East Lancashire Hospitals
NHS Trust
A University Teaching Trust

# EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

Personal

Effective

**TRUST BOARD MEETING (OPEN SESSION)**

**11 MAY 2022, 13.00**

**VIA MS TEAMS**

**AGENDA**

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

| OPENING MATTERS | | | | |
|---|---|---|---|---|
| **TB/2022/051** | **Chairman's Welcome** | Chairman | v | |
| **TB/2022/052** | **Apologies**<br>To note apologies. | Chairman | v | |
| **TB/2022/053** | **Declaration of Interest Report**<br>To note the directors register of interests and note any new declarations from Directors. | Chairman | d✓ | Information/ Assurance |
| **TB/2022/054** | **Minutes of the Previous Meeting**<br>To approve or amend the minutes of the previous meeting held on 9 March 2022. | Chairman | d✓ | Approval |
| **TB/2022/055** | **Matters Arising**<br>To discuss any matters arising from the minutes that are not on this agenda. | Chairman | v | |
| **TB/2022/056** | **Action Matrix**<br>To consider progress against outstanding items requested at previous meetings. | Chairman | d✓ | Information |
| **TB/2022/057** | **Chairman's Report**<br>To receive an update on the Chairman's activities and work streams. | Chairman | v | Information |
| **TB/2022/058** | **Chief Executive's Report**<br>To receive an update on national, regional and local developments of note. | Interim Chief Executive | d✓ | Information |
| **QUALITY AND SAFETY** | | | | |
| **TB/2022/059** | **Patient / Staff Story**<br>To receive and consider the learning from a patient story. | Executive Director of Nursing | p | Information/ Assurance |
| **TB/2022/060** | **Corporate Risk Register**<br>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/2022/061** | **Board Assurance Framework Review**<br>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 | v | Information/ Assurance |
| **TB/2022/062** | **Patient Safety Incident Response Assurance Report** | Executive Medical Director | d✓ | Information/ Assurance |

| | | | | |
|---|---|---|---|---|
| **ACCOUNTABILITY AND PERFORMANCE** | | | | |
| **TB/2022/063** | **Integrated Performance Report**<br>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:<br>a) Introduction (Interim Chief Executive)<br>b) Safe (Executive Medical Director and Executive Director of Nursing)<br>c) Caring (Executive Director of Nursing)<br>d) Effective (Executive Medical Director)<br>e) Responsive (Chief Operating Officer)<br>f) Well-Led (Executive Director of HR and OD and Executive Director of Finance) | Executive Directors | d✓ | Information/ Assurance |
| **TB/2022/064** | **Behaviour Framework Implementation Update** | Executive Director of HR & OD | d✓ | Information /Assurance |
| **TB/2022/065** | **National Staff Survey Report 2021/22** | Executive Director of HR & OD | d✓ | Information /Assurance |
| **STRATEGIC ISSUES** | | | | |
| **TB/2022/066** | **Quality Strategy** | Executive Medical Director | d✓ | Information /Approval |
| **TB/2022/067** | **Clinical Strategy Development - Progress Update** | Executive Medical Director / Interim Executive Director of Service Development | v | Information /Assurance |
| **TB/2022/068** | **New Hospitals Programme Quarter 4 Board Report** | Programme Director, New Hospitals Programme | d✓ | Information /Approval |
| **GOVERNANCE** | | | | |
| **TB/2022/069** | **Ratification of Board Sub-Committee Terms of Reference**<br>a) Audit Committee<br>b) Finance & Performance Committee<br>c) Quality Committee | Committee Chair<br>Committee Chair<br>Committee Chair | d✓<br>d✓<br>d✓ | Approval<br>Approval<br>Approval |
| **TB/2022/070** | **Finance and Performance Committee Information Report**<br>To note the matters considered by the Committee in discharging its duties. | Committee Chair | d✓ | Information |

| | | | | |
|---|---|---|---|---|
| **TB/2022/071** | **Quality Committee Information Report**<br>To note the matters considered by the Committee in discharging its duties. | Committee Chair | d✓ | Information |
| **TB/2022/072** | **Audit Committee Information Report**<br>To note the matters considered by the Committee in discharging its duties. | Committee Chair | d✓ | Information |
| **TB/2022/073** | **Trust Board (Closed Session) Information Report**<br>To note the matters considered by the Committee in discharging its duties. | Chairman | d✓ | Information |
| **FOR INFORMATION** | | | | |
| **TB/2022/074** | **Any Other Business**<br>To discuss any urgent items of business. | Chairman | v | |
| **TB/2022/075** | **Open Forum**<br>To consider questions from the public. | Chairman | v | |
| **TB/2022/076** | **Board Performance and Reflection**<br>To consider the performance of the Trust Board, including asking:<br>1. Have we, as the Board, via the agenda and our discussions fulfilled our objective of supporting our:<br>a. Communities<br>b. Staff<br>c. Stakeholders<br>2. Have we, as the Board fulfilled our statutory obligations | Chairman | v | |
| **TB/2022/077** | **Date and Time of Next Meeting**<br>Wednesday 13 July 2022, 1.00pm, via MS Teams | Chairman | v | |

# TRUST BOARD REPORT

| | | **Item** | **53** |
|---|---|---|---|
| **11 May 2022** | | **Purpose** | Information |

| | |
|---|---|
| **Title** | Declarations of Interest Report |
| **Author** | Mrs A Bosnjak-Szekeres, Director of Corporate Governance / Company Secretary |

**Summary:** Section 5 of the Trust's Standing Orders describes the duties and obligations of Board Members in relation to declaring interests. The Register is available for public inspection. The presented Directors' Register of Interest will be included in the Trust's Annual Report for 2021/22.

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

**Report linkages**

| | |
|---|---|
| Related 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 | Financial | No |
| The Trust would be in breach of its own Standing Orders and its regulatory obligations should it omit to have proper arrangements in place for the Directors' declarations of interests. | | | |
| Equality | No | Confidentiality | No |

(53) Declarations of Interest Report

| Name and Title | Interest Declared | Date last updated/ Confirmed |
|---|---|---|
| **Professor Eileen Fairhurst MBE**<br>Chairman | • Honorary Doctorate UCLan awarded 2018<br>• Visiting Professor, Chester University<br>• Members of the Good Governance Institute Faculty | 13.04.2022 |
| **Martin Hodgson**<br>Interim Chief Executive (from 01.09.2021)<br><br>Deputy Chief Executive Officer/ Executive Director of Service Development (until 31.08.2021) | • Spouse is the Chief Operating Officer at Liverpool University Hospital NHS Foundation Trust.<br>• Spouse's son worked at University Hospitals of Morecambe Bay NHS Foundation Trust (from November 2019 to October 2021) | 19.04.2022 |
| **Patricia Anderson**<br>Non-Executive Director | • Accountable Officer at Wigan Borough CCG (until 31.05.2018).<br>• Public Sector Director on One Partnership (LIFTCO) (January 2015 until 31.05.2018)<br>• Spouse is a recently retired Consultant Psychiatrist formerly employed at Mersey Care NHS Trust.<br>• Assignment with Knowsley Clinical Commissioning Group, supporting the Accountable Officer for a period of six months (10.05.2019 to 01.10.2019). During this time Mrs Anderson took a leave of absence from the Trust Board at ELHT.<br>• Partnership of East of London Collaborative – Assignment of 1.5 days per month (from 01.12.2020 until 01.02.2021) | 04.04.2022 |

| **Name and Title** | **Interest Declared** | **Date last updated/ Confirmed** |
|---|---|---|
| **Kate Atkinson**<br>Interim Executive Director of Service Development and Improvement (from 07.10.2021) | • Brother is the Clinical Director of Radiology at the Trust<br>• Sister-in-law is a Trauma and Orthopaedic Consultant at the Trust | 22.01.2022 |
| **Professor Graham Baldwin**<br>Non-Executive Director | • Director of Centralan Holdings Limited<br>• Director of UCLan Overseas Limited<br>• Deputy Chair and Director of UCEA<br>• Chair of Maritime Skills Commission<br>• Member of Universities UK<br>• Treasurer of Million Plus<br>• Chair of University Vocational Awards Council | 31.03.2022 |
| **Stephen Barnes**<br>Non-Executive Director | • Chair of Nelson and Colne College.<br>• Member of the National Board of the Association of Colleges (from 02.03.2017).<br>• Chair of the National Council of Governors at the Association of Colleges<br>• Chair of the Nelson Town Regeneration / Deal Board | 31.03.2022 |
| **Michelle Brown**<br>Executive Director of Finance | • Positive nil declaration | 19.05.2022 |
| **Sharon Gilligan**<br>Chief Operating Officer | • Positive nil declaration | 31.03.2022 |

| Name and Title | Interest Declared | Date last updated/ Confirmed |
|---|---|---|
| **Jawad Husain**<br>Executive Medical Director | • Spouse is a GP in Oldham | 31.03.2022 |
| **Naseem Malik**<br>Non-Executive Director | • Independent Assessor- Student Loans Company- Department for Education - Public Appointment.<br>• Fitness to Practice, Panel Chair: Health and Care Professions Tribunal Service (HCPTS) - Independent Contractor (until 31.07.2020)<br>• Investigations Committee Panel Chair at Nursing and Midwifery Council (NMC) - Independent Contractor (until 30.07.2021).<br>• Relative (first cousin) is a GP.<br>• Relative (brother-in-law) is a registered nurse employed by Lancashire and South Cumbria Care NHS Foundation Trust. | 31.03.2022 |
| **Tony McDonald**<br>Executive Director of Integrated Care, Partnerships and Resilience | • Spouse is an employee of Oxford Health NHS Foundation Trust<br>• Member of Board of Trustees for Age Concern Central Lancashire Charity | 31.03.2022 |
| **Kevin Moynes**<br>Executive Director of Human Resources and Organisational Development | • Spouse is a very senior manager at Health Education England (from 02.10.2017)<br>• Governor of Nelson and Colne College (until 01.02.2018).<br>• Joint Appointment as Executive Director of HR and OD at East Lancashire Hospitals NHS Trust and Blackpool Teaching Hospitals NHS Foundation Trust (10.10.2018 until 31.01.2022) | 14.04.2022 |

| Name and Title | Interest Declared | Date last updated/ Confirmed |
|---|---|---|
| **Feroza Patel**<br>Associate Non-Executive Director | • Positive Nil Declaration | 31.03.2022 |
| **Christine Douglas**<br>Executive Director of Nursing | • Seconded to Manchester Health Care Commissioning as Clinical/Nursing Board member for 4 days per month (from 01.12.2019) | 31.03.2022 |
| **Khalil Rehman**<br>Non-Executive Director | • Director at Salix Homes Ltd<br>• Director at Medisina Foundation.<br>• NED at Leeds Community Healthcare Trust (from 01.12.2020) | 07.04.2022 |
| **Richard Smyth**<br>Non-Executive Director | • Spouse is a Patient and Public Involvement and Engagement Lay Leader for the Yorkshire and Humber Patient Safety Translational Research Centre, based at Bradford Institute for Health Research, Bradford Royal Infirmary.<br>• Spouse is a Non-Executive Director at Lancashire Teachings Hospitals Foundation Trust as from 04.02.2019. | 06.04.2022 |
| **Michael Wedgeworth**<br>Associate Non-Executive Director | • Board member of Inspire Motivate Overcome (IMO) Charity | 31.03.2022 |

| Name and Title | Interest Declared | Date last updated/ Confirmed |
| --- | --- | --- |
| **Shelley Wright**<br>Joint Director of Communications and Engagement for East Lancashire Hospitals NHS Trust (ELHT) and Blackpool Teaching Hospitals NHS Foundation Trust (BFWH)<br>(from 04.01.2021) | • Post held jointly with Blackpool Teaching Hospitals NHS Foundation Trust | 26.04.2022 |

**Members of the Trust Board who left the Trust during the 2021/22 year**

| Name and Title | Interest Declared | Date last updated |
| --- | --- | --- |
| **Harry Catherall**<br>Associate Non-Executive Director<br>(until 10.01.2022) | • Member STAR Multi Academy Trust former Tauheedul Academy Trust<br>• Former Chief Executive Blackburn with Darwen Council.<br>• Interim Chief Executive at St Helens Council (from 07.10.2019 to 11.03.2020)<br>• Interim Chief Executive of Oldham Council (from 26.08.2021). This position was made permanent in January 2022, and Harry subsequently stepped down from the Trust Board. | 10.01.2022 |

| Name and Title | Interest Declared | Date last updated |
|---|---|---|
| **Kevin McGee**<br>Joint Chief Executive Officer and Accountable Officer for East Lancashire Hospitals NHS Trust (ELHT) and Blackpool Teaching Hospitals NHS Foundation Trust (BFWH)<br>(From 01.10.2019 until 31.08.2021) | • Spouse is the Director of Finance and Commercial Development at Warrington and Halton Hospitals NHS Foundation Trust<br>• Honorary Fellow at University of Central Lancashire<br>• Interim Chief Executive, Blackpool Teaching Hospitals NHS Foundation Trust (from 01.05.2019), this became a permanent appointment across both Trust's on 01.10.2019.<br>• Lancashire and South Cumbria Hospital Cell Lead from 01.04.2020 | 26.02.2021 |

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

| **TRUST BOARD REPORT** | | **Item** | **54** |
|---|---|---|---|
| **11 May 2022** | | **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 9 March 2022 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

(54) Minutes of the Previous Meeting

**EAST LANCASHIRE HOSPITALS NHS TRUST**

**TRUST BOARD MEETING, 1.00PM, 9 MARCH 2022**

**MINUTES**

**PRESENT**

| | | |
|---|---|---|
| Miss N Malik | Non-Executive Director | Chairman |
| Mr M Hodgson | Interim Chief Executive/Accountable Officer | |
| Mrs K Atkinson | Interim Director of Service Development and Improvement | Non-voting |
| Professor G Baldwin | Non-Executive Director | |
| Mr S Barnes | Non-Executive Director | |
| Mrs M Brown | Executive Director of Finance | |
| Mrs S Gilligan | Chief Operating Officer | |
| Mr J Husain | Executive Medical Director | |
| Mr T McDonald | Executive Director of Integrated Care, Partnerships and Resilience | Non-voting |
| Mr K Moynes | Executive Director of HR and OD | Non-voting |
| Mrs F Patel | Associate Non-Executive Director | |
| 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 | |
| Mrs A Brown | Associate Director of Quality and Safety | |
| Mr D Byrne | Corporate Governance Officer | Minutes |
| Professor D Harrison | Director of Public Health, Blackburn with Darwen Council | |
| Mr M Pugh | Corporate Governance Officer | Minutes |
| Mrs K Quinn | Operational Director of HR and OD | |

**APOLOGIES**

| | |
|---|---|
| Professor E Fairhurst | Chairman |
| Mrs P Anderson | Non-Executive Director |
| Mr S McGirr | Director of Nursing & Urgent Care, Midlands and Lancashire CSU and Director of Integrated System and Clinical Analytics at East Lancashire Hospitals NHS Trust (on behalf of Lancashire & South Cumbria Integrated Care System (ICS)) |

**TB/2022/026 CHAIRMAN'S WELCOME**

Miss Malik welcomed attendees to the meeting and explained that she was standing in for Professor Fairhurst as Chair.

**TB/2022/027 APOLOGIES**

Apologies were received as recorded above.

**TB/2022/028 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.

Mrs Bosnjak-Szekeres informed Directors that the full Register of Interests Report would be provided at the next meeting prior to its inclusion in the Trust's 2021-22 Annual Report.

**RESOLVED:** **Directors noted the position of the Directors' Register of Interests. The full Directors Register of Interests Report will be provided at the next meeting.**

**TB/2022/029 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 19 January 2022 were approved as a true and accurate record.**

**TB/2022/030 MATTERS ARISING**

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

**TB/2022/031 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. The following updates were provided:

**TB/2021/112: Pennine Lancashire ICP Update and Partnership Agreement for 2021-22 –** Mr Hodgson confirmed that work continued to develop the Pennine Lancashire IPC Partnership Agreement and that the recruitment process for a Place-based Lead was due to take place later in the month.

**TB/2022/014: Raising Concerns Annual Report –** In response to the query raised by Mr Wedgeworth at the previous meeting in relation to the Raising Concerns Annual Report, Mrs Quinn confirmed that it would be possible to drill down into more detail and that she had requested that more information was included in future versions of the Freedom to Speak Up Report. She also stated that the issue would be picked up as a key piece of work to tie into the Trust's Behavioural Framework.

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

**TB/2022/032 CHAIRMAN'S REPORT**

Miss Malik provided a summary of Professor Fairhurst's activities since the previous meeting, including participation in the Lancashire and South Cumbria (LSC) Chairs and Chief Executive Officers meeting, the Integrated Care System Board, Provider Collaboration Board (PCB) and LSC Pathology Service Board.

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

**TB/2022/033 CHIEF EXECUTIVE'S REPORT**

Mr Hodgson provided updates on national headlines and informed Directors that two pivotal publications were due to be released into the public domain soon. He clarified that the first of these would be the Government's 'Living with COVID-19' plan which was expected to cover four main areas, including the continued provision of COVID-19 vaccines and additional booster doses to those over 75. Mr Hodgson stressed that while there had already been a wider relaxation of domestic restrictions, masks and hand gel were expected to remain as requirements in healthcare settings for the immediate future. Continuing, Mr Hodgson advised that the second publication was the NHS Elective Recovery Plan, which would set out the vision on how Trusts would address the significant patient backlogs that had built up during the pandemic. He clarified that this was expected to cover several areas, including capacity,

prioritisation of diagnosis and treatments, transforming how elective care was provided and providing better information and support for patients. Mr Hodgson reported that the Trust was already performing well against many of the ambitious targets set out in the plan, in comparison to other Trusts both regionally and nationally.
Mr Hodgson informed Directors that a number of developments had also taken place at an LSC level, including the appointment of five new Independent Non-Executive Directors for the Integrated Care Board (ICB). He also advised that the New Hospitals Programme (NHP) was moving into a critical phase, in which the longlist of ten solutions agreed in September 2021 would be whittled down to a shortlist which would then be presented to the Strategic Commissioning Board at the end of the month. Mr Hodgson added that he would provide a further update on the outcome of this process at a later date. Mr Hodgson reminded members that the Health Equity Commission (HEC) for LSC had been launched the previous year with the assistance of Professor Sir Michael Marmot and other partners across the region and advised that a final draft of recommendations and associated action plans was in the process of being developed.

Moving onto Trust matters, Mr Hodgson confirmed that the pressure on the Trust's Urgent and Emergency Care (UEC) services had continued to intensify throughout February and March 2022. He advised that a substantial amount of improvement work was taking place in relation to patient experience and to ensure that more patients could be discharged home as quickly and safely as possible. Mr Hodgson also informed Directors that a new Trust podcast channel had been developed and stated that this was a good example of how the Trust continued to innovate and communicate with its staff. He concluded his update by advising that a significant change management programme was taking place to implement the Trust's new Cerner Electronic Patient Record (EPR) and that it had hit all milestones so far. Mr Hodgson confirmed that he would provide further updates on the EPR system at future Board meetings.

Mr Barnes commented that the Health Equity Commission was a significant opportunity and suggested that it would be productive to utilise the evidence that it had gathered to promote a debate in the wider system to maximise the advantages that could be given to those in more deprived areas. Mr Hodgson agreed and pointed out that health equity was a wider topic than just the financial allocations involved. He advised that waiting lists were being considered in granular detail to determine if patients waiting for longer tended to live in deprived areas as well as what could be done to avoid exacerbating this.

Mrs Pearson informed Directors that since the previous meeting, a Safe, Personal and Effective Care (SPEC) panel had taken place on ward C18 and that there had been very positive feedback from patients. She confirmed that it had been agreed for the ward to be put forward for its second SPEC award and asked the Board they whether they were content to support this. Directors confirmed that they were content.

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

**An update on the NHP Shortlisting Process will be provided at a future meeting.**

**Updates on the implementation of the Cerner Electronic Patient Record system will be provided at future meetings.**

**The Board agreed to award Ward C18 its second SPEC award.**

**TB/2022/034 PATIENT STORY**

Mrs Pearson explained that the story being presented focused on a patient who was diagnosed with breast cancer and accessed treatment during the pandemic.

The patient was first diagnosed following a fast-track two-week referral and was then informed during a visit to the Breast Care Unit. The patient later underwent surgery, requiring self-isolation for three days, after which they met with their consultant to discuss their pathology results. The patient was informed that their tumour had been upgraded from a grade two to a grade three due to its size and was told that the next step would be to begin their chemotherapy treatment. The patient reported very little sickness until they received their first COVID vaccination, after which they reported suffering from a high temperature. This required an ambulance to be sent out to the patient and they were then admitted to the Acute Medical Unit (AMU) for treatment. The patient reported that several tests were carried out during their stay and commented on being impressed at the thoroughness of the Trust staff. They later had their chemotherapy medication switched and reported feeling terrible, after which they were again extensively tested. Following consultation with their oncologist, the patient's dosage was reduced, and their last chemotherapy cycle took place on the 9 April 2021. The patient praised the Chemotherapy Unit at Burnley General Teaching Hospital (BGTH) and the conduct of the staff working there. They also praised the team members who had seen them following their diagnosis and stated that they had felt constantly supported. The patient noted that during their two most difficult periods, the examinations had been very thorough and that no stone had been left unturned. The patient stated that they could not fault the care that they

received from the Trust and expressed their gratitude that they were still present to tell the tale.

Mrs Pearson informed Directors that the patient had recorded a video following their experiences to promote more donations to the chemotherapy unit which had been shared via the Trust's social media channels. A link to this video can be found here.

Mr Hodgson advised that he had recently had the opportunity to visit the chemotherapy unit at BGTH and that he would echo the positive views presented in the patient story.

Miss Malik extended thanks to the patient on behalf of the Board for coming forward to tell their story and for taking part in raising funds for the chemotherapy unit.

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

**TB/2022/035 CORPORATE RISK REGISTER (CRR)**

Mr Husain referred Directors to the previously circulated report and requested that it be taken as read. He confirmed that the Trust's new Assistant Director for Health and Safety and Risk, John Houlihan, had begun to work on the format of the report and had included a new dashboard to summarise any open risks across the organisation. Mr Husain also advised that a substantial amount of work was being done to look at all risks scoring 15 or above and that a recent audit carried out by the Trust's internal auditors had raised a number of concerns that were being addressed. He added that a detailed report on the audit recommendations and the actions taken in response would be provided at the next meeting of the Trust's Quality Committee at the end of March. Mr Husain reported that all risks that were overdue by a month were being actively managed by Mr Houlihan and that there were 1687 open at the time of the Board meeting.

Mr Husain reminded Directors that had it been agreed at the previous meeting for risk ID 8914 (potential interruption of high-flow oxygen therapy to critically ill patients across RBTH) to be removed from the CRR and confirmed that this would be done once the necessary conversation had taken place with the risk handler. He also confirmed that risk ID 8126 (potential to compromise patient care due to lack of Trust wide advanced electronic patient record system), risk ID 8243 (absence of an end to end IT maternity system), risk ID 8257 (loss of Transfusion Service) and risk ID 7762 ((Risks associated with providing HDU (High Dependency Unit) care in DGH with no funding for HDU provision)) were on track to have their scores reduced in the near future.

Mr Smyth commented that the inclusion of the dashboard in the CRR had been particularly helpful as it had clearly shown which risks were more visible than others. He requested that

more visibility was provided around higher scoring risks in future iterations, as there was still a lack of clarity when some had been reviewed and whether there was any consistency with the timescales involved. He added that this would help to provide assurance that risks were being monitored appropriately and that there was less room for things to be missed. Mr Husain advised that a further update on the CRR was due at the Audit Committee meeting taking place in April 2022 and that a full breakdown of all risks scoring 15 or over would be provided as part of this.

Mr Wedgeworth requested clarification on whether risk ID 7762 would be removed from the CRR if its score was lowered, as it was his understanding that the funding currently being provided for it could potentially be lost at the end of the current financial year. Mr Husain provided assurances that although the score for the risk would likely be reduced, it would not be removed from the CRR until the Trust was completely assured.

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

**TB/2022/036 BOARD ASSURANCE FRAMEWORK (BAF)**

Mr Husain referred Directors to the previously circulated report and reminded them that a new format for the BAF was being actively worked on with regard to risks, mitigations and controls and that this revised version would be presented to the Board later in the year.

Mr Husain summarised the main changes made since the previous meeting, advising that more information had been added around the Trust acting as lead employer for the ICS NHS Reservist Programme and the positive work that was taking place with its partner organisations to underpin its clinical and quality strategies.

Mr Hodgson advised that the Executive team had recently met to formally consider the BAF and explained that the Trust had been benchmarking itself against organisations that were rated as ‘Outstanding’ by the Care Quality Commission (CQC). He added that although there hadn’t been any significant differences in terms of content in this benchmarking exercise, it had been agreed that the Trust’s BAF would need further work in terms of its formatting and presentation.

Directors confirmed that they were content to approve the updated BAF and to note the work being undertaken on its revision.

**RESOLVED:** **Directors received, discussed and approved the updated Board Assurance Framework and noted the work on its revision.**

**TB/2022/037 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) ASSURANCE PROCESS REPORT**

Mrs Alison Brown provided some brief background to the PSIRF, explaining that the Trust had agreed to be an early adopter and that it would replace the current Serious Incidents Framework. She clarified that the transition to the PSIRF had been put on hold due to the COVID-19 pandemic but that the Trust had gone live with the new rules for incident investigations and reporting from the 1 December 2022. Mrs Alison Brown added that the Board would be taking responsibility for approving and closing all serious incident investigations going forward. This function had previously been provided by Clinical Commissioning Groups. Mrs Brown informed Directors that a key internal Patient Safety Incident Response Plan (PSIRP) had been developed that detailed the national and local priorities which the Trust would be required to investigate. She also advised that the quantity of investigations required under the PSIRF would be significantly lower and that it would promote much quicker and more immediate learning within divisions. Directors noted that a number of changes would be made to the Trust's assurance structures, including the introduction of a new Patient Safety Incident Requiring Investigation (PSIRI) panel, new Divisional Patient Safety Incident Reporting Groups (DPSIRGs) and the revision of meeting terms of reference to ensure that the new processes were embedded. Mrs Alison Brown confirmed that CCGs would continue to be involved and advised that regular meetings were taking place with NHS England (NHSE) to ensure that the Trust was keeping pace and that any learning could be fed into the national programme.

Mr Husain informed Directors that four dedicated patient safety investigators had recently been appointed to support the implementation of the PSIRF.

Mrs Atkinson advised that the PSIRP would be used to shape the Trust's approach to improvement work over the coming months and that this would be focused on five key areas; cancer diagnosis, nil by mouth for vulnerable patients, slips, trips and falls, end of life care and Emergency Department (ED) transfers.

Mr Smyth noted that paragraph 3.7 of the report referred to CCG involvement and requested clarification whether any new arrangements would be put in place once they ceased to exist and, if so, what these would be. Mrs Brown explained that this was still unclear, but that it was expected that the Trust would report into a system wide quality structure.

Directors confirmed that they were content to receive the information and the assurance provided from the report.

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

**TB/2022/038 OCKENDEN REVIEW OF MATERNITY SERVICES – ONE YEAR ON**

Mrs Pearson reminded Directors that the initial report from the Ockenden Maternity Review had been published in December 2020 and had outlined seven immediate and essential actions (IEAs) and 13 clinical priorities to bring about a sustained improvement in maternity services. This had been followed by a letter sent to all Trust Boards to ensure that they were aware of the progress to date within their organisations against these and she advised that a follow up letter had now been received thanking Trusts for their efforts. She added that the final version of the Ockenden report was due to be published by the end of the month.

Mrs Pearson stated that the Quality Committee continued to receive regular updates on maternity services, as well as updates on its progress with Ockenden and Clinical Negligence Scheme for Trusts (CNST) compliance. Directors noted that the Trust had been successful in securing additional funding through the national response to the Ockenden review and was fully compliant against ten of the clinical priorities identified in the initial report. Mrs Pearson confirmed that the Trust was aiming to be complaint against all standards by the next submission of the Ockenden assessment tool. She went on to inform Directors that a professional judgement staffing review within maternity services had been completed in November 2021. Mrs Pearson requested confirmation from Directors that they were content to approve the recommendation to continue the implementation of the seven IEAs and 12 clinical priorities outlined in the Ockenden report.

Mr Wedgeworth stated that he felt assured that the Trust was doing an exemplary job regarding its maternity services, which had been underlined by its recent positive visit from the Chief Midwifery Officer, Jacqueline Dunkley-Bent OBE. He noted that there some worrying issues in maternity services nationally and that it would be crucial to ensure that the Trust was keeping up with the right standards.

Mr Rehman suggested aligning future updates on the Ockenden report with the wider Health Equity agenda, as he felt that any improvements made in relation to race or other social care determinants had been less clear than those made in the workforce. Mrs Pearson confirmed that she would pass on Mr Rehman's feedback to the maternity team and would raise the matter via the Quality Committee for further discussion.

Directors confirmed that they were content to receive the report and approve the recommendations outlined within.

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

**Mrs Pearson to pass on the feedback to the maternity team about health equity and raise the issue via the Quality Committee for further discussion.**

**TB/2022/039 INTEGRATED PERFORMANCE REPORT (IPR)**

**a) Introduction**

Mr Hodgson introduced the item and confirmed that it covered the period to the end of January 2022. He stressed that when the data was considered in the context of the pressures seen in the Trust at the time, caused by the Omicron variant and usual winter pressures, it painted a relatively positive picture. Mr Hodgson acknowledged that there were clearly areas of challenge, including the pressures in the Trust's urgent and emergency care pathways and the length of time some patients were having to wait, but pointed out that this was offset by the positive progress made in reducing waiting lists and increasing elective recovery.

**b) Safe**

Mr Husain requested that the safe section of the report be taken as read and provided a summary of highlights. He commended the efforts of the Trust's Infection Prevention and Control (IPC) and Estates teams in keeping wards and other environments as safe as possible, adding that there had only been two unavoidable cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) reported in the current year. Mr Husain advised that the outbreak of Escherichia coli (E. coli) on the Trust's Neonatal Intensive Care Unit (NICU) was still open but stressed that there had been no new clinical cases of the bacteria since January 2021. He confirmed that, as a result, the Outbreak Committee set up in response would be wound down over the coming months on the recommendation of external experts.
Mr Husain reported the Trust's total number of Clostridium difficile (C. diff) infections was 43, against a trajectory of 67, and its total number of nosocomial infections from June 2020 to January 2022 was 579, 53 of which had been determined to be hospital acquired. He concluded by reporting the total for Venous Thromboembolism (VTE) assessments at 98.6%, against a target of 97%.
Mrs Pearson reported that the Trust's staffing position in January had been very challenging due to the Omicron variant of COVID-19 and that there had been increased usage of bank and agency staff during this period. Directors noted that a number of wards had fallen below the 80% fill rate and that a number of actions had been taken to mitigate the associated risks.

Mrs Pearson also advised that there had been a relaunch of the Trust's recruitment strategy and that one of its key aims was to reduce vacancies to zero by 2023.

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

**c) Caring**

Mrs Pearson referred Directors to the Caring section of the report and requested that it be taken as read. She confirmed that work was underway to increase the numbers of responses provided through the Friends and Family Test (FFT) and that extra focus was being put into capturing information from the ED.

Mrs Pearson reported that there had been 60 new complaints made to the Trust in January and confirmed that these were being looked at to identify any themes.

**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 107.4, following a recent rebasing exercise by the team at Dr Foster. He explained that when COVID mortality was removed, this figure came down to 102, which is well within expected tolerances.

Mr Husain informed Directors that higher numbers of patients were coming in for treatment with more advanced diseases, such as cardiovascular disease and chronic obstructive pulmonary disease (COPD) and explained that this was another long-term effect of the COVID pandemic.

Professor Harrison provided more detail on the points raised by Mr Husain, adding that Blackburn with Darwen had among the largest hits in terms of cumulative case rates across the country which, when combined with heightened admissions from COVID-19 and staff absences, had led to the strain currently being seen on the local health and care economy. He commented that the Trust and other local authorities had performed exceptionally well in the face of these pressures and noted that the successful implementation of surge capacity had resulted in lower case rates from the Delta and Omicron variants of COVID-19 than had been seen elsewhere. Professor Harrison explained that despite these successes, it was likely that LSC would experience a much lengthier impact from the pandemic regarding long term conditions and increased risk of hospital admissions due to the generally poorer health of its

local population. He stated that it would be critical to ensure that the Trust secured its fair share of the recovery funds that would be made available over the coming months as it would need the extra resources to be able to raise local residents' life chances to those seen in the rest of the country.

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

**e) Responsive**

Mrs Gilligan provided a brief summary of operational data. She reported that ED performance had remained extremely challenging, with more than 233 patients waiting over 12 hours from a decision to admit (DTA) in the last reporting period. Mrs Gilligan clarified that of these patients, 214 had attend for physical health issues and 19 for mental health conditions. She confirmed that despite these challenges, the Trust continued to perform well regarding ambulance handover times and that it was doing everything possible to maintain this.

Mrs Gilligan informed Directors that the Trust remained on track with its elective care trajectories but was continuing to struggle to meet cancer standards. She stressed that as the significant backlog of patients was cleared a dip in performance was to be expected due to the numbers of patients coming in for treatment. Mrs Gilligan concluded by reporting that patient length of stay was within normal ranges and that the Trust's emergency readmission rates were as expected.

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

**f) Well-Led**

Mrs Quinn reported the Trust's latest sickness rate at 5.93% and noted that this was a significant reduction from the levels seen in January 2022. She informed Directors that additional work was taking place around the Trust's recruitment agenda and confirmed that an update would be provided in due course. Mrs Quinn also advised that the Trust had some success in reducing agency spend through December, January and February by enhancing bank rates. Directors noted that work would be taking place to improve appraisal compliance rates across the Trust following their temporary suspension during the pandemic.

Mrs Michelle Brown confirmed that the Trust was currently on plan for the financial year and reported that its capital programme stood at £32,500,000. She advised that there hadn't been

any further information regarding the expected financial envelope for 2022/23 since the previous meeting and pledged to provide an update at the meeting in May 2022.

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

**An update on the work taking place around the Trust's recruitment agenda will be provided at a future meeting.**

**An update on the expected financial envelope for 2022/23 will be provided at the meeting due in May 2022.**

**TB/2022/040 NEW HOSPITALS PROGRAMME Q3 REPORT**

Mrs Malin referred to the previously circulated report and requested that it be taken as read. She informed Directors that the second of two workshops to appraise the longlist of options for the NHP had taken place in February and explained that this would inform the final shortlist of options for any new hospitals. Mrs Malin reported that attendance had been positive and that all attendees had received information packs to appraise the options list. She advised that the revised shortlist of options was expected to be approved at the meeting of the Strategic Commissioning Committee taking place on 10 March 2022. Mrs Malin confirmed that focused engagement work on the shortlist process would continue over the coming period and that other work had continued on interdependent workstreams regarding primary and community care.

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

**TB/2022/041 NHS GREEN PLAN**

Mrs Michelle Brown referred Directors to the previously circulated report and explained that it had been developed to reduce the Trust's carbon footprint and facilitate its journey to achieving 'Net Zero' within the timeframes set out in the 'Delivering a Net Zero NHS' guidance. She advised that a significant amount of work had taken place with the Trust's partner organisations to measure the current carbon footprint and reported that this currently stood at 122,000 which is equivalent to 650 tonnes of carbon dioxide. Mrs Michelle Brown clarified that it had been agreed to monitor any progress made against the plan through the Audit Committee and that it would be revised according to the Trust's needs. She requested confirmation from Directors that they were content to approve the plan as it currently stood, to allow it to be published with partner organisations and for it to be published on the Trust website.

Miss Malik noted that there were only seven charging points for electric vehicles (EVs) between Royal Blackburn Teaching Hospital (RBTH) and BGTH and enquired if any consideration had been given as to how more could be installed to encourage more staff to switch to EVs . Mrs Brown explained that plans for a multi-storey car park were being worked through with the Estates and Facilities team and that the first level was planned to be reserved for EVs.

Mr Wedgeworth praised the intentions laid out in the report but enquired if a condensed version could be provided, adding that he was concerned that the amount of the content presented could detract from the overall message. Mrs Michelle Brown clarified that in its current format the report met all relevant requirements but confirmed that it was likely to be amended and streamlined through the Audit Committee over the coming years.

Mr Barnes pointed out that the Green Plan would only be as effective as the resources that would underpin it and requested clarification on how the ICS would be able to provide the capital requirements for individual Trusts, as well as for any system-based strategies. Mrs Michelle Brown explained that the ICS was developing its own strategies and confirmed that these would form part of the Trust's decision-making. She acknowledged Mr Barnes' points around the need for additional capital investment and advised that discussions would continue with the system to facilitate this.

Mr Hodgson commented that the Green Plan was a comprehensive one and commended colleagues for their efforts in developing it. He noted that the Trust was currently seen as a significant leader in the reduction of anaesthetic gases and that the introduction of the Cerner EPR system would allow it to develop more sustainable models in the future.

Mr Smyth stated that the scale of the challenge before the Trust in reaching 'Net Zero' could not be underestimated but pointed out that there was a significant array of options available to achieve it. He added that ensuring that the small advances made over the previous two years during the pandemic were not lost would be a good starting point.

Directors confirmed that they were content to approve the Green Plan and for it to be shared via the Trust website.

**RESOLVED:** **Directors approved the Green Plan and for its publication on the Trust website.**

**TB/2022/042 TRUST CHARITABLE FUNDS REPORTING**

The report was presented to the Board for information.

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

**TB/2022/043 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/2022/044 QUALITY COMMITTEE INFORMATION REPORT**

The report was presented to the Board for information.

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

**TB/2022/045 AUDIT COMMITTEE INFORMATION REPORT**

The report was presented to the Board for information.

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

**TB/2022/046 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/2022/047 ANY OTHER BUSINESS**

Mr Hodgson informed Directors that the meeting would be Professor Harrison's last in his current role and stated that the value of his contributions both recently during the pandemic, and throughout the rest of his career, could not be understated. He went on to wish Professor Harrison a long and happy retirement.

Miss Malik echoed the comments made by Mr Hodgson and extended her gratitude to him on the Board's behalf for his contributions.

Professor Harrison thanked Directors for their comments and stated that it had been a pleasure and honour to be a member of the Trust's Board over recent years. He commented that he hoped to see public health continue to go from strength to strength in the future.

**TB/2022/048 OPEN FORUM**

It was confirmed that there had been no questions received from members of the public.

**TB/2022/049 BOARD PERFORMANCE AND REFLECTION**

Miss Malik 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 Wedgeworth noted that workforce issues had been a constant thread throughout the topics discussed in the meeting and stated that the Trust would need to make the best of the limited funding that it was due to receive.

Mr Hodgson acknowledged that Directors had gone into more detail than they normally would have for some of the items discussed but pointed out that it was incumbent on them to provide assurance and in the right way.

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

**TB/2022/050 DATE AND TIME OF NEXT MEETING**

Miss Malik informed Directors that the next Trust Board meeting would be taking place on Wednesday, 11 May 2022 at 13:00, via MS Teams.

# TRUST BOARD REPORT

| | |
|---|---|
| **Item** | **56** |
| **Purpose** | Information |

**11 May 2022**

| | |
|---|---|
| **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<br>Invest in and develop our workforce<br>Work with key stakeholders to develop effective partnerships<br>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.<br>Recruitment and workforce planning fail to deliver the Trust objectives<br>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.<br>The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework.<br>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 |

(56) Action Matrix

# ACTION MATRIX

| Item Number | Action | Assigned To | Deadline | Status |
|---|---|---|---|---|
| **TB/2021/134: Board Assurance Framework (BAF)** | The Board Assurance Framework annual review will be completed in Quarter 4 and presented at a future meeting. | Executive Medical Director | July 2022 | Update: an Executive Team meeting is taking place on 6 May 2022 followed by a Board workshop on the 10 May to review the proposed new BAF risks and discuss the new risk appetite with a view to present the new BAF to the Committees in June and to the Board in July 2022. |
| **TB/2021/139: Behavioural Framework Launch** | An update on the progress made with the rollout of the Trust's new Behavioural Framework will be provided at a future meeting. | Executive Director of HR & OD | May 2022 | Agenda Item: May 2022 |
| **TB/2022/015: ELHT Staff Health and Wellbeing Programme Action Plan** | An update on the progress made with the implementation of the Staff Health and Wellbeing actions will be provided at the meeting in July 2022. | Executive Director of HR & OD | July 2022 | Agenda Item: July 2022 |

| Item Number | Action | Assigned To | Deadline | Status |
|---|---|---|---|---|
| **TB/2022/033: Chief Executive's Report** | An update on the New Hospitals Programme Shortlisting Process will be provided at a future meeting.<br><br>Updates on the implementation of the Cerner Electronic Patient Record system will be provided at future meetings. | Interim Chief Executive<br><br>Executive Director of Finance | May 2022<br><br>May 2022 | An update will be provided under item 68 (New Hospitals Programme Quarter 4 Board Report) on the May Trust Board agenda.<br><br>An update will be provided under the Chief Executive's Report item. |
| **TB/2022/038: Ockenden Review of Maternity Services – One Year On** | Mrs Pearson to pass on the feedback to the maternity team about health equity and raise the issue via the Quality Committee for further discussion. | Executive Director of Nursing | May 2022 | Update: Regular updates on maternity services are provided to the Quality Committee by the Trust's maternity team. These include updates on the Ockenden Review and the Clinical Negligence Scheme for Trusts and these will be more closely aligned with the health equity agenda in future Committee meetings. |
| **TB/2022/039: Integrated Performance Report – Well-led** | An update on the work taking place around the Trust's recruitment agenda will be provided at a future meeting. | Executive Director of HR & OD | May 2022 | Update: an email has been circulated to Board members summarising the work taking place within the Trust around recruitment. |

| Item Number | Action | Assigned To | Deadline | Status |
|---|---|---|---|---|
| | An update on the expected financial envelope for 2022/23 will be provided at the meeting due in May 2022. | Executive Director of Finance | May 2022 | An update will be provided under the Integrated Performance Report item. |

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

| **TRUST BOARD REPORT** | **Item** | **58** |
|---|---|---|
| **11 May 2022** | **Purpose** | Information |

| | |
|---|---|
| **Title** | Chief Executive's Report |
| **Author** | Mrs E-L Cooke, Joint Deputy Director Communications and Engagement |
| **Executive sponsor** | Mr M Hodgson, Interim 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<br>Invest in and develop our workforce<br>Work with key stakeholders to develop effective partnerships<br>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.<br>Recruitment and workforce planning fail to deliver the Trust objectives<br>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.<br>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

# CEO Report

May 2022

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.

## One - National Headlines

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

### UK COVID-19 update

More than 121 million COVID vaccination doses have now been administered in England including more than 2.4 million spring boosters. Across Lancashire and South Cumbria more than 4 million doses have been administered including almost 100,000 spring boosters.

The spring booster campaign is going well and uptake among over 75s, those immunosuppressed, and those living in care homes is pleasing. However, the rollout to healthy 5-11-year-olds is much slower. Communications activity is running to encourage further uptake however priority is being put on ensuring the spring booster uptake is maximised.

The UK is now managing the virus like other respiratory infections as set out in the Living with COVID-19 Plan. While a different disease to COVID-19, the most common comparison is to influenza. Both viruses can result in severe illness and complications and are thought to spread in similar ways. The virus that causes COVID-19 is far more contagious and can cause more serious illness, even in otherwise healthy people. Influenza is managed through ongoing surveillance, annual vaccination and annual public messaging, including campaigns to increase vaccine uptake and the 'Catch it, Bin it, Kill it' campaign to reduce transmission from coughs and sneezes. Influenza still produces regular winter epidemics, causing pressure on the NHS every winter. The interaction of future COVID-19 waves with other respiratory infections, like influenza, will be important to monitor. Co- or sequential circulation could lead to an increased or longer period of pressure on healthcare services.

Over time, though hard to predict, it is likely that COVID-19 will become a predominantly winter seasonal illness with some years seeing larger levels of infection than others. This may take several years to occur and waves of infection may occur during winter or at other times in the year.

