidents requiring a level 1 or 2 investigation will have a Family Liaison Officer appointed by the Division the incident took place in. They are responsible for ensuring appropriate support is offered to the patient/family/carers and confirming any questions of concern the family/patient/carer would like including as part of the terms of reference of the investigation and linking in with the Patient Safety Incident Investigation Lead. The Family Liaison Officer will not be involved in the investigation but will ensure that the patient/family/carer are kept up to date with the investigation and given the opportunity to provide relevant information that may inform the outcome of the investigation.

In the case of serious incidents leading to the death of a patient, the bereaved families should have access to the information and support they need, including specialist support or counselling services where appropriate. For further information on support please see C066 Policy for Care after Death and support of the bereaved and other sources of support / information is available:

- National guidance for NHS trusts engaging with bereaved families

  https://www.england.nhs.uk/ourwork/part-rel/nqb/national-guidance-for-nhs-trusts-engaging-with-bereaved-families/

- Learning from deaths – information for families explains what happens after a bereavement (including when a death is looked into by a coroner) and how families and carers should comment on care received.

  https://www.england.nhs.uk/wp-content/uploads/2018/08/information-for-families-following-a-bereavement.pdf

- Mental health homicide support materials for staff and families. This information has been developed by the London Region Independent Investigation Team in collaboration with the Metropolitan Police. It is recommended that following a mental health homicide or attempted homicide the principles of the Duty of Candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.

  https://www.england.nhs.uk/london/our-work/mhsupport/

- Patient Advice and Liaison Services (PALS) offers patients, families and carers confidential advice, support and information on health-related matters. As well as informally helping to resolve issues, PALS can guide people on filing a formal complaint and advise on accessing advocacy services.

  https://www.nhs.uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service/

- **NHS complaints.** Everyone has the right to make a complaint about any aspect of NHS care, treatment or service. The NHS website gives guidance on how to do this and details of local advocacy providers. The independent NHS Complaints Advocacy Service will provide someone to help navigate the NHS complaints system, attend meetings and review information given during the complaints process.

  https://www.nhs.uk/using-the-nhs/about-the-nhs/how-to-complain-to-the-nhs/

- Local Healthwatch also provides information about making a complaint, including sample letters.
  - Healthwatch Lancashire: Tel: 01252 4239 100
  - Healthwatch Blackburn with Darwen Tel: 01254 480002

- Parliamentary and Health Service Ombudsman makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

  https://www.ombudsman.org.uk/

- Citizens Advice Bureau provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

  https://www.citizensadvice.org.uk/

8. Procedures to support staff affected by PSIs

Being involved in an incident which is under investigation can be a stressful experience. Help and support is available through Occupational Health or through the Trusts Employee Assistance Programme. Staff and line managers can access on the Trust staff website the Wellbeing Directory for a list of how to access all of the different interventions within the Trust. Staff can also seek advice from Union / Staff Side Representatives if appropriate, the Staff Guardian and/or Chaplaincy service.

As a member of staff involved in an incident you may be asked to attend a round table meeting, be interviewed or provide a witness report. This procedure will take place as soon after the incident as can be arranged, to ensure that memories remain as clear as possible for participants. Staff should be encouraged to make notes surrounding the event as soon as possible after it happened. Staff who are asked to provide a witness report should use the witness report template and guidance provided. (c012 Version 9 Policy for Investigation of Incidents, Complaints and Claims)

Staff may bring a colleague or staff representative to attend the interview to support them. This session is aimed at establishing accurate sequence of events, and the conditions in the environment at the time of the incident. The information presented by witnesses will remain confidential to the Patient Safety Incident Investigation team and individuals will not be identified in the report. If however it is identified that an individual needs to learn from the incident as a result of the investigation recommendations will be made for individual learning.

Mental Health First Aid (MHFA) – England

Provides:

- workplace guidance for employers and employees
- information on mental health first aid training.

Caring for the caregivers

The Improvement Academy hosts the 'second victim support website'.
https://improvementacademy.org/tools-and-resources/second-victim-support-website.html

The term ‘second victim’ is under review but refers to healthcare workers who are impacted by patient safety incidents. While patients and families will always be the first priority following safety incidents, the wellbeing of staff involved is often overlooked but can leave staff lacking confidence, unable to perform their job, requiring time off or leaving their profession.

There is existing evidence on the importance and effectiveness of support programmes for such staff and their potential to counter the negative impact outlined above to result in more positive impact for staff and patients alike.

Freedom to Speak Up

If staff have a concern about the organisation failing to respond to a patient safety incident, or about the nature of its response, they can seek support from their organisation’s Freedom to Speak Up Guardian.

A just culture guide

A just culture guide is useful when assessing concerns about individuals to ensure they are treated consistently, constructively and fairly. This should have a particularly positive effect on staff groups who have traditionally faced disproportionate disciplinary actions, eg Black, Asian and Minority Ethnic (BAME) groups.

The ASSIST ME model

Managers and others can use the ASSIST ME model (produced by the Irish Health Service Executive) to guide appropriate conversations and to develop the necessary procedures to support staff following their involvement in patient safety incidents.

Local occupational health services

Occupational health services help keep employees healthy and safe while in work and manage any risks in the workplace that are likely to give rise to work-related ill health.

Occupational health teams keep people well at work – physically and mentally – and will be happy to talk to you about the services they can provide.

A-EQUIP midwifery supervision model

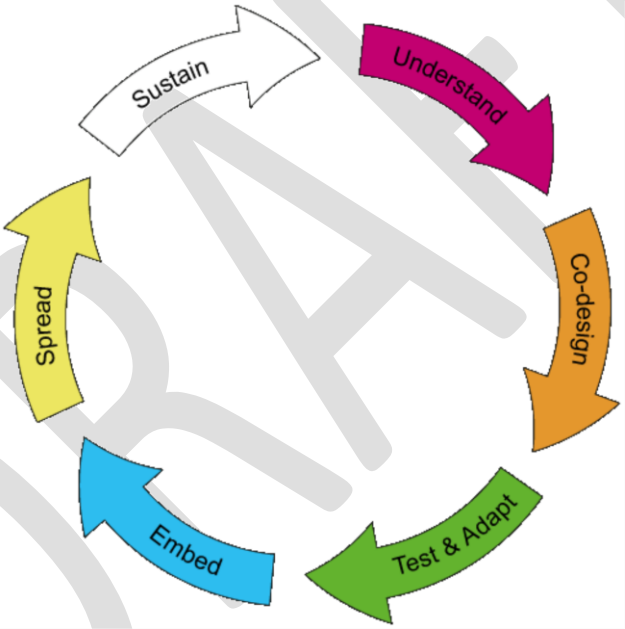
A-EQUIP is an acronym for ‘advocating for education and quality improvement’. The A-EQUIP model is made up of four distinct functions: normative, restorative, personal action for quality improvement, and education and development. It supports a continuous improvement process that builds personal and professional resilience, enhances quality of care, and supports preparedness for appraisal and professional revalidation. The ultimate aim of using the A-EQUIP model is that through staff empowerment and development, action to improve quality of care becomes an intrinsic part of everyone’s job, every day, in all parts of the system.

Midwives, the Local Supervising Authority national taskforce and the project’s Editorial Board developed the A-EQUIP operational guidance which has four parts:

- Part 1: Describes the impact of the legislative change on midwifery regulation and the changes to midwifery supervision.
- Part 2: Describes the A-EQUIP model and its benefit to midwives and users of maternity services Part 3: Has a clinical focus. Case studies show how the model can be used to support staff working in clinical and non-clinical roles, and its benefits to the multidisciplinary team
- Part 4: provides guidance for midwives and providers of maternity services, and describes key actions for maternity providers, clinical commissioning groups (CCGs) and higher education institutes (HEIs).

9. Mechanisms to develop and support improvements following PSIIs

East Lancashire Hospitals NHS Trust has developed a robust approach to continuous learning and improvement. *'Improving Safe, Personal and Effective Care'* (SPE+) is our Improvement Practice of understanding, designing, testing and implementing changes that lead to improvement across the Trust. We work with our partners across Pennine Lancashire to provide better care and outcomes for our patients, staff and communities by using a 6 phase approach to improvement which brings together the improvement principles of the IHI Model for Improvement and Lean. This approach is summarised below:



The development of our Improvement Practice is being supported through our involvement in the national NHS Improvement and NHS England Vital Signs Programme.