However, it remains the case that in the third year of the pandemic – even with effective vaccines – the NHS has remained under extreme pressure due to the prevalence of COVID-19 in the community. There are close to 200,000 NHS staff absences each week and 1.7 million people are suffering from Long Covid. Nearly 20,000 patients are currently in hospital with the virus, resulting in more than 1,000 deaths per week, while A&E waiting times are over four hours and, in some cases, up to 12 hours or more.

We are doing all we can to encourage the public to continue to follow public health advice to minimise the chance of catching Covid and help protect family and friends. This includes by letting fresh air in when meeting indoors, wearing a face covering in crowded and enclosed spaces where there is contact with people outside normal social/work environments, and practising strict hand hygiene principles.

### Publication of the Independent Review of maternity services at The Shrewsbury and Telford Hospital NHS Trust

The final report of The Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust, led by Donna Ockenden, was published 30 March 2022.

The independent multi–professional team of midwives and doctors including obstetricians, neonatologists, obstetric anaesthetists, a physician, cardiologist, neurologist and others examined the maternity care and treatment provided to 1,486 families over two decades at the Trust. They reviewed 1,592 clinical incidents where medical records and family consent was gained.

The report identifies more than 60 Local Actions for Learning for the Trust and another 15 key Immediate and Essential Actions to improve all maternity services in England, including financing a safe and sustainable maternity and neonatal workforce and ensuring training for the whole maternity team meets the needs of today's maternity services.

The review found repeated failures in the quality of care and governance at the Trust throughout the last two decades, as well as failures from external bodies to effectively monitor the care provided. This final report identifies hundreds of cases where the Trust failed to undertake serious incident investigations, with even cases of death not being examined appropriately.

These combined failings led to missed opportunities to learn, with families experiencing repeated serious incidents and harm throughout the period of the review.

The report states that Trust Boards must have oversight and understanding of their maternity services. Trust boards must ensure that they listen to and hear local families and their own staff.

### Multimillion-pound maternity boost for patients and families

NHS England has announced a £127 million funding boost for maternity services that will help ensure safer and more personalised care for women and their babies. The major investment will boost the workforce and help improve the culture in maternity units.

More than £50 million will be provided to Trusts across the country over the next two years to boost staffing numbers in maternity and neonatal services. Around £34 million will also be invested in local maternity systems, in culture and leadership development programmes and in supporting staff retention roles. In addition, £45 million of capital funding will be available to hospitals over the next three years to increase the number neonatal cots across England, so that babies will receive the best quality care, in the most appropriate clinical setting.

### Pioneering treatments rolled out on NHS

A tiny balloon to treat chronic sinus infection and steam bursts to shrink an enlarged prostate are among a range of new treatments being rolled out by the NHS. Every hospital in England will be able to access the seven new gadgets, which also include a portable chest drainage device to help patients recover more quickly from heart and lung problems and an automated blood cell replacement system to treat people with sickle cell disease.

The full list of treatments which have been approved for use if clinically appropriate for patients include:

- XprESS, a novel treatment for blocked sinuses which works by inflating a tiny balloon inside the patient's nose, clearing blockages and relieving headaches and pain.
- Thopaz+, a portable digital chest drainage device to help patients recover more quickly from heart and lung problems using the latest digital technology to provide an accurate measure of a patient's progress.
- Spectra Optia is a system that helps sickle-cell patients by automatically replacing disease-affected red blood cells with healthy ones from a donor.
- PLASMA, a new way of treating enlarged prostate, where an electrical current passed through a surgical tool is used to cut out tissue while sealing the wound at the same time, reducing bleeding during surgery.
- Rezum is a prostate treatment which avoids the need for longer, more complicated surgery by using bursts of steam to shrink an enlarged prostate.
- Urolift is a much less invasive treatment that relieves the symptoms of an enlarged prostate by using small, permanent implants to stop the gland blocking the flow of urine.
- GreenLight laser treatments are also used for treating prostate issues and can be carried out in a day without the need for patients to stay overnight.

The innovations will ensure tens of thousands of patients can be treated for often debilitating conditions faster, while also saving time for staff and helping address covid-19 backlogs.

### Top jobs in NHS more diverse than any point in history

Black and minority ethnic (BME) representation in senior positions in the NHS are at their highest ever level according to an annual report into race equality across the NHS. The NHS Workforce Race Equality

Standard shows the number of BME staff at very senior manager level has almost doubled between 2020 to 2021 – up from 153 to 298.

The analysis also shows the number of BME board members across all NHS Trusts have increased by a quarter between 2020 and 2021 and are up by three quarters on 2018 when the data was first published. The survey also showed the NHS workforce is more diverse than at any point in NHS history with more than 300,000 staff from a BME background – the equivalent of 22.4% of all NHS staff. This is up from 18% in 2017.

However, despite this rise, BME staff remain underrepresented in senior positions – particularly in board executive roles – which is why the Long Term Plan has called on every NHS Trust to set its own target on senior BME representation by the end of 2022, to reflect their overall workforce.

### Mobile units and same-day surgery helping thousands get NHS treatment

Same-day hip replacements, one stop shops and mobile cataract units are just some of the ways NHS colleagues are helping hundreds of thousands of patients receive faster care. Despite pressure on various fronts, treating COVID-19 patients and increasing numbers of emergency patients, the NHS has carried out an additional 230,000 vital diagnostic tests through one stop shops since the publication of the Elective Recovery Plan.

The elective recovery plan set out a blueprint for addressing COVID-19 backlogs that have inevitably built up during the pandemic as well as tackling long waits for care. NHS colleagues across the country are already working flat-out to deliver as much routine care for patients as possible.

Hospitals have treated more than 690,000 patients with the virus, including over 180,000 who have been admitted so far during the Omicron wave. This is alongside NHS healthcare professionals pulling out all the stops to deliver more than 120 million vaccine doses – including more than one million spring boosters in just two weeks – as part of the biggest and most successful vaccination programme in health service history.

# 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.

### New Hospitals Programme update

Lancashire and South Cumbria New Hospitals Programme has announced the shortlist of proposals for new hospital facilities. This is a significant development in our aim to develop new, cutting-edge facilities, offering the absolute best in modern healthcare and addressing significant problems with the ageing Royal Preston Hospital and Royal Lancaster Infirmary buildings. The shortlisted proposals are:

1. A new Royal Lancaster Infirmary on a new site, with partial rebuild/refurbishment of Royal Preston Hospital
2. A new Royal Preston Hospital on a new site, with partial rebuild/refurbishment of Royal Lancaster Infirmary
3. Investment at both Royal Lancaster Infirmary and Royal Preston Hospital, allowing partial rebuilding work on both existing sites
4. Two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital (new sites).

These proposals also include investment in Furness General Hospital, required due to its geographically remote location, its proximity to some of the UK's major strategic national assets, and its need to meet NHS environmental goals.

In line with NHS guidelines, the shortlisted proposals will be benchmarked against options for no change to, and/or limited investment in Royal Lancaster Infirmary and Royal Preston Hospital to address the list of tasks that need to be performed to repair or maintain the buildings and keep them in a suitable working condition.

The shortlist of proposals for new hospital facilities was endorsed by the Lancashire and South Cumbria Strategic Commissioning Committee and reflects extensive feedback gathered from more than 12,000 local people, patients, NHS staff, community representatives and stakeholders over the last year.

### Two-hour Urgent Community Response

As an ICS we have now achieved the national standard for Urgent Community Response (UCR) which was introduced in the NHS Long Term Plan, to ensure that rapid services are available to all people within their homes or usual place of residence including care homes. The achievement of this national standard includes the completion of the following actions by March 2022:

- Providing a consistent service at scale: ensuring full geographical coverage of a two-hour UCR
- Providing services from 8 am to 8 pm, seven days a week, as a minimum
- Accepting referrals into two-hour UCR services from all appropriate sources
- Submitting complete data returns to the CSDS to demonstrate the achievement of the two-hour standard

We will now begin to work on the next set of two-hour UCR requirements set out in the 2022/23 national planning guidance.

### New service launched for people facing maternity struggles

A new NHS service in Lancashire and South Cumbria will offer support and therapy for people who have had a traumatic experience connected to pregnancy.

The Reproductive Trauma Service has been set up to offer a variety of support and therapies to those who have experienced birth trauma, fear of childbirth (tokophobia), or perinatal loss including early miscarriage, recurrent miscarriage, stillbirth, neonatal death, termination of pregnancy for any reason, or parent-infant separation at birth.

The new service, operated by Blackpool Teaching Hospitals NHS Foundation Trust, is available to people across Lancashire and South Cumbria and is one of the first in the country to meet the promises of the NHS Long Term Plan. Support can be accessed by speaking with a health visitor, midwife, or GP.

### £1m for maternity improvements in Lancashire and South Cumbria

Lancashire and South Cumbria Local Maternity and Newborn System (LMNS) has been awarded £1m of NHS funds to improve digital maternity services, helping to deliver a better experience for maternity service users and staff.

The money will fund a new electronic maternity record, joining up four hospital Trusts, ensuring that women can access their own health records and information needed to make informed decisions. The electronic maternity record will also allow maternity care providers access to accurate and up-to-date records wherever a pregnant woman presents for care.

Lancashire and South Cumbria Health and Care Partnership is one of 128 successful bidders to the Digital Maternity Fund, which is given to NHS organisations across the country to improve infrastructure, technology systems and connectivity.

### Lancashire and South Cumbria Pathology Collaboration Update

ELHT is one of the four hospital Trusts in Lancashire and South Cumbria which are part of the Lancashire and South Cumbria Pathology Collaboration working together to improve pathology services for patients.

The project aims to provide a single streamlined, sustainable pathology service which is high quality, clinically and cost effective by 1 July 2022 and there is an absolute commitment from all partners in the collaboration to deliver the benefits this will bring in relation to quality, resilience and improved outcomes for patients.

A decision has now been taken to pause the process to allow for further listening and engagement with those colleagues who are affected by the proposed changes.

# 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 16 March 2022 the seal was applied to the Lease for 1.12 acres of land at St Andrews Recreation Ground, Burnley between the Trust and Burnley Borough Council. The agreement was signed by Mr Martin Hodgson, Interim Chief Executive and Mrs Sharon Gilligan, Chief Operating Officer.
- On 6 April 2022 the seal was applied to the Lease relating to Haslingden Health Centre, Manchester Road, Haslingden between NHS Property Services Limited and the Trust. The agreement was signed by Mrs Christine Pearson, Executive Director of Nursing and Mrs Sharon Gilligan, Chief Operating Officer.

## Staff Survey

In the Survey's most significant refresh for at least a decade, the 2021 results are reported against the seven People Promise elements and two themes (Staff engagement and Morale). In each of these indicators, the Trust scored higher than the national average except one – the theme of 'We are always learning' – where the Trust scored a little lower than the average.

This year, a record 58% of ELHT colleagues, or 5,265 people, took the time to have their say – during one of the busiest and most pressured times any of us have ever faced in our careers. Other figures show that:

- 65% of staff would recommend the organisation as a place to work
- 69% would be happy with the standard of care if a friend or relative needed treatment
- 78% believe care of patients/service users is the organisation's top priority.

We've had some great feedback, with highlights including people reporting that the organisation takes positive action on health and wellbeing, on career progression and improved numbers of people reporting they do not experience harassment, bullying, abuse or physical violence in their jobs.

While it is heartening to hear that our colleagues feel the Trust is getting safer year on year, colleagues are actively encouraged to raise any concerns in this regard with their manager, our Freedom to Speak Up colleagues or to any one of the Executive Team.

There have been significant improvements to the way we work since the last survey including:

- Over 90 wellbeing and engagement champions recruited across the Trust
- The introduced our Behavioural Framework
- Staff networks established or further developed including BAME, Mental Health, Disability, LGBTQ and the women's network
- The introduction of our flexible and agile working policy
- Establishing a staff safety group to support violence reduction across the Trust.

The Trust is committed to building on this year's results and the improvements already made. There will be a keen focus on the individual comments received as part of the survey process, as much as in the figures themselves.

### Behaviour Framework

Since the launch of the Trust's Behaviour Framework during our Festival of Inclusion in 2021, colleagues have been increasingly observed role modelling positive behaviours, respecting, valuing and supporting each other - this has been further evidenced in the recent NHS Staff Survey results.

Adopting and embracing a key set of behaviours is helping the Trust to achieve its ambition to deliver Safe, Personal and Effective care and continue to make ELHT a great place for everyone.

Over the past month there has been focused communications activities to further explain and embed the principles of the Behaviour Framework, including a . There will be more opportunities to hear about the Behaviour Framework over the coming weeks as a podcast series is currently being recorded.

Colleagues from across the Trust will be coming together to discuss why they think setting behaviour expectations is important for individuals, teams, the organisation and ultimately patients. You can listen to all the latest ELHT podcasts by searching 'ELHT Audio' on your smart speaker or phone or click here to go to our Apple podcast page. The Executive team will also be talking about this at the next Teams brief so please do tune in to hear more.

### Take a Moment

The Trust marked the second anniversary of the admission of our first COVID-positive patient and sadly, their passing in March. The whole #ELHTfamily was encouraged to 'Take a Moment' and reflect on their experiences during the pandemic, focusing on their wellbeing and resilience.

The 'Take a Moment' Hub on the Trust's Sharepoint was updated with useful resources and information to help our colleagues take some well-deserved time out and to support practicing self-care.

Throughout the week a range of events took place to mark the anniversary and to provide some hope in looking forward to the future. Alfie, the Trust's newest Therapy Dog, visited the Garden of Memories. A special edition of Teams Brief was held offering a period of remembrance and reflection and an

opportunity to share positive stories and 'CEO Shout Outs'. In addition, the Executive Team visited wards and departments across the Trust, spending some time discussing colleagues' experiences, both during the pandemic and currently.

A podcast was released on the ELHT Audio channel featuring Tony McDonald, Executive Director of Integrated Care, Partnerships and Resilience, Linda Gregson, Matron on Critical Care, David Anderson, Chaplain and Counsellor and Eleanor Davies, Communications Specialist at the Trust. They talked about lessons learned, moments of inspiration and hope, positives moving forward and the importance of self-care and self-compassion. You can listen here or search 'ELHT Audio' on a phone or smart speaker.

As a token of appreciation, 'Thank You NHS' cupcakes were distributed across our hospital sites by the Catering Team and were very well received.

### eLancs Update

The Trust has hit a major milestone in the eLancs programme to implement a new Electronic Patient Record (EPR) system. The recent Future State Validation event presented the fruits of months of labour and planning with a first look at the system. The workflows which will create ELHT's EPR have now been successfully signed off and will enable the Trust to provide safer and more effective care for patients.

The professionalism, knowledge and commitment from everyone involved, from IT and clinicians to the nursing and clerical teams has been outstanding.

There will be plenty of opportunities for everyone to see the new system in action over the coming months. Roadshows, walkarounds, drop-in sessions and more are planned to give all colleagues a chance to see how the system works, to try it out for themselves and to ask questions. Trust-wide training begins in September, with the go-live in November.

Work has also begun on the creation of a Change Networks. Change Networks consist of representatives (ambassadors/points of contact) in the Trust who are supportive of the eLancs programme and influential within their own teams. They help to promote communications and benefits, lead behavioural changes, as well as encourage ongoing positive behaviours after the 'go live' dates.
Over 600 names have been put forward to become Ambassadors, of which 120 attended the recent Change Network and Ambassador launch events.

### ELHT Maternity Services National insight visit

ELHT maternity services held their first insight visit 27 April 2022 for interim assurances with both regional and local maternity system colleagues.

As a result of the recommendations from the Ockenden Reports each and every one of our maternity staff have taken the task of either scoping, planning, delivering clinical care pathways both enhanced or redesigned to implement the clinical priorities and the immediate essential actions.

These priorities encompass strong team collaboration, exceptional leadership with a focus on key project transformation and quality improvements for the mothers and families of ELHT.

The formal response is being awaited, however the feedback received on the day was excellent.

### Searching for our STARs

The Trust's has opened nominations for its annual STAR Awards. The STAR awards recognise those who have gone above and beyond to provide care for our patients, to support fellow colleagues or assist the Trust in its everyday work.

After a pause in these awards due to the pandemic, we are delighted that we are now able to able to take the opportunity once more to give recognition to our hard-working colleagues for the commitment they have given to delivering safe, personal and effective care to our patients throughout the most challenging times known to the NHS. This year the awards will be held in a virtual format, opening the occasion to a wider audience, by streaming it live on the ELHT YouTube channel.

A new inclusivity award has been added, giving nominees 13 categories covering all aspects of ELHT life to choose from.

More information about the awards, the categories and how to nominate can be found on the Trust's website. The closing date for nominations is midnight, 27 May 2022

### Electronic system revolutionises referrals at East Lancashire Hospitals

An innovative project using Robotic Process Automation to manage referrals from GP's was highly commended at the NDL Community Awards, a celebration of public sector teams working towards digital transformation.

Previously, colleagues would have to manually retrieve and print referral paperwork before appointments. This was time-consuming for staff, reducing the time they had to spend caring for patients, was an expensive process and wasted paper – approximately 83,000 sheets a month. In a matter of days, the team was able to implement a new automated system which resolved these issues rapidly, managing an average of 15,000 e-referrals per month.

Patient records are then accessible on the clinical portal, allowing clinicians to view the referral letter electronically, rather than relying on a printed copy. They can then be seen well in advance of clinical appointments, enabling for better preparation, prioritising, and patient experience.

The successful project was shortlisted for NDL RPA Project of the Year and won a donation of £250 for a charity of choice - ELHT&Me, the Trust's official charity. The charity funds projects and initiatives that improve patient and staff environment and experience.

### SPEC ward information for May 2022 Trust Board

Surgical Admissions and Day Case Unit (SADU) and Burnley East District Nurses have achieved their first three consecutive Green NAPF outcomes and have both presented at SPEC panel. B14 is a current SPEC area that has achieved a further green NAPF outcome and presented at SPEC panel.

The all wards provided a portfolio of evidence and delivered a presentation to the SPEC (Safe, Personal, and Effective Care) panel to demonstrate how they have maintained consistently high standards of care delivery.  Colleagues also described quality improvement initiatives that have been undertaken and how they will showcase this to the rest of the organisation.

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 these areas SILVER for delivering Safe, Personal and Effective Care at all times.

| Ward | SPEC date | Previous SPEC |
| --- | --- | --- |
| SADU | 21/03/2022 | NEW |
| B14 | 28/03/2022 | Second SPEC |
| Burnley East DNs | 26/04/2022 | NEW |

# Four – Communications and Engagement

A summary of the external communications and engagement activity.

March 2022

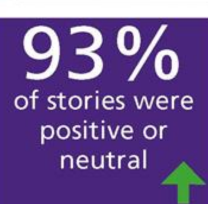
## Communications and Engagement

# Monthly Media Update

### Top Stories...

- ELHT Healthcare Assistant, Natalie Taylor, scoops prestigious Prince's Trust Award
- Building work under way at new kidney disease centre in Blackburn
- Role model' Neil Riding takes home Employee of the Month
- Patient Care the focus for ELHT

### Press and Media Relations...




### Projects the Communications Department has supported...

| | |
|---|---|
| **A&E/System pressures** | • Working with system partners to encourage apprpriate use of services - Promotion of NHS 111 and Minor Injuries Unit<br>• Promotion of 'Why not home, why not today' campaign internally and externally - encouraging use of discharge lounge.<br>• Planning for a '24-hours in A&E social media exercise highlighting pressures facing ED colleagues |
| **Green Plan** | • Ensuring the plan meets Trust style and brand guidelines<br>• Supporting to ascertain what information needs to be included in the supporting video |
| **Staff Survey** | • Promotion of the NHS National Staff Survey results internally and externally<br>• Promotion of the subsequent 'big conversations' |
| **International Women's Day** | • Social media - photos - videos - Teams Live Webinar - Podcast |
| **Take A Moment** | • Social media - photos - videos - Teams Live Webinar - Podcast - Remembrance Service |

## Website...

Our website got 180,223 page views by 144,089 people.

The most viewed webpage was – Waiting times

## Social media and digital...

## The most talked about issues on our social networks..

- We are currently experiencing a high demand for Emergency and Urgent Care services.
- Our Minor Injuries Unit at Accrington Victoria is available for a range of injuries
- ELHT Healthcare Assistant, Natalie Taylor, scoops prestigious Prince's Trust Award
- Blackburn Birth Centre is closedfor births until further notice (Most engaged post)
- Blackburn Birth Centre has reopened as normal

## Posts of the month...

**Important Maternity Update - Closure of Blackburn Birth Centre**

Likes/Reactions - 106
Reach - 43,288
Link Clicks - 8683
Comments - 214

**Chanelle is #BreakingThe Bias this International Women's Day**

Impressions (views) - 43.6k

## NEW to ELHT - the ELHT AUDIO Podcast

Our new podcast 'ELHT Audio' has now been launched.

The podcasts published in March were:

- Women in Leadership (part of International Women's Day) - 55 listens.
- Take a Moment - Reflecting on two years of living throught the COVID-19 pandemic - 49 listens

We look forward to this channel growing as we add more content and additional topics

Staff Facebook Group
Total members - 1,632 90

Staff App
Total downloads - 1,518 258

Safe | Personal | Effective

Please email communications@elht.nhs.uk for more information on this report.

Safe | Personal | Effective

April 2022

## Communications and Engagement

# Monthly Media Update

## Top Stories...

- Electronic system revolutionises referrals at East Lancashire Hospitals
- ELHT rolls out NHS Rainbow Badge Survey
- Consultant Orthapaedic Surgeon, Professor Paton, retires after 31 years service
- Mohammed Saraj is employee of the month

## Press and Media Relations...

**4** media releases issued this month

**94%** of stories were positive or neutral

## Projects the Communications Department has supported...

| | |
|---|---|
| **A&E/System pressures** | • Working with system partners to encourage apprpriate use of services - Promotion of NHS 111 and Minor Injuries Unit<br>• Promotion of 'Why not home, why not today' campaign encouraging early discharges to create capacity over Easter and Bank Holidays<br>• Campaign launched asking people to be kind and patient with colleagues<br>• Supporting the Trust's 'reset week'<br>• Streaming tool messages and posters |
| **Parliamentary Awards** | • Supporting drafting submissions which has resulted in two nominations by two of our local MPs |
| **Admin Professionals Day** | • Supporting colleagues to share their messages of thanks to our administrative professionals |
| **IND/IMD** | • Preparations for International Nurses and Midwives Days in May including gathering videos, shout outs and planning activity for the respective days |
| **STAR Awards** | • Confirmed as taking place on 14 July 2022 plans and preparation has been underway to launch the awards on 3 May. |

## Website...

Our website got **170,629** page views by **136,104** people.

The most viewed webpage was – Our vacancies

## Social media and digital...

## The most talked about issues on our social networks..

- Happy National Admin Professionals Day (11.3k reach, 249 comments, 419 likes and reactions)
- Blackburn Birth Centre temporarily closed over Bank Holidayweekend (18.5k reach, 46 likes and reactions, 64 comments)
- High demand for Emergency Department (10.9k reach, 37 likes and reactions, 8 comments)
- Clarification for extension of maternity services (8.4k reach, 24 reactions, 15 comments)

## Posts of the month...

## The ELHT AUDIO Podcast

Our new podcast 'ELHT Audio' has now been launched.

The podcasts published in April were:

- Dying Matters week - Starting the conversation - 25 plays

We look forward to this channel growing as we add more content and additional topics

Staff Facebook Group
Total members - 1,684

52

Staff App
Total downloads - 1,946

428

**Safe | Personal | Effective**

Please email communications@elht.nhs.uk for more information on this report.

# Five - Chief Executive’s Meetings

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

## April 2022 Meetings

| Date/Frequency | Meeting |
|---|---|
| Weekly – Tuesday | Executive Team |
| Weekly – Tuesday | Senior Leadership Group |
| Weekly – Tuesday | Chairman/Chief Executive Briefing |
| 6 April | Pathology visit |
| 6 April | Specialised Commissioning Leadership Team |
| 7 April | Launch of ELHTMe Football team |
| 7 April | Virtual Quality Walk Round AMU |
| 11 April | Lancashire, South Cumbria and Wigan Vascular Network Board |
| 12 April | PL Chairs and Chief Officers Advisory Group |
| 13 April | Trust Board Strategy |
| 14 April | Task and Finish Group in preparation for CQC Well Led Visit |
| 20 April | LSC System Leaders |
| 21 April | Team Brief |
| 22 April | Provider Collaboration Board |
| 25 April | Finance and Performance Committee |
| 26 April | Combined NW Leaders and Chairs |
| 27 April | Ockenden Assurance Visit |
| 27 April | LSC CEOs Briefing |

| Date/Frequency | Meeting |
|---|---|
| 28 April | Population Health Board |
| 29 April | LSC Pathology Service Board |

## May 2022 Meetings

| Date/Frequency | Meeting |
|---|---|
| Weekly – Tuesday | Executive Team |
| Weekly – Tuesday | Senior Leadership Group |
| Weekly – Tuesday | Chairman/Chief Executive Briefing |
| 5 May | EPR Strategic Committee |
| 9 May | ICP Business |
| 10 May | PL Chair and Chief Officers Advisory Group |
| 10 May | Christine Douglas MBE Investiture |
| 11 May | Trust Board |
| 11 May | LSC CEO Briefing |
| 12 May | Task and Finish Group |
| 13 May | Recruitment Partnership Panel |
| 16 May | NHP Programme Management Group |
| 18 May | LSC System Leaders |
| 18 May | HPL Partnership Leaders' Forum |
| 19 May | Provider Collaboration Board |
| 19 May | Team Brief |
| 19 May | Population Health Board |

| Date/Frequency | Meeting |
|---|---|
| 20 May | Joint VMI/VS Transformation Guiding Board |
| 23 May | Finance and Performance Committee |
| 23 May | ICP Business |
| 24 May | Combined NW System Leaders and Chairs Call |
| 24 May | NHS Providers NW Regional Meeting |
| 25 May | Formal ICS Board |
| 25 May | LSC CEO Briefing |
| 26 May | Memorial Tree Planting – Clitheroe Hospital |
| 27 May | LSC Pathology Service Board |

# TRUST BOARD REPORT

**11 May 2022**

| **Item** | **60** |
|---|---|
| **Purpose** | Information<br>Action<br>Monitoring |

| | |
|---|---|
| **Title** | Corporate Risk Register Report |
| **Author** | Mr J Houlihan, Assistant Director of Health, Safety and Risk<br>Mrs A Brown, Associate Director of Quality and Safety |
| **Executive sponsor** | Mr J Husain, Executive Medical Director |

**Summary:** This report provides an overview of the Corporate Risk Register (CRR) as of the 29th April 2022. Risks continue to be managed through the interim process aligned to the Quality Governance Framework during the COVID-19 measures.

**Recommendation:** Members are requested to note and approve the contents of this report and seek assurances the CRR is being reviewed, scrutinised and managed in line with best practice and guidance.

**Report linkages**

| | |
|---|---|
| Related strategic aim and corporate objective | Put safety and quality at the heart of everything we do<br>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.<br>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.<br>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 |

Previously considered by:

## Risk Performance

1. There are a total of 1,581 open risks on the risk register, of which, 16 are on the Corporate Risk Register.
2. Highest numbers of open risks by risk type relate to clinical risks, comprising 47% of the total number, followed by health and safety risks with a percentage of 32%.
3. A breakdown of open risks by division shows Surgical and Anaesthetic Services having the most risks, closely followed by Corporate Services and Diagnostic and Clinical Support.
4. The total number of overdue risks continues to decrease, from 197 in January 2022 to the current position of 169 at the end of April 2022.
5. Work with services remains a priority action in decreasing numbers of overdue risks and proactively ensuring 1,101 risks due for review over the coming three months are being suitably managed.
6. It is expected total numbers of open risks will significantly decrease as a result of improvement works being undertaken to avoid unnecessary duplication, improve standardisation and the quality of risks held.

## Summary of Current Focus Areas

7. The table below provides a basic overview of current focused activity.

| | **Description** |
|---|---|
| 1. | Review of all live risks scoring 15+ held on the DATIX risk register. |
| 2. | Completion of action plan of recommendations from the Mersey Internal Audit Agency (MIAA) Risk Management Audit. Action plan monitored by the Risk Assurance Meeting. |
| 3. | Review and improve the quality and integrity of all open risks and, where necessary, challenging the validity of the risk, its approval status and or risk scoring. |
| 4. | Undertake a targeted review of open health and safety risks, as the second highest risk type, to act as a benchmark and key indicator of performance. |

**Next Steps**

8. The table below provides a basic overview of the next steps in focused activity.

| | Description | Target Date |
|---|---|---|
| 1. | Ensure risk register accurately reflects levels of risk to services for the recovery and restoration stages of COVID-19 | April 2022 |
| 2. | Strengthen strategic and operational risks with senior leads in line with organisational strategy, objectives and targets. | May 2022 |
| 3. | Seek assurances all risk types are managed and monitored effectively by a Committee or Group e.g., Clinical Risks, Corporate Services etc. | May 2022 |
| 4. | Evaluate the function, duties and performance of the Risk Assurance Meeting and use of a generic template to support risks being presented. | May 2022 |
| 5. | Review training needs analysis for senior leaders and managers responsible for the strategic and operational management of risks. | June 2022 |
| 6. | Review of risk assessment competency framework and training of managers and staff. | June 2022 |

**Risks removed from the Corporate Risk Register**

9. The table below outlines risks removed from the Corporate Risk Register due to suitability of controls.

| ID | Title | Current Risk Score | Movement | Comments |
|---|---|---|---|---|
| 9252 | Increased risk of nosocomial infection due to impact of pressure on established COVID-19 pathways. | 12 | ↓ | Risk score downgraded and deescalated. Risk being mitigated appropriately. |

| 9224 | Outbreak of infection on Neonatal Unit. | 12 | ⬇ | Risk score downgraded and deescalated. Risk being mitigated appropriately. |
|---|---|---|---|---|
| 7762 | Delivery of non-commissioned L2 critical care of children. | 12 | ⬇ | Risk score downgraded and deescalated. Risk being mitigated appropriately. |
| 8914 | Potential interruption of high flow oxygen therapy to critically ill patients. | 10 | ⬇ | Risk score downgraded and deescalated. Risk being mitigated appropriately. Emergency funding application made. |
| 8221 | Delayed review of Clinical Nurse Practitioner services in light of current service activity. | 8 | ⬇ | Risk score downgraded and deescalated. Risk being mitigated appropriately. Investment made towards the Autism Spectrum Disorder pathway. |
| 9073 | Risk to patient safety due to unavailability of test results due to industrial action in Blood Sciences Department. | 8 | ⬇ | Risk score downgraded and deescalated. Risk being mitigated appropriately. |
| 8652 | Failure to meet internal and external financial targets for 2021-22. | 2 | ⬇ | Risk score downgraded and deescalated. Risk being mitigated appropriately. New risk for 2022-23 being reviewed. |

**Table 1:** List of Corporate Risks

| No | ID | Where is this risk being managed? | Title | Rating (current) | Effectiveness of Controls (taken from Datix) | Changes since last report |
|---|---|---|---|---|---|---|
| 1 | 9336 | Medical | Lack of capacity across the Trust can lead to extreme pressure resulting in delayed care delivery | 20 | Limited | ↔ |
| 2 | 8441 | Corporate | Coronavirus (COVID19) Outbreak | 20 | Adequate | ↔ |
| 3 | 8126 | Corporate | Aggregated Risk – Potential to compromise patient care due to lack of Trust Wide advanced electronic patient record (EPR) system | 20 | Limited | ↔ |
| 4 | 8061 | Corporate | Management of Holding List | 20 | Limited | ↑ |
| 5 | 2636 | DCS | Inability to maintain establishment of Consultant Histopathologists | 15 | Limited | ↓ |
| 6 | 6190 | SAS | Insufficient capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescale | 16 | Limited | ↔ |
| 7 | 8960 | Family Care | Risk of undetected foetal growth restriction & possible preventable still birth given non-compliance with PI (Ultrasound Guidance) | 15 | Limited | ↔ |
| 8 | 8839 | SAS | Failure to achieve performance targets | 15 | Limited | ↔ |
| 9 | 8808 | Corporate | BGTH – Breaches to fire stopping in compartment wall and fire door surrounds allowing spread of fire and smoke | 15 | Adequate | ↔ |
| 10 | 8257 | DCS | Loss of Transfusion Service | 15 | Limited | ↔ |
| 11 | 8243 | Family Care | Absence of an end to end IT maternity system | 15 | Limited | ↔ |
| 12 | 7764 | Corporate | RBTH – Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke | 15 | Adequate | ↔ |
| 13 | 7067 | Medical | Aggregated Risk – Failure to obtain timely MH treatment impacts adversely on patient care, safety & quality | 15 | Adequate | ↔ |
| 14 | 7008 | SAS | Failure to comply with the 62-day cancer waiting time target | 15 | Limited | ↔ |
| 15 | 5791 | Corporate | Aggregated Risk – Failure to adequately recruit to substantive nursing and midwifery posts may adversely impact on patient care | 15 | Adequate | ↔ |
| 16 | 4932 | Trust Wide | Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained | 15 | Limited | ↔ |

**Table 2:** New Financial Risk

| No | ID | Where is this risk being managed? | Title | Rating (current) | Effectiveness of Controls (taken from Datix) | Changes since last report |
|---|---|---|---|---|---|---|
| 17 | 9439 | Trust Wide | Failure to meet internal and external financial targets for 2022-23 | 20 | Limited | ↔ |

Table 2 above highlights a new Trust Wide Financial Risk (DATIX ID 9439) currently going through the Risk Management Framework Process for presentation on the Corporate Risk Register in due course. More detailed risk information is contained in Table 4.

**Table 3:** Detailed risk information

| No | ID | Title |
|---|---|---|
| 1 | 9336 | **Lack of capacity across the Trust can lead to extreme pressure resulting in a delayed care delivery** |

<table>
<tr><td>Lead</td><td>David Simpson / Sharon Gilligan</td><td>Current score</td><td>20</td><td>Score Movement</td><td colspan="4"></td></tr>
<tr><td>Description</td><td colspan="2">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, impacting on clinical flow.<br><br>There is also an increased risk of nosocomial infection spread as a result of overcrowding and poor patient experience leading to complaints. The staffing requirement are not calculated as standard to care for increased numbers of patients with increased complexity (i.e., 1:5 Rn: patient ration in majors at current). Inadequate capacity within specialist areas such as cardiology, NIV and stroke to ensure adequate flow and optimum care.</td><td rowspan="2">Actions</td><td colspan="5" rowspan="2">1. Emergency Care Improvement Programme (ECIP) being utilised to health address challenges.<br>2. Ongoing discussions taking place with Clinical Commissioning Group to help with health economy solutions, decreased admissions and attendance avoidance.<br>3. Incidents with harm noted.<br>4. Improved ambulance turnaround times. All over 60-minute breaches reviewed.<br>5. Gold command in place to support.</td></tr>
<tr><td>Top Controls</td><td colspan="2">1. Operational Pressures Escalation Levels (OPEL) triggers and actions now completed for Emergency Department (ED) and Acute Medical Units (AMU).<br>2. Redesign and review of code black standard operating process.<br>3. MEC are trialling a new standard work for divisional flow so escalation of pull through can be much clearer with actions.<br>4. ED / UCC /AMU to take stable assessed patients out of the trolley space / bed to facilitate putting the un-assessed patients in to bed / trolley.<br>5. Corridor care standard operating procedure embedded.<br>6. Hourly rounding by nursing staff embedded in ED.<br>7. Completion of Phase 6 building.<br>8. Review of processes across acute and emergency medicine in line with coronial process and incidents.<br>9. Established 111/GP direct bookings to Urgent Care.<br>10. 111 Development board designing patient pathways from GP/NWAS directly to AECU.<br>11. Segregation of ED in line with COVID-19 risk reducing likelihood of cross contamination. Clear red and green pathways within ED.<br>12. Estate increased into fracture clinic to provide ‘clean’ and ‘dirty’ areas for ED patients.<br>13. Daily staff capacity assessments completion.<br>14. Departmental board rounds done at cubicles so review of care and plans are undertaken.<br>15. Streaming pathways increased and workforce redesign aligned to demands.<br>16. Full recruitment of established consultants. Staff allocation of registered nurses changed to reflect increase in patient demand.<br>17. Continued daily and weekly work rounds with Associate Director of Nursing and Head of Nursing.<br>18. Safe Care Tool designed for Emergency Department (ED).<br>19. Daily consultant ward round on wards.<br>20. Matrons undergone coaching and development on board rounds.</td></tr>
<tr><td rowspan="4">Update since the last report</td><td colspan="2" rowspan="4">Update 26/03/22<br><br>Risk Review and remains the same score. There have been over 500 12-hour breaches for March 2022 an increase from 300 from the previous month. Incident with harm have been noted, not having daily 15-minute briefing calls with the executive team about ED overcrowding, lack of capacity and lack of flow.<br><br>Next Review Date 06/05/22</td><td>Date last reviewed</td><td colspan="5">26/03/2022</td></tr>
<tr><td>Risk by Quarter 2021</td><td colspan="2">Q1<br>20</td><td>Q2<br>20</td><td>Q3<br>20</td><td>Q4<br>20</td></tr>
<tr><td>8 week score projection</td><td colspan="5">20</td></tr>
<tr><td>Current Issues</td><td colspan="5">Impact of COVID-19 pandemic and restoration pressures.</td></tr>
</table>

| No | ID | Title |
|---|---|---|

| No | ID | Title | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 2 | 8441 | **Coronavirus (COVID-19) Outbreak** | | | | | | |
| **Lead** | | Alison Whitehead / 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 Operational Command and Control (OCC) meetings throughout the Trust.<br>2. Change of isolation rules for staff.<br>3. Senior Management Leadership meetings held weekly for key decision making and escalation. | | | | |
| **Top Controls** | | 1. Increased staffing during core hours to alleviate pressures including outcome of winter pressure measures.<br>2. Regular communications about next steps and working group outcomes to keep staff and patients informed.<br>3. Co-ordination centre set up Trust HQ to enable the management and implementation of plans, processes and procedures, with daily / regular update meetings taking place.<br>4. Senior nurse and operational management presence on-site based at Royal Blackburn Teaching Hospital (RBTH) at weekends (in addition to on-call team) now instigated.<br>5. Regular Trust-wide Covid-19 Bulletin implemented (previously daily / weekly).<br>6. NHS 111 referral measures - including home testing and support to alleviate Urgent Care Centre and ED pressures.<br>7. Plans and processes in place to re-locate staff to provide additional support in those areas most in need.<br>8. Implementation of internal vaccination programme for staff<br>9. Establishment of vaccination centres and deployment of mobile vaccination units across local regional for public and staff including walk ins.<br>10. Weekly Senior Leadership Group established to maintain oversight and governance.<br>11. Asymptomatic testing i.e., use of LFT / LAMP etc.<br>12. All population groups have been offered vaccination (at least one dose) and the booster / third dose.<br>13. Surge capacity plan in place with phase 1 (24 beds at Royal Blackburn Hospital) and phase 2 (24 beds at Victoria Wing, Burnley General Hospital) mobilised.<br>14. Weekly / regular IMT and Exec meetings<br>15. Covid wards mobilised across acute and community settings.<br>16. Why not home why not today campaign to maximise discharges, patient flow and bed capacity. | | | | | | |
| **Update since the last report** | | **Update 03/03/22**<br><br>Changes to government legislative requirements and guidance have been made since the last report. This risk is anticipated to reduce upon its next review to a risk score of 16.<br><br>Next update 01/07/22 | **Date Last reviewed** | 03/03/2022 | | | | |
| | | | **Risk by Quarter 2021** | **Q1** | **Q2** | **Q3** | **Q4** | |
| | | | | 20 | 20 | 20 | 20 | |
| | | | **8 week score projection** | 16 | | | | |
| | | | **Current issues** | Impacted by COVID-19 pandemic. Variants causing high numbers of infections. | | | | |

| No | ID | Title | | | | |
|---|---|---|---|---|---|---|
| 3 | 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** | 1. Win Dip scanning solution not across all specialities and case note groups<br>2. EMIS system only supports community activity, with no significant system in acute setting | | |

<table>
<tr><td rowspan="4">Top Controls</td><td rowspan="4">1. Stable PAS system (albeit 25+ years old).<br>2. Extra-med patient flow system, including capture of nursing docs.<br>3. ICE and EMIS systems.<br>4. Winscribe digital dictation system.<br>5. Win-dip scanning solution.<br>6. Orion Portal.<br>7. 24/7 system support services and additional administrative staff.<br>8. Paper contingencies for data capture.<br>9. All critical systems managed by informatics or services with direct links to Informatics.<br>10. Register of non-core systems capturing patient information (feral systems) in place.<br>11. Improved infrastructure (including storage) to maintain and manage existing systems.</td><td rowspan="4"></td><td colspan="4">3. Not all systems are registered or known<br>4. Contracts for current systems being ‘rolled over’ annually, cannot identify specific ‘switch over’ dates.<br>5. Inability to rapidly flex the current system to emerging demands from NHSI for additional information.<br>6. Limited capital budget to invest in additional hardware / software as clinical requirements develop.</td></tr>
<tr></tr><tr></tr><tr></tr>
<tr><td rowspan="5">Update since the last report</td><td rowspan="5">Update 14/04/2022<br><br>1. Consistent monitoring of current clinical systems and support via helpdesks and informatics service.<br>2. Significant amount of Business Intelligence system data quality and usage reports<br>3. There is not enough admin or clinical resource to action<br>4. Unable to plan infrastructure as new technologies and clinical techniques develop in isolation from the main EPR<br><br>EPR still remains on track to go live in November 2022 at which point this risk will then be removed from the Corporate Risk Register<br><br>Next Review Date 26/05/22</td><td>Date Last reviewed</td><td colspan="4">14/04/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2021</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>20</td><td>20</td><td>20</td><td>20</td></tr>
<tr><td>8 week score projection</td><td colspan="4">20</td></tr>
<tr><td>Current issues</td><td colspan="4">Work remains ongoing with Cerner on implementation.</td></tr>
</table>

<table>
<tr><th>No</th><th>ID</th><th colspan="6">Title</th></tr>
<tr><td>4</td><td>8061</td><td colspan="6">Aggregated Risk - Management of Holding List</td></tr>
<tr><td colspan="2">Lead</td><td>Victoria Bateman</td><td>Current score</td><td>20</td><td colspan="2">Score Movement</td><td>↑</td></tr>
<tr><td colspan="2">Description</td><td colspan="2">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.<br><br>Due to the impact of covid 19 the size of the Trust holding list is significantly higher than previous months.</td><td rowspan="2">Actions</td><td colspan="3" rowspan="2">1. Continued micro-management at specialty level.<br>2. Implementation of new patient led follow up and virtual pathways.<br>3. Capacity and demand reviews at speciality level for longer term management.<br>4. Audit of holding management undertaken by Mersey Internal Audit Agency.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. Suitable RAG ratings included on all outcome sheets in outpatient clinic.<br>2. Daily holding list report circulated to all Divisions to show the current and future size of the holding list.<br>3. Weekly updates provided at Patient Transfer List (PTL) meetings.<br>4. Restoration plan in place to restore activity to pre-covid levels.<br>5. Individual specialities are undertaking their own review of the holding list to identify if patients can be managed in alternative ways.<br>6. Meetings held between the Divisional and Ophthalmology Triads to discuss current risk and agree next steps.<br>7. Requests sent to Directorates for all patients on holding lists to be initially assessed for any potential harm that could have been caused due to delays being seen, with suitable RAG ratings applied to these patients.<br>8. RAG status for each patient to be added to the comments field on the patient record in OWL to capture current RAG status. This will allow future automated reports to be produced.<br>9. Meetings held with Directorate Managers from all Divisions to understand position of all holding lists.<br>10. All patients where harm is indicated or flagged as a red rating to be actioned immediately with agreed plans between Directorates to manage these patients depending on numbers.<br>11. A process has been agreed to ensure all follow up patients in the future are assigned a RAG rating at time of putting them on the holding list. Process rolled out and monitored daily.<br>12. Underlying demand and capacity gaps are 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.<br>13. Regular updates provided weekly to the Executive Team.</td></tr>
<tr><td colspan="2" rowspan="5">Update since the last report</td><td colspan="2" rowspan="5">Update 29/04/22<br><br>Issues surrounding the holding list remains challenging. A lack of capacity is compounded by longer backlogs since the COVID-19 pandemic and higher volumes of cancer and urgent patients requiring treatment. Each speciality is working on their highest risk and clinically urgent priorities first.<br><br>12,307 patients are on the holding list. 5,993 patients are currently on the surgical holding list. 1,976 patients are unknown or uncoded. 1,861 red patients are across the Trust.<br><br>Next Review Date 27/05/22</td><td>Date last reviewed</td><td colspan="3">29/04/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2021</td><td>Q1</td><td>Q2</td><td>Q3 | Q4</td></tr>
<tr><td>16</td><td>16</td><td>16 | 20</td></tr>
<tr><td>8 week score projection</td><td colspan="3">16</td></tr>
<tr><td>Current issues</td><td colspan="3">Impacted by COVID-19 pandemic</td></tr>
</table>

| No | ID | Title |
|---|---|---|

<table>
<tr><td>5</td><td>2636</td><td colspan="6">Inability to maintain establishment of consultant histopathologists</td></tr>
<tr><td colspan="2">Lead</td><td>Pamela Henderson / Yacoob Nakhuda</td><td>Current score</td><td>15</td><td colspan="2">Score Movement</td><td>↓</td></tr>
<tr><td colspan="2">Description</td><td colspan="2">National shortage of histopathologists and increasing service demand may lead to delays in cancer diagnosis and targets.</td><td rowspan="2">Actions</td><td colspan="3" rowspan="2">1. Continuous monitoring via Clinical Leadership Meetings (CLM).<br>2. Process mapping and pathways being reviewed.<br>3. Demand outstripping capacity. Position on meeting turnaround times remains challenging.<br>4. Job advert currently advertised with 2 interested applications, 1 of which may commence in post early September 2022.<br>5. Delayed turnaround time inevitable consequence exasperated by bank holidays and sickness etc.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. Cases are triaged on reception and divided into;<br>- Urgent. Cases marked urgent or with a specific target e.g. two week rule.<br>- Allocated. Surgical cancer resections allocated to a named pathologist.<br>- Routine. Cases which should be reported on site but not in categories 1 or 2 above.<br>- Referred. Cases of a non-urgent nature which can be sent to an external reporting service.<br>2. Workload which are over capacity reported via capacity lists on weekends, or is sent to an external reporting service (depending on clinical need).<br>3. Medical staffing looking to fill all vacancies on a permanent or locum basis. Workload allocated via a system based on clinical priority to prioritise cancer cases. Non reported routine work available for capacity list reporting at weekends. Lowest priority work identified at triage and sent to external reporting service.<br>4. Over the summer months the capacity provided by external reporting services has been reduced, although this has now picked up again into Autumn and there is a scheduled plan to export work.<br>5. Since 1st January 2022 the entire gynae / cancer pathology workload is now reported by Lancashire Teaching Hospital (LTH). Similarly the entire breast cancer pathology workload is now shared by LTH and University Hospitals Morecambe Bay.<br>6. New Clinical Director from LTH continuously monitoring situation along with ELHT Divisional Director.<br>7. Weekly consultants meeting chaired by new Histopathology Lead.<br>8. New overseas locum started end February 2022 and ‘bedding’ in, with another overseas locum commencing 09 May 2022.<br>9. Continued use of outsourcing companies to keep up with backlog.</td></tr>
<tr><td colspan="2" rowspan="5">Update since the last report</td><td colspan="2" rowspan="5">Update 03/05/22<br><br>Current staffing levels maintained at six whole time equivalents (WTE). Recruitment and meeting turnaround times (TAT) remains ongoing and very challenging. Contingency plans are well established. Assistance with workloads provided by external agencies, Lancashire Teaching Hospitals and University Hospitals Morecambe Bay.<br><br>Next Review Date 01/06/22</td><td>Date last reviewed</td><td colspan="3">03/05/22</td></tr>
<tr><td rowspan="2">Risk by Quarter 2021</td><td>Q1</td><td>Q2</td><td>Q3 / Q4</td></tr>
<tr><td>20</td><td>20</td><td>20 / 20</td></tr>
<tr><td>8 week score projection</td><td colspan="3">15</td></tr>
<tr><td>Current Issues</td><td colspan="3">National Recruitment Shortages and COVID-19 restoration pressures adding to demand.</td></tr>
</table>

| No | ID | Title |
|---|---|---|
| 6 | 6190 | **Insufficient Capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescale (Ophthalmology)** |

<table>
<tr><th>Lead</th><td>Jack Carney / Victoria Bateman</td><th>Current score</th><td>16</td><th>Score Movement</th><td></td></tr>
<tr><th>Description</th><td colspan="3">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 a risk to patients.<br><br>Demand far outweighs capacity, and this has been exacerbated since the COVID-19 pandemic, with the requirement for social distancing meaning less patients can be accommodated in waiting areas.<br><br>All patients are risk stratified (red, amber, green) but still cannot be seen within timescales with additional risk that amber patients could be become red over time etc.</td><th rowspan="2">Actions</th><td rowspan="2">1. Agreement of new contract for integrated eye service to develop new community pathways.<br>2. Weekly review of holding position in Patient Tracking Listing (PTL) meetings.<br>3. Weekly operational meetings review outpatient activity and recovery.</td></tr>
<tr><th>Top Controls</th><td colspan="3">1. A failsafe officer is in place who validates the holding list, focusing on appointing red patients and those longest waiting<br>2. Capacity sessions are held where doctors are willing and available.<br>3. Increased flexibility of staff.<br>4. The Integrated Eye Care Service keeps relevant patients out of hospital eye services where possible.<br>5. Use of clinical virtual pathways where appropriate.<br>6. Expanded non-medical roles e.g., orthoptists, optometrists, specialised nurses etc.<br>7. Action plan and ongoing service improvements identified to reduce demand.<br>8. Continuous review and micro-management of sub-specialties.<br>9. Ability to flex theatres to outpatient departments and vice versa but opportunities are limited.<br>10. Holding list patients reviewed by administrative staff with patients highlighted to clinical teams.</td></tr>
<tr><th rowspan="5">Update since the last report</th><td colspan="3" rowspan="5">Update 03/05/22<br><br>Holding list remains high with actions in place to reduce and maintain the holding list. Locums previously used but not in place due to lack of available space, calibre of personnel, specialised areas of expertise required and discharge issues adding to later holding list concerns.<br><br>No change in risk score. Next Review Date 07/06/22.</td><th>Date last reviewed</th><td colspan="4">03/05/2022</td></tr>
<tr><th rowspan="2">Risk by Quarter 2021</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>16</td><td>16</td><td>16</td><td>16</td></tr>
<tr><th>8 week score projection</th><td colspan="4">16</td></tr>
<tr><th>Current Issues</th><td colspan="4">Impacted by COVID-19 pandemic</td></tr>
</table>

Safe | Personal | Effective


Retain 30 years
Destroy in conjunction with National Archive Instructions

| No | ID | Title | | | | |
|---|---|---|---|---|---|---|
| 7 | 8960 | **Risk of undetected foetal growth restriction and possible preventable stillbirth given non-compliance with national Ultrasound guidelines** | | | | |
| **Lead** | | Charlotte Aspden / Helen Collier | **Current score** | **15** | **Score Movement** | ↔ |
| **Description** | | Diagnosis of intrauterine growth restriction could be missed due to inability to report/action pulsatility index on uterine artery doppler measurement.<br><br>The introduction of national/international recommendations will require investment of resources including the obstetric reporting package, increase in sonography and midwife sonography hours currently allocated and an update of ultrasound machines within maternity services. | **Actions** | 1. The mitigation of this risk was dependent on enhancing the midwifery ultrasonography workforce which is now in place but requires further recruitment and training (training typically taking 18 months to 2 years).<br>2. Currently awaiting results of an audit which is intended to quantify the future capacity needs of the foetal growth restriction service. | | |
| **Top Controls** | | 1. Additional funding and implementation of ultrasound machine.<br>2. Staff trained in measuring and interpreting pulsatility index.<br>3. Rollout of viewpoint reporting software allowing interpretation and reporting of pulsatility index.<br>4. Reporting of umbilical artery end diastolic flow, absent or reversed, with no measurement of the pulsatility index which will identify some babies with foetal growth restriction less sensitive than the recommended pulsatility index. Those babies that we feel demonstrate foetal growth restriction are referred to placenta clinic for further management.<br>5. Women at very high risk of early-onset growth restriction are seen within placenta clinic.<br>6. Full recruitment to the midwifery sonography team of 163 hours of band 7 now in place. All are qualified, however there is no maternity vacancy backfill - with 1 planned for maternity leave and 1 pending. An expression of interest to be sought to backfill and succession planning to meet CNST requirements.<br>7. Audit to assess pulsatility index within midwife sonography services to understand potential volumes of demand going forward has now been completed | | | | |
| **Update since the last report** | | Current lack of Ultrasonography capacity for dating and anomaly scans has exacerbated the ability to mitigate this risk because the midwifery sonographers are now being used to support the Diagnostics and Clinical Services (DCS) colleagues.<br><br>An audit has now commenced which is intended to quantify future capacity needs of the foetal growth restriction service.<br><br>Increased midwifery sonography training for another member of staff to join the team<br><br>No change to current practice. Risk remains unchanged.<br><br>Next Review Date 17/05/22. | **Date Last reviewed** | **17/04/2022** | | |
| | | | **Risk by Quarter** | **Q1**: 15 | **Q2**: 15 / **Q3**: 15 | **Q4**: 15 |
| | | | **8-week score projection** | **10** | | |
| | | | **Current issues** | Capacity issues and operational pressures have impacted on the mitigation of the risk. | | |

Safe | Personal | Effective


Retain 30 years
Destroy in conjunction with National Archive Instructions
\\ELHT\Depts\Common\Corporate Governance\Corporate Meetings\TRUST BOARD\2022\03 May\Part 1\(060) Board Report Corporate Risk Register - May 2022.docx

<table>
<tr><th>No</th><th>ID</th><th colspan="5">Title</th></tr>
<tr><td>8</td><td>8839</td><td colspan="5">Failure to meet performance targets (SAS)</td></tr>
<tr><td colspan="2">Lead</td><td>Victoria Hampson / Victoria Bateman</td><td>Current score</td><td>15</td><td>Score Movement</td><td></td></tr>
<tr><td colspan="2">Description</td><td colspan="2">There is a concern of the Division's ability to meet national performance targets set for referral to treatment times, with non-achievement on the standards impacting on delays in patient treatment.<br><br>Due to the COVID-19 pandemic, all surgical specialities are currently significantly challenged for meeting Referral to Treatment (RTT). The failure of this standard means that individual patient care is impacted as patients will have to wait an extended length of time for treatment which will further impact on patient experience and treatment plans. Patients may also deteriorate waiting for treatment for extended lengths of time.<br><br>As this standard is externally monitored failure may lead to organisational reputational damage and patients choosing not to be treated by the Trust.</td><td rowspan="2">Actions</td><td colspan="2" rowspan="2">1. Weekly schedule and meetings to maximise theatre capacity.<br>2. Regular meetings held with the Clinical Commissioning Group to work on demand management.<br>3. Exploration of options for mutual aid where possible and outsourcing capacity.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. Strong monitoring across the Trust at divisional and directorate level.<br>2. Weekly Patient Treatment List (PTL) meetings within division to ensure awareness of current position and controls in place to focus on achievement of the standard.<br>3. Addition of priority code monitoring as part of PTL meeting meaning all P2 (clinically urgent patients) are tracked for dates.<br>4. Bi-weekly performance meetings held with directorate managers.<br>5. Weekly update of recovery plans, planning and information sets for trajectory.<br>6. Monitoring at directorate meetings and Divisional Management Board (DMB).<br>7. Strong management of standard at DMB and at performance meetings with the Executive Team.<br>8. Provision of exception reporting whereby the 28-day reattendance standard is not met.<br>9. Monthly performance meeting with Executive Team and DMB where divisional position is discussed and where appropriate challenged.<br>10. Additional Waiting List Initiatives (WLI) for theatres and clinics to close capacity and demand gaps.</td></tr>
<tr><td colspan="2" rowspan="5">Update since the last report</td><td colspan="2" rowspan="5">Update 29/04/22<br><br>No patients are over 104 weeks in the pathway. Patients continue to be micromanaged over 78 weeks. 33 patients over 78 weeks and surgery have 419 patients over 52 weeks. All patients over 52 weeks are tracked weekly by the Deputy Directorate Manager. General surgery and orthopaedics have over 100 patients each.<br><br>No change in risk scoring. Next Review Date 27/05/22</td><td>Date Last reviewed</td><td colspan="2">29/04/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2021</td><td colspan="2">Q1 | Q2 | Q3 | Q4</td></tr>
<tr><td colspan="2">15 | 15 | 15 | 15</td></tr>
<tr><td>8 week score projection</td><td colspan="2">15</td></tr>
<tr><td>Current issues</td><td colspan="2">Increased COVID-19 prevalence has impacted on workforce across the elective pathway and patient availability for surgery</td></tr>
</table>

| No | ID | Title |
|---|---|---|
| 9 | 8808 | **Burnley General Teaching Hospital (BGTH) - Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke.** |

| Lead | Duncan Emmett / Tony McDonald | Current score | 15 | Score Movement | |
|---|---|---|---|---|---|

| | | | |
|---|---|---|---|
| **Description** | Breaches to fire stopping in compartment walls and fire door frame surrounds due to poor workmanship or incorrect product usage may result in the faster spread of smoke or fire between compartments within a timescale lower than an hour or 30 mins that these compartments and doors are designed to provide. | **Actions** | 1. Monthly Executive and Senior Management meetings held with Finance, PFI Partners, Estates and Facilities and Health and Safety (Fire) to review position and suspension of work due to COVID-19 pandemic activity.<br>2. Fire Cell created and led by Executive Director of Finance and the Executive Director of Integrated Care, Partnerships and Resilience to frequently monitor actions and restoration works |
| **Top Controls** | 1. Fire alarm system throughout building providing early warning of fire.<br>2. Evacuation procedures in place.<br>3. Staff fire wardens are in most areas.<br>4. All staff trained in awareness of alarm and evacuation methods.<br>5. Fire safety awareness training modules are a core and statutory training requirements for all staff.<br>6. Fire safety policy and performance monitoring regularly reviewed by the Health and Safety Committee.<br>7. Provision of on-site fire safety team response.<br>8. Agreement of external response times with Lancashire Fire and Rescue Service.<br>9. External monitoring, servicing and maintenance of fire safety alarm system and suitable fire safety signage in place.<br>10. Contractual arrangements in place between PFI and ELHT in establishing duty holder responsibilities regarding building controls, the regular servicing of systems and planned preventative maintenance programmes.<br>11. Collaborative working arrangements in place between ELHT, Consort and third parties to address remedial works and correct defects around fire doors and frame sealings.<br>12. Total Fire Safety Ltd have commenced program of work on phases 1-4 with Balfour Beatty undertaking work in phase 5.<br>13. Project team established to manage passive fire protection remedial works throughout phase 5.<br>14. Random sampling and audit of project works of fire stop door surrounds in phase 5 and phases 1-4.<br>15. ELHT Estates and Facilities team working closely with Consort and third parties to address high risk areas e.g., plant rooms etc.<br>16. Additional fire wardens provided by ENGIE to patrol common areas of hospital, maintain extra vigilance and undertake basic fire safety checks.<br>17. All before and after photographic evidence of remedial works being recorded and appropriately shared.<br>18. Independent advice established to oversee process, materials and methods used. | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Update since the last report** | **Update 11/04/22**<br><br>Additional issues have been identified following a recent third-party sampling survey regarding the fascial cavity barrier and external wall internal lining. Project Co are in receipt of actions and are progressing these. The decision to stop work as a result of the COVID-19 pandemic places a significant risk with ELHT with Project Co unable to carry out work until a decision is made by ELHT to reinstate work.<br><br>Lancashire Fire and Rescue Services have attended site to review the action plan. Work on the action plan remains ongoing and a road map from Project Co has been shared with all parties. | **Date Last reviewed** | **11/04/2022** | | | |
| | | **Risk by Quarter 2021** | Q1 | Q2 | Q3 | Q4 |
| | | | 15 | 15 | 15 | 15 |
| | | **8 week score projection** | 15 | | | |
| | | **Current issues** | Impacted by COVID-19 pandemic | | | |

| | Next Review Date 11/05/22 | | |
|---|---|---|---|

| No | ID | Title |
|---|---|---|
| 10 | 8257 | **Loss of Transfusion Service** |

| Lead | Lee Carter / Jane Oakey | Current score | 15 | Score Movement | ⟷ |
|---|---|---|---|---|---|

| | | | |
|---|---|---|---|
| **Description** | Denial of the laboratory premises at Royal Blackburn Teaching Hospital (RBTH), especially blood transfusion, due to:<br><br>1. Planned evacuation due to fire alarm test.<br>2. Unplanned evacuation, in response to local fire alarm activation.<br>3. Evacuation due to actual fire within the laboratory.<br>4. Evacuation due to flooding within the laboratory.<br><br>In all 4 scenarios above there would be no access to the blood stocks or issuable blood stocks within the laboratory. The hospital site currently operates 2 blood bank units situated within the laboratory area and the effects of no access to units of blood or blood components are of the inability to supply:<br><br>1. Routine transfusions.<br>2. Blood for surgical procedures.<br>3. Blood for major haemorrhages.<br><br>In the latter of the two instances, this would have a profound clinical, organisational and reputational impact. | **Actions** | 1. Fridges remain within the testing phase and subsequently the laboratory remains prone to the risk until the blood track system has been fully rolled out and implemented. |
| **Top Controls** | 1. Meetings held with project lead for haemonetics.<br>2. Emergency bloods can be stored in temporary insulated boxes for a period of time.<br>3. The Bio-Medical Scientist (BMS) would station themselves outside the entrance to the laboratory where they could issue emergency units out.<br>4. If level 0 was out of bounds, clinical flow room would be the point of contact for skilled staff.<br>5. As testing of the system is rolled out changes to IT processes will occur to meet plans for the electronic release of blood from remote fridges.<br>6. On the Burnley General Hospital (BGH) site the fridge has been enabled and label print runs have been successfully carried out with a room opposite AMU at RBTH available awaiting fridge installation and testing.<br>7. The purchase of a single unit, under bench blood fridge, in a remote site would reduce this risk but would raise other risks regarding monitoring and maintenance of stock levels, increasing staff time and resource, limited numbers of units stored or available for transfusions weighted against delivery timescales, units needing to be 0+ and 0- and issues of track and traceability of bloods | | |

| Update since the last report | Date Last reviewed | 12/04/2022 | | | |
|---|---|---|---|---|---|
| **Update 12/04/22**<br><br>No change has been made regarding the storage sites of blood. All bloods are still held within the laboratory. Risk scoring remains the same at present.<br><br>The risk is being reviewed and in due course should reduce in score as the Trust overall plan for electronic release of blood from remote fridges is rolled out. | Risk by Quarter 2021 | Q1: 15 | Q2: 15 | Q3: 15 | Q4: 15 |
| | 8 week score projection | 10 | | | |

Safe | Personal | Effective

| | | | |
|---|---|---|---|
| | Next Review Date 12/05/22 | **Current issues** | Risk scoring will reduce as the blood track system is being rolled out |

| No | ID | Title |
|---|---|---|
| 11 | 8243 | **Absence of an end to end IT maternity system (Family Care)** |

| | | | | | |
|---|---|---|---|---|---|
| **Lead** | Andrew Lumsden / /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.<br><br>Maternity service may not be able to meet Maternity Services Data Sets (MSDS) and other requirements such as the Clinical Negligence Scheme for Trusts (CNST).<br><br>Inability to collate data for national teams regarding implementation outcomes and identify accurately the cohort of women receiving continuity of care, as well as measuring patient outcomes relating to optimisation and stabilisation of pre-term births and reduction in pre-term births from 8% to 6%, smoking at time of delivery, episiotomy, reduction in stillbirths and of capturing patient satisfaction.<br><br>Impact on midwifery workloads as data capture will be manual, time consuming and inconsistent with potential gaps and risks of inaccurate data capture. | **Actions** | 1. The score is graded as 15 as ELHT Maternity Services do not have the infrastructure to accurately capture patient reported outcome measures or patient reported experience measures as mandated in Better Births. Therefore, it is not possible to effectively report data into the Local Maternity System and inform the national agenda and measure and monitor national targets to improve outcomes.<br>2. IT support provided with long term solution plan in place to address gap in data collection |
| **Top Controls** | 1. An IT Digital Midwife is employed across ELHT.<br>2. An Integrated Care System (ICS) procurement process has concluded with the Clever Med Badger Net Maternity IT system being the chosen supplier.<br>3. A divisional, multidisciplinary maternity system steering group has been formed which meets every fortnight to oversee and monitor implementation.<br>4. A review of equipment used by midwives in the community to access systems is underway. | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Update since the last report** | **Update 19/04/22**<br><br>Badger Net booked women are now starting to be seen in other hospital settings and women booked and having to complete paper documentation continues.<br><br>The new IT equipment has arrived and is being prepared for distribution for the staff by IT. All women now have a pregnancy record created for potential Admissions and Day Case Unit (ADU) triage visits.<br><br>The Data Protection Application Programming Interface (DPAPI) error continues to be investigated and the temporary fix appears to be working, with fewer issues reported.<br><br>Next Review Date 20/05/22 | **Date Last reviewed** | 19/04/2022 | | | |
| | | **Risk by Quarter 2021** | Q1 | Q2 | Q3 | Q4 |
| | | | 15 | 15 | 15 | 15 |
| | | **8 week score projection** | 12 | | | |
| | | **Current issues** | Roll out has been delayed which has paused delivery of training. | | | |

| o | ID | Title |
|---|---|---|
| 12 | 7764 | **Royal Blackburn Teaching Hospital (RBTH) Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke** |

<table>
<tr><td>Lead</td><td>Duncan Emmett / Tony McDonald</td><td>Current score</td><td>15</td><td>Score Movement</td><td colspan="3">↔</td></tr>
<tr><td>Description</td><td colspan="3">Breaches to fire stopping in compartment walls and fire door frame surrounds due to poor workmanship or incorrect product usage may result in the faster spread of smoke or fire between compartments within a timescale lower than an hour or 30 mins that these compartments and doors are designed to provide.</td><td rowspan="2">Actions</td><td rowspan="2" colspan="3">1. Monthly Executive and Senior Management meetings held with Finance, PFI Partners, Estates and Facilities and Health and Safety (Fire) to review position and suspension of work due to COVID-19 pandemic activity.<br>2. Fire Cell created and led by Executive Director of Finance and the Executive Director of Integrated Care, Partnerships and Resilience to frequently monitor actions and restoration works.</td></tr>
<tr><td>Top Controls</td><td colspan="3">1. Fire alarm system throughout building providing early warning of fire.<br>2. Evacuation procedures in place.<br>3. Staff fire wardens are in most areas.<br>4. All staff trained in awareness of alarm and evacuation methods.<br>5. Fire safety awareness training modules are a core and statutory training requirements for all staff.<br>6. Fire safety policy and performance monitoring regularly reviewed by the Health and Safety Committee.<br>7. Provision of on-site fire safety team response.<br>8. Agreement of external response times with Lancashire Fire and Rescue Service.<br>9. External monitoring, servicing and maintenance of fire safety alarm system and suitable fire safety signage in place.<br>10. Contractual arrangements in place between PFI and ELHT in establishing duty holder responsibilities regarding building controls, the regular servicing of systems and planned preventative maintenance programmes.<br>11. Collaborative working arrangements in place between ELHT, Consort and third parties to address remedial works and correct defects around fire doors and frame sealings.<br>12. Total Fire Safety Ltd have commenced program of work on phases 1-4 with Balfour Beatty undertaking work in phase 5.<br>13. Project team established to manage passive fire protection remedial works throughout phase 5.<br>14. Random sampling and audit of project works of fire stop door surrounds in phase 5 and phases 1-4.<br>15. ELHT Estates and Facilities team working closely with Consort and third parties to address high risk areas e.g., plant rooms etc.<br>16. Additional fire wardens provided by ENGIE to patrol common areas of hospital, maintain extra vigilance and undertake basic fire safety checks.<br>17. All before and after photographic evidence of remedial works being recorded and appropriately shared.<br>18. Independent advice established to oversee process, materials and methods used.</td></tr>
<tr><td rowspan="4">Update since the last report</td><td rowspan="4" colspan="3">Update 11/04/22<br><br>Additional issues have been identified following a recent third-party sampling survey regarding the fascial cavity barrier and external wall internal lining. Project Co are in receipt of actions and are progressing these. The decision to stop work as a result of the COVID-19 pandemic places a significant risk with ELHT with Project Co unable to carry out work until a decision is made by ELHT to reinstate work.<br><br>Lancashire Fire and Rescue Services have attended site to review the action plan. Work on the action plan remains ongoing and a road map from Project Co has been shared with all parties.<br><br>Next Review Date 11/05/22</td><td>Date Last reviewed</td><td colspan="4">11/04/2022</td></tr>
<tr><td>Risk by Quarter 2021</td><td>Q1<br>15</td><td>Q2<br>15</td><td>Q3<br>15</td><td>Q4<br>15</td></tr>
<tr><td>8 week score projection</td><td colspan="4">15</td></tr>
<tr><td>Current issues</td><td colspan="4">Impacted by COVID-19 pandemic</td></tr>
</table>

<table>
<tr><th>No</th><th>ID</th><th colspan="4">Title</th></tr>
<tr><td>13</td><td>7067</td><td colspan="4">Aggregated Risk - Failure to obtain timely mental health (MH) treatment impacts adversely on patient care, safety and quality</td></tr>
<tr><td colspan="2">Lead</td><td>David Simpson / Tony McDonald</td><td>Current score</td><td>15</td><td>Score Movement ↔</td></tr>
<tr><td colspan="2">Description</td><td>ELHT is not a specialist provider or equipped to provide inpatient mental health services.<br><br>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.<br><br>Due to lack of specialist knowledge, this may cause deterioration of the patient.</td><td rowspan="2">Actions</td><td colspan="2" rowspan="2">1. Management structures remain in place to monitor and manage performance.<br>2. Escalation of adverse incidents through internal and external governance processes.<br>3. Meetings held with Lancashire Constabulary and LSCFT to improve management of patients who abscond.<br>4. Monitoring and escalation processes in place to highlight, manage and mitigate risks.<br>5. Mental Health cubicles ligature free to support higher risk patients within the department.<br>6. Collaborative working with external partners on pathway and design improvements.</td></tr>
<tr><td colspan="2">Top Controls</td><td>1. Frequent meetings to minimise risk between senior Lancashire and South Cumbria Foundation Trust (LSCFT) managers, specialist and urgent care commissioners and senior ELHT managers to discuss issues and develop pathways to mitigate risk.<br>2. The instigation of a mental health shared care policy and standard operating procedures including out of hours escalation process and a Mental Health Urgent Care Assessment Centre (MHUAC) to stream lower risk patients directly for review within this environment.<br>3. Monthly performance monitoring via Accident and Emergency Delivery Board (AEDB) in providing a system wide response.<br>4. Bi-monthly Mental Health Clinical Working Group (MHCWG) meetings between ELHT and LSCFT.<br>5. Daily Gold Command System meetings.<br>6. Monthly performance activity reported to Trust Board.<br>7. Shared approach to searching patients who consent.<br>8. Ongoing progress with digitalisation of section 136.<br>9. Expanded Mental Health Liaison Team Service based in the Emergency Department (ED) with 24 hr provision, including shared care and in parallel with the ED triage nurse.<br>10. Triage risk assessment toolkit in place alongside shared mental health and physical documentation between LSCFT and ED.<br>11. Regular monitoring and review of near misses and concerns discussed bi-monthly as part of the MHCWG<br>12. Cluster reviews of 12- hour breaches and presented at AEDB.<br>13. Themes from timelines / cluster reviews discussed weekly with Clinical Commissioning Groups, NHS England and LSCFT.<br>14. Ongoing monitoring of patient feedback through a variety of sources.</td></tr>
<tr><td colspan="2" rowspan="4">Update since the last report</td><td rowspan="4">Update 26/03/22<br><br>Risk scoring continues to be regularly reviewed and remains the same. The process of ELHT registration with the CQC as a mental health service provider remains ongoing.<br><br>Delays in patients remaining in ED makes it difficult to assess onward impact of their care.<br><br>Next review date 06/05/22</td><td>Date last reviewed</td><td colspan="2">26/03/2022</td></tr>
<tr><td>Risk by Quarter 2021</td><td colspan="2">Q1: 15 | Q2: 15 | Q3: 15 | Q4: 15</td></tr>
<tr><td>8 week score projection</td><td colspan="2">15</td></tr>
<tr><td>Current issues</td><td colspan="2">Clinical model pathways and design improvements to be embedded</td></tr>
</table>

<table>
<tr><th>No</th><th>ID</th><th colspan="6">Title</th></tr>
<tr><td>14</td><td>7008</td><td colspan="6">Failure to comply with the 62 day cancer waiting time.</td></tr>
<tr><td colspan="2">Lead</td><td>Matthew Wainman / Sharon Gilligan</td><td>Current score</td><td>15</td><td>Score Movement</td><td colspan="2">↔</td></tr>
<tr><td colspan="2">Description</td><td colspan="2">The Trust will fail to achieve the operational standard of 85% for the 62-day GP referred (classic) cancer waiting time target resulting in potential harm to patients and organisational reputation.</td><td rowspan="2">Actions</td><td rowspan="2" colspan="3">1. Medical Vacancies - Many areas suffering with excessive waiting times are resulting from vacancies for key posts. Vacancies for posts that are notoriously difficult to recruit to due to national shortages.<br>2. Unavoidable Breaches - some breaches are outside of ELHT control, patients breaching targets because of complexities in their pathway, comorbidities, or patient choice can at times eat into the tolerance we have.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. ELHT Cancer Action Plan – a document summarising all key actions aimed at improving performance, quality, or patient experience in relation to cancer care. This is monitored bi-weekly through the Cancer Performance Meeting.<br>2. Cancer Performance Meeting – a weekly meeting aimed at reviewing all patients at risk of breaching a National Cancer Waiting Times Treatment Standard chaired by the Director of Operations.<br>3. Tumour Site Patient Treatment List (PTL) Meetings – meetings held weekly per tumour site with key individuals present. In these meetings the PTL is reviewed patient by patient identifying actions as they go through the list.<br>4. External Funding – Regular investment of the Lancashire and South Cumbria (L&SC) Cancer Alliance & NHS England funding into problem areas.<br>5. Cancer Reporting – “Hot List” representing all patients at risk of breaching distributed twice weekly and reviewed in detail at the Cancer Performance Meeting. Cancer Performance Pack issued once weekly to all key stakeholders in Cancer and additional report of in month. Performance issues to all key stakeholders weekly.<br>6. Breach Analysis Process – each month all breaches or near misses of a 62-day standard are mapped out in a template, delays identified, and then reviewed by the responsible directorate to identify areas for learning and improvement that will feed into their Action Plan.<br>7. External Meetings – L&SC Cancer Alliances Rapid Recovery Team, key stakeholders from across the cancer alliance attend and discuss performance, progress, and ideas for improvement. Pennine Lancashire Cancer Tactical Group, the Trust and Clinical Commissioning Group (CCG) colleagues discuss performance, progress, and ideas for improvement.</td></tr>
<tr><td colspan="2" rowspan="5">Update since the last report</td><td colspan="2" rowspan="5">Update 07/03/22<br><br>In January 2022 increased COVID-19 prevalence has impacted on the workforce across the elective pathway and patient availability for investigation and surgery.<br><br>Significant challenges within endoscopy, lower gastrointestinal demand, clinical oncology, pathology and outpatient capacity across all specialities. Weekly micro-management undertaken at specialty level.<br><br>Next review date 23/05/22</td><td>Date Last reviewed</td><td colspan="3">07/03/2022</td></tr>
<tr><td rowspan="2">Risk By Quarter 2021</td><td>Q1</td><td>Q2</td><td>Q3 / Q4</td></tr>
<tr><td>15</td><td>15</td><td>15 / 15</td></tr>
<tr><td>8 week score projection</td><td colspan="3">15</td></tr>
<tr><td>Current issues</td><td colspan="3">Impacted by COVID-19 pandemic</td></tr>
</table>

| No | ID | Title |
|---|---|---|

<table>
<tr><td>15</td><td>5791</td><td colspan="6">Aggregated Risk - Failure to adequately recruit to substantive nursing and midwifery posts may adversely impact on patient care and finance.</td></tr>
<tr><td colspan="2">Lead</td><td>Julie Molyneux / Chris Pearson</td><td>Current score</td><td>15</td><td>Score Movement</td><td colspan="2"></td></tr>
<tr><td colspan="2">Description</td><td colspan="2">The use of agency staff is costly in terms of finance, is challenging and does not support continuity of patient care.</td><td rowspan="2">Actions</td><td rowspan="2" colspan="3">1. Regular dashboard review of good rostering compliance.<br>2. Regular performance reporting including planned and actual staffing levels at the Quality Committee and monthly reports at Trust Board meetings.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. Daily staffing teleconference held with the Director of Nursing and repeated throughout the day as required of acuity, dependency and staffing levels.<br>2. Appointment of Lead Recruitment Nurse with focus on ongoing local, national and international recruitment of registered nurses and healthcare support workers.<br>3. Formal review and exercising of professional clinical judgement as required to allocate or reallocate staff appropriately and address deficits in skills shortages and or numbers.<br>4. The use of e-rostering, both planned and actual nurse staffing numbers recorded daily and formally reported monthly following quality assurance processes.<br>5. Use of Safe Care Tool within Allocate to support decision making regarding acuity and dependency.<br>6. Senior nursing staff authorisation of agency usage<br>7. Robust system implemented to manage and monitor utilisation of temporary staff including overtime worked.<br>8. Establishment of internal bank staff arrangements.<br>9. Business continuity plan available in response to the pandemic with escalated bank and agency rates offered.<br>10. Monitoring of red flags, incident reporting (IR1's), complaints and other patient experience data.<br>11. Monthly financial reporting and non-medical agency group reviews of spending.</td></tr>
<tr><td colspan="2" rowspan="5">Update since the last report</td><td colspan="2" rowspan="5">Update 07/04/22<br><br>Nurse staffing levels continue to remain extremely challenging. Although temporary staffing and recruitment into the Trust continues, it may not always be able to staff to agreed levels due to gaps created by vacancies, sickness absence, maternity leave, unfilled bank or agency shifts, the effects of the COVID-19 pandemic and crowding within the Emergency Department.<br><br>Next review date 09/05/22</td><td>Date Last reviewed</td><td colspan="3">07/04/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2021</td><td>Q1</td><td>Q2</td><td>Q3 / Q4</td></tr>
<tr><td>15</td><td>15</td><td>15 / 15</td></tr>
<tr><td>8 week score projection</td><td colspan="3">15</td></tr>
<tr><td>Current issues</td><td colspan="3">Risks arising from the COVID-19 pandemic and local, national and international recruitment remains an issue</td></tr>
</table>

<table>
<tr><th>No</th><th>ID</th><th colspan="6">Title</th></tr>
<tr><td>16</td><td>4932</td><td colspan="6">Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained.</td></tr>
<tr><td colspan="2">Lead</td><td>Howard Stanley</td><td>Current score</td><td>15</td><td>Score Movement</td><td colspan="2"></td></tr>
<tr><td colspan="2">Description</td><td colspan="2">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.<br><br>The Local Authority (Supervisory Body) is aware but has not been able to process the assessments within the statutory timescales.</td><td>Actions</td><td colspan="3">1. Quarterly review of risk by Internal Safeguarding Board.<br>2. Resourcing issues of the supervisory body not being able to meet the requirements for the assessment of patients is outside of the control of ELHT.<br>3. ELHT is unable to extend urgent authorisations beyond the minimum time permitted of 14 days. In the absence of assessments undertaken by the</td></tr>
</table>

<table>
<tr><td>Top Controls</td><td>1. The Mental Capacity Act Policy and DoLS procedure has been updated to reflect the 2014 Supreme Court ruling.<br>2. The policy and procedure are being adhered to by wards with applications made in a timely manner.<br>3. Support is provided by the Adult Safeguarding Team.<br>4. Mental Capacity Act DoLS training is available to all employees.<br>5. Additional training and support to ward-based staff is provided by the Mental Health Capacity Act Lead and other members of the Adult Safeguarding Team.<br>6. Applications are tracked by the Adult Safeguarding Team, with changes in patient status related back to the local authority as the supervisory body.<br>7. The ability to extend urgent authorisations for all patients up to 14 days in total provides some defence to the Trust.<br>8. Legal advice and support are readily available.<br>9. Despite the legal framework issues, it is anticipated patients will not suffer any adverse consequences or delays in treatment etc. and the principles of the Mental Health Act will still apply.</td><td></td><td colspan="4">supervisory body patients will not have their DoLS authorised and will not have had relevant checks undertaken to ensure they are legally detained.</td></tr>
<tr><td rowspan="5">Update since the last report</td><td rowspan="5">Update 08/04/22<br><br>An increase in DoLS applications is adding to pressures on the safeguarding team to manage the process.<br><br>Plans to change from DoLS to Liberty Protection Safeguards (LPS) with LPS guidance open for consultation until July 2022<br>All risks relating to DoLS remain unchanged.<br><br>Next review date 06/05/22.</td><td>Date Last reviewed</td><td colspan="4">08/04/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2021</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>15</td><td>15</td><td>15</td><td>15</td></tr>
<tr><td>8-week score projection</td><td colspan="4">15</td></tr>
<tr><td>Current issues</td><td colspan="4">Awaiting response from LA and escalation to Commissioners and NHS England</td></tr>
</table>

**Table 4:**

<table>
<tr><th>No</th><th>ID</th><th colspan="6">Title</th></tr>
<tr><td>17</td><td>9439</td><td colspan="6">Failure to meet internal and external financial targets for the 2022-23 financial year</td></tr>
<tr><td colspan="2">Lead</td><td>Charlotte Henson / Michelle Brown</td><td>Current score</td><td>20</td><td colspan="2">Score Movement</td><td>↔</td></tr>
<tr><td colspan="2">Description</td><td colspan="2">Failure to meet the Trusts financial plan and obligations together with the wider Lancashire and South Cumbria Integrated Care Systems financial plan and obligations 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.<br><br>The financial risk is made up of the following:<br><br>- Lack of control as in the current financial regime monies are allocated to ICS to agree how they are allocated out to other the system partner organisations<br>- A 5% efficiency target that has been set for the 2022-23 financial year to reduce costs by £28.8 million, a level that has never previously been achieved<br>- Unknown extent of the increase in the cost of living and inflation rates<br>- Unknown impact of Covid in the 2022-23 financial year<br>- A system financial gap that still has to be closed</td><td rowspan="2">Actions</td><td colspan="3" rowspan="2">Frequent, accurate and robust financial reporting and challenge by the way of:<br>- Trust Board Report<br>- Finance and Performance Committee Finance Report<br>- Audit Committee Reports<br>- Integrated Performance reporting<br>- Divisional and Directorate Finance reports<br>- Budget Statements<br>- Staff in Posts Lists<br>- Financial risks<br>- External Reporting and Challenge</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. Robust financial planning arrangements, to ensure financial targets are achievable and agreed based on accurate financial forecasts.<br>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.<br>3. Enforcement of Standing Financial Instructions through financial controls to ensure expenditure commitments to incur expenditure are made in accordance with delegated limits.<br>4. Arrangements to monitor and improve delivery of the Waste Reduction Programme.<br>5. Training and guidance for budget holders.<br>6. A senior finance presence in internal and external conversations influencing the direction of travel.</td></tr>
<tr><td colspan="2" rowspan="6">Update since the last report</td><td colspan="2" rowspan="6">New Trust Wide Identified<br><br>Next Review Date 06/06/22</td><td>Date Last reviewed</td><td colspan="3">03/05/22</td></tr>
<tr><td rowspan="2">Risk by Quarter 2021</td><td>Q1</td><td>Q2</td><td>Q3 | Q4</td></tr>
<tr><td>20</td><td></td><td></td></tr>
<tr><td>8-week score projection</td><td colspan="3">20</td></tr>
<tr><td>Current issues</td><td colspan="3">Unknown impact of inflation, impact of coronavirus pandemic and 5% efficient target.</td></tr>
</table>

# TRUST BOARD REPORT

**11 May 2022**

| **Item** | **62** |
|---|---|
| **Purpose** | Information<br>Decision |

| | |
|---|---|
| **Title** | Patient Safety Incident Response Assurance Report |
| **Author** | Mr L Wilkinson, Incident and Policy Manager<br>Mrs J Hardacre, Assistant Director of Patient Safety and Effectiveness |
| **Executive sponsor** | Mr J Husain, Executive Medical Director |


**Summary:** The Trust Board is asked to receive the paper as a summary update on the incidents reported under the new Patient Safety Incident Response Plan (PSIRP) and the management of serious incidents reported to CCG under the Serious Incident Framework (SIF) up to 30th November 2021, including lessons learnt. This report includes information on maternity specific serious incidents reporting as required by Ockenden recommendations.

The Board is asked to receive the included update on the implementation of PSIRF.


**Report linkages**

| | |
|---|---|
| Related strategic aim and corporate objective | Put safety and quality at the heart of everything we do<br>Invest in and develop our workforce<br>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.<br>The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework.<br>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. Incidents reported under the Patient Safety Incident Response Framework (PSIRF) from 1st December to 27th April 2022

### 1.1 Patient Safety Incident Investigations (PSII)

1.1.1 As part of the Trust being an early adopter of the PSIRF, certain incidents that meet a national or local priority are selected for investigation by the (PSII) Team, as of 27th April 2022 the Trust has reported a total of:

- 10 Incidents to be investigated by the PSII team, these have been allocated to a member of the PSII team who are working with patients and families to develop Terms of Reference and agree timescales.
- A further 4 Incidents are currently being investigated by the Healthcare Investigation Branch (HSIB)
- See appendix 1 for the category of each of the above

1.1.2 The PSII Team are currently reviewing 2 incidents to determine if the incidents meet either national or local criteria.

1.1.3 Completed reports will be reviewed and approved by Patient Safety Incidents Requiring Investigation (PSIRI) panel, and the improvement plans monitored by Lessons Learnt Group.

1.1.4 The first new PSIRI panel is booked for 18th May 2022.

### 1.2 Patient Safety Responses (PSR)

1.2.1 All incidents that are of moderate or above harm, that do not meet the national/local requirement for a PSII are required to have a Patient Safety Response (PSR) completed and managed within division. See appendix 2 for the types and numbers of PSRs undertaken as of 27th April 2022.

1.2.2 Divisions are required to provide assurance of their internal process and management of PSRs at the Patient Safety Group (PSG) and Lessons Learnt Group. Since the last report there has been one meeting of Lessons Learnt Group, two divisions each presented an incident and the learning from these incidents, further detail of the Lessons Learnt Group is provided in section 5.

## 2 Incidents Reported Under the Serious Incident Framework (SIF) to CCG

2.1 Prior to 1st December 2021 the Trust reported Serious Incidents to the Strategic Executive Information System (StEIS) and these required submission to the CCG for closure. Work continues to progress these investigations so that they can be approved by the SIRI panel and sent to the CCG for final closure. As of 27th April 2022, there are 47 open investigations:

- 14 are awaiting feedback from division following queries from the CCG
- 16 are awaiting completion of SIRI feedback
- 13 are awaiting a response from the CCG
- 4 are being investigated by HSIB

2.2 Since the last report 4 investigation reports have been approved and closed by the CCG.

2.3 Quality Governance are working with Divisions to manage the number of outstanding investigations with the aim of having all SIF investigations completed and sent to the CCG by end of April 2022. All divisions were requested to send the outstanding reports by 27th April 2022, and if unable to do so a reason and expected submission date is to be provided. Reporting will continue until all investigation reports have been closed by the CCG.

## 3 Never Events reported from 1st April 2021 to 31st March 2022

3.1 The Trust reported 6 Never Events in the financial year 1st April 2021 to 31st March 2022.

- 4 wrong site surgery
- 1 wrong implant
- 1 overdose of insulin due to incorrect device.