Our improvement priorities are directly informed by our patient safety priorities identified from patient safety investigations and identification of themes, as well as by key operational and pathway improvement priorities from across the organisation and wider Integrated Care Partnership, and in line with national requirements. We have a comprehensive set of agreed improvement programmes spanning:

- Quality – key quality of care priorities
- Operational delivery – non-elective pathways

- Operational delivery – elective pathways
- Operational delivery – outpatient pathways
- People – delivery of our people strategy

Our Quality improvement programme currently comprises a combination of:

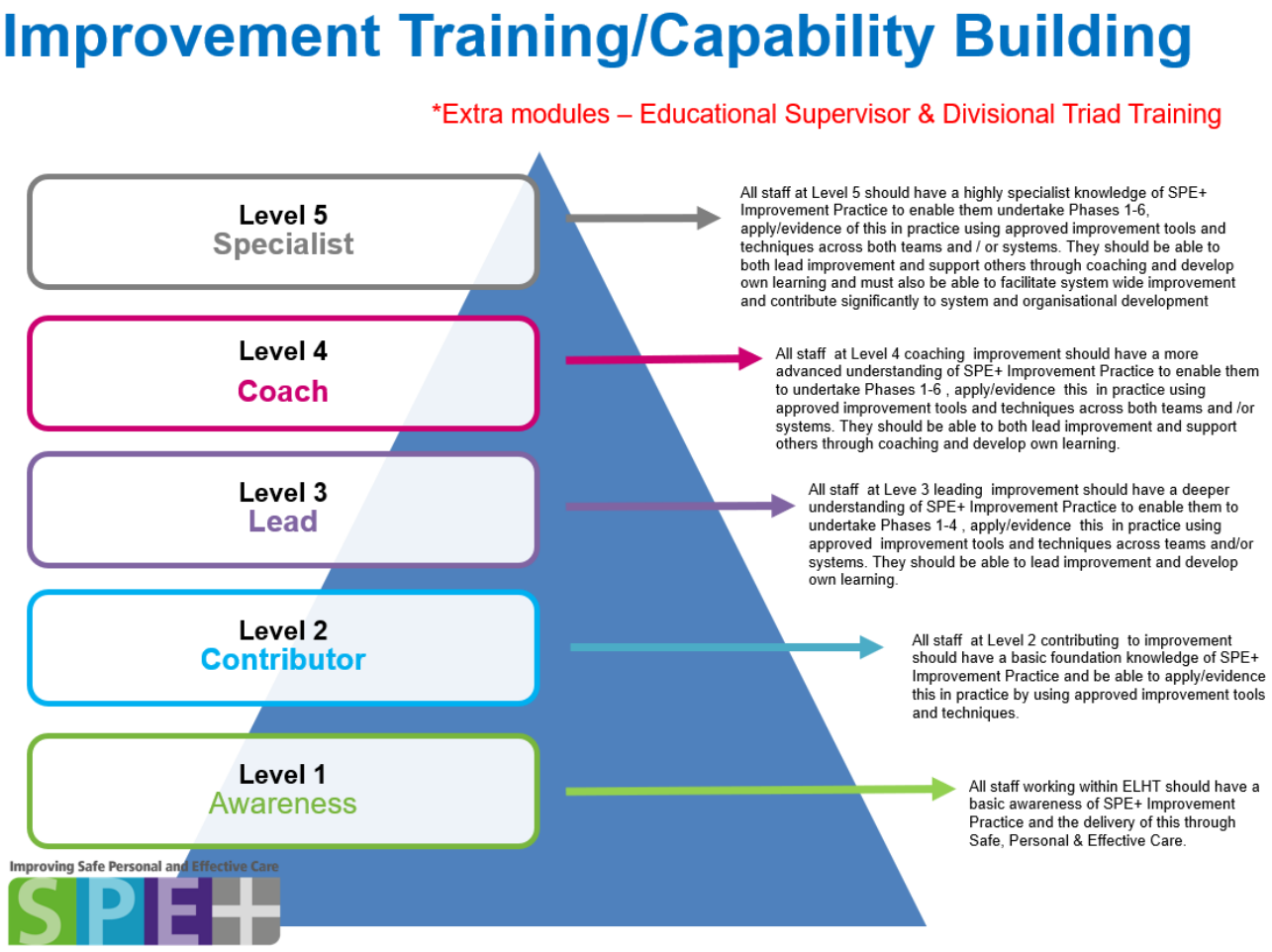
- Trust-wide harms reduction priorities (falls, SAFER surgery, deteriorating patient, medication errors, maternity/neonates and hand hygiene)
- Other key improvement priorities arising from national reports/audit, incidents and complaints e.g. nutrition and hydration, End of Life care
- Directorate and Divisional quality improvement projects
- Quality improvement (QI) projects for clinicians in training

We have an active Improvement register with over 240 live Improvement projects currently ongoing.

Our future improvement priorities will be directly informed by implementation of the PSIRF, providing us with an opportunity to streamline and prioritise future improvement activity.

Our improvement priorities are supported by a specialist team of improvement practitioners, our Improvement Hub. The team provide support, facilitation and coaching for improvement activity across the Trust as well as providing a range of training/development opportunities to build capacity and capability at all levels. Our approach to supporting improvement is tailored to support the needs of each priority e.g. facilitation of large scale improvement events, patient safety collaboratives, utilisation of a 6-week improvement burst methodology, providing coaching and support for small scale projects.

Last year we supported over 200 staff in participating in improvement training, ranging from Lean basics awareness (2 hour course), an introduction to QI course (3 hours) and Practice Coach training (3 days). Work has been undertaken to revise our Improvement Practice training offer to full align to the 6-phase SPE+ improvement methodology. This is depicted below:



We are in the process of developing a comprehensive Improvement Network, across the organisation and wider Integrated Care Partnership to bring together colleagues involved in improvement to support shared learning and spread and celebration of success.

We measure improvement activity benefits in terms of Delivery, Quality, Cost and People (morale of both staff and patients), focussing on key process, outcome and balancing measures. We are developing a series of dashboards in order that on-going monitoring and assurance on key improvements can be demonstrated and continued after formal improvement work has been completed to ensure that there is ongoing delivery of the improvement identified and implemented. This will also support review and adaption of actions wherever the desired outcome is not being delivered.

10. Monitoring outcomes of PSIIs and PSRs

Regular update reports will be created for Quality Committee and Trust Board for review and assurance. Contents may vary, but will likely include aggregated data on:

- Patient safety incident reporting
- Findings from PSIIs
- Findings from PSR reviews
- Progress against the PSIRP
- Progress on System Improvement Plans
- Lessons Learnt
- Updates on findings from the 5 local priorities including any quality improvement progress
- Results of surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- Results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents.

11. Complaints and appeals

We value the comments and compliments about the services we provide. Learning from our patients, carers and relatives experience will actively contribute to the continued development of our services.

We recognise that for patients, carers and relatives, participation in a safety incident investigation could be a distressing time as well as being an empowering experience. Within this dynamic it is possible the patient may raise issues regarding the process.

In the event a patient, carer or relative has concerns regarding any aspect of the investigation process, including a matters relating to the Patient Safety Incident Investigator we will:

- If appropriate, seek to resolve the matter locally through a discussion between the patient and/or relative the Patient Safety Incident Investigator and the nominated Family Liaison Officer.
- Escalate the concern to the Assistant Director of Safety and Effectiveness, Assistant Director of Patient Experience and/or Associate Director of Quality and Safety for local resolution.
- Refer the matter as a formal complaint via the Trust's Customer Relations Team to receive a CEO response

Advice, advocacy and further information on the concerns and complaints process can be accessed via the following link: https://elht.nhs.uk/about-us/comments-concerns-and-compliments

Appendix A: National priorities

National priorities requiring a response

1. National priorities are set by the PSIRF and other national initiatives for the period 2020 to 2021. These priorities require a PSII to be conducted by the organisation.
2. There are three categories of national priorities requiring local PSII: incidents that meet the criteria set in the Never Events list (2018); incidents that meet Learning from Death criteria; and Death or long-term severe injury of a person in state care or detained under the Mental Health Act. Further detail is provided below.

Incidents that meet the criteria set in the Never Events list 2018

Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Incidents that meet the 'Learning from Deaths' criteria;

Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.

Examples include:

- deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's mortality review tool and which have been determined by case record review to be more likely than not due to problems in care
- deaths of persons with learning disabilities where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the LeDeR review
- deaths of patients in custody, in prison or on probation where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS

Death or long-term severe injury of a person in state care or detained under the Mental Health Act.

- Examples include suicide, self-harm or assault resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act.