3.2 Of these 5 investigations have been completed and 2 have now been de-escalated as never events

- 3 upheld as never events (2 wrong site surgery, 1 wrong implant)
- 2 wrong site surgery incidents agreed for de-escalated as no issues or gaps were identified in line with national patient safety standards.

3.3 The Trust has report one Never Event since the 1st April, chest drain guidewire left in situ in the emergency department. This incident is currently under investigation and terms of reference are being drafted with patient.

3.4 Each division has been requested to complete an audit on compliance of LocSSIPs within their areas. Findings of these audits will be presented at the next Patient Safety Group in May 2022.

## 4 Serious Incident Requiring Investigation (SIRI) Panel Overview (April 2022)

4.1 SIRI Panel(s) including Pressure Ulcer SIRI Panel a total of 4 investigation reports were discussed:

- 4 reports were approved with learning, divisions share learning though divisional governance and share to care meetings in clinical areas. From February 2022 divisional learning will be monitored by the new Lessons Learnt Group for assurance and identification of any Trust wide themes

4.2 A summary of themes is conducted at each SIRI, at the April meeting the following themes were identified:

- The Pressure Ulcer steering group are to review recent action plans against the overarching pressure ulcer action plan, and refresh the action plan following a deep dive to provide assurance that the overarching actions are resulting in improvements given that there seems to be similar themes in recent occurrences of pressure ulcers. Pressure Ulcer Steering Group to submit the overarching action plan to Patient Safety Group for review at the next meeting for an overview of the priorities in the management of pressure ulcer care.

4.3 This was the last meeting of the SIRI Panel in its current format, in the next report this section will cover an overview of the Patient Safety Incident Requiring Investigation (PSIRI) Panel.

## 5 Lessons Learnt from Patient Safety Events

5.1 At the first full Lessons Learnt group took place on 26th April, a number of themes were identified and discussed at the meeting.

5.1.1 LocSSIPs – highlighted within the resent Never Event, the importance of using LocSSIPs when carrying out any invasive procedure. The issue/learning was raised at the clinical leaders forum and new Spot Light on Patient Safety bulletin will focus on learning and staff education of LocSSIPs.

5.1.2 Needle stick injury's – increase in the number of needle stick injury's, Health and Safety Committee are now reviewing the policy for the

management of sharps and will provide an update on any learning or improvements at the August LLG meeting.

5.1.3 Falls – Overall no increase in the number of falls reported across the Trust but within ED and AMU an increase in harm levels has been noted. The department are working on back to basic falls action plan, this will be monitored by the Falls Steering Group and assurance fed back to the LLG.

5.1.4 LeDeR reviews have highlighted a theme with regards to staff understanding and how to support patient with behavioural issues. Learning Disability Nurse picking up staff training with DERI.

5.2 To help disseminate learning the first of two planned Patient Safety Learning Event took place on 5th April with Burnley with theatre staff, the second event is booked for 5th May with Blackburn Theatre staff.

5.2.1 72 staff attended the first event and revied learning from the wrong implant (ophthalmology wrong size lens) never event.

5.2.2 Staff participated in group work to gain a greater understanding of issues related to the 5 steps to safer surgery and identified areas for improvement.

5.2.3 On completion of both events, themes of issues and safety improvements from both events will be collated and provided to the division for action.

## 6 Maternity specific serious incident reporting in line with Ockenden recommendations

6.1 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS on the status of the open investigations. Since March 2020 41 maternity related incidents have been reported on StEIS of which:

- 19 have been closed by the CCG
- 12 have been agreed for de-escalated from StEIS by the CCG
- 4 are currently being investigated by HSIB
- 1 are awaiting feedback from division following queries from the CCG
- 2 are awaiting completion of SIRI feedback
- 2 is awaiting a response from the CCG
- 1 investigation underway by PSII team

6.2 Under Ockenden recommendations the Trust is required to provide the Board with the details of all deaths reviewed and consequent action plans using the Perinatal

Mortality Review Tool on a quarterly basis, this was included in the previous report and the next update will be provided in report following the end of quarter 1.

6.3 On 27th April 2022 the Trust received an inspection of compliance of the recommendations from Ockenden report part 1. At the verbal feedback session the trust was reported as having good standards of governance arrangements for the management of maternity incidents.

## 7 Patient Safety Incident Response Framework (PSIRF)– Early Adaptors Update

7.1 Quality Governance has developed DATIX Patient Safety Response Dashboards to support divisions in monitoring and providing assurance of appropriate levels of investigations are being assigned and completed in a timely manner.

7.2 The PSII team have developed a draft incident investigation feedback form for staff and patient/carers/families to help monitor the Trust safety culture and identify areas of the investigation process that may need improving. The feedback form is due to be approved at the next Lessons Learnt Group on 26th April 2022.

7.3 As part of the early adopters programme the Quality Governance team have been providing an overview and guidance to Trusts within the Northwest on the implementation of PSIRF including Lancashire Teaching Hospitals, Blackpool Teaching Hospitals, Stockport NHS FT, Southport and Ormskirk NHS Trust, University Hospitals of Morecambe Bay NHS FT.

7.4 The team have been invited and presented PSIRF to key members of the Northwest CQC group and provide a monthly update to NHS England Northwest.

7.5 Members of the Quality Governance team are arranging a visit to Leeds NHS Teaching Hospital who is also an early adopter of PSIRF to share learning and good practice in May 2022.

**Lewis Wilkinson – Incident and Policy Manager**

**Jacquetta Hardacre – Assistant Director of Patient Safety and Effectiveness**

**29th April 2022**

## Appendix 1: Priority and category of incidetns accepted for Patient Safety Incident Investigations as of 27th April 2022

| PSIIs (National or Local Priority) | Categories |
|---|---|
| National | Death – Diagnosis failure/problem/transfer<br>Death – Fall (subdural haemorrhage)<br>Death – Unwitnessed fall patient on CPAP<br>Death – Diagnosis failure/problem/transfer<br>Never Event – Overdose of insulin due to incorrect device<br>Never Event – Guidewire left in situ |
| National (HSIB) | Maternal death<br>2 x Unexpected term admission to NICU<br>Early neonatal death |
| Local | 2 x falls resulting in a fractured neck of femur<br>Nil by mouth in a vulnerable adult (6 days or more)<br>DNACPR communication with patient/family |

## Appendix 2: Patient Safety Response tools used as of 27th April 2022

| No. of PSRs | |
|---|---|
| **Investigation Tool** | **No.** |
| Immediate actions | 2 |
| Open discussion | 6 |
| Rapid review | 57 |
| Risk assessment | 1 |
| Falls checklist | 4 |
| Pressure checklist | 249 |
| Clinical/Peer review | 16 |
| Concise report | 19 |
| Specialised reviews | 43 |
| Timeline mapping | 9 |
| Round table | 8 |
| Unassigned | 28 |
| Total | 442 |

# TRUST BOARD REPORT

**Item** 63

**11 May 2022**

**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 March 2022

**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<br>Invest in and develop our workforce<br>Work with key stakeholders to develop effective partnerships<br>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.<br>Recruitment and workforce planning fail to deliver the Trust objectives<br>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.<br>The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework.<br>The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements |

(63) Integrated Performance Report

**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 medication errors causing serious harm.
- There were no confirmed post 2 day MRSA bacteraemia in month.
- Average fill rates for registered nurses/midwives and care staff remain above threshold, although continue to be extremely challenging. Fill rates for registered nurses/midwives and care staff for day and care staff at night showed significant deterioration in March.
- The complaints rate remains below threshold.
- The Hospital Standardised Mortality Ratio (HSMR) has decreased and is 'within expected levels'.
- The 28 day faster diagnosis standard was met in February at 79.7% but is still showing significant deterioration from normal variation.
- The emergency readmission rate is within the normal range.
- The Trust is reporting a draft (subject to audit) adjusted surplus of £17,000 for the 2021-22 financial year.

**Areas of Challenge**

- There was one never event reported in month which met national priorities and was reported onto steis.
- There were 5 healthcare associated clostridium difficile infections detected in month (3 were 'Hospital onset healthcare associated (HOHA)' and 2 were 'Community onset healthcare associated (COHA).
- Friends & family scores have deteriorated in all areas. A&E and maternity are below threshold.
- The 'Emergency Care 4 hour standard' (Pennine A&E Delivery Board) was not achieved in February at 71.10%.
- There were 809 breaches of the 12 hour trolley wait standard (11 mental health and 798 physical health), which is a significant deterioration.
- There were 493 ambulance handovers > 30 minutes and 12 > 60 minutes. Following validation, 4 of the 12 were ELHT breaches. The trend is showing significant improvement.
- Performance against the cancer 31 and 62 day standards has deteriorated and the standards were not met in February at 95.2% and 55.2%.
- There were 13 breaches of the 104 day cancer wait standard.

- The 6wk diagnostic target was not met at 16.59% in March.
- In March, the Referral to Treatment (RTT) number of total ongoing pathways has decreased slightly on last month to 36,918, and the number over 40 weeks has increased to 1,552.
- In March, there were 454 breaches of the RTT >52 weeks standard due to COVID-19, which is below the monthly trajectory.
- In March, there were 9 breaches of the 28 day standard for operations cancelled on the day.
- The Trust vacancy rate is above threshold at 5.3%.
- Sickness rates are above threshold at 6.5% (February)
- 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 89%
- Temporary costs as % of total pay bill remains above threshold at 13%.
- All areas of core skills training are above threshold, with the exception of information governance, fire safety, safeguarding adults and basic life support.

**No Change**

- The Summary Hospital-level Mortality Indicator (SHMI) has remained as expected at 1.06.
- Venous Thromboembolism (VTE) risk assessment performance remains above threshold.
- Length of stay is within normal levels.
- There were 93 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 March 2022 and follows the NHS Oversight Framework. The narrative provides details on specific indicators under the five areas; Safe, Caring, Effective, Responsive, Well Led

## Safe

| | Indicator | Target | Actual | Variation | Assurance |
|---|---|---|---|---|---|
| M64 | Clostriduim difficile (C.diff) - 'Hospital onset healthcare associated (HOHA)' | n/a | 3 | | No target set to provide assurance against |
| M64.3 | Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)' | n/a | 2 | | |
| M64.4 | Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA) | 67 | 57 | | |
| M65 | MRSA | 0 | 0 | | |
| M124 | E-Coli (HOHA) | n/a | 6 | | |
| M155 | P. aeruginosa bacteraemia (HOHA) | n/a | 1 | | |
| M157 | Klebsiella species bacteraemia (HOHA) | n/a | 3 | | |
| M66 | Never Event Incidence | 0 | 1 | | |
| M67 | Medication errors causing serious harm (Steis reported date) | 0 | 0 | | |
| M68 | Maternal deaths | 0 | | | |
| M64.2 | C Diff per 100,000 Occupied Bed Days (HOHA) | No Threshold Set | 11.4 | | |
| M69 | Serious Incidents (Steis) | No Threshold Set | 1 | | |
| M70 | Central Alerting System (CAS) Alerts - non compliance | 0 | 6 | | |
| C29 | Proportion of patients risk assessed for Venous Thromboembolism | 95% | 99% | | P |

## Caring

| | Indicator | Target | Actual | Variation | Assurance |
|---|---|---|---|---|---|
| C38 | Inpatient Friends and Family - % who would recommend | 90% | 97% | | P |
| C31 | NHS England Inpatients response rate from Friends and Family Test | No Threshold Set | 35% | | |
| C40 | Maternity Friends and Family - % who would recommend | 90% | 88% | | P |
| C42 | A&E Friends and Family - % who would recommend | 90% | 58% | | F |
| C32 | NHS England A&E response rate from Friends and Family Test | No Threshold Set | 11% | | |
| C44 | Community Friends and Family - % who would recommend | 90% | 96% | | P |
| C38.5 | Outpatient Friends and Family - % who would recommend | 90% | 92% | | P |
| C15 | Complaints – rate per 1000 contacts | 0.40 | 0.21 | | ? |
| M52 | Mixed Sex Breaches | 0 | | | |

## Effective

| | Indicator | Target | Actual | Variation | Assurance |
|---|---|---|---|---|---|
| M53 | Summary Hospital Mortality Indicator (HSCIC Published data) | Within Expected Levels | 1.06 | | |
| M54 | Hospital Standardised Mortality Ratio (DFI Indicative) (as at Dec-21) | Within Expected Levels | 104.6 | | |
| M74 | Hospital Standardised Mortality Ratio - Weekday (as at Dec-21) | Within Expected Levels | 103.1 | | |
| M75 | Hospital Standardised Mortality Ratio - Weekend (as at Dec-21) | Within Expected Levels | 109.1 | | |
| M73 | Deaths in Low Risk Conditions (as at Dec-21) | Within Expected Levels | N/A | | |
| M159 | Stillbirths | <5 | | | F |
| 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

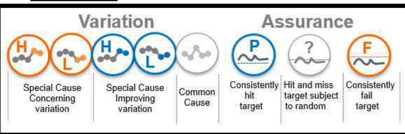
| | Indicator | Target | Actual | Variation | Assurance |
|---|---|---|---|---|---|
| C2 | Proportion of patients spending less than 4 hours in A&E (Trust) | 95.0% | 69.3% | | F |
| C2ii | Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board) | 95.0% | 71.1% | | F |
| M62 | 12 hour trolley waits in A&E | 0 | 809 | | F |
| M82.1 | Handovers > 30 mins ALL (Arrival to handover) | 0 | 493 | | F |
| M84 | Handovers > 60 mins (Arrival to handover) | 0 | 12 | | F |
| C1 | Referral to Treatment (RTT) admitted: percentage within 18 weeks | No Threshold Set | 45.7% | | |
| C3 | Referral to Treatment (RTT) non- admitted pathways: percentage within 18 weeks | No Threshold Set | 77.1% | | |
| C4.1 | Referral to Treatment (RTT)waiting times Incomplete pathways Total | No Threshold Set | 36,918 | | |
| C4.2 | Referral to Treatment (RTT) waiting times Incomplete pathways -over 40 wks | No Threshold Set | 1552 | | |
| C37.1 | Referral to Treatment (RTT) 52 Weeks (Ongoing) | 679 | 454 | | |
| C17 | Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test | 1.0% | 16.6% | | ? |
| C18 | Cancer - Treatment within 62 days of referral from GP | 85.0% | 55.2% | | ? |
| C19 | Cancer - Treatment within 62 days of referral from screening | 90.0% | 46.4% | | ? |
| C20 | Cancer - Treatment within 31 days of decision to treat | 96.0% | 95.2% | | ? |
| C21 | Cancer - Subsequent treatment within 31 days (Drug) | 98.0% | 100.0% | | P |
| C22 | Cancer - Subsequent treatment within 31 days (Surgery) | 94.0% | 92.3% | | ? |
| C36 | Cancer 62 Day Consultant Upgrade | 85.0% | 77.6% | | ? |
| C25.1 | Cancer - Patients treated > day 104 | 0 | 13 | | ? |
| M9 | Urgent operations cancelled for 2nd time | 0 | 0 | | |
| C27a | Not treated within 28 days of last minute cancellation due to non clinical reasons - actual | 0 | 9 | | ? |
| M138 | No.Cancelled operations on day | No Threshold Set | 90 | | |
| M55 | Proportion of delayed discharges attributable to the NHS | New reporting in development | | | |
| C16 | Emergency re-admissions within 30 days | No Threshold Set | 13.4% | | |
| M90 | Average length of stay elective (excl daycase) | No Threshold Set | 3.5 | | |
| M91 | Average length of stay non-elective | No Threshold Set | 5.4 | | |

## Well Led

| | Indicator | Target | Actual | Variation | Assurance |
|---|---|---|---|---|---|
| M77 | Trust turnover rate | 12.0% | 8.2% | | |
| M78 | Trust level total sickness rate | 4.5% | 6.5% | | |
| M79 | Total Trust vacancy rate | 5.0% | 5.3% | | |
| M80.3 | Appraisal (Agenda for Change Staff) | 90.0% | 65.0% | | |
| M80.35 | Appraisal (Consultant) | 90.0% | 97.0% | | |
| M80.4 | Appraisal (Other Medical) | 90.0% | 98.0% | | |
| M80.2 | Safeguarding Children | 90.0% | 92.0% | | |
| M80.21 | Information Governance Toolkit Compliance | 95.0% | 89.0% | | |
| F8 | Temporary costs as % of total paybill | 4% | 13.0% | | |
| 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 | -£1.90 | | |
| F3 | Liquidity days | >(7) | (6.5) | | |
| F4 | Capital spend v plan | 85.0% | 92.0% | | |
| 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% | 96.4% | | |
| F13 | Better Payment Practice Code (BPPC) Non NHS Value of Invoices | 95.0% | 97.1% | | |
| F14 | Better Payment Practice Code (BPPC) NHS No of Invoices | 95.0% | 95.0% | | |
| F15 | Better Payment Practice Code (BPPC) NHS Value of Invoices | 95.0% | 97.5% | | |

**NB: Finance Metrics are reported year to date.**

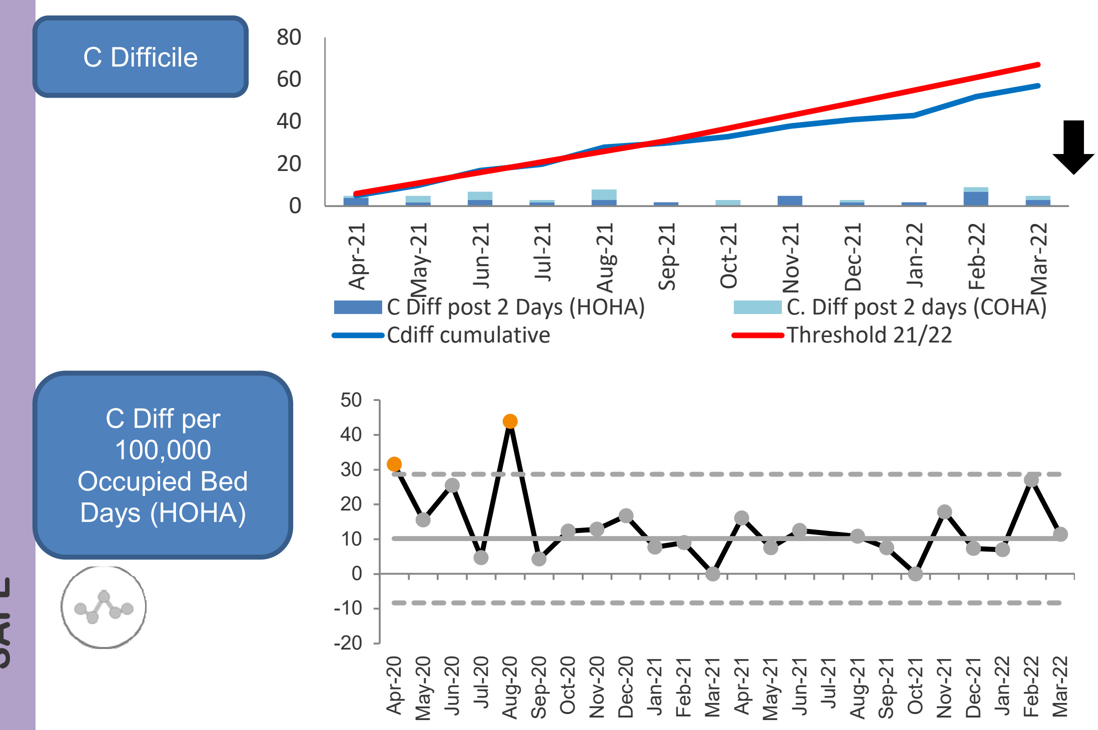
KEY




**SPC Control Limits**

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

**SAFE**

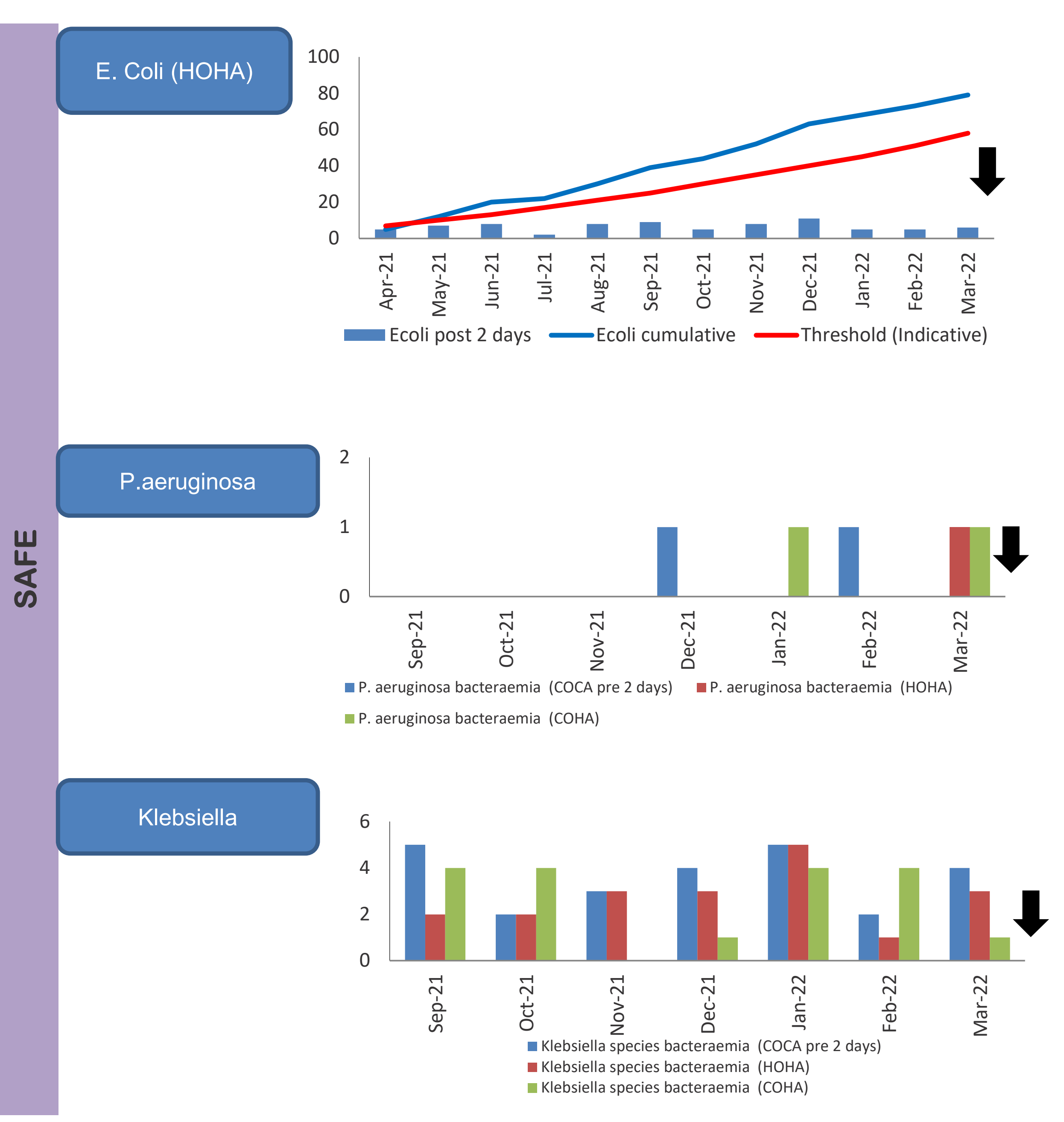



There were no post 2 day MRSA infection reported in March. So far this year there have been 2 cases attributed to the Trust.

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.

There were 5 healthcare associated *Clostridium difficile* toxin positive isolates identified in the laboratory in February, post 2 days of admission, 3 of which were 'Hospital onset healthcare associated (HOHA)' and 2 were 'Community onset healthcare associated (COHA)'.
The year to date cumulative figure is 57 (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 decreased and is still within the normal range in March.




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 6 post 2 day E.coli bacteraemia (HOHA) detected in March.

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

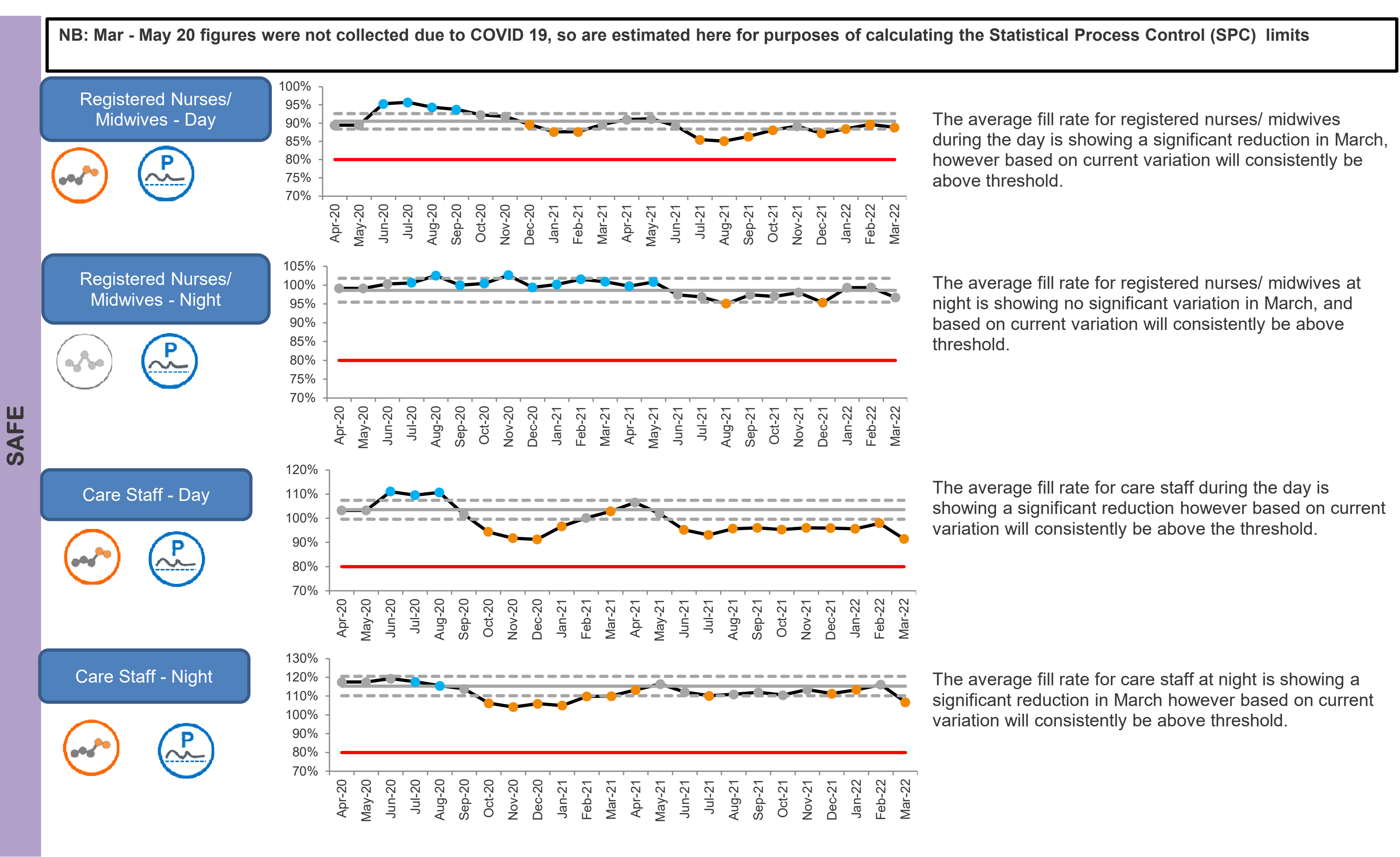
From 21/22 the a trajectory has been introduced for *Klebsiella* and *Pseudomonas.* The Trust should have no more than 35 cases this year for *Klebsiella* and 8 cases for *Pseudomonas.*

So far this year, there have been 55 *Klebsiella* cases and 6 *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

**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**




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

The average fill rate for registered nurses/ midwives at night is showing no significant variation in March, and based on current variation will consistently be above threshold.

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.

The average fill rate for care staff at night is showing a significant reduction in March however based on current variation will consistently be above threshold.

SAFE

Staffing in March 2022 remains extremely challenging, particularly as a consequence of the OMICRON variant, impacting on staff sickness, isolation and pressures due to last minute sickness.

The already established vacancies, maternity leave, and effect of acuity is also impacting on staffing.  Lots of cross cover between wards, the movement of staff to support crowding in the Emergency Department and the high use of bank and agency staffing continues. The constant movement of staff to cover other areas is having an effect on staff morale. Escalated bank and agency rates continued.  Preparedness for the continuation of the effects of OMICRON commenced with the updating of a previously produced briefing paper (Impact of the Pandemic on nursing and midwifery staffing levels) to highlight the potential minimal staffing levels for each ward.

In March, 3 wards fell below the 80% for Registered Nurses/Midwives in March for the day shift. The filling of Health Care Support Worker shifts remains extremely challenging, and much work is ongoing looking at recruitment of more HCSW staff.

**MEC**

**Ward C5 -** This was due to a lack of shift coordinators. No harms reported

**Marsden ward -** This was partially due to sickness and partially due to a reduced number of patients on the ward when staff were reallocated to support other areas.

**OPU/ OPRA -** This was due to a lack of shift coordinators. No harms reported

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. Every option is explored throughout the day and night to support staffing.

SAFE

**Red Flags**

**MEC**

**B2** increased acuity and a shortfall of 25% RN on a nightshift, this resulted in a delay to administer analgesic medication for some patients >30 mins.  No harm but delays

**SAS**

**No red flags**

**CIC**

**No red flags**

Anecdotally staff resilience is low, they are tired, 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. Staff are working extremely hard and are doing a remarkable job. Staffing the wards safely and supporting staff remains the highest of priority. Through the senior nursing teams, discussion has taken place particularly in relation to ensuring rest breaks are provided and supported with encouragement to the staff to report inability to take breaks to the matron and or clinical site manager.

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)

Weekly staffing meetings with relevant senior leads to review staffing and proactively manage staffing gaps

SOP for safe maternity staffing levels in extremis – support particularly for out of hours

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, with regular monthly meetings monitoring progress

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 with looking for block bookings

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

Between January 2021 and March 2022, we will have recruited 122 international nurses. We have received some funding to recruit a further 71 nurses with an aim to bring 10 or 11 nurses over a month between April and October

**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 |
| Mar-22 | 88.8% | 91.5% | 96.7% | 106.7% | 26,267 | 9.18 | 3 | 3 | 0 | 1 |

SAFE

**Monthly Trend**

| | Average Fill Rate | | | | CHPPD | | Number of wards < 80 % | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Day | | Night | | | | Day | | Night | |
| | Average fill rate - registered nurses/mid wives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses/mid wives (%) | Average fill rate - care staff (%) | Sum of Midnight Counts of Patients | Care Hours Per Patient Day (CHPPD) | Average fill rate - registered nurses/mi dwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses/mid wives (%) | Average fill rate - care staff (%) |
| 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 |
| Oct-21 | 88.1% | 95.3% | 97.0% | 110.6% | 28,426 | 8.61 | 6 | 3 | 0 | 2 |
| Nov-21 | 89.2% | 96.0% | 98.0% | 113.4% | 27,594 | 8.77 | 4 | 4 | 0 | 2 |
| Dec-21 | 87.2% | 95.9% | 95.3% | 111.4% | 27,266 | 9.06 | 3 | 3 | 1 | 2 |
| Jan-22 | 88.4% | 95.6% | 99.3% | 113.4% | 28,602 | 8.88 | 3 | 5 | 2 | 2 |
| Feb-22 | 89.6% | 97.9% | 99.4% | 116.1% | 25,833 | 8.93 | 2 | 1 | 0 | 1 |
| Mar-22 | 88.8% | 91.5% | 96.7% | 106.7% | 26,267 | 9.18 | 3 | 3 | 0 | 1 |

SAFE

**Family Care Staffing Summary – March 2022**

On reviewing Datix, there were 23 staffing incidents reported overall in Family Care in March 2022. These were all in Maternity

14 incidents were reported was due to a shortage of midwives across all areas of maternity which resulted in having to close the Birth Centres at times and divert staff to other areas and divert women to a place of birth that was different to where they wanted to birth.

9 were reported as local red flags, no harm or delays in care.

**None of these were National Midwifery Staffing Red Flag events.**

**Maternity (Midwife to Birth Ratio)**

| Month | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staffed to full Establishment | 01:27 | 01:27 | 01:28 | 01:27 | 01:26 | 01:26 | 01:28 | 01:26 | 01:27 | 01:27 | 01:26 | 01:27 | 01:28 |
| Excluding mat leave | 01:28 | 01:28 | 01:29 | 01:27 | 01:27 | 01:27 | 01:29 | 01:27 | 01:28 | 01:29 | 01:27 | 01:27 | 01:30 |
| 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 | Bank Usage |
| Per week | 19.53wte | 11.25wte | 24.14wte | 17.98wte | 17.40wte | 18.54wte | 21.84wte | 16.71wte | 23.40 wte | 17.43 | 42.28 | 17.33 | 18.76 |

SAFE

**Maternity-** March bank filled hours were covering vacancies/ pregnancy shielding, extensive short, long-term sickness, extended staff isolation periods. Covid sickness has been high, a specialist midwife rota to cover gaps in addition to bank has been recommenced to cover gaps in ANC roster planned for April as an additional contingency.

An Enhanced hourly rate of pay continued in view of the significant increase with self-isolation/sickness/ substantive gaps.

Safe midwifery Staffing levels continued to be reviewed with the appropriate risk assessments throughout the day at each safety huddle. Plus, additional staffing/ leadership huddles most days in view of extreme staffing pressures to mitigate throughout the whole of maternity services.

Cross family care divisional cover was recommenced In March 2022 to cover some shortfalls with safe staffing, i.e. bank transitional care (TC) nurse on night duty to cover acuity on the Post-Natal Ward. A paediatric nurse to cover room 4 or 5 in NICU to allow redeployment of a TC nurse for the same rationale on occasions. Daily staffing plans following risk assessment with clear redeployment allocations for safe midwifery skill sets within all wards and departments.
Additional MSWS/ HCAS booked to cover some gaps in acuity, if a midwife is required to give one-to-one care in labour overnight as a proactive measure.
Amalgamation of triage services and birth centres has been enacted to maintain safety within staffing levels on several night duties and some weekend days towards month end.

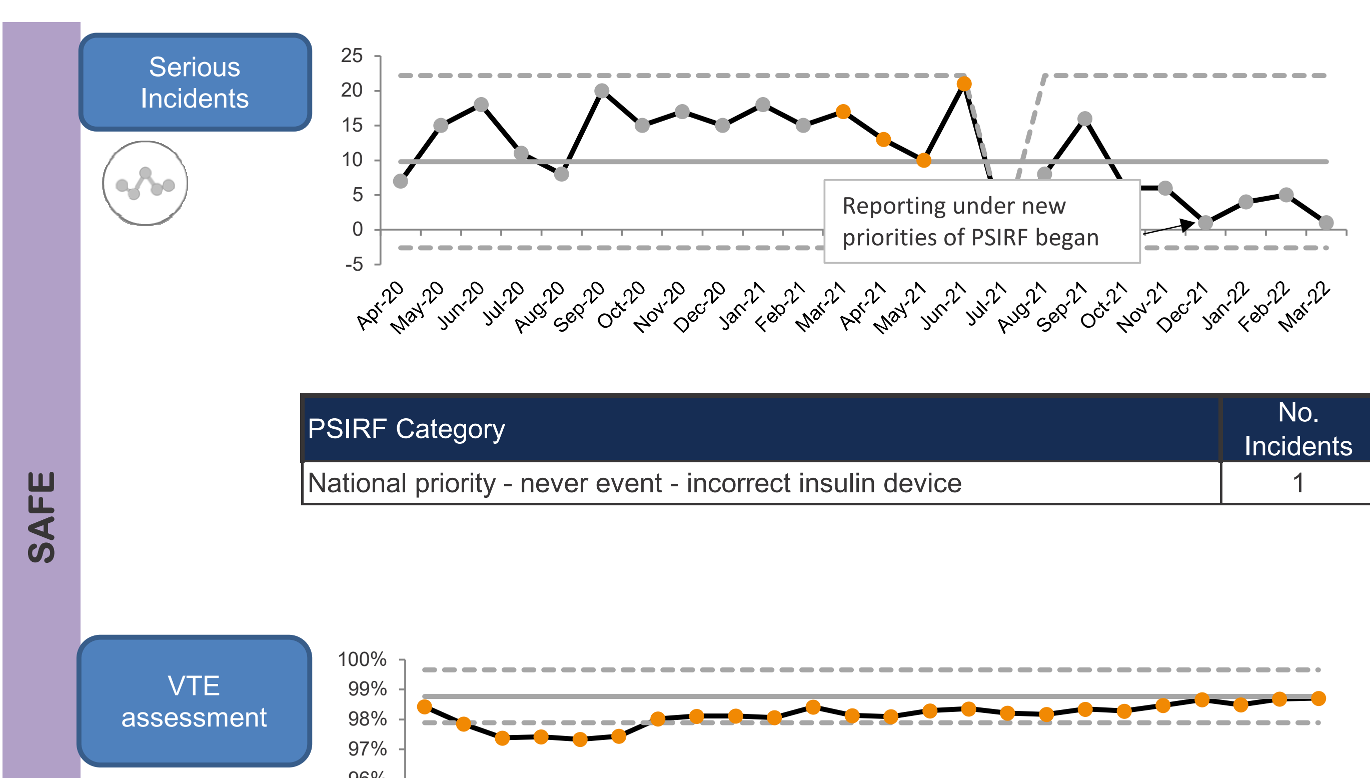
The CBS coordinator will receive the staffing plan at the onset of duty with a view to redirect if deemed appropriate at handover in tandem with the duty manager cover on the weekend day duties. Close monitoring with a proactive approach to breaks particularly in times of shortfalls being supported by the CBS coordinator and duty manager. ELHT site manager has supported further staffing escalation together with the CBS coordinator out of hours resulting in the Acute Care Team providing some cross cover on occasions and the Blackburn Birth Centre being fully closed on night duty of the 26th of March until Monday 28th March where reopening was safe to proceed.

**Neonatology –** All Nursing duties were covered to safe staffing levels aligned with the x 3 daily staffing NW connect tool in March. Cross divisional working with paediatrics to cover any nursing gaps in view of an increase in staff isolation periods, primarily in the nursery room 5 from paediatrics to cover room one continues to be an option. Enhanced pay remained in place to cover staffing gaps with request to agency where required and not covered with internal bank shifts. Lower acuity and activity in the month of March – No red flags or exceptions reported

**Paediatrics-** Cross divisional support sought With NICU as above. Staffing managed within safe levels – No red flags or exceptions reported

**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 red flags or exceptions reported.

# SAFE




| PSIRF Category | No. Incidents |
|---|---|
| National priority - never event - incorrect insulin device | 1 |

There was one never event reported in March.

One incident meeting a national or local priority and whereby a patient safety incident investigation (PSII) is underway, has been reported onto STEIS.The Trust starting reporting under these priorities on 1st December 2021.

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

VTE assessment

100%
99%
98%
97%
96%
95%
94%
93%
92%
Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22

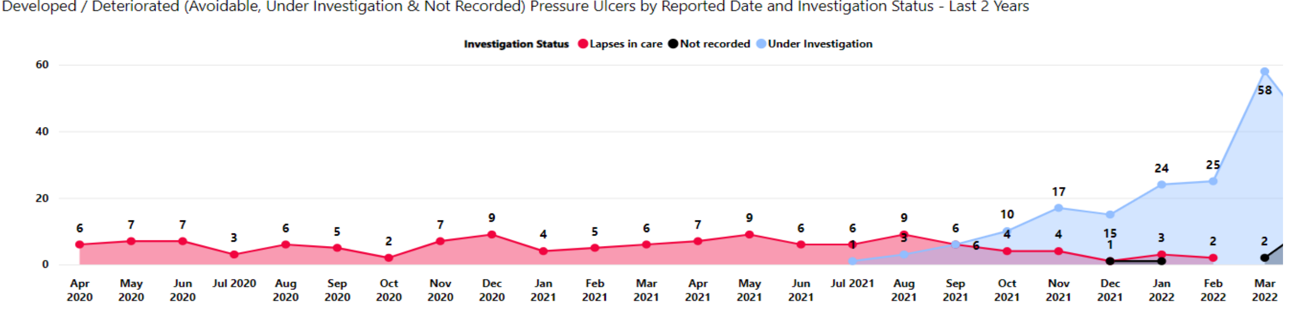
The Venous Thromboembolism (VTE) assessment trend continues to be below previous levels, however is still above the threshold.

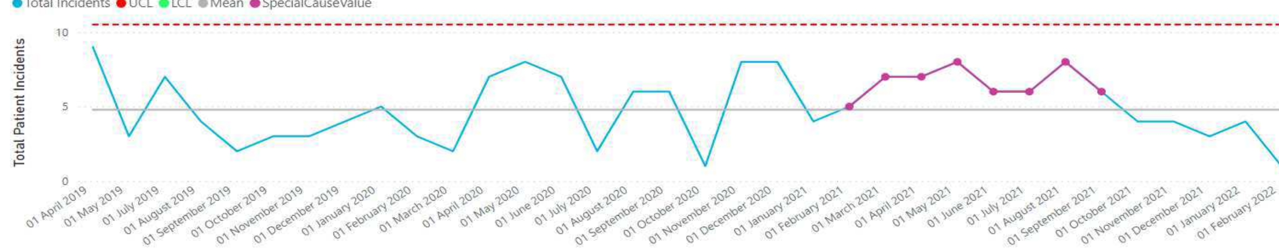
SAFE

## Pressure Ulcers

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

Developed/ Deteriorated (Lapses in care, Under Investigation & Not Recorded)




The data shows the current position of pressure damage. Months of June 21-March 22 are currently pending investigation. The number of incidents can fluctuate when the incident is approved via the Pressure Ulcer Review & Learning Panel (PURLP) process.

The pressure ulcer collaborative will have a refresh from the end of April. Divisions have been invited to nominate thier ward/ teams to take part.

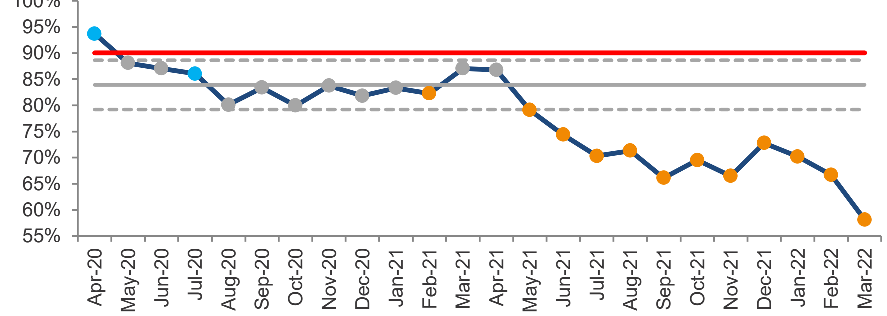
We have had agreement across the north west that we will commence a working group including all Pennine Lancs organisations to agree what to report with regards to pressure damage. This piece of work will include North West KPIs, we will then be able to compare our practice with each other.

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.

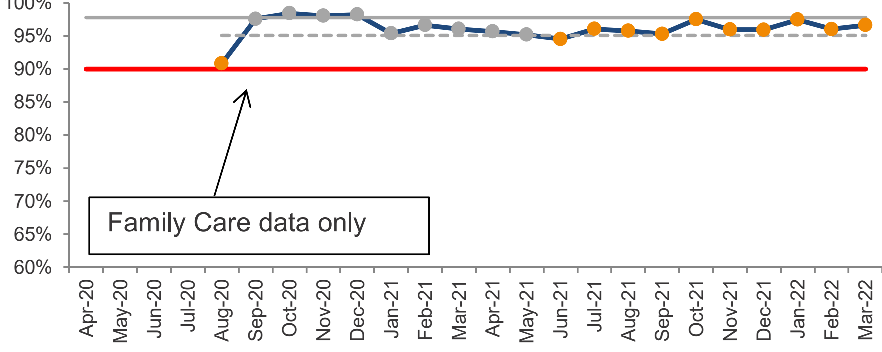
Inpatient data collection was suspended April 20 - Sep 20 due to COVID

Friends & Family A&E



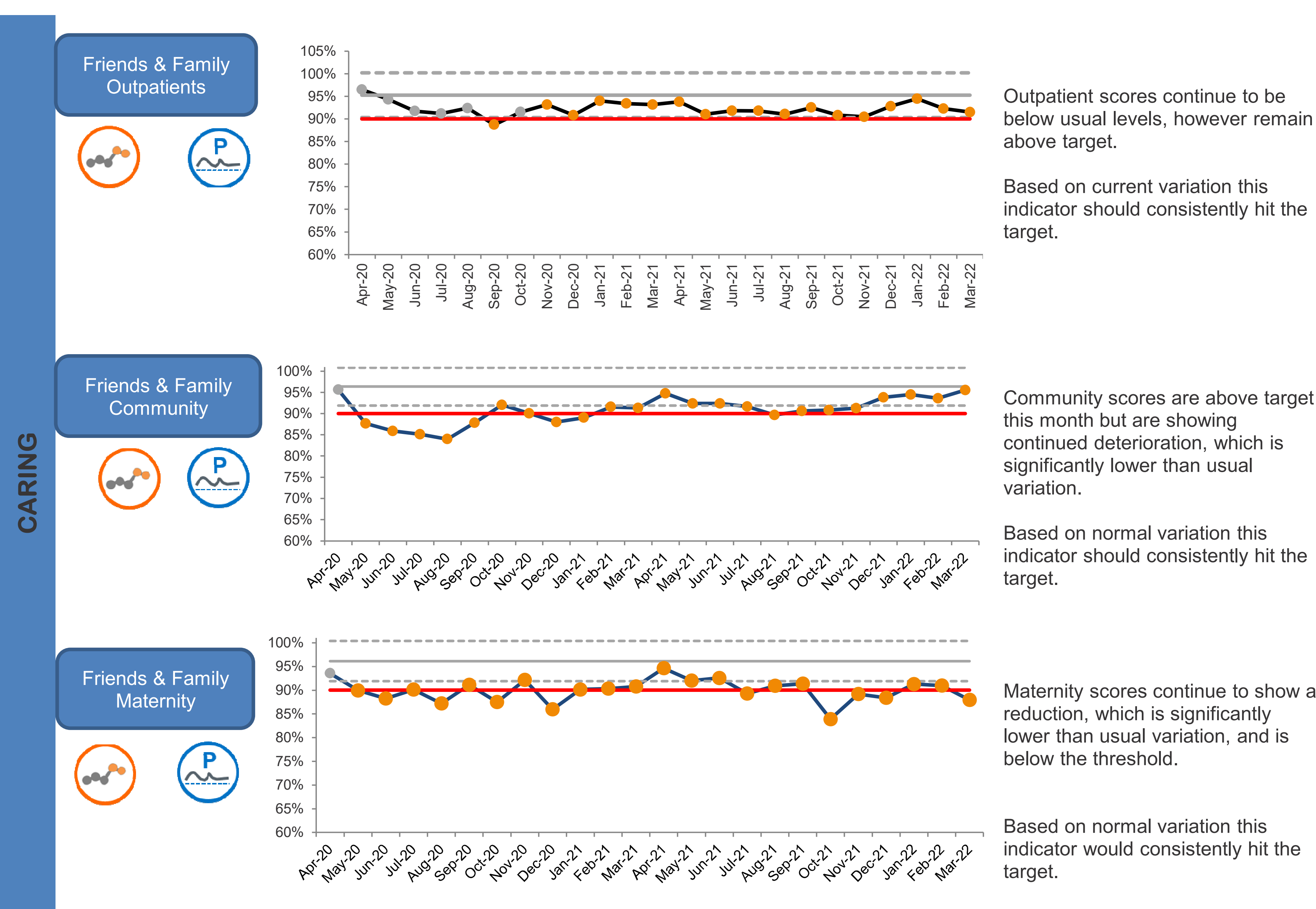

A&E scores are showing a significant deterioration in the last 11 months. Based on current variation this indicator is not capable of hitting the target routinely.

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.




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

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

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

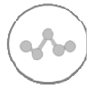
Based on normal variation this indicator should consistently hit the target.

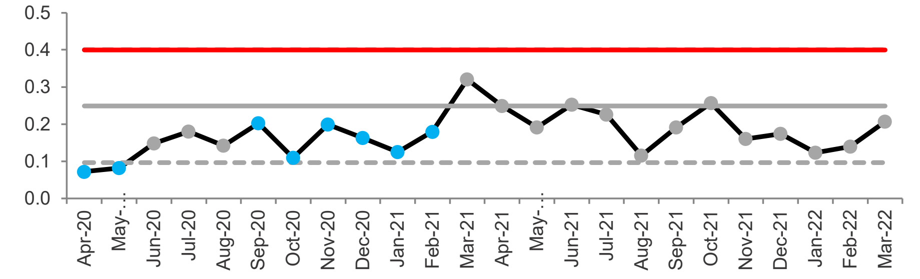
Maternity scores continue to show a reduction, which is significantly lower than usual variation, and is below the threshold.

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

CARING

Complaints per 1000 contacts






The Trust opened 26 new formal complaints in March.

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 March the number of complaints received was 0.21 Per 1,000 patient contacts.

The trend is showing normal variation and based on current variation is at risk of not meeting the standard.

Patient Experience

| Type | Division | Dignity<br>Average Score | Information<br>Average Score | Involvement<br>Average Score | Quality<br>Average Score | Overall<br>Average Score |
|---|---|---|---|---|---|---|
| Antenatal | Family Care | 100.00 | 66.67 | 60.00 | 100.00 | 93.75 |
| Community | Community and Intermediate Care Services | 94.21 | 92.33 | 90.95 | 93.67 | 92.30 |
| Community | Diagnostic and Clinical Support | 100.00 | 95.12 | 92.86 | | 95.56 |
| Community | Family Care | 100.00 | | | 88.33 | 90.79 |
| Community | Surgery | 95.24 | 96.55 | | | 96.20 |
| Delivery | Family Care | 100.00 | | 100.00 | 100.00 | 100.00 |
| ED_UC | Medicine and Emergency Care | 71.43 | 61.49 | 40.63 | 63.16 | 55.53 |
| Inpatients | Community and Intermediate Care Services | 100.00 | 85.42 | 63.64 | 84.38 | 80.00 |
| Inpatients | Diagnostic and Clinical Support | 100.00 | 97.27 | 95.97 | 89.47 | 97.05 |
| Inpatients | Family Care | 93.45 | 86.72 | 91.96 | 91.35 | 91.19 |
| Inpatients | Medicine and Emergency Care | 85.50 | 68.23 | 65.85 | 69.38 | 70.12 |
| Inpatients | Surgery | 95.85 | 89.27 | 89.55 | 89.24 | 90.89 |
| OPD | Diagnostic and Clinical Support | | | 100.00 | 100.00 | 100.00 |
| OPD | Family Care | 94.87 | 92.86 | 95.10 | 94.23 | 94.41 |
| OPD | Medicine and Emergency Care | 100.00 | 88.71 | 98.33 | 96.08 | 94.55 |
| OPD | Surgery | 99.11 | 88.24 | 94.42 | 99.23 | 95.17 |
| Postnatal | Family Care | 100.00 | 98.94 | 97.96 | 97.44 | 98.28 |
| SDCU | Family Care | 96.15 | 97.83 | 99.29 | 100.00 | 98.27 |
| | **Total** | **95.28** | **86.61** | **87.25** | **91.18** | **89.55** |

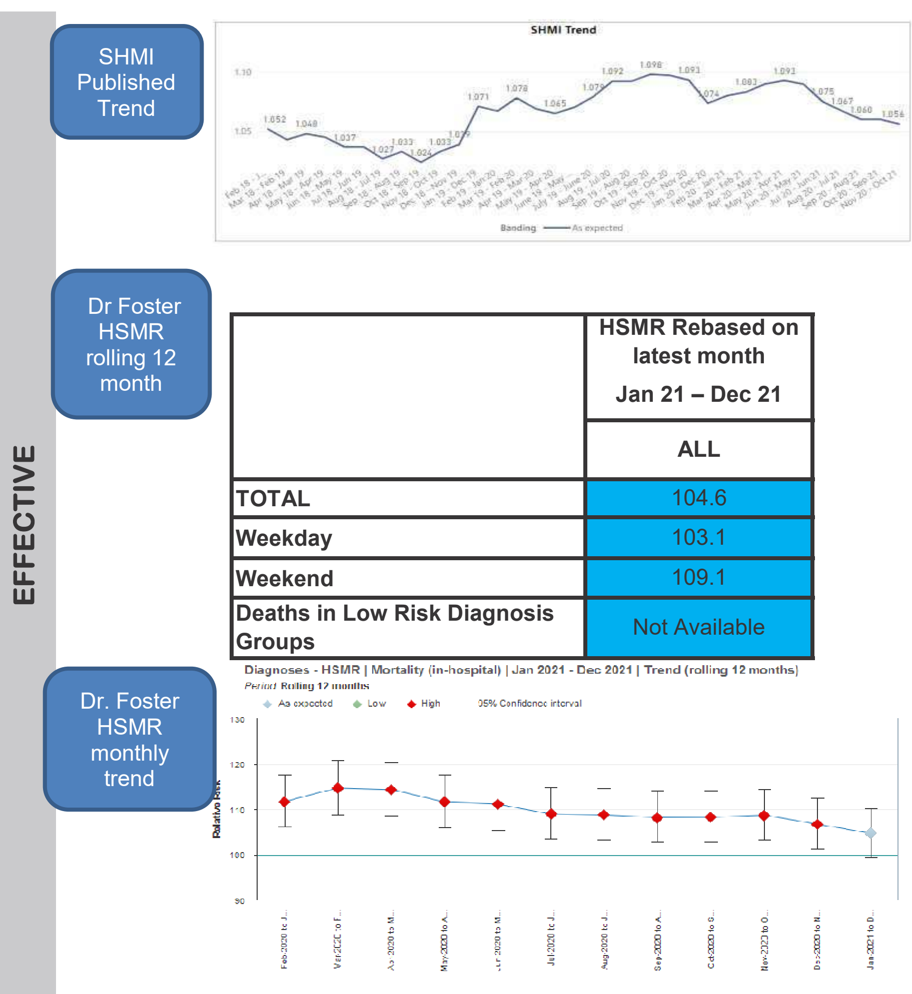
From 1st May 2020 the Trust moved to a new system, CIVICA to manage the Friends & Family Test (FFT) and patient experience surveys.

The new reports have now been configured and the table demonstrates divisional performance from the range of patient experience surveys in March 2022.

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 2 of the 4 competencies.

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




| | HSMR Rebased on latest month Jan 21 – Dec 21 |
|---|---|
| | ALL |
| TOTAL | 104.6 |
| Weekday | 103.1 |
| Weekend | 109.1 |
| Deaths in Low Risk Diagnosis Groups | Not Available |

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 Nov 20 to Oct 21 has remained within expected levels at 1.06, as published in March 22.

The latest indicative 12 month rolling Hospital Standardised Mortality Ratio (HSMR), (Jan 21 – Dec 21) has reduced from last month and is 'within expected levels' at 104.6 against the monthly rebased risk model.

The benchmark model has been adjusted this month to account for data upto September 21, meaning risk scores are increasingly adjusted for changes seen during the pandemic.

There are currently two HSMR diagnostic groups with a significantly high relative risk score: Acute cerebrovascular disease and Septicemia (except in labour).

Septicemia (except in labour) and Urinary tract infections are 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.

**Learning Disability Mortality Reviews**

There are currently 24 learning disability and autism deaths for review at time of report.

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 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | TOTAL |
| Deaths requiring SJR (Stage 1) | 46 | 212 | 250 | 262 | 213 | 15 | 20 | 15 | 24 | 16 | 14 | 13 | 6 | 10 | 9 | 10 | 152 |
| Allocated for review | 46 | 212 | 250 | 262 | 213 | 15 | 20 | 15 | 24 | 16 | 14 | 13 | 6 | 10 | 9 | 6 | 148 |
| SJR Complete | 46 | 212 | 250 | 262 | 209 | 15 | 19 | 14 | 24 | 16 | 14 | 11 | 6 | 4 | 3 | 2 | 128 |
| 1 - Very Poor Care | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2 - Poor Care | 8 | 19 | 22 | 34 | 34 | 0 | 4 | 3 | 3 | 3 | 3 | 0 | 0 | 2 | 0 | 2 | 20 |
| 3 - Adequate Care | 14 | 68 | 70 | 70 | 63 | 3 | 4 | 3 | 6 | 6 | 3 | 3 | 2 | 1 | 1 | 0 | 32 |
| 4 - Good Care | 20 | 106 | 133 | 129 | 102 | 10 | 9 | 7 | 14 | 7 | 7 | 7 | 1 | 1 | 2 | 0 | 65 |
| 5 - Excellent Care | 3 | 18 | 25 | 29 | 9 | 2 | 2 | 1 | 1 | 0 | 1 | 1 | 3 | 0 | 0 | 0 | 11 |
| **Stage 2** | | | | | | | | | | | | | | | | | |
| Deaths requiring SJR (Stage 2) | 9 | 20 | 22 | 34 | 35 | 0 | 4 | 3 | 3 | 3 | 3 | 0 | 0 | 2 | 0 | 2 | 20 |
| Deaths not requiring Stage 2 due to undergoing SIRI or similar | 3 | 2 | 1 | 4 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Allocated for review | 6 | 18 | 21 | 30 | 34 | 0 | 4 | 3 | 3 | 3 | 2 | 0 | 0 | 2 | 0 | 2 | 19 |
| SJR-2 Complete | 6 | 18 | 21 | 30 | 33 | 0 | 4 | 3 | 3 | 3 | 2 | 0 | 0 | 2 | 0 | 2 | 19 |
| 1 - Very Poor Care | 1 | 1 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2 - Poor Care | 3 | 6 | 7 | 13 | 13 | 0 | 2 | 1 | 1 | 1 | 0 | 0 | 0 | 2 | 0 | 2 | 9 |
| 3 - Adequate Care | 2 | 10 | 13 | 13 | 19 | 0 | 2 | 2 | 2 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 10 |
| 4 - Good Care | 0 | 1 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 5 - Excellent Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | pre Oct 17 | Oct 17 - Mar 18 | Apr 18 - Mar 19 | Apr 19 - Mar 20 | Apr 20 - Mar 21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| stage 1 requiring allocation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 4 |
| stage 1 requiring completion | 0 | 0 | 0 | 0 | 4 | 0 | 1 | 1 | 0 | 0 | 0 | 2 | 0 | 6 | 6 | 4 | 20 |
| Stage 1 Backlog | 0 | 0 | 0 | 0 | 4 | 0 | 1 | 1 | 0 | 0 | 0 | 2 | 0 | 6 | 6 | 8 | 24 |
| stage 2 requiring allocation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| stage 2 requiring completion | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Stage 2 Backlog | 0 | 0 | 0 | 0 | 1 | 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 71.10% in March, 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

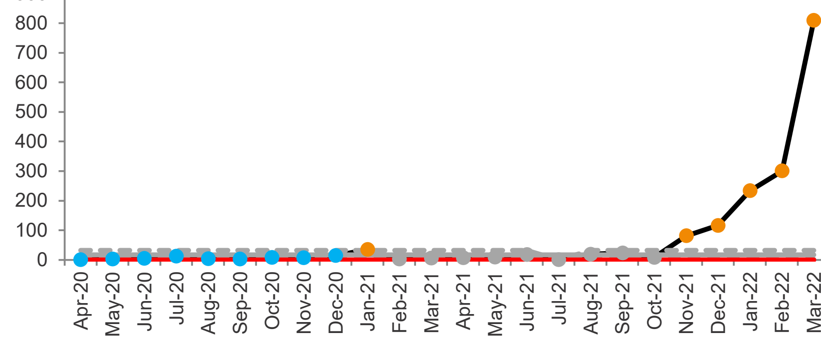
Performance against the ELHT four hour standard was 69.31% in March.

The national performance was 71.6% in March (All types) with none of the 111 reporting trusts with type 1 departments achieving the 95% standard.

## A&E Attendances - Trust

The number of attendances during March was 17,940, which is within the normal range.

RESPONSIVE

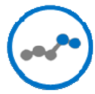


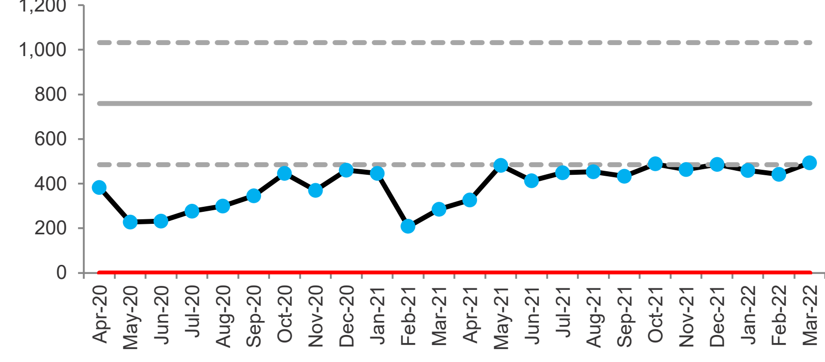

There were 809 reported breaches of the 12 hour trolley wait standard from decision to admit during March, which is higher than the normal range.11 were mental health breaches and 798 were physical health.

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 | 11 | 798 |
| Average Wait from Decision to Admit | 31hr 27 min | 17hr 47 min |
| Longest Wait from Decision to Admit | 67hr 24 min | 51hr 09 min |

Ambulance Handovers -

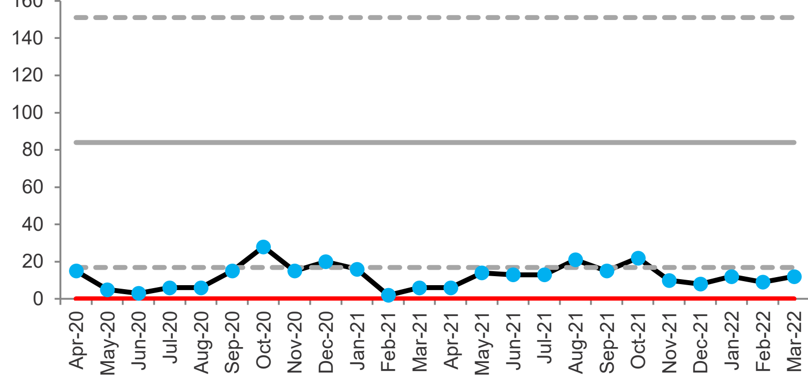





Following a review of North West Ambulance Service data and reporting, the ambulance handover metrics have been amended and now show the arrival to handover time, having previously shown the notification to handover.

There were 493 ambulance handovers > 30 minutes in March. The trend is still showing significant improvement from previous levels, but based on current variation is not capable of hitting the target routinely.

Ambulance Handovers - >60 Minutes




There were 12 ambulance handovers > 60 minutes in March, which continues to demonstrate a signifcant improvement. Following validation, 4 of the 12 were actual ELHT breaches and 8 were due to non-compliance with the handover screen.

The average handover time was 22 minutes in March and the longest handover was 1hr 46 minutes. Due to increased > 60 minutes numbers reported by NWAS for 31st October and 1st November, the average arrival to handover times may have been overinflated.

RESPONSIVE

Referral to Treatment (RTT) Total Ongoing

At the end of March, there were 36918 ongoing pathways, which has increased on last month and is above pre-COVID levels.

RTT Total Over 40 wks

The number of pathways over 40wks increased in March with 1552 patients waiting over 40 wks at month end.

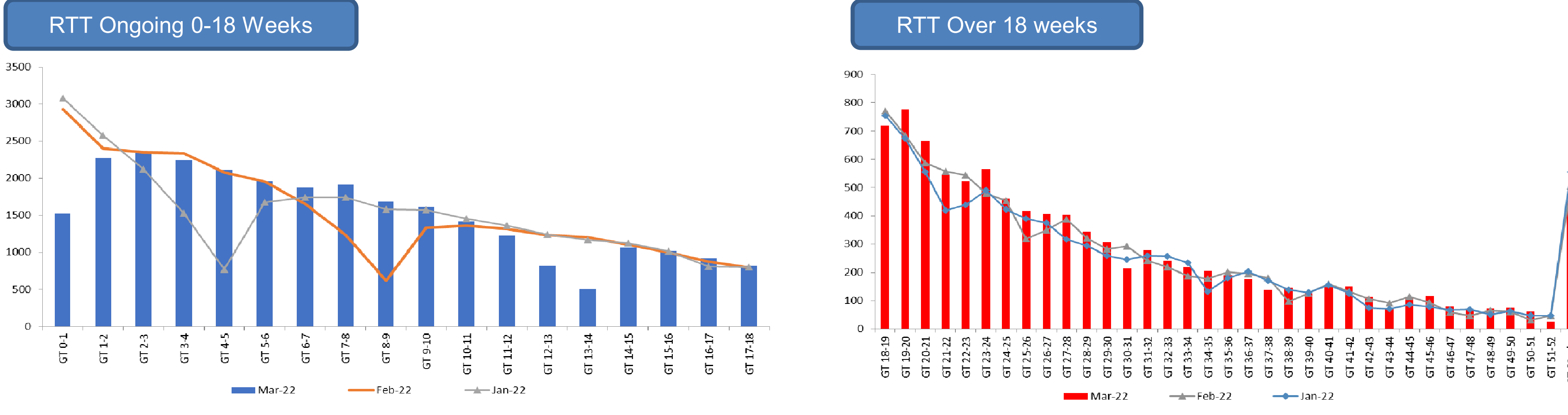
RTT Total Over 52 wks

There were 454 patients waiting over 52 weeks at the end of March, which was below the month end trajectory (679).

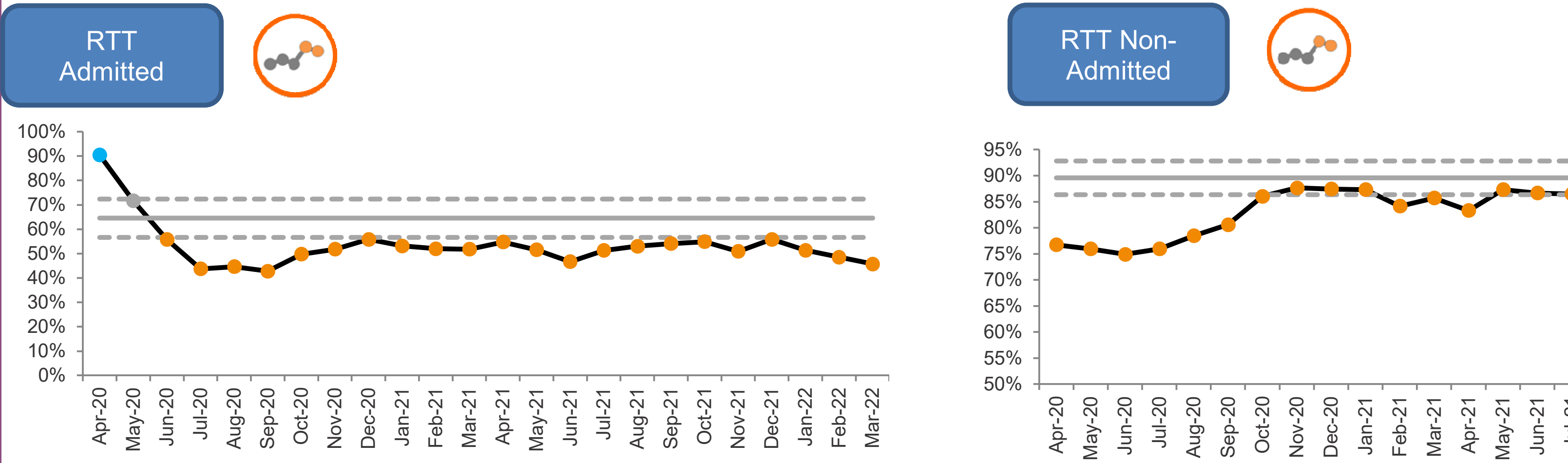
There was 1 patient waiting over 104 weeks.

RESPONSIVE

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

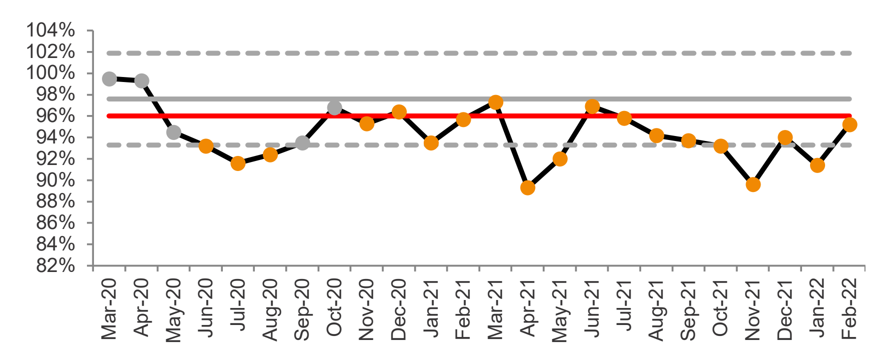



Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information. During April 20 and May 20, only priority and urgent patients were admitted.



**RESPONSIVE**

Cancer 31 day

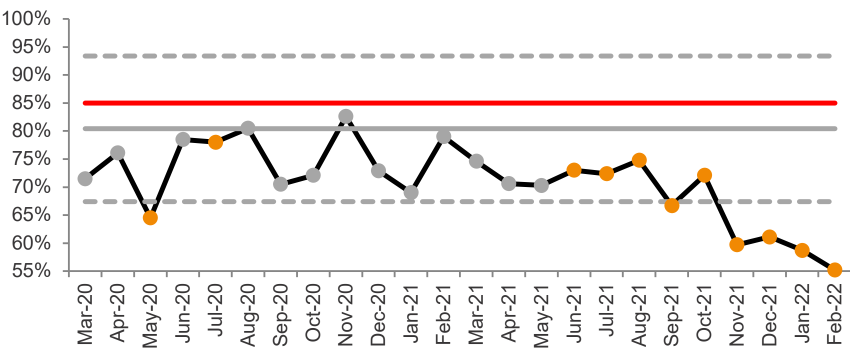



The 31 day standard was not achieved in February at 95.2%, below the 96% threshold.

Q3 was not achieved at 92.3%

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

Cancer 62 Day

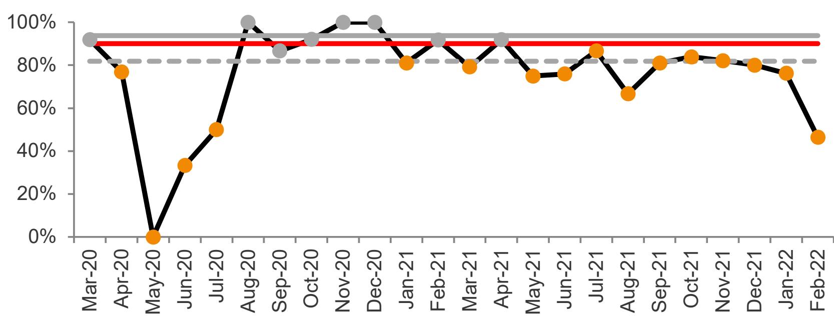



The 62 day cancer standard was not achieved in February at 55.2% below the 85% threshold.

Q3 was not achieved at 67.0%

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



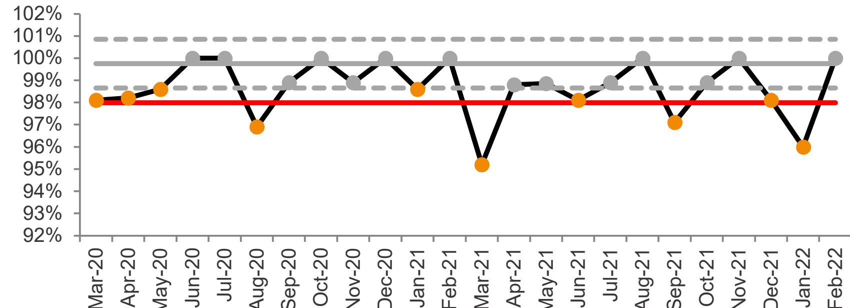

The 62 day screening standard was not achieved in February at 46.4%, below the 90% threshold.

Q3 was not achieved at 82.6%

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)



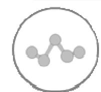
The subsequent treatment - drug standard was met in February at 100%, above the 98% threshold.

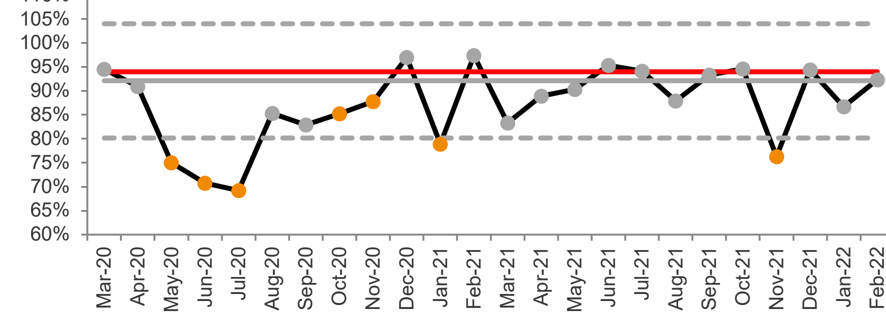
Q3 was achieved at 99%*

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

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

Cancer - Subsequent treatment within 31 days (Surgery)



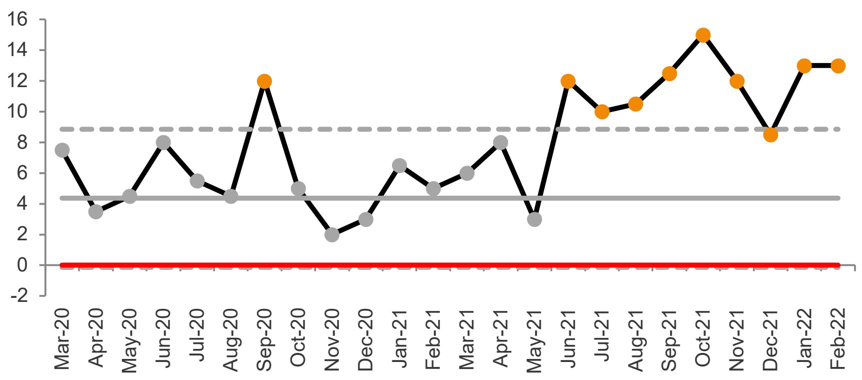


The subsequent treatment - surgery standard was not met in February at 92.3%, below the 94% standard.

Q3 was not achieved at 88.1%

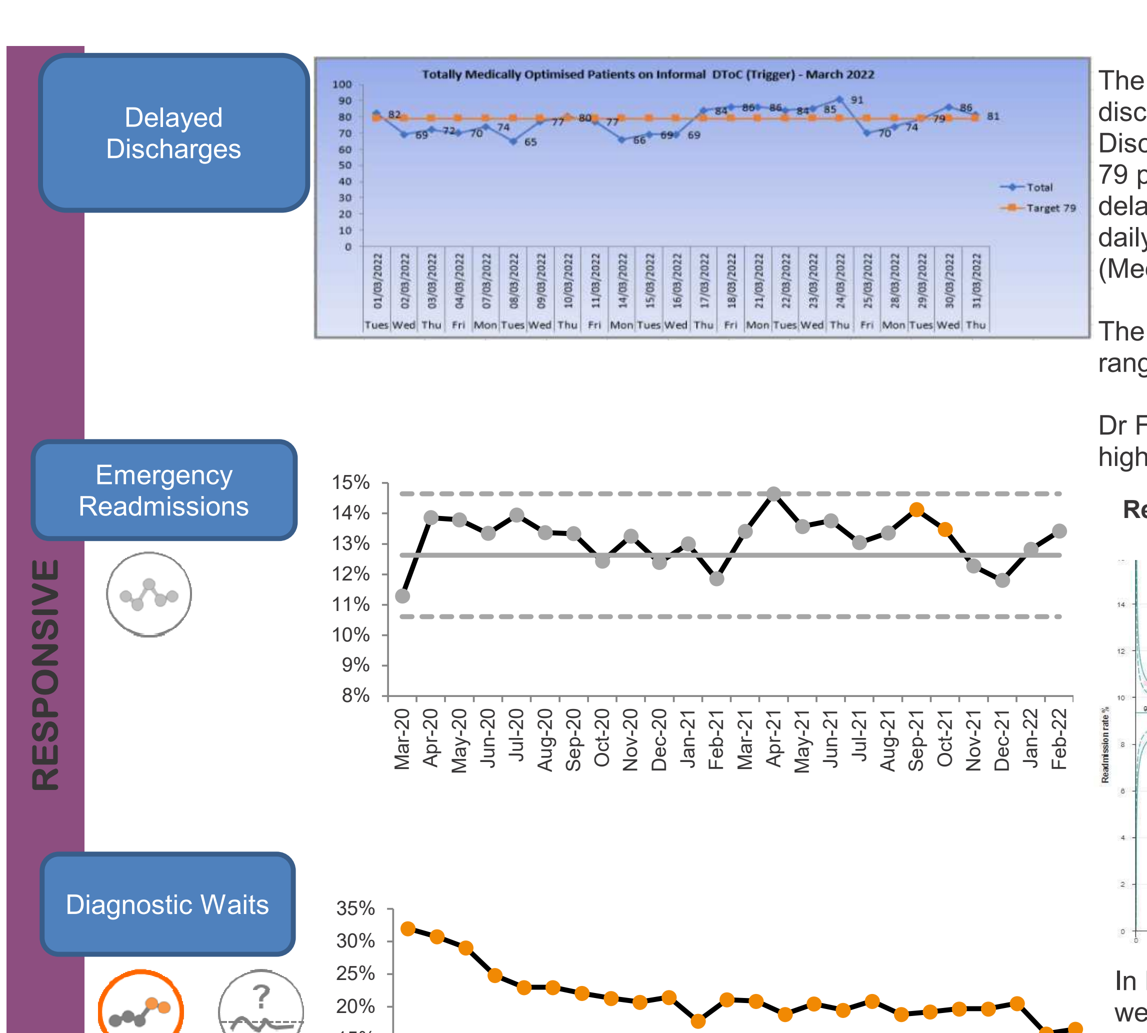
The trend is showing normal variation this month and based on the current variation, the indicator is at risk of falling below threshold.

Cancer Patients Treated > Day 104



There were 13 breaches allocated to the Trust, treated after day 104 in February 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.

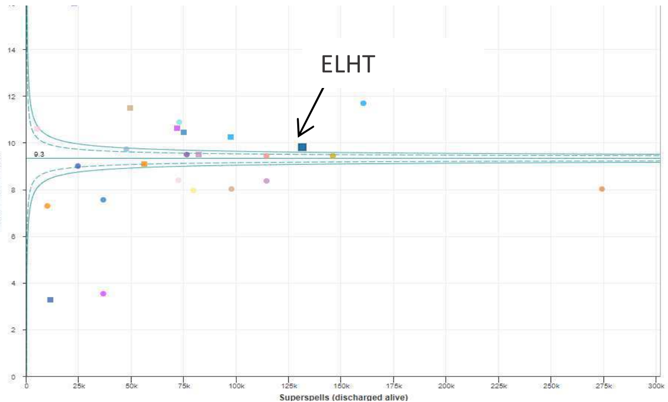



The formal reporting has now stopped as performance around discharge is being monitored regionally and nationally by the Discharge Patient Tracking List. The aim is to have fewer than 79 patients delayed in hospital and this is monitored daily. The delayed transfer of care work is now monitored locally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

The emergency readmission rate trend is within the normal range.

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

**Readmissions within 30 days vs North West - Dr Foster**




In March 16.59% 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 24% in February (reported 1 month behind).

RESPONSIVE

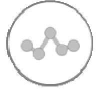
Average length of stay

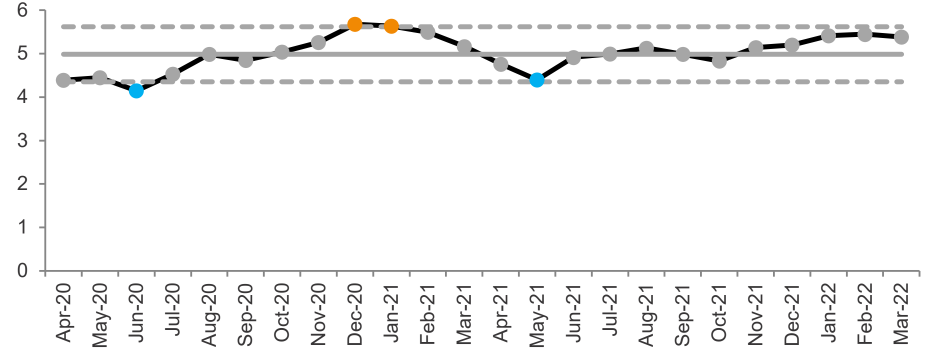
Dr Foster Benchmarking January 21 - December 21

| | Spells | Inpatients | Day Cases | Expected LOS | LOS | Difference |
|---|---|---|---|---|---|---|
| Elective | 58,994 | 9,613 | 49,381 | 3.3 | 2.6 | -0.7 |
| Emergency | 62,755 | 62,755 | 0 | 4.3 | 4.2 | -0.1 |
| Maternity/ Birth | 13,323 | 13,323 | 0 | 2.3 | 2.2 | -0.1 |
| Transfer | 227 | 227 | 0 | 8.9 | 24.1 | 15.2 |

Dr Foster benchmarking shows the Trust length of stay to be below expected for non-elective, elective, and maternity/birth when compared to national case mix adjusted, for the period January 21 - December 21.

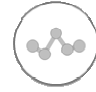
Average length of stay - non elective

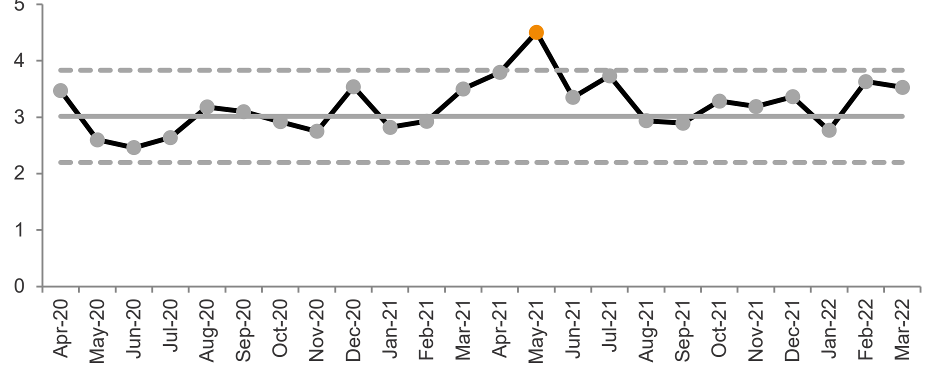





The Trust non-elective average length of stay is showing normal variation this month.

Average length of stay - elective

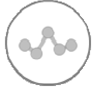


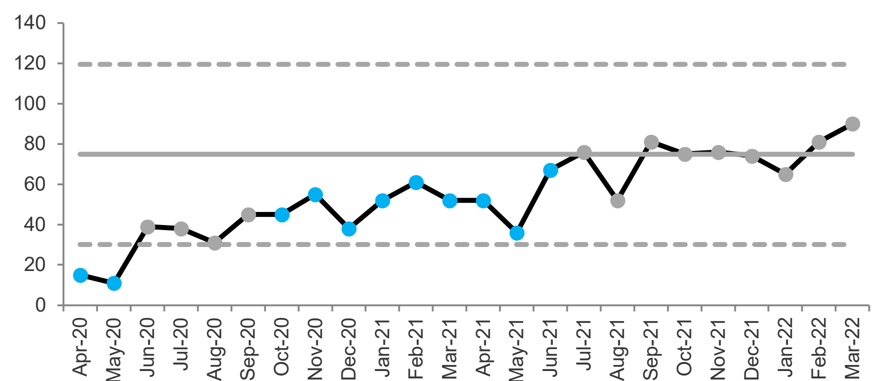



The Trust elective average length of stay is showing normal variation.

**RESPONSIVE**

Operations cancelled on day

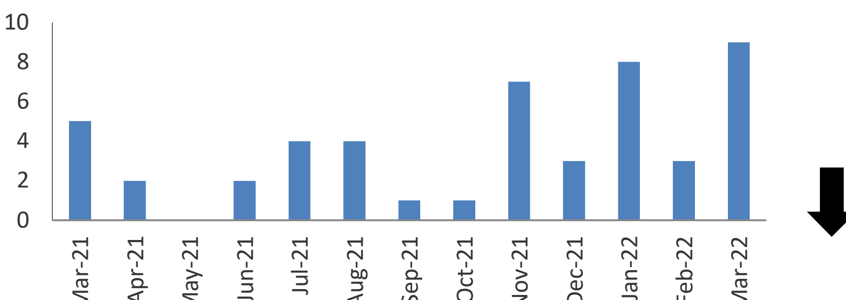





There were 93 operations cancelled on the day of operation - non clinical reasons, in March.

The trend is showing a return to normal variation.

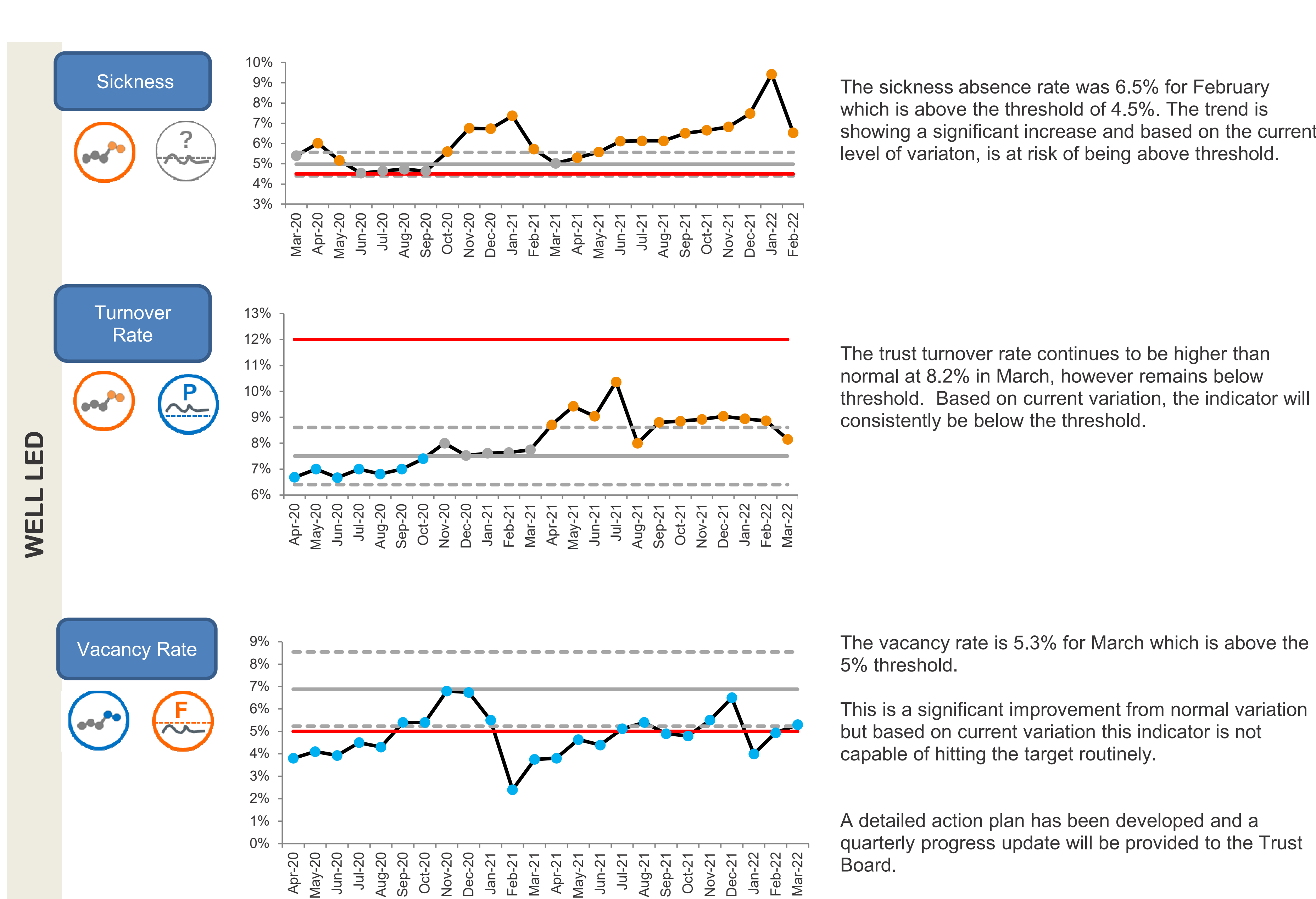
Operations cancelled on day - breaches of 28 day




Not treated within 28 days of last minute cancellation due to non clinical reasons - actual

There were 9 'on the day' cancelled operations not rebooked within 28 days in March.
These will be provided to the Finance & Performance Committee.