National priorities to be referred to another team

The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) for the period 2020 to 2021 are as follows, further details are provided below:

- Maternity and neonatal incidents
- Mental health related homicides by persons in receipt of mental health services or within six months of their discharge
- Child deaths
- Deaths of persons with learning disabilities
- Safeguarding incidents
- Incidents in screening programmes
- Deaths of patients in custody, in prison or on probation

Maternity and neonatal incidents:

1. Incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation (https://www.hsib.org.uk/maternity/)
2. All cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme
3. All perinatal and maternal deaths must be referred to MBRRACE

Mental health-related homicides by persons in receipt of mental health services or within six months of their discharge

11.1.1. These must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)

Child deaths

11.1.2. For further information, see: *Child death review statutory and operational guidance*

11.1.3. Incidents must be referred to child death panels for investigation

Deaths of persons with learning disabilities

11.1.4. Incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme

Safeguarding incidents:

11.1.5. Incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multi-professional investigation

Incidents in screening programmes

11.1.6. For further information see: **incidents in screening programmes**

11.1.7. Incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)

Deaths of patients in custody, in prison or on probation

11.1.8. Where healthcare is/was NHS funded and delivered through an NHS contract, incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

Appendix B: PSII and Patient Safety Reviews

Patient Safety Incident Investigation (PSII) • National Priorities • Local Priorities • Ad hoc Complex cases	Full Investigation (Including case notes, interviews with staff, national guidance, policies, patient and family evidence etc.)	Focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurable reduce repeat patient safety risks and incidents Transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents	Patient Safety Incident Investigation Team	*In*vestigations to be completed within 3 months but no longer than 6 months with agreement with patient/family

PSR type	Methods	Objective	Who	Timeframe
Incident recovery Immediate measures taken to: • Address serious discomfort, injury or threat to life • Respond to concerns raised by the affected patient, family, or carer • Determine the likelihood and severity of an identified risk	Immediate actions	To take urgent measures to address serious and imminent: • discomfort, injury, or threat to life • damage to equipment or the environment.	All staff	Immediate
	Risk assessment	To assess the likelihood and severity of identified hazards in order that risks can be determined, prioritised, and control measures applied	All staff	Immediate
	Open Discussion (Duty of	To provide the opportunity for a verbal disuc	Most appropriate clinical/medical staff member	This should be done as soon as possible but most

	Candour)			be completed within 10 days
	Rapid Review	To gain a greater understanding of the incident and identify any immediate actions / learning required to keep patient(s) safe.	Nominated divisional lead	2 working days
Team reviews Post-incident review as a team to: • Identify areas for improvement • Celebrate success • Understand the expectations and perspectives of all those involved • Agree actions • Enhance teamwork through communication and collaborative problem solving	Debrief (Hot)	An unstructured, moderated discussion The simplest and most informal method to gain understanding and insight soon after an incident (debriefs held immediately after an incident are known as 'hot' debriefs).	All staff involved in the incident	Within 48hrs
	Safety huddle	**Proactive:** a planned team gathering to regroup, seek collective advice, or talk about the day, shift, next few hours. Allows for on-the-spot assessment, reassessment, and consideration of whether there is a need to adjust plans. **Reactive:** triggered by an event to assess what can be learned or done differently. Focused on process-oriented reflection to find actionable solutions	All staff All staff	Daily As and when required
	Round Table	A 'cold' structured debrief facilitated by a senior manager. Based around four overarching questions: 1. What is expected to happen? 2. What happened? 3. Why was there a difference between what was expected and what happened? 4. What are the lessons that can be learnt?	All staff involved in incident	Within 5 working days of incident or as soon as possible

		Minutes are required of meeting with safety issues identified, lessons learnt and any safety improvement plans.		
Systematic reviews (PSR) To determine: • The circumstances and care leading up to and surrounding the incident • Whether there were any problems with the care provided to the patient	Case record/note review (e.g., SJR, LeDeR)	To determine whether there were any problems with the care provided to a patient by a service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.)	Trained reviewer	As per national guidance for each type of review
	Mortality review	A systematic review of a series of case records using a structured or semi-structured methodology to identify any problems in care and draw learning or conclusions that inform action needed to improve care, within a setting or for a specific patient group, particularly in relation to deceased patients	Nominated by Mortality Steering Group	To be agreed by Mortality Steering Group
	Specialised reviews	For example, falls, pressure ulcers, IPC reviews, return to theatre, pharmacy	Appointed Divisional staff member	4 weeks
	Clinical/Peer Review	To review the clinical documentation and comment on the overall quality of care as well as specific aspects or phase of care		2 months
	Timeline mapping	To provide a detailed documentary account of what happened in the style of a 'chronology'	Appointed Divisional staff member	4 weeks
	Cluster Review	To conduct a clinical review of documentation of a number of incidents against trust policy and national guidance	Nominated Divisional Lead or Trust Lead	2 months
	Concise report	To conduct a clinical review of documentation and a review of staff statements in line with Trust policy and national guidance	Nominated Divisional Lead	2 months

	Incident Checklist	To review the clinical documentation against an agreed checklist of questions / statements to identify any areas of learning i.e. Pressure Ulcers, Falls, VTE	Ward / Team Managers	1 month

Contact us:

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This publication can be made available in a number of other formats on request.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

10 November 2021

Item 141

Purpose Action

Title	Doctors Appraisal and Revalidation Annual Report
Author	Uma Krishnamoorthy, Associate Medical Director (Appraisal and Revalidation)
Executive sponsor	Jawad Husain, Responsible Officer, Executive Medical Director

Summary: (summarise the key points from the report and what the committee is being asked to do) This reports provides evidence of compliance against GMC and NHS England standards for Medical Appraisal and Revalidation.

Recommendation: (advise the Board/Committee of a suggestion or proposal as to the best course of action.) The Board is asked to approve the report and sign the compliance statement for submission to NHS England.

Report linkages

Related strategic aim and corporate objective *(Delete as appropriate)*	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework *(Delete as appropriate)*	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objective Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to 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 *(delete yes or no as appropriate and give reasons if yes)*

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

Previously considered by:

Designated Body Annual Board Report

Introduction

1. This is the eleventh annual report on doctors' appraisal to come to the Board, the seventh since Revalidation was introduced in 2012. This year, 2020/21, was Year 3 of the second 5 year cycle.
2. At the time of writing this report on 2nd November 2021, there are 622 doctors with a prescribed connection to ELHT as their Designated Body (DB). The number of doctors with a prescribed connection to ELHT for the reporting period 2020/21 was 588. These are Consultants, SAS doctors and Clinical Fellows. This number changes over the year as doctors' start and leave. Doctors in training have a prescribed connection with the North West Deanery and consequently do not form part of this report.
3. The first revalidation cycle of 5 years finished on 31.03.2018. Medical Appraisal and Revalidation (A&R) is now well embedded at ELHT. This report details the performance and governance in place for medical A&R, using the new report template provided by NHS England in 2019. As this is the third year this template has been used, the actions from previous years report were reviewed and pleased to assure the board that these actions were completed apart from a couple of actions that are ongoing and currently being progressed as highlighted within the report.
4. The unprecedented Covid19 global pandemic impacted medical appraisal and revalidation (A&R) whereby NHS England and General Medical Council recommended that routine appraisals can be suspended during this period and revalidations were deferred by a one year period by the GMC. The Trust plans for preparedness towards medical appraisal and revalidation were made electively at the onset of the pandemic as in Appendix1.

Section 1 – General:

The Board of East Lancashire Hospitals NHS Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been completed as in Appendix 2.

Date of AOA submission: November 2021 further to Board. (appendix 2).
Action from last year: Completed - Review communication strategies with communications team to assure public regarding medical A&R at ELHT. This action was completed after the last report and web page can be accessed here Medical Appraisal and Revalidation :: East Lancashire Hospitals NHS Trust (elht.nhs.uk).
Comments: AOA for 2020/21 demonstrates the impact of the Covid19 pandemic on the medical appraisals and revalidation. 407 doctors had their appraisals suspended in line with NHS England and General Medical Council (GMC) guidance in the wake of the pandemic to relieve pressure on doctors so that they can focus on their clinical priorities. The AOA report reveals that 30.6% % of doctors (180 out of 588) completed an appraisal during this period despite the pandemic and were supported by the Trust Appraisal and Revalidation team accordingly. 38 overseas doctors who joined the Trust during the pandemic and were new to the UK and NHS were supported with A&R specific induction and priming appraisals during this period for enhanced support. Board assurance is provided regarding the medical appraisal processes having resumed as routine as it was pre Covid since April 2021 and the Trust is on trajectory to meet the consistent high annual appraisal rates over 96% again in the

current year 2021/22 similar to last year's figures (96.5%) that was higher than same sector and all sector organisations. AOA submission to NHSEI will be made in November 2021 after Board. Please see further details on AOA in response to section 2 question1 in page 4.

Actions : Information in Trust web site page will be further updated after this report.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N.A.

Comments: Mr Jawad Husain is the appointed Responsible Officer (RO) for ELHT.

Action for next year: None

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: Completed - Review the resource for medical appraisal and revalidation to ensure that appropriate support that is proportionate to the 74% rise in number of doctors connected to ELHT since 2013 is in place. This includes a review of the banding of the appraisal co-ordinator role in line with other peer organisations and hours of support available for medical A&R team besides enabling further administrative support to the role to ensure systemic avoidance of a single point of failure within the relevant administrative processes. This action is completed since last report with upgrading medical appraisal co-ordinator's band from Band 4 to Band5 and appointment of a Band 3 administrative assistant. We are grateful to the Trust Board for supporting this.

Comments: The demand on and function of the Appraisal and revalidation administration team has increased over the years, e.g. including the appraisal and revalidation specific induction of new doctors, enhanced support for doctors new to the UK NHS through Priming Appraisals and organising in-house GMC course for this cohort of doctors, recruitment and development of appraisers, managing appraiser networks, running Trust wide medical appraisal workshops etc. The number of doctors connected to ELHT has risen from 331 in 2013 to 622 doctors currently connected to ELHT which represents a 90.3% rise since 2013 which is great for our patients and services and at the same time highlights that the support needed for the medical appraisal and revalidation team will continue to rise as this number grows.

Action for next year: The recently appointed Band 3 staff is yet to commence in role since appointment due to health reasons. If the return is potentially delayed further by months, then an appropriate interim admin staff to support the appraisal co-ordinator will need to be considered given the extra pressures as routine appraisals have resumed. The team will closely monitor this situation and enable this interim support as appropriate.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: N.A.