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.



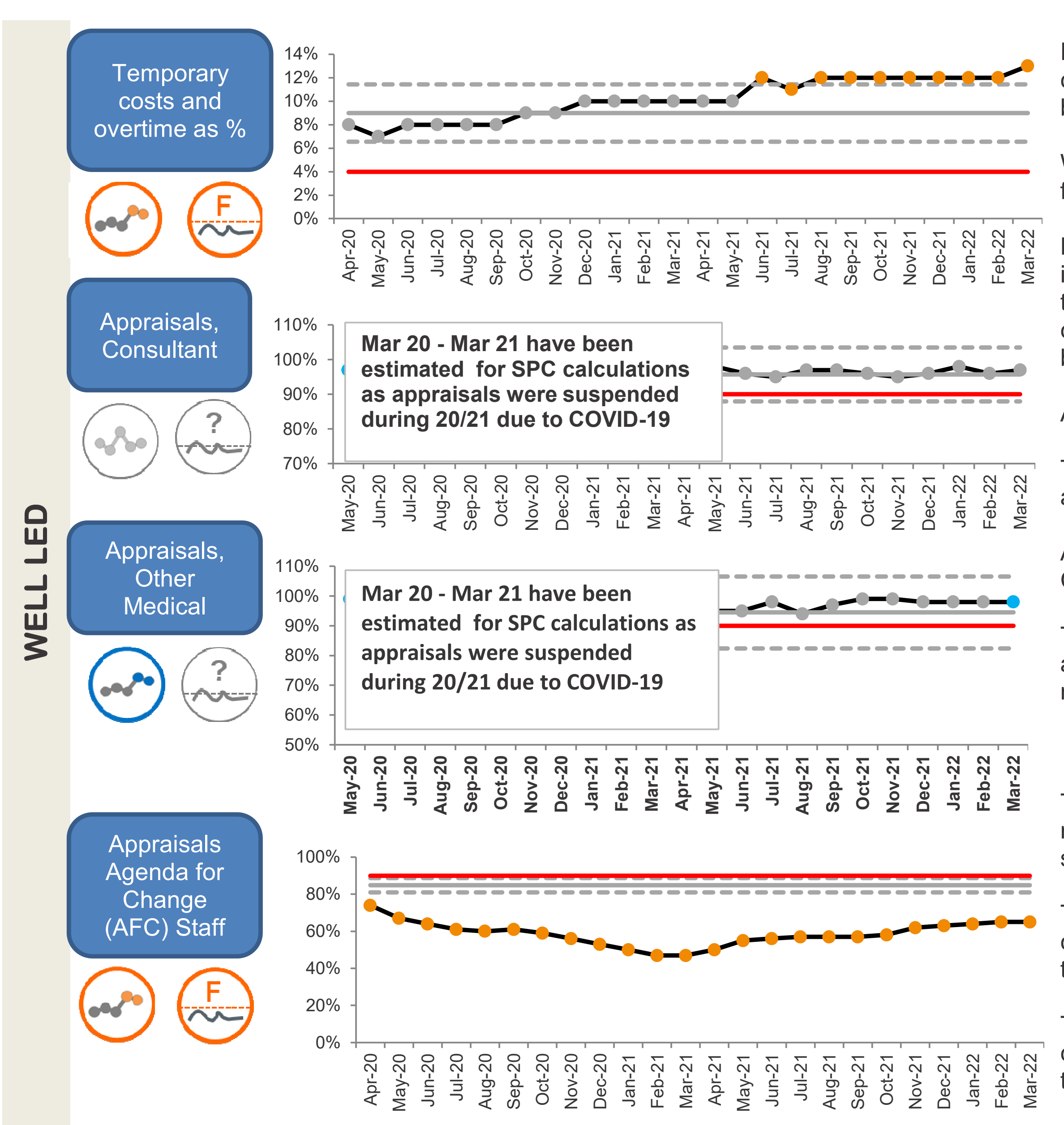

The sickness absence rate was 6.5% for February which is above the threshold of 4.5%. The trend is showing a significant increase and based on the current level of variaton, is at risk of being above threshold.

The trust turnover rate continues to be higher than normal at 8.2% in March, however remains below threshold. Based on current variation, the indicator will consistently be below the threshold.

The vacancy rate is 5.3% for March which is above the 5% threshold.

This is a significant improvement from normal variation but based on current variation this indicator is not capable of hitting the target routinely.

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




In March 2022, £7.9 million was spent on temporary staff, consisting of £1.8 million on agency staff and £6.1 million on bank staff.

WTE staff worked (9,732 WTE) was 463 WTE more than is funded substantively (9,269 WTE).

Pay costs are £29.1 million more than budgeted establishment in March, largely due to the impact of a £4.8 million increase in the accrual for annual leave and £17.0 million of employer contributions to NHS Pensions for 2021-22 paid by NHSE on behalf of Trust, which have been accounted for in month.

At the end of March 22 there were 481 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.

The appraisal rates for consultants and career grade doctors are reported cumulative year to date to March 22 and reflect the number of reviews completed that were due in this period.

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.

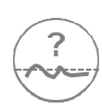
WELL LED

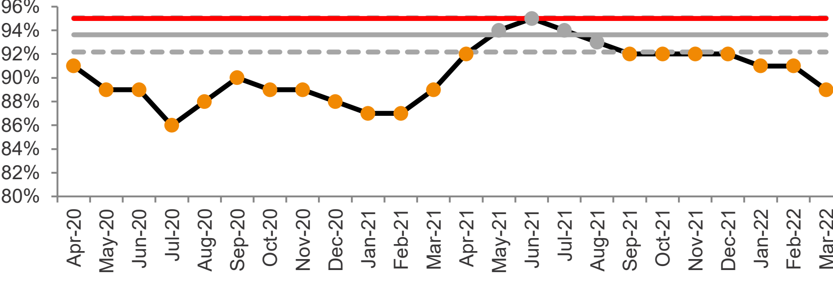
## Job Plans

| Stage | Consultant | SAS Doctor |
|---|---|---|
| Not Published | 0 | 0 |
| Draft | 1 | 5 |
| In discussion with 1st stage manager | 180 | 25 |
| Mediation | 0 | 0 |
| Appeal | 0 | 0 |
| 1st stage sign off by consultant | 44 | 8 |
| 1st stage sign off by manager | 39 | 6 |
| 2nd stage sign off | 22 | 4 |
| 3rd stage sign off | 30 | 8 |
| Signed off | 44 | 13 |
| Locked Down | 0 | 0 |

As at March 2022, there were 360 Consultants and 69 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 89% in March which is below the 95% threshold. The trend is showing deterioration and based on current variation, the indicator is at risk of not meeting the target.

## Core Skills Training % Compliance

The core skills framework consists of twelve 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 and Fire Safety which have thresholds of 95%

| | Target | Compliance at end February |
|---|---|---|
| Basic Life Support | 90% | 85% |
| Conflict Resolution Training Level 1 | 90% | 95% |
| Equality, Diversity and Human Rights | 90% | 95% |
| Fire Safety | 95% | 92% |
| Health, Safety and Welfare Level 1 | 90% | 96% |
| Infection Prevention L1 | 90% | 95% |
| Infection Prevention L2 | 90% | 92% |
| Information Governance | 95% | 89% |
| Prevent Healthwrap | 90% | 94% |
| Safeguarding Adults | 90% | 81% |
| Safeguarding Children | 90% | 92% |
| Safer Handling Theory | 90% | 93% |

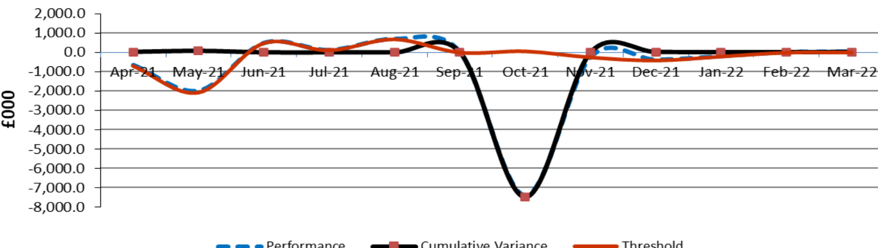
Four core training modules are below threshold; Basic Life Support, Fire Safety, Information Governance and Safeguarding adults.

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.

WELL LED

Adjusted financial

## Adjusted financial performance surplus/ (deficit)




The Trust is reporting a draft (subject to audit) adjusted surplus of £17,000 for the 2021-22 financial year.

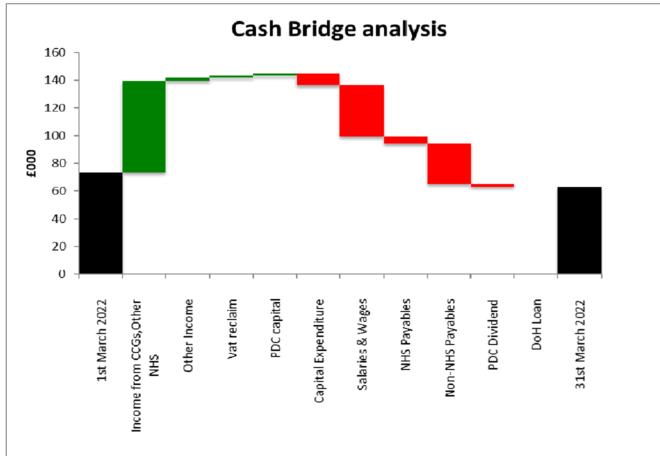
The cash balance on 31st March 2022 was £63.3 million, the reduction primarily due to the phasing of capital expenditure towards March and April and the push to clear inter NHS debt further; this was offset against additional ERF income for the draft Q4 position.

The Trust has met its Better Payment Practice Code (BPPC) of 95%.

There has been a £9.1 million increase in the 2021-22 capital programme in the final month resulting in capital spend of £30.5 million, a £2.0 million underspend against plan.

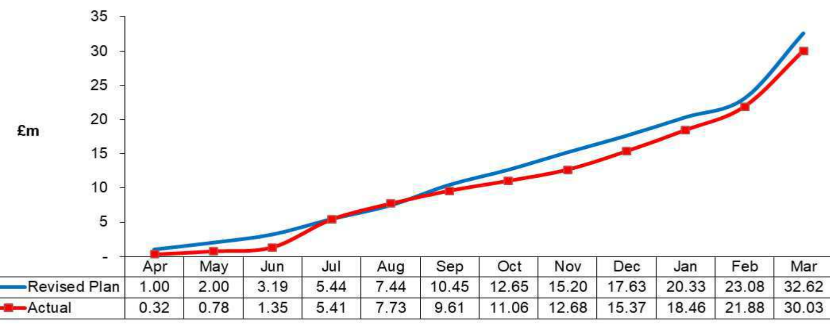
Cash

## Cash bridge




Capital expenditure

## Capital expenditure profile




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Revised Plan | 1.00 | 2.00 | 3.19 | 5.44 | 7.44 | 10.45 | 12.65 | 15.20 | 17.63 | 20.33 | 23.08 | 32.62 |
| Actual | 0.32 | 0.78 | 1.35 | 5.41 | 7.73 | 9.61 | 11.06 | 12.68 | 15.37 | 18.46 | 21.88 | 30.03 |

# TRUST BOARD REPORT

**11 May 2022**

| | |
|---|---|
| **Item** | **64** |
| **Purpose** | Information<br>Action<br>Monitoring |

| | |
|---|---|
| **Title** | Behaviour Framework Implementation Update |
| **Author** | Mrs L Atherton, Workforce Innovation & Design Manager<br>Mrs Jo Hargreaves, Senior HR Business Partner |
| **Executive sponsor** | Mr J Husain, Medical Director (Sponsor)<br>Mrs K Quinn, Operational Director of HR&OD (Exec lead) |

**Summary:** The purpose of this report is to update the Trust Board following the design and launch of the East Lancashire Hospital NHS Trust's (ELHT) Behaviour Framework in September 2021. The Trust Board is asked to note the contents of the report and support the integration of these behaviours across the organisation.

**Recommendations:** The Trust Board is asked to:

- Continue to embrace, support and role model our 5 Behaviours
- Help to integrate 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 12 months' time.

**Report linkages**

| | |
|---|---|
| Related strategic aim and corporate objective | Put safety and quality at the heart of everything we do<br>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.<br>Recruitment and workforce planning fail to deliver the Trust objectives<br>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: Trust Board November 2021

## 1. Purpose

1.1 The purpose of this report is to update the Trust Board on progress made following the launch of the Behaviour Framework in September 2021. The Trust Board is asked to note the contents of the report and to continue to play a part in creating our desired culture, and leading by example, in displaying these behaviours.

## 2. Aim of the Behaviour Framework Programme

2.1 The overall aim of this programme of work is to '*design and deliver a bespoke behaviour framework and embed our ELHT behaviours throughout each stage of the employment lifecycle, from recruitment and on boarding to exit.* The Behaviour Framework describes 'how' colleagues will behave and interact and underpins the 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.'*

2.2 The success of this programme post launch depends on the work over the next 12 to 18 months to fully embed these behaviours in the Trust's way of working. A number of measures of success have been identified that will enable the Trust to assess the impact and report regularly on these.

## 3. Benefits

3.1 The benefits of focusing on behaviour and culture change to improve patient and colleague experience was documented in the previous Trust Board report and are widely recognised. It is important now to ensure that the expectations laid out in the framework are widely known, accepted and embraced.

3.2 It is timely to remember 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 The continued integration and embedding of this programme of work will have a pivotal impact in creating the desired culture and the journey to becoming an 'outstanding' organisation.

**4. Progress to Date**

4.1 The Framework was launched at the Festival of Inclusion in September 2021. A Behaviour Framework Resource Hub was designed and launched providing information and resources to help colleagues and managers to understand and use the Framework and continues to be a work in progress with new resources being developed and added.

4.2 The working group members, Behaviour Framework Champions along with HR colleagues have attended Directorate and Divisional meetings to promote the new Framework and ask colleagues to:

- review the Behaviour Framework and reflect on their own strengths and areas for development
- use the Framework to support 1:1 conversations with colleagues in holding each other to account
- use the Framework 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.

4.4 There has been some success so far and the Framework is being used to start conversations and is welcomed by colleagues, enabling them to hold peers to account to create a more compassionate and inclusive working environment.

4.5 However, it is fair to say, amidst significant operational, covid related and winter pressures, engagement with the framework has not been consistently high.

4.6 The planned Trust wide communications campaign has also been challenging, again due to the level of other, operationally critical communications that have rightly been prioritised over the last few months. However, with the support of the Executive Director of Communications and Engagement, a new communication and engagement plan has been developed and launched recently. It is intended that this

will ensure the Framework remains visible, at the forefront of colleagues' minds and becomes integral to everything the Trust does.

4.7 To support this, Tony McDonald, Executive Director of Integrated Care, Partnerships and Resilience used the April Trust Briefing to remind all colleagues of the importance of the Framework, as well as other work that has been done and what else colleagues can expect to see over the coming weeks and months. This includes:

- **Podcasts** with colleagues from different roles, teams and Divisions across the Trust on which they discuss why they think setting behaviour expectations is important and what it means to them in their role or team. Each podcast relates to an element of the Framework – Excellence, Keeping it Simple, Building Trust and Respect, Working Together and Taking Responsibility.
- **Acknowledgement cards** which are a way for colleagues to pass to thank and acknowledge others for displaying positive behaviours (listening, positivity, support, innovation, adaptability and role modelling).
- **Star Awards** nomination criteria have been extended to include Behaviour expectations, another example of using the Framework to highlight, acknowledge and reward the positive behaviours we expect.
- **Appraisal** documentation has been updated to include a conversation about behaviours, giving everyone the opportunity to reflect upon their own performance and identify areas for development.
- **Training** for managers in having Difficult Conversations has been developed and launched. This was done in response to requests from managers who want to develop the skills and approach needed to appropriately challenge unhelpful behaviours and resolve conflict and disagreements informally, quickly and professionally.
- **Work with Teams** following requests for support from managers to facilitate conversations about the Framework, why is it important, identifying what positive behaviours at work look like and what poor behaviours teams need to change and challenge. Ultimately the aim is for teams to create their own Behaviour Framework team agreement.

## 5. Next steps

5.1 The following activities are prioritised for the next 6-12 months, at which point the cultural survey will be re-run to evaluate progress and determine next steps:

- Behaviour Framework pop-up Hubs organised across Trust sites to encourage engagement and understanding on our behaviours
- Launch of the re-branded ‘This is how we do it around here’ promotional materials
- On-going development of resources and toolkits for the Resource Hub
- Embed the Behaviour Framework into the Trust and local Induction processes
- Embed into new leadership and development programme
- Articulate our behaviour expectations to our patients, explain why this is important to the Trust and be clear of what they can expect to see
- Design a simple feedback tool for teams to use, to seek customer feedback on their experience, based on our behaviours
- Further review reward and recognition approaches and recognition for displaying our behaviours with colleagues, patients and customers
- Review 2022 Staff Survey results to identify early impact
- Re-analyse patient complaints and compliments to determine any change in patient experience

## 6. Measures of Success

6.1 As with all culture change work, measuring the specific impact of the Behaviour Framework is multifaceted and so several methods will be used to measure overall impact including:

- Patient complaints and compliments
- Reduction in formal resolutions relating to behaviour
- Reduction in disciplinary cases relating to behaviour
- Reduction in interventions by the Staff Guardian team relating to behaviour
- Feedback from ‘Moving on’ surveys when colleagues leave the organisation
- Feedback from the second cultural survey in Autumn 2022

6.2 The results of the annual Staff Survey provide an opportunity for us to measure levels of staff satisfaction. These will also be used as one of the measures to determine the impact of the Behaviour Framework. The launch of the Framework in September 2021 was almost immediately followed by the launch of the Staff Survey, so it is unrealistic to expect this to have a positive impact so quickly. The results from the 2021 Staff Survey

do, however, provide a useful benchmark against which to measure impact in the future. Shown below are results by levels of disagreement for the whole Trust.

A number of key questions have been chosen against which responses from the 2022 (published 2023) survey results will be compared.

6.3 The results from the 2021 Staff Survey, also provide useful feedback to use with Divisional teams and in our communications and engagement to show where adopting the behaviours in the Framework could have a positive impact on staff satisfaction and in turn, on the services we deliver to our patients and service users.

| Question | Level of *disagreement* | Behaviour Framework Expectations |
|---|---|---|
| Satisfied with recognition for good work | 49.05% | Recognise and value others; give praise, say thank you |
| Satisfied with extent organisation values my work | 56.00% | 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 |
| Relationships at work are unstrained | 55.25% | Reflect on your behaviours and how this might impact on others<br>Aim to resolve issues informally before escalating |
| Receive the respect I deserve from my colleagues at work | 29.76% | Respectful and considerate in language and action |
| Enjoy working with colleagues in team | 17.83% | Think about others' pressures and support them where needed; be willing to help<br>Support each other when things are challenging |
| Team deals with disagreements constructively | 45.05% | Resolve conflict and disagreements quickly and professionally |
| Feel valued by my team | 31.70% | Recognise and value others; give praise, say thank you<br>Seek out, listen to and value others' ideas and opinions |
| Colleagues are understanding and kind to one another | 30.73% | Compassionate, inclusive, caring and empathetic towards colleagues, patients and their families<br>Seek out, listen to and value others ideas and opinions |
| Colleagues are polite and treat each other with respect | 28.72% | Positive, polite, professional and friendly -approach to all colleagues, patients and visitors to our Trust |
| Colleagues show appreciation to one another | 33.58% | Celebrate team successes and create a positive team spirit<br>Recognise and value others; give praise, say thank you |
| Immediate manager encourages me at work | 31.94% | Coach, mentor and challenge others to reach their potential, encouraging an organisational learning approach<br>Think about others' pressures and support them where needed; be willing to help |
| Immediate manager asks for my opinion before making decisions that affect my work | 46.07% | Seek out, listen to and value others' ideas and opinions<br>Listen to patients, colleagues and stakeholders in order to understand the impact that decisions have on them |
| Immediate manager takes a positive interest in my health & well-being | 35.60% | Appreciate the importance of rest and relaxation and the need to switch off from work and avoid burnout |

| | | Offer support if you recognise a colleague is struggling |
|---|---|---|
| Immediate manager values my work | 31.68% | Recognise and value others; give praise, say thanks<br>Lead by example and role model our Trust values |
| Not experienced harassment, bullying or abuse from managers | 8.84% | Lead a culture of honesty, respect, fairness and trust by being inclusive in approach<br>Challenge disrespectful or discriminatory behaviour or language |
| Not experienced harassment, bullying or abuse from other colleagues | 14.12% | Reflect on your behaviours and how this might impact on others<br>Respectful and considerate in language and action |
| Not experienced discrimination from manager/team leader or other colleagues | 6.59% | Ensure that inclusion is at the heart of everything<br>Respectful and considerate in language and action |
| Feel organisation respects individual differences | 25.95% | Work well with people who have different ideas, perspectives and backgrounds<br>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 |
| Would recommend organisation as place to work | 35.20% | |
| I don't often think about leaving this organisation | 53.03% | |
| I am unlikely to look for a job at a new organisation in the next 12 months | 44.80% | |
| I am not planning on leaving this organisation | 53.63% | |
| Often/always look forward to going to work | 46.28% | |

## 7. Recommendation

7.1 The Trust Board is asked to:

- Continue to embrace, support and role model our 5 Behaviours
- Help to integrate 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 12 months.

**Lorraine Atherton. Workforce Innovation & Design Manager**

**Jo Hargreaves. Senior HR Business Partner**

# TRUST BOARD REPORT

| | |
|---|---|
| **11 May 2022** | **65** |
| | **Purpose** Information |

| | |
|---|---|
| **Title** | National Staff Survey Report 2021/22 |
| **Author** | Mrs L Barnes, Associate Director Staff Wellbeing & Engagement |
| **Executive sponsor** | Mr K Moynes, Executive Director of Human Resources and Organisational Development |

**Summary:** Colleagues are asked to note the 2021 National Staff Survey summary report, key findings identified, actions taken since the publication and next steps.

**Report linkages**

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

**Impact**

| | | | |
|---|---|---|---|
| Legal | Yes | Financial | Yes |
| Equality | Yes | Confidentiality | No |

Previously considered by:

- Trust Board part 2 March 2022
- Employee Engagement Sponsor Group March 2022
- Joint Quality, Finance and Performance Committee April 2022

(65) 2021 National Staff Survey Summary Report

## Executive summary

1 This report summarises the findings from the 2021 NHS Staff Survey for East Lancashire Hospitals Trust (ELHT). Board members are asked to note the 2021 national staff survey report, the key findings identified, actions taken since the publication and support the next steps in our continuous drive to improve employee experience and engagement throughout 2022.

## Background

2 The NHS Staff Survey is an official statistic ran to the highest standards of quality and accuracy. It is one of the world's largest workforce surveys and is considered the key performance indicator of staff experience and engagement in the NHS. Over 1.3 million NHS employees in England were invited to participate in the survey between September and December 2021 and 648,594 staff responded (up from 595,270 in 2020).

3 The refresh of the survey for 2021 was the most significant change for at least a decade. From 2021 the questions in the NHS Staff Survey are aligned to the People Promise. The move to link questions to the NHS People Promise themes means comparison with 2020 data is very limited.

4 Seven of the overall themes are new and cannot be compared with previous years. Of the two themes that have been retained, morale and staff engagement, both scores worsened nationally across the NHS. Also, where questions can be compared between 2020 and 2021, they generally worsened nationally across the NHS and there were notable increases in work pressure, increased negative staff experiences, and a decline in health and wellbeing measures nationally.

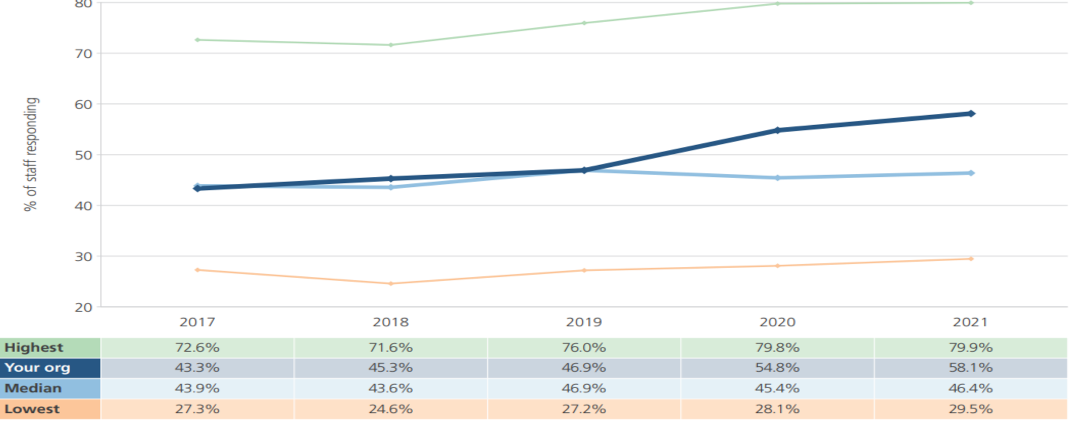
### Introduction to the ELHT 2021 NHS Staff Survey results

5 For reference the full 2021 ELHT NHS Staff Survey report can be viewed via appendix 1 and the 2021 NHS Staff Survey report for Healthier Lancashire and South Cumbria can be viewed via appendix 2.

6 The Trust undertook a full census in 2021 and a total of 9062 staff were eligible to complete the survey. 5265 staff returned a completed questionnaire, giving a response rate of 58% which is significantly above the average of 46% for Combined Acute and Community Trusts in England, and compares with a response rate of 55% (4795) in the ELHT 2020 survey.

7 This is an increase of 3% from the previous year's response rate and an indicator that staff engagement through employee voice has improved within the last 12 months and taking a longer-term analysis it can be seen that the response rate has significantly improved as a trend over the last 5 years by 14.8%.

**Figure 1 below details the response rate trend over the last 5 years:**




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Highest | 72.6% | 71.6% | 76.0% | 79.8% | 79.9% |
| Your org | 43.3% | 45.3% | 46.9% | 54.8% | 58.1% |
| Median | 43.9% | 43.6% | 46.9% | 45.4% | 46.4% |
| Lowest | 27.3% | 24.6% | 27.2% | 28.1% | 29.5% |

Figure 2 below details the return rate by division and compares with 2020 response rates. **Figure 2: Return rate by division:**

| **Locality** | **Response rate 2020** | **Response rate 2021** |
|---|---|---|
| Corporate Services | - | 75.7% |
| Diagnostics & Clinical Support | 60% | 64.4%↑ |
| Estates and Facilities | 64% | 64.1%↑ |
| Family Care | 56% | 54.2%↓ |
| Medicine & Emergency Care | 42% | 47.1%↑ |
| Community & Intermediate Care Services | 46% | 51.6%↑ |
| Education, Research & Innovation | - | 78.6% |
| Surgical and Anaesthetics Services | 53% | 57.8%↑ |
| **Trust Overall** | **55%** | **58.1%**↑ |

**Summary of Themes**

8 The National Staff Survey Benchmark report for East Lancashire Hospitals Trust contains results for themes and questions from the 2021 NHS Staff Survey, and historical results back to 2017 where possible. These results are presented in the context of the best, average and worst results for similar organisations where appropriate. Data in this report is weighted to allow for fair comparisons between organisations (see appendix 1 for the full report).

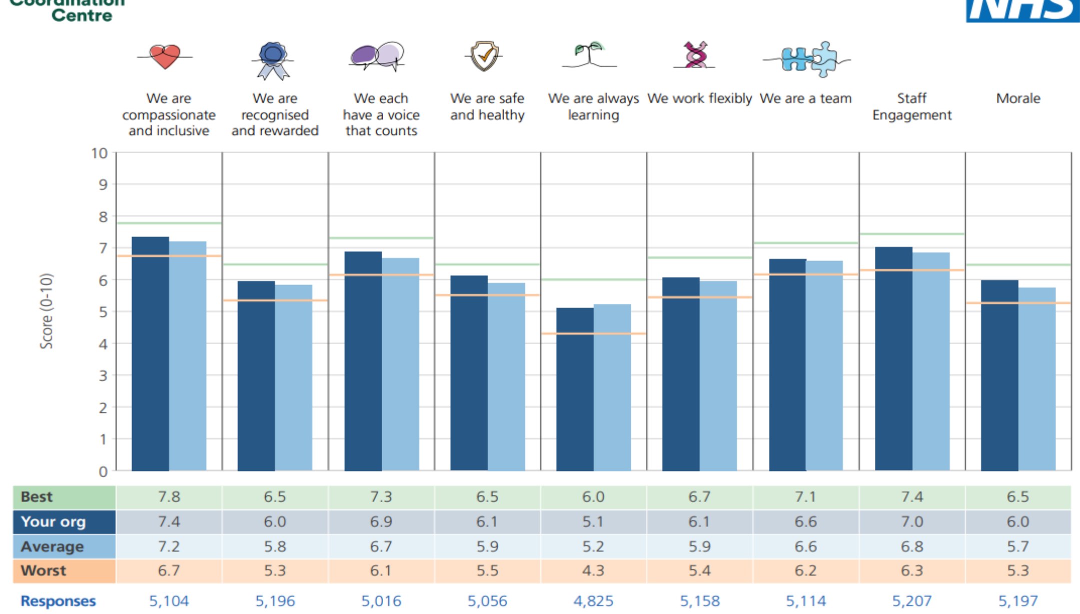
9 For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. In support of this, the results of the NHS Staff Survey are now measured against the seven People Promise elements depicted in the graphic below and against two of the themes reported in previous years (Staff Engagement and Morale).

10 The nine themes are scored consistently on a 0-10pt scale with 10 being the best possible score. As in previous years the question level data is presented in percentage scores.

11 The Trust staff satisfaction responses scored above average for 7 of the 9 themes when compared with all Combined Acute and Community Trusts.

12 The Trust staff satisfaction responses scored average for 1 of the 9 themes when compared with all Combined Acute and Community Trusts, which was “we are a team”.

13 The Trust staff satisfaction responses scored below average for 1 of the 9 themes when compared with all Combined Acute and Community Trusts, which was “we are always learning”. **Figure 3 below outlines the theme results:**




| | We are compassionate and inclusive | We are recognised and rewarded | We each have a voice that counts | We are safe and healthy | We are always learning | We work flexibly | We are a team | Staff Engagement | Morale |
|---|---|---|---|---|---|---|---|---|---|
| Best | 7.8 | 6.5 | 7.3 | 6.5 | 6.0 | 6.7 | 7.1 | 7.4 | 6.5 |
| Your org | 7.4 | 6.0 | 6.9 | 6.1 | 5.1 | 6.1 | 6.6 | 7.0 | 6.0 |
| Average | 7.2 | 5.8 | 6.7 | 5.9 | 5.2 | 5.9 | 6.6 | 6.8 | 5.7 |
| Worst | 6.7 | 5.3 | 6.1 | 5.5 | 4.3 | 5.4 | 6.2 | 6.3 | 5.3 |
| Responses | 5,104 | 5,196 | 5,016 | 5,056 | 4,825 | 5,158 | 5,114 | 5,207 | 5,197 |

## Statistically significant changes

14 Figure 4 below presents the results of significance testing conducted on the theme scores calculated in both 2020 and 2021*. Note that results for the People Promise elements are not available for 2020. The table details the organisation's theme scores for both years and the number of responses each of these are based on. The final column contains the outcome of the significance testing: indicates that the 2021 score is significantly higher than last year's, whereas indicates that the 2021 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

15 The table below demonstrates 2 themes with statistically significantly lower scores when tested using a two-tailed t-test with a 95% level of confidence. The themes demonstrating the significantly lower scores compared to last year are: staff engagement & morale.

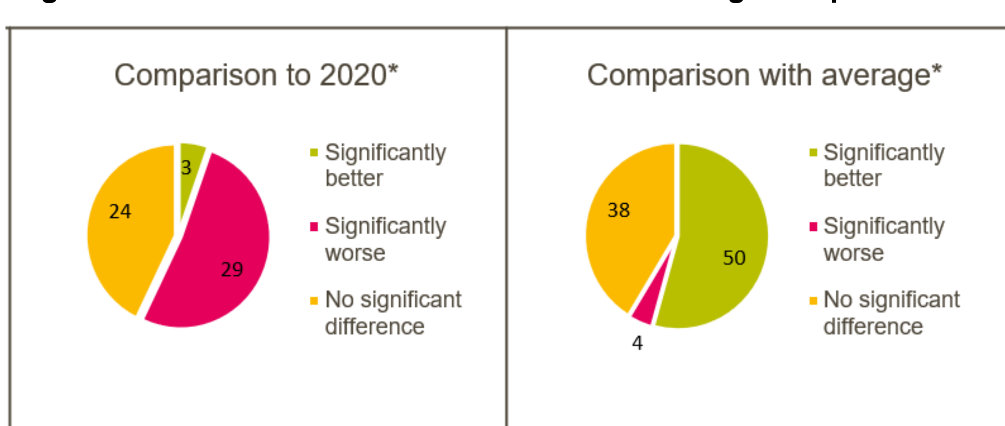
**Figure 4: Significance testing – 2020 v 2021 theme results:**

| People Promise elements | 2020 score | 2020 respondents | 2021 score | 2021 respondents | Statistically significant change? |
|---|---|---|---|---|---|
| We are compassionate and inclusive | | | **7.4** | 5104 | N/A |
| We are recognised and rewarded | | | **6.0** | 5196 | N/A |
| We each have a voice that counts | | | **6.9** | 5016 | N/A |
| We are safe and healthy | | | **6.1** | 5056 | N/A |
| We are always learning | | | **5.1** | 4825 | N/A |
| We work flexibly | | | **6.1** | 5158 | N/A |
| We are a team | | | **6.6** | 5114 | N/A |
| **Themes** | **2020 score** | **2020 respondents** | **2021 score** | **2021 respondents** | **Statistically significant change?** |
| Staff Engagement | **7.2** | 4733 | **7.0** | 5207 | ↓ |
| Morale | **6.3** | 4704 | **6.0** | 5197 | ↓ |

**Question level comparisons**

16 A total of 117 questions were asked in the 2021 survey. 56 questions can be compared historically between 2020 and 2021. The historical comparison pie chart below demonstrates that 3 questions scored significantly better, 24 questions no significant difference and 29 questions significantly worse when compared with ELHTs 2020 questions. When compared with the Picker average 50 questions scored significantly better, 38 questions scored average and 4 questions significantly worse.

**Figure 5: Question level historical and Picker average comparison:**




**Comparison to 2020 (ELHT v ELHT)**

17 The 3 questions ELHT scored significantly better compared to 2020 historical comparisons are:
- ✓ q3c Opportunities to show initiative frequently in my role.
- ✓ q14b Not experienced harassment, bullying or abuse from managers.
- ✓ q14c Not experienced harassment, bullying or abuse from other colleagues.

18 The 29 questions ELHT scored significantly worse compared to 2020 historical comparison are:
- ✗ q2a Often/always look forward to going to work.
- ✗ q2b Often/always enthusiastic about my job.
- ✗ q2c Time often/always passes quickly when I am working.
- ✗ q3f Able to make improvements happen in my area of work.
- ✗ q3g Able to meet conflicting demands on my time at work.
- ✗ q3i Enough staff at organisation to do my job properly.
- ✗ q4a Satisfied with recognition for good work.
- ✗ q4b Satisfied with extent organisation values my work.
- ✗ q4c Satisfied with level of pay.
- ✗ q4d Satisfied with opportunities for flexible working patterns.
- ✗ q5a Have realistic time pressures.
- ✗ q5b Have a choice in deciding how to do my work.
- ✗ q5c Relationships at work are unstrained.
- ✗ q6a Feel my role makes a difference to patients/service users.
- ✗ q9d Immediate manager takes a positive interest in my health & well-being.
- ✗ q10b Don't work any additional paid hours per week for this organisation, over and above contracted hours.
- ✗ q10c Don't work any additional unpaid hours per week for this organisation, over and above contracted hours.
- ✗ q11c In last 12 months, have not felt unwell due to work related stress.
- ✗ q11d In last 3 months, have not come to work when not feeling well enough to perform duties.
- ✗ q15 Organisation acts fairly: career progression.
- ✗ q21a Care of patients/service users is organisation's top priority.
- ✗ q21b Organisation acts on concerns raised by patients/service users.
- ✗ q21c Would recommend organisation as place to work.

- q21d If friend/relative needed treatment would be happy with standard of care provided by organisation.
- q21e Feel safe to speak up about anything that concerns me in this organisation.
- q22a I don't often think about leaving this organisation.
- q22b I am unlikely to look for a job at a new organisation in the next 12 months.
- q22c I am not planning on leaving this organisation.
- q28b Disability: organisation made adequate adjustment(s) to enable me to carry out work.

**Actions taken so far**

19 The following actions have been taken since the publication of the staff survey:

- Our national staff survey findings have been communicated throughout the Trust following the lifting of the national embargo.
- Findings and further information and data is available to all staff on our dedicated national staff survey share-point page for further interrogation at a team level.
- National staff survey feedback workshops were completed for all divisions to help managers better understand their data to identify strengths and challenges facilitated by the Picker Institute and the Well Team.
- The findings and perspectives from colleagues were discussed at the Employee Engagement Sponsor Group chaired by the Chief Executive in March 2022 and the Joint Quality, Finance and Performance Committee in April 2022.
- Our trust-wide timetable of divisional and network Big Conversations has been agreed and commenced with colleagues from March-June to support a participative approach to enhance staff experience and engagement action planning for 2022.
- Divisional leaders host Big Conversations throughout these months which we ask all staff to support and participate in. Divisional results are presented, and senior leaders listen to suggestions to help them develop robust divisional action plans to improve what matters most to staff.
- Our staff wellbeing & engagement champions have been feeding back information, issues and ideas to enhance staff experience, wellbeing and engagement from their teams to support improvements at a team level.
- The Freedom to Speak Up Guardians and Inclusion Lead have been triangulating data to better understand the experience of our diverse workforce to ensure we address any inequalities with help by the participation and support of our staff networks.

**Next Steps**

20 Divisional leaders will present their co-produced action plans based on the survey data aligned to the NHS People Plan, People Promise and crucially feedback from the Big Conversations.
The agreed divisional and corporate action plans will be discussed and approved at the June 2022 Employee Engagement Sponsor Group. Divisions will report progress made towards achieving their objectives and sharing best practice and together we will commit to driving forward our actions collectively to further improve employee engagement and experience throughout 2022 and beyond.

**Lee Barnes**

**Associate Director Staff Wellbeing & Engagement ELHT 13.04.22**

# ELHT Quality Strategy

2022 – 25 (Draft Version 2.0)

Insert new branding and pictures here – (to include photos of the Quality Teams...)

Safe | Personal | Effective

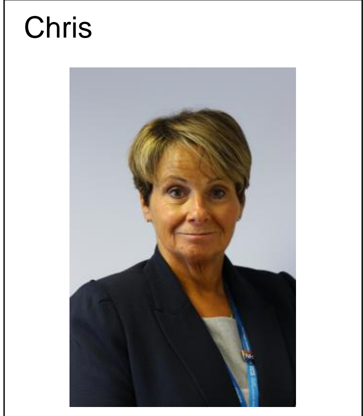
# Contents – to be completed once agreed at Quality Committee (30.03.22)

# Our Commitment

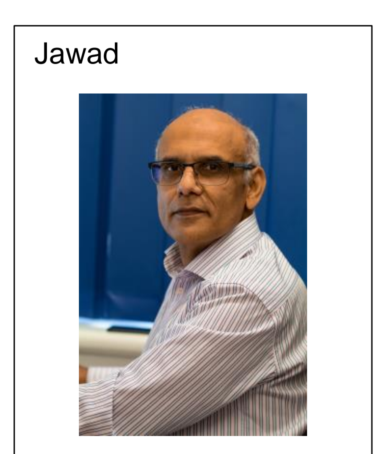
## 1. Trust Statement

Commitment to be added from Jawad/Chris P following Quality Committee

Chris



Jawad



Christine M Peace.

## 2. East Lancashire Hospitals NHS Trust – Who are we?

**Insert Picture of Trust (example only above)**

East Lancashire Hospitals NHS Trust (ELHT) was established in 2003 and is a large integrated health care organisation providing high quality acute secondary healthcare for the people of East Lancashire and Blackburn with Darwen (collectively called Pennine Lancashire) as well as a range of tertiary services for the wider population of Lancashire and South Cumbria.

Our population includes patients who live in several of the most socially deprived areas of England. We aim to deliver high quality, high value care and contribute to a health gain for our community. Located in Lancashire in the heart of Northwest England, with Bolton and Manchester to the South, Preston to the West and the Pennines to the East we have a combined population of approximately 530,000.

We employ over 9,600 staff, some of whom are award winning and internationally renowned for their work and achievements. We treat over 700,000 patients a year from the most serious of emergencies to planned operations and procedures.

Our high-quality healthcare services are offered across five hospital sites, and various community locations, using state-of-the-art facilities. In addition, our patients are also offered a range of specialist hospital services which are provided either by the Trust, neighbouring Trusts, with some being delivered in Manchester. Most of the Trust's services are funded by NHS East Lancashire and Blackburn with Darwen Clinical Commissioning Groups (CCGs) and NHS England. The Trust continues to work alongside our commissioners and local authorities to deliver the best possible care in the most appropriate locations for the people of East Lancashire.

Quality underpins the vision of East Lancashire Hospitals NHS Trust (ELHT) which is to be "widely recognised for providing safe, personal and effective care." This has been demonstrated in the Trust's continued progress and being rated 'Good with areas of outstanding' by the Care Quality Commission (CQC). This Quality Strategy will enhance the safety and effectiveness of care, whilst continuing to improve patient experience and outcomes over the next three years (2022 - 25).

## 3. Our ELHT Vision and Values – What guides us?

This Quality Strategy is an enabling Strategy that supports the delivery of our overall Trust Strategy, which is summarised in our Strategic Framework:

This Quality Strategy sets out our plans and commitment for the next three years, to support the achievement of our Trust goals and the delivery of safe, high-quality care.

## Putting Quality at the heart of everything we do – Delivering Safe, Personal and Effective Care.

Our quality commitments focus on initiatives that will:

- **Provide Safe care** - Reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information.

- **Provide care that is Personal** – Deliver patient centred care which involves patients, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety.

- **Provide Effective care** – Deliver consistently effective and reliable care, based on best practice which is delivered in a culture that encourages and enables innovation to Improve outcomes.

The experiences of our colleagues and our patients will continue to be the most important measure of our progress.

It is the delivery of this Strategy, together with the supporting strategies of patient experience, risk management, clinical effectiveness and our sustainability plans that will ensure that we act with kindness as role models in line with our newly developed Behavioural Framework; to deliver safe, personal, and effective health and care services for the local population of Pennine Lancashire and beyond.

The Quality Strategy will support the delivery of the Trust's Clinical and People Strategies, as a core focus within the overarching Strategic Framework. This framework further supports and links to the priorities of Lancashire and South Cumbria Integrated Care Board (ICB), and the Pennine Lancashire Place-based Partnership (PBP).

## Behavioural Framework

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 behavioural 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 our ELHT colleagues and it supports the delivery of our strategic priorities, values, and culture.