Comments: There are Standard operating procedures (SOPs) in place for ensuring new starters are added to GMC connect site and leavers are removed. These are reviewed regularly between Medical appraisal and revalidation team and medical staffing team and were updated again in August 2020 aligned with timing of the updates to Trust medical appraisal policy HR 46 V3.3.

Action for next year: None

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Completed - Ensured formal ratification of the updated HR 46 Appraisal Policy through Trust Policy Council.

Comments: HR46 v3.3 was reviewed in August 2020 and content approved through the Professional Standards Committee in July 2020 and subsequently ratified through Policy Council with a further review date of August 2023.

Action for next year: NA

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes

Action from last year: In Progress - The Acute Trusts' across the ICS held a Peer review group meeting on 23rd July 2021 and agreed on consensus to revisit the Peer review process after the pandemic settles in 2022. Thank you to Board for support in identifying Richard Smyth as the Non Exec Director to support peer review when that happens.

Comments: Regional and National level benchmarking of organisational performance of medical appraisal and revalidation is enabled through the higher level RO's AOA report from NHSEI with benchmarking outcome report received annually by Trust RO. This report is delayed due to Covid impact. A Peer group is well established across the Acute trusts in the Pan Lancashire ICS. Peer group review was last conducted in 2017 and decision was to review in 2-3 years. At the peer group meeting held in October 2019, the consensus decision was to hold the next Peer review in 2020 summer. However, this had to be deferred due to Covid19 pandemic as was agreed at the latest Peer Review Group meeting held on 23rd July 2021.

Action for next year: Repeat ICS Trusts' Peer review on medical A&R processes after the pandemic settles as per consensus across peer organisations in 2022.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: In progress - Audit on short term and locum doctors' appraisal

Comments: An induction information bundle for locum doctors was developed in 2018/19 and this continues to be provided to new short term/ locum doctors. A strengthened process has been put in place since 2018/19 to check the identity of locum doctors since this bundle implementation which continues. Exit reports are requested for all locum doctors and provided to doctor and their agency. Where concerns are raised about a locum doctor, there is direct RO (deputy) to RO information sharing.

Action for next year: Complete the re- audit on short term and locum doctors appraisals

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: NA

Comments: 180 doctors completed their appraisals despite the pandemic in 2020/21 despite the Trust supporting the suspension of appraisals in line with GMC and NHSE guidance during this period. 38 of these doctors were new to the UK and NHS and all of them received an A&R specific induction and Priming appraisal within 4-6 months of joining Trust in order to ensure that appropriate experiential learning of appraisal process in UK is enabled through this with a tailored personal/professional development plan in place that they can work towards for their next appraisal with support resources. 35 out of these 38 priming appraisals were personally undertaken by the Associate Medical Director for A&R to reduce burden on appraisers working in clinical priority areas. This support was in place despite pandemic challenges acknowledging the unique pressures on these overseas doctors and their wellbeing while they work away from their family in a new country and new health care system with often nil network support at a time of the unprecedented global pandemic. A wellbeing module was developed and implemented within the L2P appraisal portfolio as a resource to support all doctors to have facilitated discussions on their wellbeing and Covid time experiences with appraiser using this module.

Given the trends from last 5 consecutive years, ELHT appraisal rates have been consistently higher than same sector and all sector organisations nationally and regionally. Apart from one doctor with exception due to a deferral action plan that needed completion during this period, all other 407 doctors who did not have an appraisal were those approved due to the pandemic. One of the doctors had early non engagement concerns discussed with GMC as highlighted in last annual report and new appraisal date agreed for April 2020 but this was subsequently deferred by GMC due to Covid19 Pandemic and moved to April 2021. However, this doctor did not complete his deferral action plans advised by Responsible officer ahead of his revalidation date and non-engagement concerns were notified to GMC and currently under GMC review. Plans are out in place as added support for this doctor to have an appraisal meeting in November with a new appraiser allocated and this is monitored closely through the Professional standards committee and review progressed as per Maintaining High Professional Standards.

100% of medical appraisals completed at ELHT are subject to quality assurance review and feedback. 20% of appraisals are quality assured using a detailed numerically scored National tool called PROGRESS tool and the remaining 80% are quality assured using a generic non- numerically scored quality assurance review template developed locally. The doctor and appraiser receive feedback further to the appraisal Quality assurance review.

There is a standardised operating process (SOP) in place whereby an annual governance report is provided for each doctor the month before their appraisal as an extract from the Datix system which has all details of the complaints, claims, inquests and significant events or concerns regarding the doctor which enables reflective practice and further discussions to facilitate experiential learning through reflection and action plans agreed for the personal/professional development plan. Consultants are supported with Dr Fosters Clinical outcomes benchmarking report which enables discussions regarding performance concerns with clinical practice with appraisers to enable action plans to support developmental needs if/as identified. There is a standard operating process for this report provision that is well embedded at ELHT.

There is a process in place for sharing information about doctors regarding their scope of work outside ELHT through a locally developed, standardised template 'letter of good standing' from other places of work to feed into appraisal. This includes information about complaints, significant events, claims and/or any other concern regarding the doctor signed by the Medical director or delegated deputy from the external organisation.

Within the Appraisal and revalidation online management system (L2P), there is an 'RO note share' option whereby the Associate Medical Director (Appraisal and Revalidation) or Deputy Medical Director (Professional Standards) on behalf of RO can share information regarding doctors' concerns and action plans recommended for appraisal matters with doctor and appraiser in an open and transparent manner so that the agreed action plans and reflections, through facilitated discussions with appraiser feed into the appraisal process for enabling personal and professional development.

For doctors joining ELHT as a new starter and those leaving organisation there is a streamlined SOP developed for the medical staffing team and appraisal and revalidation teams to follow. SOP is in place for management of 'MPIT' (Medical Professional Information Transfer) from other organisational RO to ELHT RO for leavers and from ELHT to other RO's for new starters. MPIT document highlights and details whether there are any concerns about the doctor that are ongoing and may not yet appear on GMC site.

Action for next year: Re audit of a sample of appraisal Quality assurance review outcomes as part of quality improvement measures.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: NA

Comments: If any aspect of supporting information is missing at appraisal, all appraisers are trained to explore background reasons for this and ensure appropriate actions to address this are included within the doctors personal and professional development plans. The appraisal quality assurance review process identifies any gaps further and feedback is provided to doctor and appraiser besides recommendations to address any aspects noted missing. Reasons for delayed appraisals in all 407 doctors in AOA was due to approved suspension of appraisals by the A&R team during this period due to Covid19 pandemic in line with NHSE and GMC guidance. are included in the AOA. The details of the one doctor with non- engagement concern escalated to GMC are highlighted under section 2 question1.

Action for next year: Re audit of a sample of appraisal Quality assurance review outcomes as part of quality improvement measures.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Nil as Update Medical appraisal policy HR 46 V3.2- updated and implemented further to ratification through Policy council

Comments: As outlined in section 1, question 5.

Action for next year: Nil

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Completed This action is complete as 10 new appraisers were trained and joined team in December 2020

Comments: There are 78 appraisers currently at ELHT, in line with the recommended 5-10 appraisees per appraiser. An Appraiser training programme has been developed locally at ELHT as a blended programme with an e-learning component and a one day face to face workshop in 2019 that continues. This significantly saves costs to trust from the outsourcing of this training in the past. 10 new appraisers were trained in December 2020 to ensure succession planning for retired colleagues and those who gave up the role due to job plan changes.

Action for next year: Further training planned for another 14 appraisers in December 2021.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: In Progress as Re-audit of the outcomes of appraisal quality assurance review is in progress as was delayed due to pandemic impact and clinical pressures.

Comments: Appraiser network meetings are routinely organised every quarter during the pre-pandemic period. However, this was suspended during the pandemic and therefore nil network meetings for appraisers were held during this period. The appraiser networks have now resumed and his will form part of the next year annual report for the period 2021/22. Agendas include updates from national meetings, regional RO networks and Medical appraisal lead networks, peer review audits, workshops to develop coaching techniques etc. Locally developed leadership module within L2P medical appraisal platform which is the first such within any appraisal platform in UK is now well embedded at ELHT with the long term strategic aim of positively influencing the growth of a compassionate and inclusive organisational culture through reflective learning enabled through appraisal discussions on value based leadership experience. This leadership module developed by ELHT appraisal lead and team is now implemented across eleven other NHS Trusts in the country which is rewarding to see as an example of ELHT playing a part in system leadership nationally. Appraiser's are provided individual feedback through the appraisal quality assurance review of each appraisal completed (100%) and review of outcome of post appraisal questionnaire completed by doctors in anonymised manner at reques. Once the administrative assistant commences in role, the plans in place to provide individual appraiser with an annual report of their collated post appraisal feedback will be implemented for all appraisers 100% without the need for them to request this as there will be administrative capacity to support this after this role commences.

Action for next year: Re-Audit of the Quality assurance review outcomes to be completed . Implement a SOP for the administrative assistant to support the provision of Collated reports on Post appraisal feedback for each appraiser to be included as part of their own appraisals for reflective learning.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: N.A.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: See section 1, question 6

Action for next year: Re-Audit the Quality assurance review outcomes and share at appraiser network

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Continue to improve the number of recommendations made in the early part of the 'window'- completed and ongoing.