## It's about **how** we all work

Trust goals, objectives and vision

Values

Behaviours and attitudes

Patient experience and satisfaction

Staff wellbeing and experience

Partnership working

Performance

Culture (the way we do things)

Progress / continuous improvement

## NHS National Patient Safety Strategy

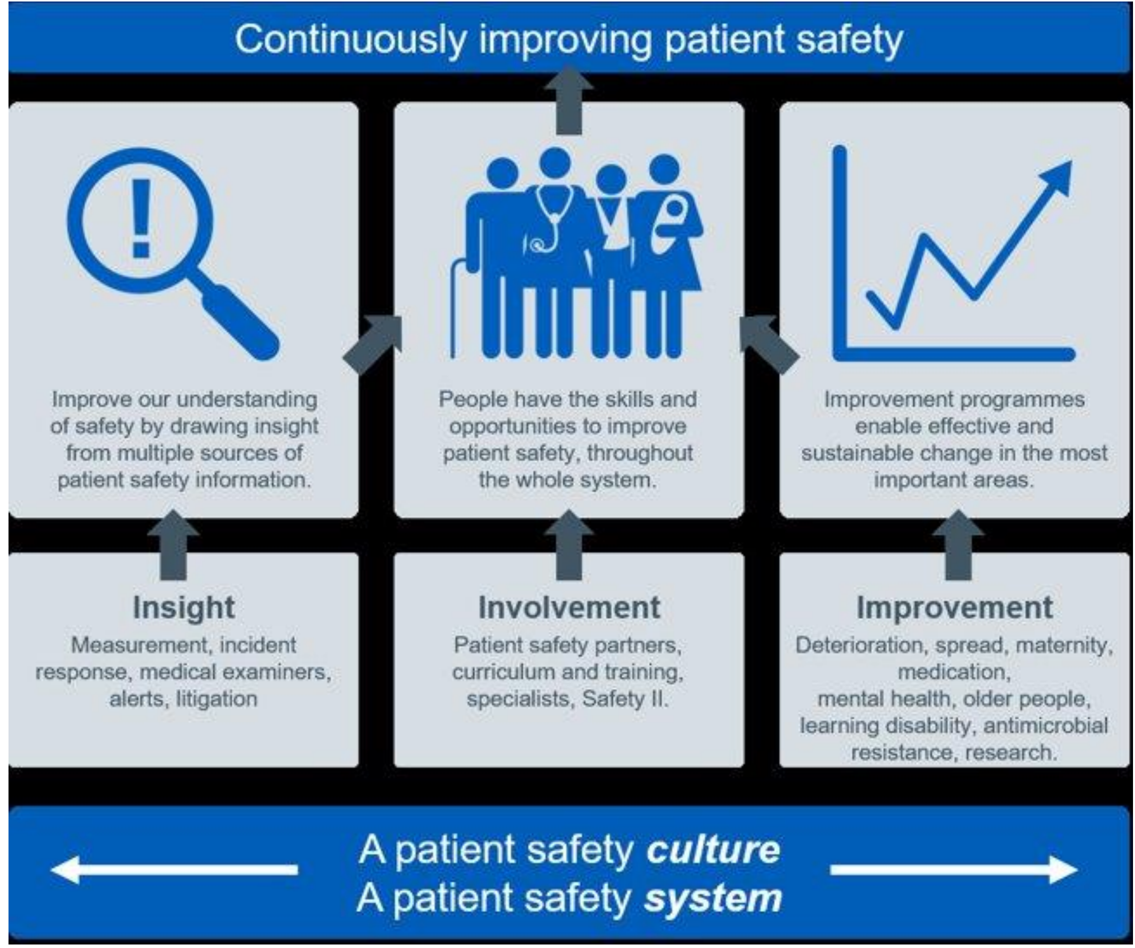
The ELHT vision aligns directly with the principles of the NHS National Patient Safety Strategy - NPSS (2019). The National Patient Safety Strategy (NHS England 2019) focuses on three key aims.

1. **Improve our understanding of safety by drawing insight from multiple sources of patient safety information**

2. **People have the skills and opportunities to improve patient safety, throughout the entire system**

3. **Improvement programmes enable effective and sustainable change in the most important areas.**

Our Quality Strategy is based on the exact same three aims, with an explicit link to our Quality Improvement programme.




**A visual summary of the NHS National Patient Safety Strategy**

The commitments contained within this strategy reflect the link between quality, staff experience and organisational culture; learning, and the link between learning and improvement being driven through patient involvement and feedback from the wider population and our system partners.

## Strengthening Our Partnership Working

Working in partnership across the Pennine Lancashire Place Based Partnership (PBP), the Lancashire and South Cumbria Provider Collaborative Board (PCB) and wider Lancashire and South Cumbria Integrated Care System/Board (ICS/ICB) has been a fundamental part of our improvement journey so far and will continue to underpin all our work as we continue that journey.

Our drive to improve the quality of care delivered across our communities will see the Trust work increasingly though partnerships across our localities. We will further develop our role as part of an integrated offer, working more closely with our commissioners and with other local providers, including GPs, Community and Mental Health Trusts, and colleagues in Social Care.

This drive to improve care through collaboration is reflected through the recent Integration and Innovation White Paper, which outlines the requirements for system working. We will work as part of a joined-up system across Lancashire and South Cumbria ICB contributing to and learning from best practice across the region and working to ensure equity of care for our communities.

National/Regional

Lancashire and South Cumbria Integrated Care System/Board

Lancashire and Cumbria Provider Collaborative Board

Pennine Lancashire Place-based Partnership and Communities

East Lancashire Hospitals NHS Trust

**Key new priority workstreams across Place and System are shown below:**

| | |
|---|---|
| Pennine Lancashire Place Based Partnership | • Population health<br>• Children, Young People and Maternity<br>• Primary care and community-based services delivered in neighbourhoods, including long-term condition management and social care<br>• Urgent and emergency care (via an A&E Delivery Board*)<br>• Intermediate Care<br>• Elective Care, Cancer, and Diagnostics (overseeing Restoration and Recovery work)<br>• Care Sector (including regulated care and wider care)<br>• Mental Health<br>• Learning Disabilities and Autism |
| Lancashire and South Cumbria Provider Collaborative Board | • MSK/T&O<br>• Frailty<br>• Respiratory<br>• Cardiac/Circulatory<br>• Mental Health and Physical Health Integration |
| Lancashire and South Cumbria Integrated Care System/Board | • Health and Wellbeing of our Communities<br>• Living Well<br>• Managing Illness<br>• Urgent and Emergency Care<br>• End of Life Care, including Frailty and Dementia |

## 4. Looking to the Future - ELHT Quality Commitments for 2022-25

In order to refocus our refreshed Quality Strategy, we have reviewed the previous strategy commitments and associated achievements which are summarised at the end of this Strategy.

This revised Quality Strategy will be supported by several underpinning frameworks. These frameworks will outline in detail the implementation plan for each of the commitments outlined below.

**Insight / Safe** - Patient Safety Incident Response Framework
**Involvement / Personal** - Patient Experience Framework
**Improve / Effective** - Clinical Effectiveness Framework
**Improve +** - Improvement Framework

**Quality Strategy 2022-25 Commitments**

These commitments were identified and developed through a series of workshops with key stakeholder groups (July – September 2021) and agreed in December 2021, following a full review of quality datasets (quantitative and qualitative) from 2018-2021.

Membership of these workshops included representatives from:

- Public Participation Panel
- Local Carers Groups
- Healthwatch
- Local Authority
- East Lancashire Clinical Commissioning Group
- Executive and Non-Executive Board Members
- Divisional Senior Leadership Teams
- A cross section of all staff from Clinical Divisions and Corporate Teams

| Insight / Safe | |
|---|---|
| 1. | To implement the **Patient Safety Incident Response Framework** as an Early Adopter (including **PSIRP priorities** and **Patient Safety Specialists**) |
| 2. | To strengthen a **patient safety culture**, in partnership with the **Workforce plan** and the roll out of the ***Just Culture*** approach |
| 3. | To strengthen the **analysis of data** to support and measure quality through improved systems and accessible dashboards |

| Involve / Personal | |
|---|---|
| 1. | To **increase the influence** of patient or public through representation in Trust governance and service development meetings. To help shape the development of patient safety and experience initiatives. |
| 2. | To **widen the engagement** of patients and public to guarantee we have a diversity of opinion and collaborate with patient representative groups to create greater consistent system wide approach to patient experience. |
| 3. | To pro-actively help the Trust **identify and minimise the impact of health inequalities** with ELHT's footprint and hold the Trust to account on the delivery / timeliness of patient experience initiatives. |
| 4. | To introduce **Patient Safety Partners** in line with the PSIRF |

| Improve / Effective | |
|---|---|
| 1. | To coordinate **clinical skills development** / training through the DERI team |
| 2. | To provide a portfolio of training aimed at **developing quality governance skills** at all levels |
| 3. | To improve the **visibility of Clinical Audit Results** by developing an internal registry |
| 4. | To develop and **embed GIRFT processes** to drive improvement priorities from learning |

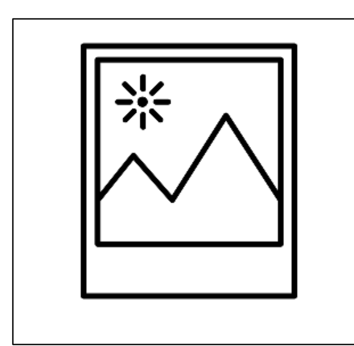
| Improve+ | |
|---|---|
| 1. | To improve outcomes against identified Trust and wider system improvement priorities using an evidence-based and consistent improvement method and tools (SPE+ Improvement Practice). |
| 2. | To develop skills and confidence of staff across the Trust and wider system to apply the Improvement Practice to secure the best possible outcomes |
| 3. | To embed improvement in all that we do as part of our organisational management system |

Our 2022-25 **Insight / Safe** Commitments:

- **NPSS definition - Insight:** *Improving understanding of safety by drawing intelligence from multiple sources of patient safety information*
- **ELHT definition - Safe:** *Reduce harm, prevent errors, and deliver consistently safe care*

| **Aim:** | **Objectives:** |
|---|---|
| We will complete the early adoption of the Patient Safety Incident Response Framework | **1.** Focus investigation resource on National and Local priorities for organisational learning<br><br>**2.** Introduce a portfolio of Patient Safety Responses to enable investigation for early learning within the Divisions<br><br>**3.** Strengthen the link between learning from investigations and improvement work |
| | |
| We will embed the Patient Safety Specialist role | **1.** Strengthen the Patient Safety culture through linking incident reporting and investigation to the Just Culture approach<br><br>**2.** Supporting the Trust's systems for planning and coordinating the actions required by National Patient Safety Alerts<br><br>**3.** Implement a suite of Patient Safety training from leadership training to Induction |
| | |
| We will review the data system (Datix) currently used to manage incidents and risk | **1.** Improve the quality of incident reporting<br><br>**2.** Improve data analysis, triangulation, visibility, and reporting through the standardisation of Quality dashboards |

**Insert picture(s) or evidence here**



| Aim: | Objectives: |
|---|---|
| We will implement organisational learning and improved performance in line with key local priorities. | These priorities below (1-5) will form the focus of the Patient Safety Incident Response Plan (PSIRP). This plan requires a full incident investigation of the next 5 reported incidents in each category. Thematic review of the learning from each case will then inform an organisational improvement plan, utilising the SPE+_ improvement approach, for each of the 5 areas.<br><br>1. **Treatment problem/issue, Diagnosis failure/problem & Radiology -** 104-day cancer breaches<br>2. **Vulnerable Adults** - Nutrition (Nil by Mouth)<br>3. **Communication with patients and families** - DNACPR, TEP (Treatment Escalation Plans), EOL (End of Life Care)<br>4. **Falls** - Fractured Neck of Femur<br>5. **Emergency Department** -Transfers & patient flow, Inappropriate Handovers, NEWS2 (National Early Warning Score Observations), Delays in treatment & Concern around care given<br><br>Routine investigation of incidents resulting in harm will be conducted using a portfolio of tools, including round tables, clinical reviews, timeline analysis. These will be coordinated within the divisions and reported/monitored at the Patient Safety Group. |

**Key enabler: Patient Safety Specialists**

As part of the introduction of the National Patient Safety Strategy, in November 2021 we established Patient Safety Specialist roles as part of our Quality Governance team and in December 2021 we transferred from the Serious Incident Framework (2015) as an Early Adopter for the Patient Safety Incident Framework (PSIRF). This will be a key enabler to achieving these commitments.

- Ensuring a Just culture is embedded within the Trust
- Supporting the Trust's systems for planning and coordinating the actions required by National Patient Safety Alerts
- Improving quality of incident reporting
- Supporting the Trust's transition from the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) to the new Learn from patient safety events (LFPSE) service for recording patient safety events
- Involvement in local implementation of the Patient Safety Incident Response Framework
- Supporting local implementation of the Framework for Involving Patients in Patient Safety

Our 2022-25 **Involvement / Personal** Commitments:

- **NPSS definition - Involvement:** *Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system*
- **ELHT definition - Personal:** *Deliver patient centred care / To influence, challenge, strengthen and promote consistently safe, high quality, reliable, accessible, and equitable patient care and outcomes*

| **Aim:** | **Objectives:** |
|---|---|
| To increase the influence of patients, families/carers, and the local community | **1.** To implement the 'Patient Safety Partner' role as a representative on governance and service development meetings.<br>**2.** To ensure patient, family/carers, public are enabled to help shape the development of patient safety and experience initiatives<br>**3.** To further embed the Public Participation Panel to influence service development opportunities |
| | |
| To widen the engagement of patients and the public | **1.** To enable a diversity of opinion to be represented in engagement opportunities<br>**2.** To collaborate widely with patient representative groups from across the local community |
| | |
| To reduce the impact of health inequalities | **1.** To integrate data collection fields into patient safety systems to enable the Trust to identify any themes of harm affecting particular groups<br>**2.** To introduce visible reporting against key performance indicators in line with key characteristics to enable the Trust to improve the accessibility of services to key groups |

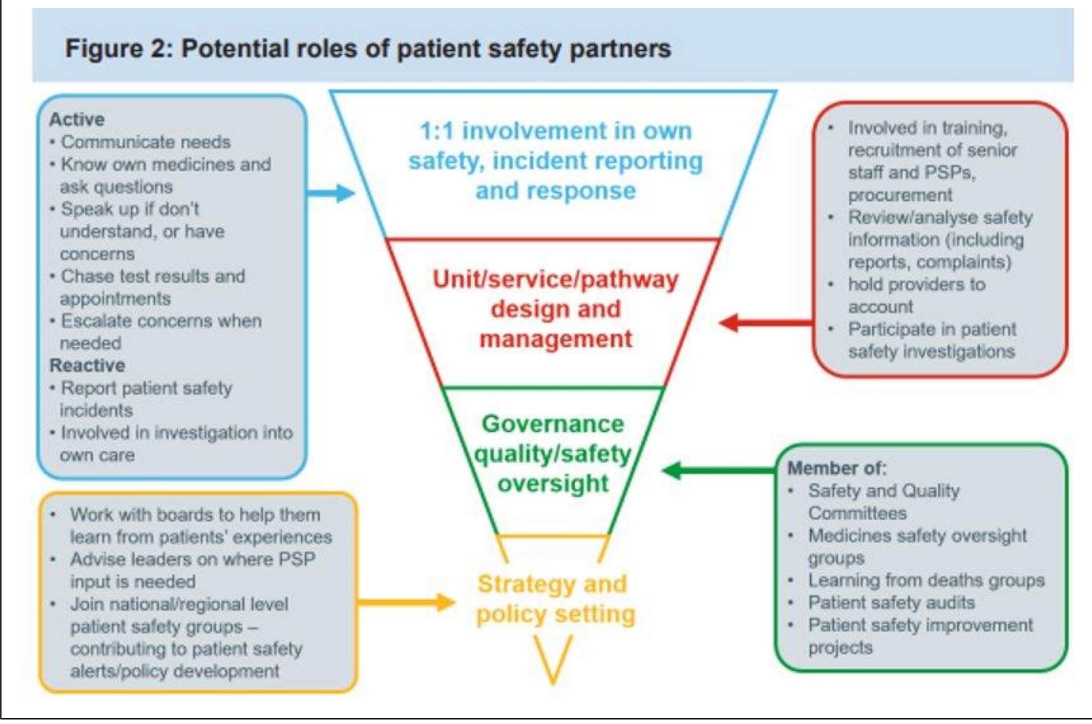
**Insert picture(s) or evidence here**

**Key enabler**: **Implementing Patient Safety Partners (PSP)**

Patient, Family and Carer involvement in organisational safety is defined in the NPSS as relating to the role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.

Roles for PSP's can include:

- membership of safety and quality committees whose responsibilities include the review and analysis of safety data
- involvement in patient safety improvement projects
- working with organisation boards to consider how to improve safety
- involvement in staff patient safety training
- participation in investigation oversight group



## Our 2022-25 Improve / Effective Commitments:

- **NPSS definition -** *Improve: Designing and supporting programmes that deliver effective and sustainable change in the most important areas*
- **ELHT definition -** *Effective: Deliver consistently effective and reliable care.*

| Aim: | Objectives: |
|---|---|
| Implement the mandatory National Audit Programme | **1.** Participate in all relevant to ELHT services including mandatory audits |
| | |
| Implement mandatory CQuIN and PSS schemes | **1.** Agree implement and monitor measures in partnership with Divisions |
| | |
| Building audit capability across the organisation through skills development | **1.** Developing an organisational training offer covering all staff groups<br>**2.** Ensure audit training is available from induction basics up to expert level |
| | |
| To increase engagement with audit and effectiveness work | **1.** To improve the visibility of Clinical Audit Results by developing an internal registry<br>**2.** Develop and embed GIRFT processes within the central team, supporting the Divisions to drive improvement priorities from learning<br>**3.** To strengthen the links between the Legal Services team and Clinical Audit/Effectiveness to support the implementation of the GIRFT Litigation standards |
| | |
| To ensure coordinated access and monitoring of clinical skills training through DERI | **1.** To enable increased visibility and reporting on training compliance and an organisational overview of core and specialist training to support our workforce |

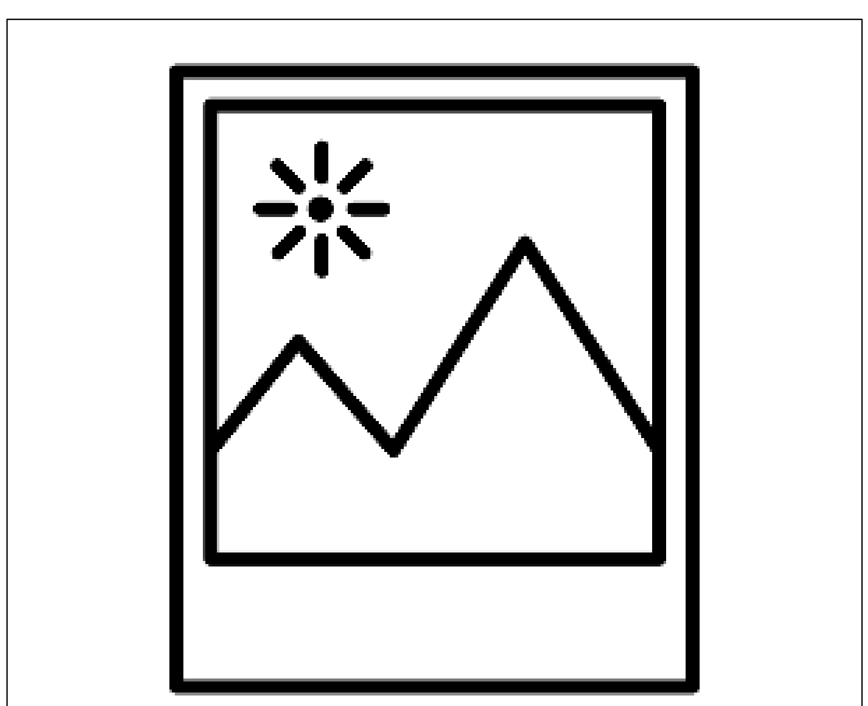
**Key enablers:**

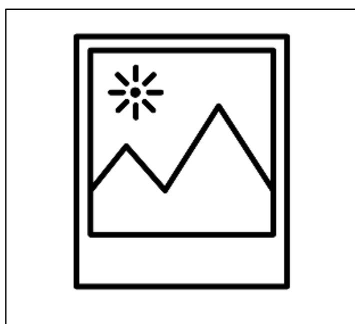
**Care Bundles**

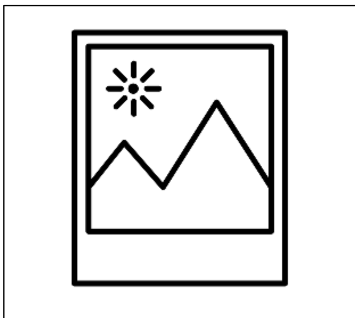
Care Bundles are 'best practice' clinical interventions, with an applied research base, that involve key clinical management steps that have been demonstrated to improve patient outcomes. The quality goals for 2022-25 will include achieving national benchmarks for implementation of the care bundles building on the work for Community Acquired Pneumonia (CAP), Acute Kidney Injury (AKI), Alcohol Related Liver Disease (ARLD) and Sepsis.

**GIRFT, Right Care and Model Hospital**

The Trust acknowledges the value of utilising best practice evidence and benchmark data to improve outcomes. As such, the Clinical Divisions are actively engaged in the GIRFT programme and utilising the Right Care and Model Hospital data. During 2020/21, the Trust reviewed the current systems and processes which support the engagement in these programmes and GIRFT is now coordinated through our wider Clinical Audit and Effectiveness Team. The Trust continues to actively participate in the GIRFT programme 2022-25 with the additional implementation of the recently developed GIRFT for Legal Services. This is to ensure a consistent, coordinated, and rigorous approach to analytical review and implementation of recommendations with an overall aim to reduce unwarranted variation; to improve care, outcomes and to reduce cost.







**Insert picture(s) or evidence here**

**Our 2022-25 Improve + Commitments:**

- **NPSS definition - Improve**: *Designing and supporting programmes that deliver effective and sustainable change in the most important areas*
- **ELHT definition – Improve +** 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 and to develop and embed a culture of continuous improvement, learning and innovation.

| **Aim:** | **Objectives:** |
|---|---|
| To improve outcomes against identified Trust and wider system improvement priorities using an evidence-based and consistent improvement method and tools (SPE+ Improvement Practice). | **1.** Embedding the SPE+ method of improvement across ELHT and Pennine Lancashire PBP<br>**2.** Working with partners across Lancashire and South Cumbria to develop a consistent system-level method of improvement<br>**3.** Ensuring a robust approach to the identification of Improvement priorities<br>**4.** Utilising the SPE+ Improvement Practice to support improved outcomes against agreed improvement priorities<br>**5.** Ensuring robust systems for measurement for improvement |
| | |
| To develop skills and confidence of staff across the Trust and wider system to apply the SPE+ Improvement Practice to secure the best possible outcomes | **1.** Developing capacity and capability of staff through a robust Improvement Practice training offer<br>**2.** To support staff on their improvement journey through high quality Improvement Coaching<br>**3.** To create a SPE+ Improvement Network to support staff in sharing best practice |
| | |
| To embed improvement in all that we do as part of our management system | **1.** To develop a robust approach to strategy development and deployment that routinely identifies and supports opportunities for improvement<br>**2.** To support the development of a learning culture where all staff strive for continuous improvement and innovation<br>**3.** To celebrate success and share learning |

The Improvement Hub team facilitate and support the delivery of our Improvement Priorities and Programme which comprises 5 main current priority areas:

- Quality improvement priorities
- People plan improvement priorities
- Operational delivery improvement priorities:
  - Non-elective pathways
  - Elective pathways
  - Outpatient pathways

Our Quality improvement programme currently comprises a combination of:

- Trust-wide Harms Reduction Programmes
- Other key improvement priorities arising from National Reports/Audit, incidents, and complaints
- Directorate and Divisional Quality Improvement Projects
- Quality improvement (QI) projects for Staff in training

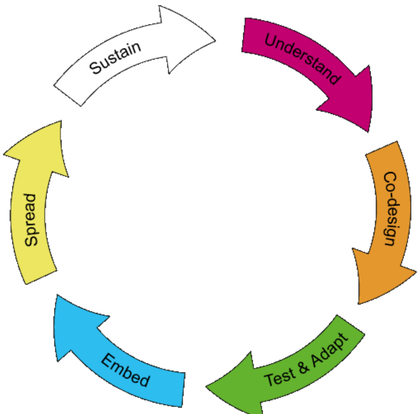
Our future Quality improvement priorities will be directly informed by implementation of the PSIRF, providing us with an opportunity to streamline and prioritise future improvement activity.

The improvement priorities supported by the Improvement Hub team will be reviewed each year to ensure they are aligned to the delivery of the Trust Strategy and key Delivery Programmes.

**Key enablers:**

**Improving Safe, Personal and Effective Care (SPE+) Improvement Practice**

We deliver 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:

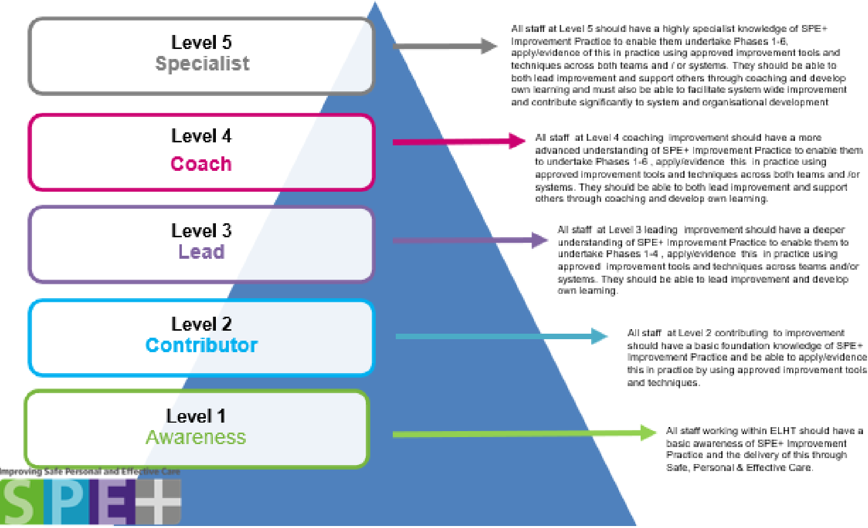



The development of our Improvement Practice has been supported through our involvement in the national NHS Improvement and NHS England Vital Signs Programme. Although this programme has now formally ceased, we continue to develop our Improvement Practice by continually reviewing national and internal best practice and through the development of local, regional, and national Improvement Networks. 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.

**SPE+ Improvement Practice Training Framework**

To support staff in the development of skills and confidence in the application of the SPE+ Improvement Practice we have developed a comprehensive training offer which is summarised in our SPE+ Improvement Practice Training Framework. This is summarised below:




**Improvement Continuum** – Improving Safe, Personal and Effective Care

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 (Clinical Audit & Effectiveness, Improvement, Research & Development, Transformation, and Innovation) to support shared learning and spread and celebration of success. This is depicted below:

## Other Key Enablers

### e-Lancs - ePR (Electronic Patient Record)

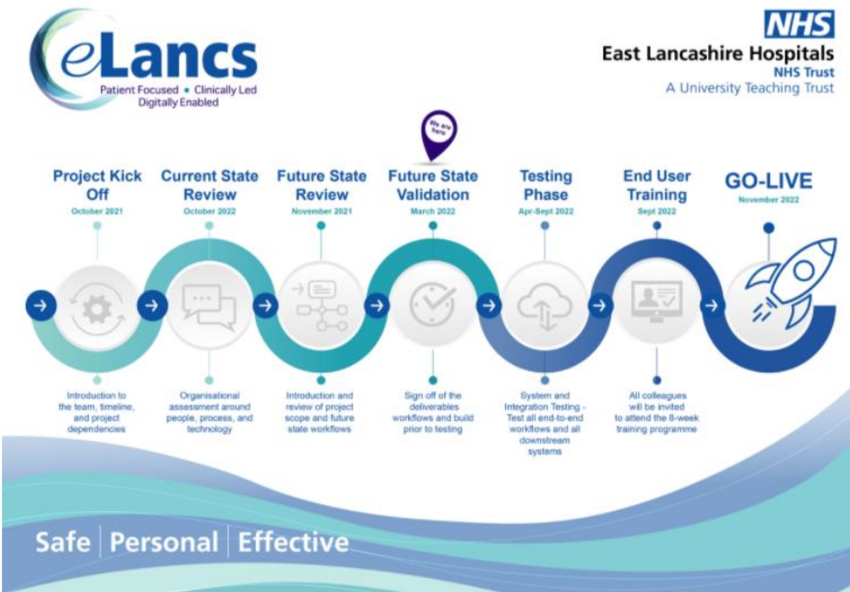
Over the coming weeks and months, the Trust will begin to implement one of the biggest programmes on the horizon: an electronic patient record (EPR). The Electronic Patient Record (EPR) will launch in November 2022 and have an impact on staff and patients right across the Trust.

Whilst it might sound simple, it has the potential to completely transform the way we work, with vast benefits for both colleagues and patients and their families. In East Lancashire Hospitals NHS Trust the programme will be known as 'eLancs' and is designed to improve patient care across the health and social care system in the area by replacing paper-based notes and records with a new suite of digital tools and technologies. The programme is patient focussed, clinically led, and digitally enabled.

These will be introduced over the coming months across hospital services and community care in Blackburn with Darwen, Burnley, Pendle, Hyndburn, the Ribble Valley, and Rossendale, but substantial changes are scheduled in November 2022 when a new electronic patient record system will go live in hospital settings. This will:

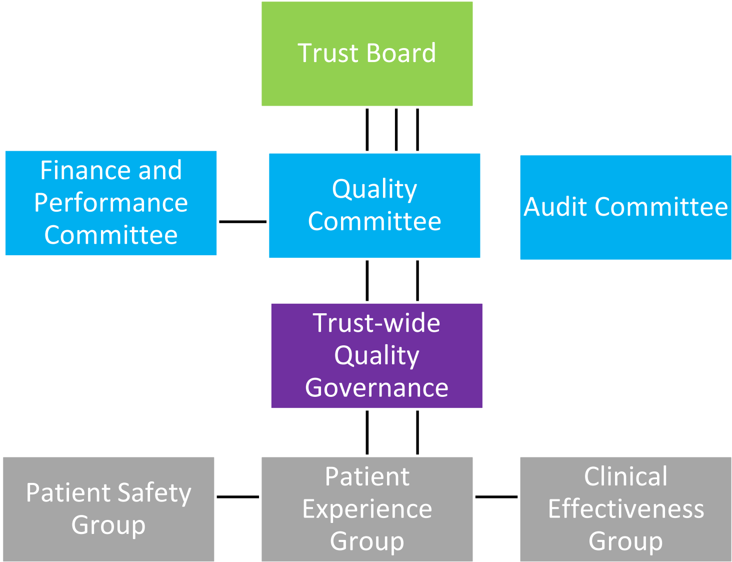
- Provide clinicians with more information at their fingertips to make better, more effective decisions
- They will have automatic access to decision support tools, meaning their decisions will be made based on the best available information
- They will be able to take information from many sources.
- It makes us more efficient and create a smoother care journey for our patients
- It will enhance communication across clinicians and teams, reduce duplication and reduce some of the data collection burdens from people by capturing some things automatically.

Paper records will be replaced by digital records and there will be new ways of working introduced to take advantage of this digital approach. It will make several administrative tasks easier to manage as information will flow around the organisation more easily.



## 5. Assurance Monitoring

Quality Governance is the combination of structures and processes both at and below Trust Board level to ensure and assure the quality of our services, together with systems to monitor and assure the Trust Board of Directors. These are listed below.




### Board of Directors

The Board of Directors has overall responsibility for the services that we deliver and is accountable for operational performance as well as the implementation of Strategy and policy. A quality dashboard is reported monthly to the Board of Directors as part of the Integrated Performance Report (IPR). Where possible we include performance indicators to measure and benchmark our progress against each quality improvement priority and local quality indicators.

### Finance and Performance Committee

The Finance and Performance Committee provide assurance about the delivery of the financial and operational plans approved by the Board for the current year and for the longer-term future, develop forward plans for subsequent fiscal years for consideration by the Board and examine in detail risks to the achievement of national and local performance and activity standards.

### Quality Committee

The Quality Committee provides assurance to the Trust Board of Directors in respect of clinical quality and patient safety, effectiveness and experience through robust reporting and performance monitoring.

### Audit Committee

The Audit Committee is the high-level risk committee operating on behalf of the Board and concerns itself with the function and effectiveness of all committees. It is the Committee that brings all aspects of governance and risk management together. The Audit Committee is charged with ensuring that the Board and Accounting Officer of the organisation gain the assurance they need on governance, risk management, the control environment and on the integrity of the financial statements, as well as other elements of the Annual Report and Accounts.

### Trust Wide Quality Governance (TWQG)

The progress of each priority is reported on a quarterly basis to the Trust-wide Quality Governance Group which reports monthly into the Quality Committee. Operational implementation of the commitments will be monitored routinely through the Patient Safety, Patient Experience and Clinical Effectiveness Groups which report monthly to TWQG. Divisional representation and Heads of Corporate services are standing members on the TWQG.

### Clinical Divisions Quality meetings

There are five Clinical Divisions within the Trust, who report into the Executive Directors and provide assurance on Strategy and risk management performance. Each Division holds a monthly Quality / Performance meeting to receive assurance or escalation from the various Directorates. Similarly, the Directorate meetings are attended by and receive escalation from their respective teams. These meetings are supported by allocated Quality and Safety teams who work closely with the respective Senior Leadership Teams.

### Patient Safety Group

Established as a sub-Group of the Trust Wide Quality Governance this is the group responsible for providing assurance that there is effective monitoring and oversight of patient safety across all spheres of Trust activity and that improvement of patient safety is at the heart of the work of the Trust. Chaired by the Assistant Directors of Patient Safety and Effectiveness, it is the Trust wide operational focus for accountability for patient safety for quality governance within corporate and the Divisions.

It brings together the business of the corporate clinical leaders within the Trust, who with senior members of the Divisional teams supported by members of the Quality and Safety Unit, have day to day responsibility for patient safety driving improvement initiatives in this area.

### Patient Experience Group

Established as a sub-Group of the Trust Wide Quality Governance this is the group responsible for providing assurance that there is effective monitoring and oversight of patient experience across all spheres of Trust activity and that improvement of patient experience is at the heart of the work of the Trust. Chaired by the Assistant Director of Patient Experience, it is the Trust wide operational focus for accountability for patient experience for quality governance within corporate and the Divisions.

This group combines an overview focus on complaints management with feedback from patients and their carers/families. This group monitors the Friends and Family Test results, Annual Patient Survey feedback themes and links with key partners such as Healthwatch to maintain direct links with community groups.

### Clinical Effectiveness Group

Established as a formal Sub-Group of the Quality Committee this is the engine room for ensuring that there are appropriate arrangements to monitor, assure and improve clinical effectiveness across the range of the Trust's services. Chaired by the Deputy Medical Director, it is the Trust-wide operational focus for assurance and accountability for clinical effectiveness and improvement for the Divisions. It brings together the business of clinical leaders and senior members of the divisional teams, supported by the corporate clinical effectiveness functions, with a day-to-day responsibility for clinical effectiveness and quality improvement.

## Lessons Learnt Group

A Lessons Learnt Group has been established as a subgroup to the Trust Wide Quality Governance meeting. This new group responsible for providing assurance that there is effective monitoring and oversight of lessons learnt from patient safety events across all spheres of Trust activity and that improvement of patient safety is at the heart of the work of the Trust. Chaired by the Assistant Directors of Patient Safety and Effectiveness, it is the Trust wide operational focus for accountability for learning lessons from patient safety events and investigations for quality governance within corporate and the Divisions.

## Quality Improvements Triage

Established as a formal Group reporting to the Clinical Effectiveness Committee it is the engine room for ensuring that the Division(s) have plans in place for the monitoring of the impact of the quality improvement project, and if necessary to ensure that impacts on other divisions are recognised.

Chaired by the Deputy Medical Director (Transformation) it brings together divisional teams and the Quality Improvement team supported by other members of the Quality and Safety Unit, who have day to day responsibility for clinical effectiveness and quality improvement.

Its purpose is to examine the detail of quality improvement projects signed off by Directorate and Divisional Teams, ensuring that plans have details of the change idea, aims and measures as well as details of the support required.

## External Assurance reporting

Established governance processes for the assurance of quality and safety across the Trust are in place. Regular Quality Review meetings take place with East Lancashire Clinical Commissioning Group (CCG). Quarterly engagement meetings with the Care Quality Commission (CQC) will be provided with regular updates.

Over the next year, we will work with our partners across the Integrated Care System and Provider Collaborative to build a new collaborative assurance arrangement for quality issues which are jointly owned by the ICS and the Trust to ensure that we are exploiting every opportunity to improve quality for our local population.

This integrated approach to health and care will be delivered through care bundles and care pathways to ensure that people are cared for as close to home as possible by the appropriate professional, and only admitted to hospital when they really need acute care.

**East Lancashire Hospitals NHS Trust is committed to continued engagement in the monitoring and review of these Quality Commitments. Partners involved in the creation of this strategy will be invited to participate in annual review workshops which will review progress and refocus priorities as required.**

## Appendix: Looking back - Reviewing the previous Quality Strategy 2017-19

Our previous Quality Strategy was designed to cover the years 2017-19. This full review was completed between June-September 2021.

In November 2019, the Trust was nominated as an Early Adopter of the Patient Safety Incident Response Framework (PSIRF), representing the NHS North-West region. The PSIRF model is described within the National Patient Safety Strategy (NPSS) and has underpinned changes to all aspects of Quality Governance and strengthens links to Improvement.

The Pennine Lancashire region was significantly impacted by the Covid 19 global pandemic, which required refocused patient safety activity between 2020-2021. These were outlined in the national document 'Reducing burden and releasing capacity to manage the COVID-19 pandemic', which was sent out on 28/03/2020 and further updated on 26/01/2021 and any other relevant guidance/information recently received that defines the governance requirements for the NHS during COVID-19.

### Our 2017 -19 Safe Commitments

1. We are committed to providing safe, high-quality services and harm-free care. We strive to ensure that our patients are cared for in surroundings which are safe and clean, delivered by caring and competent staff.
2. When patients' safety incidents do occur, we are committed to managing them in an open and transparent manner, in accordance with the Duty of Candour, and ensuring we learn and continuously improve care as a result.

| | |
|---|---|
| **Aim:** | Reduce harm, prevent errors, and deliver consistently safe care. |
| **Objectives:** | The Trust coordinated a comprehensive rolling programme of quality improvement initiatives which strived to reduce avoidable harm. With a focus on:<br>• Discharge<br>• Falls<br>• Deteriorating Patients Management<br>• Pressure Ulcers<br>• Sepsis<br>• Safe Transfers of Care |
| **Aim:** | Develop an excellent safety culture |
| **Objectives:** | Embed and spread the safety culture work undertaken in theatres and use learning from safety culture surveys to support improvement<br><br>Promoting the 'Prompt to Protect' campaign to develop an open reporting culture for infection control and safety issues |
| **Aim:** | Strengthen our incident reporting and investigation processes to reduce risks through early identification |
| **Objectives:** | Encourage staff to report incidents, take responsibility for actions to minimise risks and fully apply their Duty of Candour<br><br>Embed 'Human Factors' to examine why incidents occur. |
| **Aim:** | To strengthen internal assurance of quality |
| **Objectives:** | Extend the Nursing Assessment Performance Framework (NAPF) assessment to all wards and specialties<br><br>Support and enable all wards to achieve SPEC (Safe, Personal, Effective Care) status whereby they maintain 'good' for 24months (3 assessments) |

## Summary of Achievements - Reduce harm, prevent errors, and deliver consistently safe care.

| | |
|---|---|
| | The Trust implemented a Falls Collaborative (now the Falls Steering group) which has set standards for falls avoidance processes and monitors falls monthly. As a result, falls reduced by 36 % across the Trust. |
| | Key targets for the management of deteriorating patient have been added to our incident system to enable closer monitoring. Standards for fluid balance and antibiotic administration have been built into routine audits through the Deteriorating Patient steering group. The use of Early Warning Scores (EWS), Maternity EWS and Enhanced Care Scores have been introduced to standardise approach |
| | The Pressure Ulcer Collaborative successfully supported wards to work together to learn and improve skincare across the Trust. This led to the elimination of all Grade 2 hospital acquired pressure ulcers across the inpatient areas and further elimination of grades 3 and 4 from wards in pilot areas. The pressure ulcer steering group has now been established to continue this great work. The Trust developed a training package based on this success which our District Nurses have shared with local care homes staff. |
| | The Sepsis Care Bundle has been embedded across the Trust in line with NICE guidance. Acute Kidney Injury data reports monthly to the Deteriorating Patient steering group. The Maternity and Neutropenic Sepsis bundles have been fully implemented and a Share to Care guide to the management of Sepsis has been published and distributed. The assessment of Sepsis in the Trusts Emergency Dept increased from 52% to 88% following the introduction of the care bundle. |

**Falls Collaborative**

**Sepsis**

**Pressure Ulcer Collaborative**

## Summary of Achievements - Develop an excellent safety culture

| | |
|---|---|
| | During 2018 –19 the Trust worked in collaboration with AQuA to roll out their Safety Culture survey to identify barriers in the reporting of safety concerns and subsequent action being taken. Initially trialled in theatres this was beginning to rollout across our emergency care pathway when the Covid 19 pandemic began. This work has been picked incorporated into the Human Factors training mentioned below and will remain a core focus in this new Strategy. |
| | The Prompt to Protect campaign was launched to promote a culture of openness around infection control issues and encourage staff to step in when they feel it is not right and needs challenging. |
| | Prompt to Protect uses a wide approach of promoting no blame culture, prompting colleagues to quickly identify actions/patients who might need isolation/intervention, monitoring lines and promoting safety. Prompt to Protect has successfully been rolled out on 13 wards and departments across ELHT. |

| **Summary of Achievements** - Strengthen our incident reporting and investigation processes to reduce risks through early identification |
|---|
| We continue to perform as a high reporting, low harm organisation, demonstrating a strong patient safety culture |
| Speak Out Safely campaign – The Trust implemented the national Speak Out Safely campaign in line with the Nursing Times during 2020. This campaign supported the Trust's open and honest culture to understanding and improving when things go wrong. The Trust supported a Speak Up month in October 2020. Any concerns raised with the FTSUG are now routinely reported to the Trust Board and receive timely responses. |
| We consistently ensure that 100% patients and their families are informed of and are offered the opportunity to be involved in incident investigations, in line with the national requirements defining our Duty of Candour. |
| We have developed and provided training in the Human Factors approach to incident investigations. We have embedded Human Factors into our simulation training. |

**Incident Reporting**

**Speak Out Safely**

**Duty of Candour Quote**

| **Summary of Achievements** - To strengthen internal assurance of quality |
|---|
| Our Nursing Assessment and Performance Framework has been extended to include 60 of our ward areas routinely. Of these, 31/60 are green wards, with 13/60 having achieved SPEC status which means they have achieved green/good for three consecutive assessments. |
| The NAPF assessment has since been acknowledged to provide good internal assurance by the CQC, our Internal Auditors (MIAA) and a recent external review of assurance processes as part of an independent investigation. |

**NAPF**

**NAPF**

**NAPF**

## Our 2017 -19 Personal Commitments

1. It is our ambition to ensure that our patients, their families, and carers receive an experience that not only meets but exceeds their expectations.