Comments: GMC postponed all revalidations that were due during this reporting period to the next year in order to support the medical profession during the Pandemic times. Therefore all doctors who were originally due their revalidation recommendations during this reporting year were postponed to current year 2021/2022. However, doctors who had all the revalidation readiness assurance in place could still be recommended by the Responsible officer for a short period beween April and June 2020 before GMC closed the recommendation facility window by end of June 2020. 21 doctors were recommended their revalidation by Responsible officer during this window as their revalidation readiness assurance was already in place. All the remaining revalidation recommendations were automatically deferred by the GMC by one year. Revalidation recommendations to GMC have now resumed since April 2021 and proceeding as normal and will be part of next year's report.

One doctor who had early non engagement concerns discussed with GMC as highlighted in the 2020 report had a new appraisal date agreed for April 2020 but this was deferred further by the GMC due to Covid19 Pandemic. This doctor's revalidation was deferred further by GMC to April 2021. However the doctor did not complete the deferral action plan agreed with the Responsible Officer and this has been reported as a Non engagement concern to GMC and being reviewed. Plans are in place for this doctor to be supported through an appraisal with a new appraiser while the GMC review outcome is awaited and doctor is monitored through the Professional Standards committee in accordance with Trust policy and guidance from GMC and Maintaining High professional standards. See also section 2 response to question1.

Action for next year: Continue to improve the number of recommendations made in the early part of the 'window'.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: N.A.

Comments: All recommendations are communicated to the doctor. Where a deferral is recommended, an action plan to ensure the new revalidation date is met is agreed with the doctor.

Action for next year: None.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Action plans arising from self-assessment have been completed or ongoing.

Comments: The GMC's self-assessment tool 'Effective Clinical Governance for the medical profession' was completed and reviewed at the Quality Committee in February 2019 and action plans implemented. This will continue to be periodically reviewed. Governance report provided for doctors to be part of the appraisal inputs has been updated and enhanced since last report with additional staffing resource secured to support this provision since last report.

Action for next year: None

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: In progress
Review and Update Trust Policy for Responding to Concerns about Doctors Clinical performance HR039 V4.1 that is due for update presently by December 2020 – Delay with this action due to Covid pressures and is currently being reviewed by HR lead and Deputy Medical Director for Professional standards

Comments: Processes for monitoring the conduct and performance of all doctors were included in the GMC self- assessment tool completed in 2019. Governance report provided for doctors to be part of the appraisal inputs has been updated and enhanced since last report with additional staffing resource secured to support this since last report. Coroners Inquests are now routinely liked to respective doctors involved and added as part of the annual governance report provided to doctors to enable reflective practice and disseminate shared learning besides addressing developmental needs identified through facilitated discussions with appraiser .

Action for next year: Complete the Review and Update of Trust Policy for Responding to Concerns about Doctors Clinical performance HR039 V4.1 that is in progress and formally enable ratification through Trust Policy council.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Review of HR39 trust Policy – this is in progress as in response2 above

Comments: HR 39v4.1 Responding to concerns about Clinical Performance was ratified by policy council in June 2018, due for review in January 2020. The policy is based on the national guidance 'Maintaining high Professional Standards' and includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns. A further extension period was granted in January 2020. The new deputy medical director for professional standards commenced in role from 17th August 2020 and currently is in the process of reviewing this alongside HR team colleagues.

Action for next year: Complete the Review and Update of Trust Policy for Responding to Concerns about Doctors Clinical performance HR039 V4.1 that is in progress and formally enable ratification through Trust Policy council.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, ***as well as aspects such as consideration of protected characteristics of the doctors[2].***

Action from last year: Monitoring in progress through Professional standards committee. Re-audit planned in new year 2022. Continue monitoring and aim to ensure that ethnicity of all doctors undergoing professional standards inquiries and processes at ELHT are captured in a prospective manner so that this data is reliably assured in future audits. This re-audit was delayed due to Covid impact and clinical pressures and to be commenced soon by HR.

Comments: An audit undertaken by the former Deputy Medical Director for Professional Standards analysing concerns raised about doctors, including numbers, type and outcome of concerns and protected characteristics is performed annually. Appendix 3 shows the results for the audit on professional standards undertaken between 2015 and 2019. It is noted there are approximately 34% doctors with ethnicity in the 'unknown' category in this audit which is a wide gap compared to the 0% in this category normally in trust employed doctors. One of the contributory factors is due to most of these doctors being in the locum category and therefore unable to check and correlate in retrospect as they have left the organisation.

Action for next year: Continue monitoring and aim to ensure that ethnicity of all doctors subject to professional standards inquiries and processes at ELHT are captured in a prospective manner so that this data is reliably assured in future audits. Re audit, on Doctors with concerns (numbers, type, outcome, protected characteristics) for the period since the last audit completion and from 1st April 2019 in the new year January 2022.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: NA

Comments: Processes for sharing information about doctors were reviewed in the GMC self-assessment and found satisfactory.

Action for next year: NA

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: One action from the self-assessment: To add a section on Equality and Diversity to the Updated Medical appraisal policy. This has been completed.

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Comments: Processes to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice are fair and free from bias and discrimination were reviewed in the GMC self-assessment tool and found satisfactory.

Action for next year: Continue monitoring through annual audits as highlighted in section 4 responses to question 4 and the action agreed under that as well.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: N.A.

Comments: This was also reviewed as part of the GMC Self-assessment tool. All relevant checks are in place. A further checklist was developed and implemented to enhance the robustness of pre-employment checks by HR through questions for doctor to self- declare at time of check in prior to the formal interview related to local concerns, timing of completion of language competency assessment for overseas doctors and any ongoing local investigations. A new SOP was developed and implemented through support from HR manager and medical staffing manager since last report to enhance the robustness of pre- employment checks prior to interview by adding standard questions for HR to complete while checking in candidates for their formal interview which is not covered by NHS jobs and NHS professional application process. This pertains to local professional concerns that are not visible at GMC site checks and ongoing investigations on professional standards concern if any which the doctor can declare as part of this checklist. In addition the date when they passed language competency tests to determine whether it is still valid or needs to be repeated is also part of this enhanced pre- employment check process. (Appendix 4)

Action for next year: None

Section 6 – Summary of comments, and overall conclusion

Overall conclusion:

The Board is asked to:

1. Receive this annual report and note that it will be shared, along with the annual organisation audit on medical appraisals and revalidation, with the higher level Responsible Officer at NHS England/NHS Improvement NHSEI. The action plans arising from the AOA and this report are included in Appendix 5.

2. Approve the 'statement of compliance' section 7, confirming that the organisation, as a designated body, is in compliance with the regulations

Section 7 – Statement of Compliance:

The East Lancashire Hospitals Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief executive or chairman

Official name of designated body: East Lancashire Hospitals NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

Section 8 – Appendix

Appendix 1: Trust Preparedness report for Medical Appraisal and revalidation during the Covid19 Pandemic

TRUST MEDICAL APPRAISAL AND RE\

Appendix 2: Annual Organisational Audit Report on Medical Appraisals and Revalidation 2020

Annual Organisation Audit of Medical Appı

Appendix3: Professional Standards Audit on Doctors with Concerns 2015-2019

Appendix 6 Audit Professional Standarc

Appendix 4: Pre Interview checklist for HR with additional questions

Additional pre interview questions V

Appendix 5: Action Plan Matrix from this Designated Body Annual report to Board

	Action	By Who	By When
1	Update Trust website information on Medical A&R further this year	AMD A&R and Communications lead	Dec 2021
2	Discuss the return to work date for the newly appointed administrative staff and if it is probably likely to be delayed further by months, then an appropriate interim admin staff to support the appraisal co-ordinator will need to be considered given the extra pressures as routine appraisals have resumed.	Appraisal co-ordinator and Learning & Development Manager and HR manager	Dec 2021
3	Repeat ICS Trusts' Peer review on medical A&R processes after the pandemic settles as per consensus across peer organisations in 2022.	AMD A&R with peer review A&R team from neighbouring Trusts	July 2022
4	Complete the audit on short term and locum doctors appraisals	AMD A&R	March 2022
5	Successfully recruit the 14 new medical appraisers further to training planned for new appraisers in December 2021	AMD A&R	December 2021
6	Re-Audit the Appraisal Quality assurance review outcomes	AMD A&R	December2021
7	Develop and implement a SOP for the administrative assistant to support the provision of Collated reports on Post appraisal feedback for each appraiser to be included as part of their own appraisals for reflective learning.	AMD A&R	March 2022
8	Complete the Review and Update of Trust Policy for Responding to Concerns about Doctors Clinical performance HR039 V4.1 that is in progress and formal ratification through Trust Policy council.	HR lead and DMD for professional standards	January 2022
9	Continue monitoring and aim to ensure that ethnicity of all doctors subject to professional standards inquiries and processes at ELHT are captured in a prospective manner so that this data is reliably assured in future audits. Re audit, on Doctors with concerns (numbers, type, outcome, protected characteristics) for the period since the last audit completion.	HR Lead and DMD for professional standards	January 2022
10	Submit this Board report when signed by Chairman /CEO on behalf of designated Body to NHSEI	AMD A&R on behalf of RO and Exec MD	September 2020

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

10 November 2021

Item 142

Purpose Information

Title	Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Statement and Report 2020/2021
Author	Ms A Whitehead, Head of EPRR
Executive sponsor	Mr T McDonald, Executive Director of Integrated Care, Partnerships and Resilience

Summary: This paper outlines the Trust's assurance statement and annual report with regard to emergency preparedness, resilience and response (EPRR) as required by NHS England and NHS Improvement. It has been approved by the EPRR Committee.

Recommendations: To note that additional staffing resources continue to been allocated to the EPRR function to maintain the ICC until at least March 2022. This will ensure that existing incident management structures and systems are maintained as the Trust heads into winter whilst continuing to deal with the covid-19 pandemic.

To receive this report as assurance that the Trust has robust, evidence based and tested EPRR practices in place and that it fulfils its statutory and non-statutory duties and obligations.

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 Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes/~~No~~	Financial	Yes/~~No~~
Compliance with Health & Social Care Act 2012 Compliance with Civil Contingencies Act 2004 and subsequent amendments		Additional Investment in resources to support ICC response agreed	
Equality	~~Yes~~/No	Confidentiality	~~Yes~~/No

Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Statement and Report for 2020/2021

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.

3. On the 8th September, the Trust Board acknowledged the provision of delegated authority to the Executive Director of Integrated Care, Partnerships and Resilience to submit the EPRR Statement of Assurance on behalf of the Trust. Due to the timescales within the EPRR Annual Assurance Process, it was agreed that the final Statement of Assurance would be presented to the Trust Board on the 9th November.

2020/21 EPRR Assurance Process

4. Due to covid-19, the core standards assurance process was revised last year (2019 / 20), requiring a statement of assurance in relation to three specific areas rather than a full self-assessment against the core standards.

5. This year, the comprehensive EPRR core standards assurance process has been undertaken and ELHT demonstrates a level of **Full Compliance**, which this Trust Board is asked to ratify (Appendix A). The completed self-assessment and action plan can be found in Appendix B and C respectively.

6. The Deep Dive area (non-mandatory standards) for 2020-2021 relate to oxygen supply and medical gases. ELHT declared compliance with six out of the seven standards at the time of the submission and will be fully compliant by December.

Covid-19 Pandemic Response

7. The UK has been responding to the Covid-19 pandemic outbreak since March 2020. In line with the nationally recognised NHS command and control structure for responding to major incidents and emergencies, the Trust established an Incident Co-ordination Centre (ICC) and Divisional and Corporate Operational Co-ordination Centres (OCCs) which remain in place and will continue to be in place throughout the winter period.

8. The ICC provides the overarching co-ordination of the Trust's planning, response and resilience from an organisational, local, system, regional and national perspective.

9. The ICC continues to act as the single point of contact for the Trust, not only for the Covid-19 response but for other local and national EPRR related responses. It facilitates communication, co-ordination and leadership with respect to response and resilience. It provides robust systems to receive and disseminate information, to co-ordinate and submit situation reports and is formally overseen by the Executive Director of Integrated Care, Partnerships and Resilience as the Trust's Covid-19 Executive Lead and nominated Accountable Emergency Officer (AEO) with responsibility for EPRR.

10. Additional staffing resources continue to support the EPRR function to ensure that the ICC is maintained (at least until March 2022). This will ensure that existing structures and systems are maintained as the Trust heads into winter and the pressures associated with that, and whilst we continue to deal with the impact of covid-19 and the restoration of services.

11. In response to the Covid-19 pandemic, the Trust established a senior level, multi-disciplinary Incident Management Team (IMT) with representatives from each division / specialist area. The IMT originally met twice daily but now meets once a week, although the frequency of these meetings continues to be flexible depending on demand. The IMT support the review, approval and decisions made by the ICC and individual OCCs in relation to Covid-19 and is usually chaired by the AEO.

12. Where needed, ad-hoc, time sensitive cells have been established, chaired by the AEO or Head of EPRR, to ensure that specific programmes and targets have been achieved. This includes Swabbing and Testing (patient and staff), Personal Protective Equipment (PPE) and Clinical Consumables, and Vaccinations (flu and covid-19).

13. All Covid-19 related organisational risks have been recorded on Datix and where appropriate, escalated to the Quality Committee and Trust Board. This process ensures that all risks and their impact to quality and safety, operational performance, compliance requirements, finance, workforce and stakeholders are recorded and monitored. The Head of EPRR continues to review and update these risks on a regular basis.

14. During 2020 / 2021, all Divisional and Corporate Business Continuity Plans have been reviewed to reflect the potential impact of Covid-19 to ensure that we can maintain services and business as usual as much as is possible.

15. During winter 2020, a Gold Command structure was established across Lancashire and South Cumbria with senior level representatives from NHS providers, CCGs and mental health, North West Ambulance Service, patient transport, and Critical Care Cell. The Gold Command meeting is held once or twice a day (Monday to Friday) depending on system capacity and demand. Daily situation reports are submitted to Gold Command and these form the basis of the meeting. The Chair will review current pressures, facilitate mutual aid and escalate issues to the regional NHS E I team as necessary. From 1st November, this reporting and meeting will be facilitated seven days a week in line with regional and national winter planning arrangements.

16. The Head of EPRR continues to represent the Trust on various local, system-wide and regional multi-agency groups throughout the Covid-19 pandemic including supporting mutual aid and the management of local outbreaks.

EPRR Update

17. Over the past 12 months, several EPRR related plans and policies have been reviewed, either in response to Covid-19 or because their review is due. This includes the Major Incident Plan, Heatwave Plan, Cold Weather Plan, Lockdown Policy, Business Continuity Plans and priority services.

18. Business continuity incidents this year include a power cut, phone / bleep failure, and a gas pipe failure. Responses to such incidents have been managed through the timely establishment of effective incident response teams. After each incident, a facilitated debrief is undertaken to identify any lessons to be leaned and good practice that can further improve our response to such incidents in the future and these are shared, monitored and approved formally through the EPRR Committee.

19. The Emergency Department have worked extremely hard over the past six months to get their chemical, biological, radiological and nuclear (CBRN) training to the required level of compliance.

20. The Trust now has a decontamination unit in situ (near ED) which facilitates the decontamination of patients. This unit provides a more reliable, dignified and safer experience for contaminated patients compared to the old inflatable unit. The above points both contribute to ELHT declaring full compliance in relation to the core standards for CBRN.

Recommendations

21. The Trust Board is requested:

a. To note that additional staffing resources continue to been allocated to the EPRR function to maintain the ICC until at least March 2022. This will ensure that existing incident management structures and systems are maintained as the Trust heads into winter whilst continuing to deal with the covid-19 pandemic.

b. To receive this report as assurance that the Trust has robust, evidence based and tested EPRR practices in place and that it fulfils its statutory and non-statutory duties and obligations.

Tony McDonald

Executive Director Integrated Care, Partnerships and Resilience

Accountable Emergency Officer

26th October 2021

Appendix A – Statement of Compliance

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2021-22

STATEMENT OF COMPLIANCE

East Lancashire Hospitals Trust has undertaken a self-assessment against the NHS England Core Standards for EPRR.

Following self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating the following level of compliance against the 2021-22 standards: **Full**

Compliance Level	Criteria
Fully compliant	The organisation if fully compliant against **100%** of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against **89-99%** of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against **77-88%** of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to **76%** of the relevant NHS EPRR Core Standards

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as Red	Standards rated as Amber	Standards rated as Green
46	-	-	46
Acute providers: 46 Specialist providers: 38 Community providers: 37 Mental health providers:37 CCGs: 29 NWAS: 32/163* NHS111:29**			

**NWAS should report two assurance ratings, demonstrating compliance with the core standards for EPRR and interoperable capabilities. ***NHS111 should be reported separately.*

Where areas require further action, this is detailed in the attached EPRR Action Plan and will be reviewed in line with the organisation's governance arrangements.

I confirm that the above level of compliance with the EPRR Core Standards has been or will be confirmed to the organisation's board / governing body.

(Tony McDonald, Executive Director of Integrated Care, Partnerships and Resilience)

Signed by the organisation's Accountable Emergency Officer

08/09/2021 — *Date of board / governing body meeting (delegated authority to submit granted 08/09/2021, to go to Trust Board for formal approval 10/11/2021)*

28/09/2021 — *Date signed*

Statement of Compliance Version 1 **26/07/21**

Appendix B – Core Standards Self-Assessment

Ref	Domain	Standard	Detail	Acute Providers	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR 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 EPRR 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.
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, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	The Trusts AEO is Tony McDonald, Executive Director for Integrated Care, Partnerships and Resilience. The NED is Naseem Malik.	Fully compliant
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. 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. 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 • Include references to other sources of information and supporting documentation.	Y	The EPRR Policy C159 (due for review Sep 2022) includes resourcing commitments, access to funds, and the Trusts commitment to EPRR and appropriate training. The MIP contains an EPRR Policy Statement.	Fully compliant
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. 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 from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	The annual EPRR assurance report and action plan are presented to the Trust Board for approval / oversight and to the CCG AO. This contains details of training, incidents, exercises and compliance position.	Fully compliant
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	The EPRR Policy identifies the required resources to fulfil the EPRR function. The covid19 pandemic has highlighted the need for additional admin resources and these are now in place. This sustained resource will be required post-pandemic.	Fully compliant
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	The EPRR Policy statement and Business Continuity Plan outline how the Trust will learn from incidents and exercises.	Fully compliant

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 community and national risk registers.	Y	Risk assessment is documented in the MIP and also in the Risk Management Framework (C002) and Procedure (C145). The Trust regularly assesses the risks to the population it serves, considering community and national risk registers..	Fully compliant
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	EPRR risks are monitored through the Emergency Preparedness, Resilience and Response Committee.Where appropriate, risks are recorded on the corporate risk register.e.g. covid19, social distancing, PPE, EU exit	Fully compliant
Domain 3 - Duty to maintain plans						
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	The Trust has a major incident plan (revewied September 2021) and business continuity plan (reviewed April 2021) of which either could be used to respond to a critical incident depending on the nature of the incident. This type of incident is defined in the Major Incident Plan.	Fully compliant
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	The Trust has a major incident plan in place which is reviewed a minimum of every three years.	Fully compliant
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	The Trust has a heatwave plan and summary plan which is reviewed every 12 months in line with the national review.	Fully compliant
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	The Trust has a cold weather plan and summary plan which is reviewed every 12 months in line with the national review.	Fully compliant

18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	The Trust has a major incident plan and business continuity plan of which either could be used to respond to a mass casualty incident. ELHT have also been involved in the drafting / reviewing of the LRF Mass Casualty Plan. Critical Care are aware of the expectations on them and can expand capacity if required	Fully compliant
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	The Trust has arrangements in place (within ED) to safely manage unidentified patients.	Fully compliant
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	The Trust has arrangements in place to manage the shelter and evacuation of patients should this be necessary. The Evacuation and Shelter Policy C160 is due for review Nov 2022.	Fully compliant
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	ELHT can implement effective arrangments to safely manage site access and egress and this has been tested throughout the covid pandemic. The Trust has a Lockdown Policy in place which is reviewed every 2 years and this Policy is currently under review.	Fully compliant
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	The Trust has an Official Visitors Access Policy C137 (Reviewed August 2021)	Fully compliant

Domain 4 - Command and control						
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	The Trust has a 24 / 7 senior manager and director on-call rota. The Trust also has a 24 / 7 Clinical Site Manager. Both of these on-call systems support the receipt and response of incident notifications.	Fully compliant
Domain 5 - Training and exercising						
Domain 6 - Response						
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y	The Trust has an Incident Co-ordination Centre and an alternative fallback facilities (on and off site). There are clear instructions how to establish the on-site ICC and this is reviewed / tested regularly. All key roles within this have action cards. ICC arrangements have been in place since March 2020 to co-ordinate the Trusts response to the covid pandemic.	Fully compliant
32	**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	The Trust has a corporate BCP and all areas / wards have a local BCP (all reviewed in the past 12 months).	Fully compliant
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	The Trust responds to sitrep requests as necessary. The Trust continues to do so for covid sitreps but also submitted these through the EU 'no deal' exit. The Trust has a single point of contact e-mail address which is used for co-ordinating sitreps and briefings. The ICC Exec Lead authorises submissions as necessary.	Fully compliant
35	**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	ED staff have access to these guidelines both electronically (via email) and hard copies in the Major Incident Store Room.	Fully compliant
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	ED staff have access to this guidance both electronically (via email) and hard copies in the Major Incident Store Room.	Fully compliant

Domain 7 - Warning and informing						
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	The Trust has arrangements in place to deal with partner agencies during an incident. All Directors have had media training. Information requests are monitored / tracked through the admin hub (EPRR / Coronavirus email accounts) on behalf of the Incident Co-ordination Centre. There are standard holding responses for use in emergency situations.	Fully compliant
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	The Trust has rules and guidance on how it will interact with the media during a major incident including where and when this will happen. The comms team will support with warning and informing the public and staff as required.	Fully compliant
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	All executives are given media training to enable them to be the nominated Trust spokesperson. The comms team will support with rapid and structured comms with the public.	Fully compliant
Domain 8 - Cooperation						
42	**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. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	The Trust is signed up to the mutual aid agreement across Lancashire and South Cumbria. Mutual aid arrangements are also in place across L&SC through the Winter Hub (established winter 2020)	Fully compliant
43	**Cooperation**	**Arrangements for multi-region response**	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		NA	
44	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.		NA	
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	The Trust is signed up to sharing information and has policies aligned to FOI and GDP guidance.	Fully compliant

Domain 9 - Business Continuity						
47	**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 Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	The Trusts BCP outlines the Trusts statement of intent in relation to business continuity. This Plan is aligned to ISO 22031.	Fully compliant
48	**Business Continuity**	**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.	Y	The Trusts BCP outlines the scope and objectives of business continuity planning and the risk management process for reviewing risks. This is supported by the Trusts Risk Management Strategy (C002) and Procedure (C145). EPRR / BCM related risks are reviewed and monitored at the EPRR Committee.	Fully compliant
50	**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	The Trust is complaint with the Data Protection and Security Toolkit.	Fully compliant
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established 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	The Trust has BCPs for all wards / areas which are reviewed annually or post incident as required. These plans include disruptions to: staff, IT and telecoms, premises and suppliers.	Fully compliant
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	BCP compliance is monitored through the EPRR Committee and reported to Trust Board via the core standards assurance process. The EPRR Team are currently undertaking a quality review of all BCPs, providing feedback and support with enhancing these.	Fully compliant
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	The EPRR Policy outlines the need to review all relevant plans (including BCPs) post incident to take corrective action where necessary i.e. lessons learned and good practice. Local BCPS are reviewed post incident as part of the debrief process to ensure continual improvement.	Fully compliant
55	**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 work with their own.	Y	Procurement / EBME ensure that providers / suppliers have business continuty arrangments in place. These have been thoroughly reviewed as part of the EU 'no deal' exit preparedness work.	Fully compliant

Domain 10: CBRN						
56	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Telephone advice details are in the CBRN file in ED and the CBRN Policy (C117).	Fully compliant
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	The CBRN Policy (C117) outlines the Trust CBRN / Hazmat arrangements including the response and management procedures (last reviewed July 2021).	Fully compliant
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	The CBRN Policy outlines systems of work and required competencies of those undertaking a CBRN / hazmat response.	Fully compliant
59	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Decontamination training was paused during the first 12 months of the covid pandemic response due to social distancing and the nature of the 'buddying up' training required. However, the Trust has recently undertaken a comprehensive training programme to ensure that it has sufficient staff (nursing and medical) to provide a 24 / 7 CBRN response.	Fully compliant
60	**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. • 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 • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	The equipment inventory is currently up to date (last completed 10th Sep 2021).	Fully compliant

62	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Routine checks are carried out by the Matron in ED with responsiblity for CBRN (last completed 10th Sep 2021) In March 2020, the Trust procured a decontainer. This is now installed and ready for use.	Fully compliant
63	**CBRN**	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	The decontamination equipment is regularly checked in terms of maintenance, repair and replacement as appropriate.	Fully compliant
64	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	PPE is disposed of as per guidance. ELHT also has a Waste Management Policy C071.	Fully compliant
65	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	CBRN trainers have attended relevant training to maintain competencies	Fully compliant
67	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	The Trust has several trained CBRN trainers, sufficient to support the training programme.	Fully compliant
68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Staff in ED are trained in identifying and isolating potentially contaminated patients.	Fully compliant
69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y	All relevant staff in ED / BUCC are trained to use FFP3 masks and these are available within the ED. This has been further enhanced during covid and the requirement for staff to be mask fit tested. Mask fit testing continues to be provided by Division of Education, Research, and Innovation.	Fully compliant

Appendix C – Action Plan

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Action Plan 2021/22

Organisation: East Lancashire Hospitals Trust

Plan owner: Head of EPRR

Core Standard reference	Core Standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
Domain 1 Standard 2	EPRR Policy Statement	To maintain compliance, the EPRR Policy needs to be reviewed.	Review Policy C159 by Sep 2022	Sep 2022
Domain 1 Standard 12	Major Incident Plan	To maintain compliance, the Major Incident Plan needs to be reviewed.	Review Major Incident Plan in next three years	Sep 2024
Domain 3 Standard 13 & 14	Heatwave and Cold Weather Plan	To maintain compliance, the Heatwave and Cold Weather Plan need be reviewed.	Review the Heatwave Plan and Cold Weather Plan in the next 12 months.	Sep 2022
Domain 3 Standard 20	Evacuation and Shelter Policy	To maintain compliance, the Evacuation and Shelter Policy C160 needs be reviewed.	Review the Evacuation and Shelter Policy C160 by Nov 2022	Nov 2022
Domain 3 Standard 21	Lockdown Policy	To maintain compliance, the Lockdown Plan is under reviewed.	Review the Lockdown Plan by Dec 2021	Dec 2021
Domain 3 Standard 22	Official Visitors Access Policy	To maintain compliance, the Official Visitors Policy C137 needs be reviewed.	Review the Official Visitors Policy by August 2024	August 2024
Domain 6 Standard 32	Corporate Business Continuity Plan	To maintain compliance, the Corporate BCP needs to be reviewed.	Review the Corporate BCP by April 2023	April 2023

East Lancashire Hospitals NHS Trust
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TRUST BOARD REPORT

Item 143

10 November 2021

Purpose Information

Title	Finance and Performance Committee Update Report
Author	Mr M Pugh, Corporate Governance Team Leader
Executive sponsor	Mr S Barnes, Non-Executive Director, Committee Chair

Summary: The report sets out the matters discussed and decisions made at the Finance and Performance Committee meeting held on 22 September 2021.

Recommendation: The Board is asked to note the content of the report.

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 Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. 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: NA

Finance and Performance Committee Update

At the meeting of the Finance and Performance Committee held on 22 September 2021 members considered the following matters:

1. Members received the financial performance report for the month 5 financial position. Members noted the month 5 position was currently meeting the financial plan and the Trust was aiming to reach breakeven for the end of H1. They noted that the Trust cash balance was £45.2 million and £10.3 million of Elective Recovery Funding (ERF) had been received with £6.9 million being used to cover planned deficits. Members were advised that the threshold to receive ERF funding had been revised after additional costs to meet Accelerator targets had been incurred. Members noted that to meet the H1 position, non-recurrent savings have been used and that guidance for H2 was still to be received. Members were advised that the Capital programme had been revised to £27.4 million, however the impact of Brexit had caused many of the material costs to increase and the bids were now being reviewed to see if these can be reduced.
2. Members received a presentation on the replacement of diagnostic equipment across the Blackburn and Burnley sites, noting that support was being received from the Executive and Non-Executive teams for the replacement of 61 assets. Members were advised that NHS Supply Chain were utilised to mitigate the risks and a full business case is to be produced which will demonstrate the best value for money whilst managing risk.
3. Members received a presentation on how improvement practice will support the delivery of challenges being faced, noting how the Improvement team is working with partners across Pennine Lancashire to help deliver safe, personal and effective care through efficient partnership working.
4. The Committee received the Integrated Performance Report, noting that the Trust continued to receive an exceptional number of patients attending. Members noted that there had been several 12 hour breaches, particularly around mental health, due to a lack of mental health beds nationally and the Trust has good engagement with Lancashire and South Cumbria NHS Foundation Trust (LSCFT) who are working hard to improve the patient experience.
5. Members were advised that restoration is progressing, with Outpatient restoration performing well. In addition RTT and Cancer restoration is exceeding targets.

6. An update on the Trust's PFI partners was provided, along with current work being undertaken. In addition, members noted that the staff fire safety training compliance was continuing to improve and local fire assurance checklists were now recorded as being 97.03% completed and submitted.
7. The members were updated on the Corporate Risk Register, querying why the risk for the Electronic Patient Record (EPR) was still rated highly if the programme was progressing. It was noted that the programme will take 18 months to be fully realised and as this progresses, the risk will be reviewed. Members noted that the only risk with poor assurance was the Paediatric High Dependency Unit (HDU) which had been discussed in previous meetings.
8. As part of Any Other Business, members noted the recent awards and accreditations that areas in the Trust had been nominated for or received.

Martyn Pugh, Corporate Governance Team Leader, 10 November 2021

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 144

10 November 2021

Purpose Information

Title	Quality Committee Information Report
Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mrs P Anderson, Committee Chair

Summary: The report sets out the summary of the papers considered and discussions held at the Quality Committee meetings held on 22 September 2021.

Recommendation: The Board is asked to note the report.

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 Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. 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

Quality Committee Update

At the meeting of the Quality Committee held on 22 September 2021 members considered the following matters:

1. The Committee received an update from the Trust's Infection Prevention and Control (IPC) team. Members noted that there had been one outbreak of COVID-19 within the Trust but that it had been small and well contained. Members were also informed that an outbreak of Escherichia coli (E. coli) on the Trust's Neonatal Intensive Care Unit (NICU) had been closed as over two months had passed since a carrier had been detected.
2. Committee members received an update on patient safety matters. It was noted that three of the four never events discussed at the previous meeting had been considered at the Trust's Serious Incidents Requiring Investigation (SIRI) panel and that a request had been made to local Clinical Commissioning Groups (CCGs) for all four to be stood down at a later date. Members were also informed that 14 serious incidents had been reported between July and August 2021and that a new internal checklist approach had been applied to pressure ulcer incidents to more accurately assess when any damage caused had been due to issues of care and treatment by the Trust.
3. An update was provided to members on the implementation of the Patient Safety Incident Response Framework (PSIRF) in the Trust as part of a wider national Patient Safety Strategy that had originally been published in July 2019. Members noted that a national pause had been placed on the rollout of the PSIRF between due to the COVID-19 pandemic, but that progress had restarted as of March 2021.
4. The Committee received an update on the work underway to improve the Trust's Health and Safety processes, including a summary of the main Health and Safety priorities.
5. Members received an update on the Trust's recent mortality performance and were advised that an update on the Structured Judgement Review (SJR) process being carried out on confirmed nosocomial COVID-19 deaths would be provided at the next meeting.
6. The Committee received an update on the activity taking place within the Trust's maternity services. It was confirmed that all ten safety actions in relation to the Clinical Negligence Scheme for Trusts (CNST) had been implemented and members noted that good progress was also being made with the implementation of the BadgerNet system. An update was also provided to members on the work being

done by the Trust's Maternal Mental Health Service to reduce trauma and the numbers of maternal deaths through suicide.

Dan Byrne, Corporate Governance Officer, 3 November 2021

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 145

10 November 2021

Purpose Information Assurance

Title	Audit Committee Information Report
Author	Mr M Pugh, Corporate Governance Officer
Executive sponsor	Mr R Smyth, Non-Executive Director, Committee Chair

Summary: The report sets out the matters discussed and decisions made at the Audit Committee meeting held on 12 October 2021.

Recommendation: The Board is asked to note the content of the report.

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 Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. 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: NA

Audit Committee Update

At the meeting of the Audit Committee held on 12 October 2021 members considered the following matters:

1. The Committee received a progress update to the changes implemented since the MIAA internal audit report on Catering Services (Financial Procedure) had been presented. It was noted that since the progress report at the April meeting, all actions had now been completed and all sites were now using the same software and hardware.
2. The Committee received an update following the Mersey Internal Audit Agency (MIAA) review into Cyber Essentials, noting that work continues to strengthen the Trust's cyber security processes.
3. Members received the Internal Audit Progress report, noting that in the period August to September 2021, one review had been completed covering the Duty of Candour, which received substantial assurance. Furthermore, members were advised that MIAA was working with the Executive team to support the Trust with CQC work.
4. Members received the Sustainability update and were updated on the NHS Green Plan, noting that plan needs to be submitted to the Integrated Care System (ICS) by 14 January 2022 so that an ICS plan can be submitted by the end of March.
5. Members were updated on the External Auditors Annual Report, noting that this covered all work undertaken for financial year 2020/21. Members noted there had been many changes during the year due to the pandemic, however, despite the challenges, confirmation was received of a good understanding of performance.
6. The Committee received the Anti-Fraud Service Progress report for August and September, noting the progress being made in relation to referrals and investigations.
7. Members were advised that no waivers had been received in August and waiver reports would continue to be brought to the Committee.
8. Members discussed the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), commenting how the BAF needs to be reviewed annually by the Committee and arranging a meeting for this to take place.
9. The Committee were presented with updated Standing Financial Instructions (SFIs) for ratification. Following review, members advised that further work needed to take place on the SFIs before the policy could be approved.
10. Committee members also received copies of the minutes from the Quality Committee and the Finance and Performance Committee.

Martyn Pugh, Corporate Governance Team Leader, 10 November 2021

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 146

10 November 2021

Purpose Information

Title	Trust Board Part Two Information Report
Author	Miss K Ingham, Head of Corporate Governance
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 8 September 2021.

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 strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. 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

Trust Board Part Two Information Report

1. At the meeting of the Trust Board on 8 September 2021, the following matters were discussed in private:
   a) CQC Review Update
   b) Fire Safety Update
   c) Nosocomial Infection Update Report
   d) Pathology Collaboration Update: Governance Update and Roadmap
   e) Pathology Collaboration Update: Industrial Action
   f) Strategic Framework
   g) Board Development Programme: September 2021 – March 2022
2. The matters discussed were private and confidential and/or identified individuals and/or were commercially sensitive at this time and so the decision was taken that these items should not be discussed in the public domain. As these items progress, reports will be presented to part 1 of Board Meetings at the appropriate time.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 147

10 November 2021

Purpose Information

Title	Remuneration Committee Information Report
Author	Miss K Ingham, Acting Head of Corporate Governance
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The list of matters discussed at the Remuneration Committee held on 8 September 2021 are presented for Board members' information.

Recommendation: This paper is brought to the Board for information.

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 Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. 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

Remuneration Committee Information Report

1. At the meeting of the Remuneration Committee held on 8 September 2021 members considered the following matter:

   a) Aligning VSM Pay to AFC National Pay Award 2021