2. We are committed to capturing feedback and continually learning in order that we drive continuous improvements.

| | |
|---|---|
| **Aim:** | To improve patient experience in our hospitals |
| **Objectives:** | Listen to our patients, their families, and carers, and respond to their feedback<br><br>Implement our Patient / Carer & Family Experience Strategy<br><br>Use Experience-Based co-design in responding to patient feedback to introduce and sustain improvements across the Trust in relation to discharge<br><br>Continue to deliver patient stories at Trust Board<br><br>Implement 'Hello my name is' in all introductory interactions |
| **Aim:** | To increase patient, public and staff involvement |
| **Objectives:** | Actively involve patients, carers and staff in relevant quality improvements including Patient/Carer Information and Involvement Project<br><br>Ensure actions from the 'You said – We did' feedback is displayed and shared widely across the Trust. |
| **Aim:** | We are making a commitment to do more to help identify, support, and recognise the vital role of carers |
| **Objectives:** | Working closely with local carer groups to ensure there is a continual dialogue regarding the care provided<br><br>Raising awareness of the carer role and the right to individual carer assessments<br><br>Supporting John's Campaign for carers of those with dementia. |
| **Aim:** | To strengthen and learn from our complaints processes |
| **Objectives:** | Improve the response times for formal and informal complaints and concerns<br><br>Intervene at an early stage to address concerns prior to escalation into a formal complaint<br><br>Maintain appropriate and clear communication with families throughout the complaint process<br><br>Promote the ways in which patients can raise concerns. |

## **Summary of Achievements -** To improve patient experience in our hospitals

| | |
|---|---|
| | We have established a Public Participation Panel (PPP) in line with Patient Experience Strategy, which supports the Trust in helping our services reflect the needs of and view of the people using them. The panel has been involved in supporting patient led change throughout the Trust, with a particular emphasis on ensuring that the views of patients and carers are considered. |
| | Members of the PPP are also invited to attend our Quality Walk-rounds with members of the Board and the Patient Experience team. |
| | The use of iPads and SMS texting has been introduced to increase feedback opportunities for patients who have received our services. This has significantly increased our feedback in Maternity and Emergency Department. Our Friends and Family Test rates trust wide were maintained at higher than the national average. |
| | The Trust Board receives a patient story at every meeting, inviting patients or their families/carers to attend and discuss their experiences and influence improvement. |

**PPP Picture**

**FFT**

**Patient Experience Team**

## **Summary of Achievements -** To increase patient, public and staff involvement

| | |
|---|---|
| | The Public Participation Panel is well embedded within the organisation with members actively involved in several meetings and projects with staff, some of these being:<br>• **Improvement Hub Team Improvement Projects** - Panel members contributed to the initiative to reduce cancellations on the day for elective surgery. OPRA Improvement Event – to understand the current state and future vision of the Older Persons Rapid Assessment Unit<br>• **Nutrition and Hydration Group** – working to ensure we consistently deliver and improve nutrition and hydration for vulnerable adults.<br>• **End Of Life Care Strategy & Operational Group** – enabling our staff and developing process to consistently deliver excellent care for our patients, and their loved ones.<br>• **Phase 6 Development Project (New AMU)** – supporting a patient centred care and positive patient outcomes by ensuring patients receive the right care at the right time by the right skill mix.<br>• **Patient Safety and Experience Group** – contributing the review, monitoring, and challenge of the Trust's governance.<br>• **Below 10'000ft** – Theatre Safety Initiative |
| | The Trust implemented 'you said - we did' boards on all wards to ensure patients, staff and visitors could see evidence that issues raised are listened to and enable positive change. |

## Summary of Achievements - We are making a commitment to do more to help identify, support, and recognise the vital role of carers

| | |
|---|---|
| | Patient and Carer Involvement and engagement. The Trust's patient / public members are invited to participate in service reviews and ward environment / cleanliness inspections. |
| | The Trust's Dementia Specialist Nurse leads on the completion of the National Audit of Dementia annually. Themes and issues from the audit are reported through the Dementia Strategy Group. |
| | Examples of improvements achieved through this group include the development of a dementia friendly assessment area. the implementation of a Trust Policy protecting people with dementia from multiple wards moves and the introduction of the Butterfly scheme to identify patients who may be vulnerable. John's campaign was launched in the Trust during 2019 and will be promoted again during 2022 |

**Dementia**

**Complaints Rate/Figures**

**Complaints Team Picture**

## Summary of Achievements - To strengthen and learn from our complaints processes

| | |
|---|---|
| | The Trust has adopted the principles of good complaints handling, as set out by the Parliamentary and Health Service Ombudsman and which reflect the Trust's own vision and values. |
| | The rate of complaints remains low in comparison to comparable size acute Trusts. We are committed to resolving issues as they arise. Information on how to raise a concern or complaint is now available via the Trust website, on leaflets located on all wards and outpatient areas. |
| | An identified staff member is assigned to each complaint to keep the complainant updated. In the most serious cases the complainant or the relatives are assigned a Family Liaison Officer (FLO). |
| | The Trust has established an External Stakeholders Forum with membership from carers, advocacy and Healthwatch organisations within ELHT's footprint. The group discuss complaints, patient experience issues and areas for collaborative working. |
| | We routinely monitor patient experiential data from several sources. Including<br>• Inpatient Brief Patient Experience Survey<br>• Friends and Family Test<br>• Compliments log • Complaints<br>• NHS Website Comments<br>• Virtual quality walk-rounds<br>• Soft intelligence from the CSU<br>• Feedback from National Survey reports<br>• ELHT Bereavement Survey in addition to the National Audit of Care at the End of Life (NACEL) survey. |

## Our 2017 -19 Effective Commitments

1. It is our ambition to deliver care that is effective, reliable, and based upon the best evidence available

2. To increase the proportion of patients who receive evidenced-based care

3. To reduce variations in the quality of care

| | |
|---|---|
| **Aim:** | To ensure that the care delivered to patients is both effective and based upon the best evidence available |
| **Objectives:** | Develop and embed a series of care bundles and pathways in high-priority areas such as:<br><br>• Acute Kidney Injury<br>• Alcohol Related Liver Disease<br>• Chronic Obstructive Pulmonary Disease Community Acquired Pneumonia<br>• Sepsis<br><br>Ensure systems are in place to provide clinical areas with timely data on care bundle measurement to facilitate improvements<br><br>Participate in the relevant national audits to provide assurance of effective care delivery<br><br>Use the findings from the relevant national audits to support the continued improvement of quality outcomes by sharing learning and good practice across the organisation<br><br>Utilise Clinical Audit expertise to provide the evidence-base and measurement function which drives quality improvement initiatives |
| **Aim:** | To identify and implement evidence-based best practice guidance |
| **Objectives:** | Standardise practice across Divisions in line with best practice guidance to ensure the reliability of care<br><br>Ensure the relevant NICE (National Institute for Health and Care Excellence), NCE (National Confidential Enquiries) and specialist national guidance are regularly assessed and implemented to deliver interventions based upon the best possible evidence<br><br>Develop and maintain a system of 'Decision Support' so the Trust has a centralised repository for clinical standards, policies, guidelines, and procedures<br><br>Participate in the GIRFT (Getting It Right First Time) programme, in line with national guidance. |

## Summary of Achievements - To ensure that the care delivered to patients is both effective and based upon the best evidence available

ELHT adopts a continuous improvement practice approach, through delivering the model ward programme; striving to provide standardised quality in-patient care which is valued by patients, carers, and the community we serve.

All care bundles were implemented, and the review of their adoption has been previously included in the Safe section of this review.

The Trust participated in 95% of national clinical audits in 18-19, 100% of national enquiries and completed 268 local clinical audits, demonstrating their continued commitment to the delivery of evidence based safe care. 300 further national, regional, and local clinical audits were also completed by East Lancashire Hospitals NHS Trust in 2019-20.

The Trust successfully delivered on our CQUIN targets for 2018/19, screening all our patients and delivering antibiotics within an hour where clinically necessary. CQUIN was then stepped down during the pandemic.

| Participation Facts/Figures | Participation Facts/Figures |
|---|---|

## Summary of Achievements - To identify and implement evidence-based best practice guidance

The three endoscopy units at ELHT (Royal Blackburn Hospital, Burnley General Hospital and Rossendale Primary Health Care Centre) all successfully achieved continued Joint Advisory Group (JAG) accreditation.

National best practice studies have highlighted the benefit of specialist pathways to manage key patient groups. In mid-January 2019, the OPRA unit opened with the purpose to provide specialist geriatric assessments and treatment of frail patients. The Frailty team will admit patients into the assessment area of the unit from the Emergency Department ensuring specialist care is available.

The Trust is committed to continually review and implement best practice by ensuring timely review and implementation of NICE guidance. In order to prioritise the drive towards best practice a National Guidance Steering Group (NGSG) has been formed to ensure timely review of NICE Guidance and Quality Standards. Our commissioners are represented at both CEG and NGSG to ensure a collaborative approach to guidance implementation and assurance.

National Confidential Enquiry (NCE) activity is also monitored via NGSG with divisional assurance fed through to CEG. ELHT participated in all relevant NCE studies during the period (8 - as in previous email) and ensure presentation of reports at the relevant forums and completion of self-assessment against the recommendations.

The Trust has centralised storage of all clinical decision support tools, to enable easy access for front line staff. Resource has been allocated to the library services to support this and work is progressing though divisions to ensure the central store / resource is available across all divisions - this will also provide one single source, to reduce the risk of out-of-date documents being accessed.

ELHT has participated in all GIRFT relevant GIRFT activity. A GIRFT process has been incorporated into the CE Framework to ensure that Data packs are shared with all relevant teams and leads, participation in Observational visits and learning from GIRFT activity is captured centrally with learning i.e. success shared and action for improvement monitored via the appropriate assurance groups.

## Our 2017 -19 Improvement Commitments

1. To build the capability for delivering this strategy by developing improvement skills in staff at all levels of the organisation

| | |
|---|---|
| **Aim:** | To develop and implement an ELHT Improvement model |
| **Objectives:** | Develop improvement capability by equipping staff with the skills to deliver continuous quality improvement<br><br>Educate staff on the use of quality improvement methodologies through educational programmes, coaching support, and networking opportunities<br><br>Utilise the expertise of regional improvement specialists such as the Advancing Quality Alliance (AQuA), Haelo and the Academic Health Science Networks (AHSNs)<br><br>Support staff to effectively improve care using ELHT's 7 Steps to Safe, Personal, Effective Care improvement methodology, which is based on the Institute for Healthcare Improvement's (IHI) Model for Improvement |
| **Aim:** | Recognise, reward, celebrate and share successes of those who are actively engaged in quality improvement throughout ELHT |
| **Aim:** | Show visible commitment to encouraging a culture of continuous improvement throughout ELHT |

## Summary of Achievements - To build the capability for delivering this strategy by developing improvement skills in staff at all levels of the organisation

| | |
|---|---|
| | A combined number of 356 QI and A3 Projects were registered with the central QI and IPO Teams during this period. |
| | Regular Introduction to Quality Improvement (3hrs), Lean Basics Awareness (2hrs), Practice Coach Training (3days) and Kata Coaching sessions were delivered to ELHT staff, including our staff in training groups across multiple professional disciplines. |
| | ELHT continues to be a member of AQuA enabling staff to access bespoke training to compliment development of improvement skills and the option to join wider improvement programmes connecting with other partners. |
| | The ELHT 7 Steps to Safe, Personal and Effective Training was introduced in 2017. This was supported by a specialist team of Quality Improvement Facilitators as part of the Quality and Safety Unit. In addition to this, the Trust subsequently signed up to the Vital Signs Programme in 2018 and the Improvement Practice Office Team was formed to implement a Lean-based improvement methodology to complement the existing improvement practice. |
| | The two teams provided 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. |

**Staff Group Facts/Figures**

**Staff Group Facts/Figures**

**Summary of Achievements -** Recognise, reward, celebrate and share successes of those who are actively engaged in quality improvement throughout ELHT

- The development of Share to Care Bulletins – Quality Improvement Celebration, Sepsis, Fluid Balance, Falls Editions
- Regular Quality Improvement Triage Project Meetings, encourage cross-divisional spread and standardisation
- ELHT QI Poster Events (National) – an event ran by and attend by our Junior Doctors undertaking QI projects as part of their training requirements
- Hosted Quality Improvement Celebration Evenings
- Implementations of monthly Trust Improvement Report Out
- Certification is available at each level of the Improvement Practice Framework completed as part of an Improvement Project
- Submission for Awards – Externally (HSJ) and internally (STAR Awards) etc…

Utilising social media platforms such as closed Facebook pages, Twitter etc…

**Share to Care Bulletin**

**Report Out**

**Celebration Evening**

**Summary of Achievements -** Show visible commitment to encouraging a culture of continuous improvement throughout ELHT

A combined number of 356 QI and A3 Projects were registered with the central QI and IPO Teams during this period

Collectively the QI and IPO Teams have supported over 1133 staff in participating in improvement training, ranging from Lean basics awareness (800), an introduction to QI course (240) excluding staff in training groups as this is not captured on the learning hub, Practice Coach training (78), Improvement Coaching (15).

**Training Facts/Figures**

**Training Facts/Figures**

**Training Facts/Figures**

**Contact us:**

**East Lancashire University Teaching Hospital NHS Trust**
Quality Governance
Royal Blackburn Teaching Hospital
Haslingden Raod
Blackburn
BB2 2HH

**Telephone:** 01254 733704 (ext. 83704)

**Email:** qualityandsafetyunit@elht.nhs.uk

**Website:** www.elht.nhs.uk

**Twitter:** www.twitter.com/EastLancsHosp

**Facebook:** www.facebook.com/EastLancashireHospitals

This publication can be made available in a number of other formats on request.

# TRUST BOARD REPORT

**Item** 68

**11 May 2022**

**Purpose** Information

| | |
|---|---|
| **Title** | New Hospitals Programme Quarter 4 Board Report |
| **Author** | Mr J Hawker, Programme SRO<br>Mrs R Malin, Programme Director |
| **Executive sponsor** | Mrs K Atkinson, Interim Executive Director of Service Development |


**Summary:** The purpose of this report is to provide an update on the New Hospitals Programme for the quarter 4 period; January to March 2022.

This quarterly report is presented to the following Boards;

- University Hospitals of Morecambe Bay NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Lancashire and South Cumbria NHS Foundation Trust
- Lancashire and South Cumbria Integrated Care System (ICS)
- Provider Collaborative

And the Strategic Commissioning Committee.


**Recommendation:** It is recommended that the Board;

- Note the progress undertaken in Q4.
- Note the progress in developing key products to support business case (section 3).
- Note the activities planned for the next period, namely the detailed analysis of the shortlisted options to determine deliverability, affordability, value for money and clinically viability.

**Report linkages**

| | |
|---|---|
| Related strategic aim and corporate objective | Work with key stakeholders to develop effective partnerships<br>Encourage innovation and pathway reform, and deliver best practice |
| Related to key risks identified on assurance framework | 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 |

**Impact**

| | | | |
|---|---|---|---|
| Legal | No | Financial | No |
| Equality | No | Confidentiality | No |

# NEW HOSPITALS PROGRAMME Q4 BOARD REPORT

## 1. Introduction

1.1 This report is the 2021/22 Quarter 4 update from the Lancashire and South Cumbria (L&SC) New Hospitals Programme.

## 2 Background

2.1 Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) are working with local NHS partners to develop a case for investment in local hospital facilities. The programme is part of the Government's commitment to build 40 new hospitals by 2030. Together with eight existing schemes, this will mean 48 hospitals built in England over the next decade, the biggest building programme in a generation. Further information can be found on the **'Our NHS buildings' website (opens in new window).**

2.2 The L&SC New Hospitals Programme (NHP) offers a once-in-a-generation opportunity to transform the region's ageing hospitals and develop new, cutting-edge hospital facilities that offer the absolute best in modern healthcare.

2.3 This is a national programme, which continues to shape and develop. The national New Hospital Programme team is developing an overall programme business case, and in the interim continues to work with schemes to determine the best approach to demand modelling, sustainable buildings, standard design, assessing the benefits of new hospital facilities, as well as understanding the most effective commercial frameworks that can be applied. The programme welcomed colleagues from the DHSC and national NHP team for a visit to Royal Lancaster Infirmary and Royal Preston Hospital in March 2022 and looks forward to the visit of Natalie Forrest, national NHP Senior Responsible Officer in June 2022.

## 3 Progress against plan (for the period January to March 2022)

3.1 In Q4, the programme has achieved several significant milestones: appraising the longlist; the approval of the shortlist of options; and the commencement of engagement with the public and stakeholders on the shortlist.

3.2 In February, the programme completed the workshop to appraise the longlist of options. The workshop is a fundamental part of developing a business case, and a key

element of the programme's active engagement and transparency with the public and stakeholders. The workshop was attended by a range of NHS colleagues, wider stakeholders and patient representatives, bringing a high degree of energy, challenge and debate to input into the shortlist options.

3.3 Subsequently, on 24 February 2022, the Strategic Oversight Group (SOG) reviewed, discussed and approved the output of the workshop to form the shortlist of options. This was endorsed by the Strategic Commissioning Committee (SCC) on 10 March 2022.

3.4 **Developing our business case –** During Q4, the programme has progressed the following key building blocks towards our business case:

3.5 **Shortlist –** the shortlist of options is as follows;

- A new Royal Lancaster Infirmary on a new site, with partial rebuild / refurbishment of Royal Preston Hospital;
- A new Royal Preston Hospital on a new site, with partial rebuild / refurbishment of Royal Lancaster Infirmary;
- Investment at both Royal Lancaster Infirmary and Royal Preston Hospital, allowing partial rebuilding work on both existing sites;
- Two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital (new sites).

These proposals also include investment in Furness General Hospital, required due to its geographically remote location, its proximity to some of the UK's major strategic national assets, and its need to meet NHS environmental goals.

3.6 **Identification and quantification of benefits –** work has progressed throughout Q4, culminating in a draft Comprehensive Investment Appraisal Model (CIAM) with indicative benefit cost ratios for the options. Whilst this is a formal and technical element of the business case, it allows us to articulate and quantify the true impact of our ageing estate and the benefit new hospital facilities will bring. Work will continue on this as we understand more detail regarding each option.

3.7 The programme continues to manage the significant interdependencies within the Integrated Care System (ICS). Firstly, with the Hospitals Clinical Strategy through the PCB Clinical Integration Group, to ensure alignment with the shortlist of options.

Secondly, the implementation of digital and development of the digital strategy. Finally, the programme appreciates that the right sizing of new hospital facilities can only be achieved with primary and community care services working in parallel. Agreement has been reached to establish an ICS primary and community strategy group with an objective to develop a case for change and strategic plan aligned to the NHS Long Term Plan and the NHP ambitions.

## 4 Public, patient and workforce communications and engagement

4.1 A number of key communications, involvement and engagement activities have taken place during this period, namely:

4.2 Firstly, the programme announced the shortlist of options through NHP channels (with the issue of a media release, stakeholder updates, email news and social media), with NHS partners sharing internal communications and social media posts. To tie in with this announcement, a new online survey on the shortlist and 'what is most important in terms of new hospital facilities' was launched, running from 10 March to 3 April. The survey has received 1,466 full responses, with further partial responses also being analysed. An additional round of market research commenced w/c 14 March, comprising of face-to-face, telephone and online interviews / surveys. An advertising campaign ran on local radio, print and online media to encourage people to find out more about the programme and get involved.

4.3 Secondly, the programme held two successful Colleague Summits on 15 and 29 March 2022, which involved 196 colleagues and facilitated positive question and answer sessions.

4.4 Thirdly, a range of new website content has been published to explain more about the programme's process and to bring the Case for Change to life. This has included new blogs on: the potential for digital advances - why digital advances are so important to the New Hospitals Programme and how digital advances can help our new hospital facilities to be more sustainable; how new hospital facilities can improve urgent care in our region; patient choice and long-term goals for health in Lancashire and South Cumbria; how feedback from local people is being used to for proposals for new hospital facilities; and an article showcasing the Innovation Agency podcast featuring Jerry Hawker, Dr Som Kumar and Jane Kenny. A new webpage on Governance and

oversight has also been launched.

## 5 Stakeholder management

5.1 Board members will recognise there is a breadth of stakeholders in such a programme. During Q4, there has been stakeholder engagement on the shortlist of options, meetings and correspondence with MPs, local authorities and community groups.

## 6 Programme governance and risk

6.1 During Q4, the Mersey Internal Audit Agency (MIAA) Advisory Services independent review of the programme governance and assurance was reviewed and supported by the Governance Advisory Group (GAG). The Strategic Oversight Group (SOG) approved the report and agreed that the subsequent oversight of the action plan and implementation of the programme and statutory body decision making matrix will be undertaken by the Programme Management Group (PMG).

6.2 Throughout Q4, the programme has strengthened the risk register. The full risk register is reviewed and reported to the various groups within the programme governance framework. Risks scoring 15 and above are then reported and discussed at the Strategic Oversight Group (SOG) each month.

## 7 Next period – Q1 2022/23

7.1 Q1 takes us into a detailed yet exciting phase of the programme, including undertaking detailed analysis of the shortlisted options to determine the deliverability (incorporating land availability, planning considerations, clinical viability and service continuity), value for money and affordability (capital and revenue).

7.2 Following this detailed analysis, options determined as deliverable, value for money and affordable, that are deemed to involve a substantial service change and therefore the potential requirement to consult, will require a Pre-Consultation Business Case (PCBC) to be submitted to NHSEI.

7.3 The programme will continue to develop the PCBC and the Strategic Outline Case (SOC) in parallel, following NHSE's planning, assuring, and delivering service change for patients' guidance and the HM Treasury's guide to developing a project business case.

## 8 Conclusion

8.1 This paper is a summary of progress on the New Hospitals Programme throughout Quarter 4 2021/22.

## 9 Recommendations

9.1 The Board is requested to:

- Note the progress undertaken in Q4.
- Note the progress in developing key products to support business case (section 3).
- Note the activities planned for the next period, namely the detailed analysis of the shortlisted options to determine deliverability, affordability, value for money and clinically viability.

**Rebecca Malin**
**Programme Director**

**Jerry Hawker**
**Programme SRO**

**April 2022**

**TRUST BOARD REPORT** **Item 69**

**11 MAY 2022** **Purpose** Discussion

Approval

| | |
|---|---|
| **Title** | Ratification of Board Sub-Committee Terms of Reference<br>a) Audit Committee<br>b) Finance and Performance Committee<br>c) Quality Committee |
| **Authors** | Mrs A Bosnjak-Szekeres, Director of Corporate Governance<br>Miss K Ingham, Corporate Governance Manager |

**Summary:** The terms of reference for the Committees have been reviewed in line with their current work plans and best practice. They have been reviewed by their respective Committees during the month of April 2022 and are presented to the Board for ratification.

**Recommendation:** The Board is asked to consider and ratify the revised terms of reference for the Committees.

**Report linkages**

| | |
|---|---|
| Related strategic aim and corporate objective | Put safety and quality at the heart of everything we do<br>Invest in and develop our workforce<br>Work with key stakeholders to develop effective partnerships<br>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.<br>Recruitment and workforce planning fail to deliver the Trust objectives<br>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.<br>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 |

## TERMS OF REFERENCE: AUDIT COMMITTEE

**Constitution**

The Board has resolved to establish a Committee of the Board to be known as the Audit Committee. The Committee is an independent Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. The Audit Committee is the high-level risk committee operating on behalf of the Board and concerns itself with the function and effectiveness of all committees. It is the Committee that brings all aspects of governance and risk management together.

**Purpose**

The Audit Committee is charged with ensuring that the Board and Accounting Officer of the organisation gain the assurance they need on governance, risk management, the control environment and on the integrity of the financial statements, as well as other elements of the Annual Report and Accounts.

The role of the Audit Committee is a challenging one and it needs strong, independent members with an appropriate range of skills and experience. The Committee acts as the "conscience" of the organisation and demonstrates strong constructive challenge where required. For example, risks arising from increasing fiscal and resource constraints, new service delivery models, information flows on risk and control and the agility of the organisation to respond to emerging risks. In addition, it has a role in assuring the effectiveness of other Board sub-committees, but this should not interfere with the requirement for the Audit Committee to maintain independence.

The Audit Committee fulfils a major role in providing independent and objective assurance through the work of internal and external auditors and counter fraud, reviewing reports and intelligence from external bodies including regulators and seeking assurance from internal teams and the sub-committees of the Board, such as the Finance and Performance Committee and Quality Committee.

It is essential that the Audit Committee understands how the governance arrangements support the achievement of the Trust's strategies and objectives, especially:

- The Trust's vision and purpose.

- The mechanisms in place to ensure effective organisational accountability, performance and risk management.
- The roles and responsibilities of individuals and committees and other groups to support the effective discharge of the Trust's responsibilities, decision making and reporting.

The Committee must also understand the organisation's business strategy, operating environment and the associated risks. It must take into account the role and activities of the Board and other Committees in relation to managing risk and should ensure that the Board discusses its policies, attitude to and appetite for risk to ensure these are appropriately defined and communicated so management operates within these parameters.

**Duties and Responsibilities**

The duties of the Committee are categorised as follows:

*Governance, Risk Management and Internal Control*

- The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In particular the Committee will review the adequacy and effectiveness of:
  - All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to their endorsement by the Board.
  - The underlying assurance processes that indicate the degree of achievement of the corporate objectives, the effectiveness of the management of the principal risks and the appropriateness of the above disclosure statements.
  - The policies for ensuring compliance with the relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
  - The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.
- In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources.

It will also seek reports and assurances from directors, managers and sub-committees of the Board as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of the effectiveness.

- This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

*Internal Audit*

- The role of the Audit Committee in relation to internal audit should include advising the Accounting Officer and the Board on the:
  - Internal Audit Charter and periodic internal audit plans, forming a view on how well they reflect the organisation's risk exposure and support the Head of Internal Audit's responsibility to provide an annual opinion.
  - adequacy of the resources available for internal audit.
  - terms of reference for internal audit.
  - results of internal audit work, including reports on the effectiveness of systems for governance, risk management and control, and management responses to issues raised.
  - annual internal audit opinion and annual report.
- The Committee shall ensure that there is an effective internal audit function that meets mandatory *NHS Internal Audit Standards* and provides appropriate independent assurance to the Audit Committee, the Chief Executive and the Board. This will be achieved by:
  - consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.
  - review and approval of the Internal Audit Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.
  - considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise audit resources.
  - ensuring that the internal audit function is adequately resources and has

appropriate standing within the organisation.

- the annual review of the effectiveness of internal audit.

*External Audit*

- The Committee shall review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved by:
  - consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
  - discussion and agreement with the external auditors, before the audit commences, of the scope and nature of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
  - discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
  - review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

*Other Assurance Functions*

- The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications for the governance of the organisation.
- These will include, but will not be limited to, any reviews by Department of Health and Social Care arms- length bodies or regulators/ inspectors and professional bodies with responsibility for the performance of staff or functions.
- In order to preserve the independence of the Committee Chair and members, the Committee will receive matters of escalation from the Board Sub-Committees, particularly the Finance and Performance Committee and Quality Committee
- To ensure that the Committee maintains a strategic focus the Committee will continue to strengthen its links with the Board Assurance Framework (BAF) and will focus its agendas, where appropriate, on matters contained within the BAF, including the annual review of the BAF.
- To seek assurance on the implementation of guidance and recommendations from

external inspection and accreditation visits from the Quality Committee.

- In addition, the Committee will review the work of all other committees within the organisation whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the work and functionality of the Quality Committee and Finance and Performance Committee which report to the Board on all aspects of clinical and financial governance and risk management.
- The Audit Committee will approve the Quality Account prior to publication on behalf of the Board.

*Counter Fraud*

- The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

*Financial Reporting*

- The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.
- The Committee will receive the quarterly report on waivers.
- The Audit Committee will review the annual report and financial statements before submission to the Board, focussing particularly on:
  - The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
  - Changes in and compliance with accounting policies, practices and estimation techniques
  - Unadjusted mis-statements in the financial statements
  - Significant judgements in preparation of the financial statements
  - Significant adjustments resulting from the audit
  - Letter of Representation
  - Qualitative aspects of financial reporting
- In reaching a view on the accounts, the Committee will consider:
  - key accounting policies and disclosures;

- assurances about the financial systems which provide the figures for the accounts;
- the quality of the control arrangements over the preparation of the accounts;
- key judgements made in preparing the accounts;
- any disputes arising between those preparing the accounts and the auditors; and
- reports, advice and findings from external audit (especially the Audit Completion Report – ISA 260 Report)

*Whistleblowing*

- The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

*Management*

- The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- The Committee may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.
- The Committee shall receive the annual report on the declarations of interest and the Trust's registers of gifts and hospitality will be presented twice per year in accordance with best practice.

**Membership**

The Committee members are appointed by the Board from amongst the independent and objective Non–Executive Directors and the Associate Non-Executive Directors of the Trust and consist of not less than three members.

One of the members of the Committee will have the required qualifications to be an Audit Committee Chair and will be appointed Chairman of the Audit Committee by the Board.

The Audit Committee should corporately possess knowledge/ skills/ experience/ understanding of:

- accounting;

- risk management;
- internal / external audit; and
- technical or specialist issues pertinent to the organisation's business.
- experience of managing similar sized organisations;
- the wider relevant environments in which the organisation operates
- the accountability structures

The Chairman of the Trust shall not be a member of the Committee.

**In Attendance**

The Executive Director of Finance, Executive Medical Director, Executive Director of Nursing, Director of Corporate Governance/Company Secretary and appropriate internal and external audit representatives shall normally attend meetings. At least once a year the Committee members will meet privately with the external and internal auditors.

The Chief Executive or their deputy will be requested to attend the meeting where the Trust's Annual Governance Statement and Annual Accounts/Report are presented/ approved. They will also be invited to attend when the Committee considers the draft internal audit plan. All other Executive Directors will be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

**Frequency**

A minimum of four meetings per annum will be held in accordance with the timetable agreed by the Trust Board and an additional meeting to approve the annual accounts and report. Members or their nominated representative are expected to attend at each meeting.

The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

It is good practice for the Chair of the Audit Committee to meet with the Accounting Officer, the Executive Director of Finance, the Head of Internal Audit and the external auditor's senior representative outside of the formal Committee structure.

**Quorum**

Two members of the Committee must be present to ensure quoracy.

Members are expected to attend at least 75% of the meetings but in the unusual event that a

member of the Committee cannot attend the following are the delegated deputies.

- Chair of the Committee – A member of the Committee
- Member of the Committee – A Non-Executive Director or Associate Non-Executive Director
- Executive Directors, who would normally be in attendance or in attendance because of the nature of the agenda items, may be deputised to a senior manager within their corporate structure.

**Acting as the Auditor Panel**

- Under Section 9 of the Local Audit and Accountability Act 2014, the Trust is required to appoint an Auditor Panel.
- The role of the Auditor Panel is to advise on the selection, appointment and removal of the external auditors as well as on the maintenance of an independent relationship with that auditor, including dealing with possible conflicts of interest.
- The Trust has agreed that the Auditor Panel will be made up of the Non-Executive Directors serving on the Audit Committee and the Executive Director of Finance.
- The Auditor Panel will have a role in establishing and monitoring the Trust's policy on the awarding of non-audit services.
- The Trust must consult and take account of the Auditor Panel's advice on the selection and appointment of the external auditor. The advice given by the Panel must be published and should the Trust not follow that advice, the reasons for not doing so must also be published.
- The Auditor Panel must have at least three members, including a Chair who is an independent Non-Executive member of the Trust Board, in this case the Panel Chair will be the Chair of the Audit Committee. The majority of the Panel's members must also be independent and Non-Executive Directors/Associate Non-Executive Directors of the Trust Board.
- In order to take a decision, the Auditor Panel must be quorate, which means that the independent members (NEDs and Associate NEDs) must be in the majority and there must be at least 2 independent members present or 50% of the Auditor Panel's total membership, whichever is the highest.
- Proceedings are valid only if the majority of the members of the Panel present at the meeting are independent members.

- The Auditor Panel is an advisory body only. Responsibility to the actual procurement and appointment of the auditors remains with the Trust Board. The Chair of the Auditor Panel will be required to provide a report to the Board about the activities and decisions of the Panel.

**Other Matters**

- The minutes of the Audit Committee meetings shall be formally recorded by the Corporate Governance Team and a report submitted into the Board. From each meeting the Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.
- For monitoring compliance purposes, the Committee will report to the Board after each meeting. At least once each calendar year it will, as part of its regular reporting to the Board, the Committee will report specifically cover the statement about the fitness for purpose of the Board Assurance Framework (following the annual review by the Committee), and assurance that the risk management system is complete and embedded in the organisation and the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the Quality Accounts.

**Authority**

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee or agent and all employees are directed to co-operate with any request made by the Committee.

As well as having the permanent members of the Committee, the Committee is empowered to co-opt Non-Executive members for a period of time (not exceeding a year, and with the approval of the Board) to provide specialist skills, knowledge and experience which the Committee needs at a particular time and procure specialist advice at the expense of the organisation on an ad-hoc basis to support them in relation to particular pieces of committee business.

**Reporting**

The Committee will report to the Trust Board.

**Review**

The Committee will review its own effectiveness at least once a year taking into account the views of internal and external audit as well as other external bodies including regulators.

**Committee Services**

Lead Director: Executive Director of Finance

Secretarial Support: Corporate Governance Team

## TERMS OF REFERENCE: FINANCE AND PERFORMANCE COMMITTEE

### Constitution

The Board has established the Finance and Performance Committee to provide assurance about the delivery of the financial, workforce and operational plans approved by the Board for the current year and for the longer term future, develop forward plans for subsequent financial years for consideration by the Board and examine in detail risks to the achievement of national and local performance and activity standards.

### Purpose

To support the Trust Board in the analysis and review of Trust financial and performance plans, providing advice and assurance to the Board on financial and performance issues.

It will:

- review the annual business plans prior to Board approval and submission to the Integrated Care System (ICS)/Regulator and review plans for the longer term
- Review financial performance against income, expenditure and capital budgets and consider the appropriateness of any proposed corrective action
- Review progress against waste reduction and improvement programmes and consider the appropriateness of any proposed corrective action.
- Consider the financial performance in the current year and look ahead to expected performance for the subsequent 2-5 years and review all significant financial risks
- Regularly review cash flow forecasts, the adequacy of funding sources and receive assurance on the robustness of the Trust's key income sources
- Provide the Board with a forum for detailed discussions and assurance of progress against the annual business plan including the delivery of the Waste Reduction Plan and Improvement Plan
- Assess the performance of the organisation against all national and system/local performance and workforce standards and consider plans for the longer term
- Provide the Board with a forum for detailed discussions around the financial and performance elements of the Board Assurance Framework

### Membership

Three Non-Executive Directors/Associate Non-Executive Directors (a Non-Executive Director will be the Chair of the Committee)

Chief Executive
Executive Director of Finance
Chief Operating Officer
Executive Director of Service Development and Improvement
Operational Director of Human Resources and Organisational Development

The Executive Director of Nursing, the Executive Medical Director and the Executive Director of Human Resources and Organisational Development will attend the Committee meeting by invitation for items within their remit.

**In attendance**
Director of Corporate Governance/Company Secretary
Associate Director of Quality and Safety
Associate Director of Service Development and Improvement

A representative of the Trust's Internal Audit function will be invited to attend and observe each meeting. The Committee may direct the attendance of others at meetings as the Chair of the Committee deems appropriate.

**Frequency**
The Committee will meet a minimum of 10 times per year. Additional meetings may be called at the discretion of the Chair of the Committee as provided for in the Trust Standing Orders and the Standing Financial Instructions.

**Quorum**
Two Non-Executive Directors/Associate Non-Executive Directors and two Executive Directors. A quorum must be maintained at all meetings. Members are expected to attend all meetings but will attend at least 75% of meetings. Members who are unable to attend will arrange for the attendance of a nominated deputy, whose attendance will be recorded in the minutes, making clear on whose behalf they attend.

**Regular Reports**
*Monthly Items*
Integrated Performance Report
Finance Report

Improvement Report

Restoration Update

*Alternate Meeting Items*

Private Finance Initiative (PFI) Update

Board Assurance Framework

Corporate Risk Register

*Quarterly Items*

Workforce Report

Model Hospital Update

Education and Training Report

Procurement Report

*Annual/Alternate Years Items*

Outsourced services report (Hosted Services)

Consultancy Services spend report (Trust and system level)

Integrated Care Board Finance Report

Population Health Reports

Digital/IMT Report

Community Care Performance (2 yearly reports)

**Authority**

The Committee has no executive powers other than those specified in these Terms of Reference and by the Trust Board in its Scheme of Delegation.

The Committee is able to summon reports (and individuals) to enable the committee to discharge its duties.

The Committee forms the high-level Committee for financial and performance reporting.

The Committee is authorised to investigate any issue within the scope of its Terms of Reference.

The Committee is authorised, with the support of the Director of Corporate Governance/Company Secretary, to obtain any independent professional advice it considers necessary to enable it to fulfil these Terms of Reference.

**Reporting**

The Committee will report to the Trust Board

In addition, the Committee will report any specific risks or matters identified for escalation to the Audit Committee.

**Review**

The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board governance cycle and reported to the Board. The Committee will provide regular reports on its activities to the Trust Board. The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit Committee through the internal and external auditors and external regulatory bodies.

**Committee Services**

Lead Director: Director of Finance

Secretarial support: Corporate Governance Team

**Committees reporting**

Finance Assurance Board

Senior Operational Group

People Committee

# TERMS OF REFERENCE: QUALITY COMMITTEE

**Constitution**

The Trust Board has established a Committee with delegated authority to act on its behalf in matters relating to patient and staff safety and governance to be known as the Quality Committee.

The Committee will provide assurance to the Board and to the Audit Committee which is the high-level risk Committee of the Board, on all matters that it considers and scrutinises on behalf of the Board.

**Purpose**

The purpose of this Committee is to provide assurance to the Board that all aspects of the delivery of safe, personal and effective care are being appropriately governed and that the evidence to support that assurance is scrutinised in detail on behalf of the Board.

**Duties and Responsibilities**

The Committee will:

- Review and approve the Trust's Risk Management Strategy (and supporting documents) assuring the Board that it contains the information necessary to support good governance and risk management throughout the Trust, assuring itself that the Trust meets the requirements of all mandatory and best practice guidance issued in relation to clinical and corporate governance.
- Have the responsibility for scrutinising the Trust's (Corporate) Risk Assurance Framework on a regular basis and satisfying itself that the identified risks are being managed appropriately within the divisions and departments and at executive level.
- Be responsible for ensuring that those risks escalated to the Corporate Risk Register and Board Assurance Framework (BAF) are appropriate and proportionate, seeking further assurance from the executive team and escalating to the Board, concerns relating to unresolved risks that may require executive action or pose significant threats to the operation, resources or reputation of the Trust.
- Assure itself that adequate and appropriate integrated governance structures, processes and controls (including Risk Assurance Frameworks at all levels) are in place across the Trust.

- Receive reports from its sub-committees at which the patient safety and quality issues and risk management processes in the Divisions are debated and monitored collectively.
- Receive and oversee the production of the Trust's Quality Account and, review and endorse them for approval by the Trust Board.
- Oversee the development and implementation of the Trust's Quality Strategy.
- Receive professional staffing reviews relating to both nursing and midwifery services.
- Scrutinise the effective and efficient use of resources through evidence based clinical practice and assure itself that there is an appropriate process in place to monitor and promote compliance across the Trust with all standards and guidelines issued by the regulators, NHS England/Improvement, NHS Resolution, the Royal Colleges and other professional and national bodies.
- Promote a culture of open and honest reporting of any situation that may threaten the quality of patient care and oversee the process within the Trust to ensure that appropriate action is taken in response to adverse clinical incidents, complaints and litigation.
- Satisfy itself that examples of good practice are disseminated within the Trust, ensuring that its sub-committees have adequately scrutinised the investigation of incidents and that there is evidence that learning is identified and disseminated across the Trust.
- Satisfy itself that Safeguarding Children and Vulnerable Adults is at the heart of everything we do, ensuring that the Trust meets all of its obligations in respect of safeguarding at all times. This includes satisfying itself that all staff have training to the standard and frequency required. It will also satisfy itself that the Trust captures the learning from nationally published reports and that the learning is embedded in the practices, policies and procedures of the Trust.
- Satisfy itself that the appropriate actions in respect of patient safety and governance have been taken following recommendations by any relevant external body. This includes monitoring the Trust's compliance with the Care Quality Commission registration requirements and any reports resulting from visits.
- Receive a detailed annual report on the activity of the PALs service and complaints and litigation.
- Consider matters referred to it by other committees and groups across the Trust provided they are within the Committee's remit.

**Membership**

Three Non-Executive Directors/Associate Non-Executive Directors (a Non-Executive Director will be the Chair of the Committee)
Executive Director of Nursing
Executive Medical Director
Operational Director of HR/OD
Executive Director of Integrated Care, Partnerships and Resilience

The Executive Director of Service Development and Improvement will attend the Committee meeting on a quarterly basis to provide an update on the Trust's Improvement Programme. Other officers of the Trust may be invited to attend the Committee to report on items within their remit.

**Quorum**

Two Non-Executive Directors/Associate Non-Executive Directors and two Executive Directors
A quorum must be maintained at all meetings. Members are expected to attend all meetings but will attend at least 75% of meetings. Members who are unable to attend will arrange for the attendance of a nominated deputy, whose attendance will be recorded in the minutes, making clear on whose behalf they attend.

**Attendance**

The Director of Corporate Governance/Company Secretary and the Associate Director of Quality and Safety will be in attendance at meetings. A representative of the Trust's Internal Audit function will be invited to attend and observe each meeting. The Committee may direct the attendance of others at meetings as the Chair of the Committee deems appropriate

**Frequency**

The Committee will meet at least 10 times per year. Additional meetings may be called at the discretion of the Chair of the Committee as provided for in the Trust Standing Orders and Standing Financial Instructions.

**Authority**

The Committee has no executive powers other than those specified in these Terms of

Reference and by the Trust Board in its Scheme of Delegation.

The Committee is able to summon reports (and individuals) to enable the Committee to discharge its duties.

The Committee forms the high-level Committee for quality and safety reporting.

The Committee is authorised to investigate any issue within the scope of its Terms of Reference.

The Committee is authorised, with the support of the Director of Corporate Governance/Company Secretary, to obtain any independent professional advice it considers necessary to enable it to fulfil these Terms of Reference.

**Reporting**

The Committee will report to the Trust Board

In addition, the Committee will report any specific risks or matters identified for escalation to the Audit Committee.

**Review**

The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board business cycle and reported to the Board. The Committee will provide regular reports on its activities to the Trust Board. The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit Committee through the internal and external auditors and external regulatory bodies.

**Committee Support**

Lead Director: Executive Medical Director and Executive Director of Nursing

Secretarial Support: Corporate Governance Team

**Committees reporting**

Trust-Wide Quality Governance Group

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

# TRUST BOARD REPORT

| | |
|---|---|
| **Item** | **70** |
| **11 May 2022** | **Purpose** Information |

| | |
|---|---|
| **Title** | Finance and Performance Committee Update Report |
| **Author** | Mr M Pugh, Acting 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 23 February and 25 April 2022.

**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<br>Invest in and develop our workforce<br>Work with key stakeholders to develop effective partnerships<br>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.<br>Recruitment and workforce planning fail to deliver the Trust objectives<br>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.<br>The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework.<br>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 23 February 2022 members considered the following matters:

1. Members received the financial performance report for the month 10 financial position. Members noted the month 10 position had a £200,000 deficit in line with the financial plan and was forecasting a breakeven position at year end. They noted that the Trust cash balance had increased slightly to £58,000,000. Members were advised that capital funding had been received and the Finance Department was working to utilise this in the current 2021/22 financial year.
2. Members were informed that an improvement practice development plan was being developed which would help to build capacity and skills across the organisation. Members were advised that the Improvement team would be looking at cancer performance and histology. It was noted that a number of new measures had been introduced to improve key performance indicators within Pathology services which had resulted in a positive impact on 104-day breaches and an improvement in staff morale.
3. Members received a presentation on the Patient Level Information and Costing Systems (PLICS) and Model Hospital programme. It was noted that a new costing system would be implemented at the Trust which would bring significant benefits and more robust data.
4. The Committee received the Integrated Performance Report, noting that there had been increased numbers of attendances in the Emergency Department in February. Members noted that any changes to Trust practice would be implemented following the receipt of new national guidance.
5. Members received the Quarterly Workforce Update, noting that there had been a slight decrease in the number of vacancies. Members noted that the staff sickness level had returned to normal variation and that the NHS Staff Survey results were due to be received by the Trust.
6. An update on the Trust's Private Finance Initiative (PFI) partners was provided, along with current work being undertaken. Members noted that work continues with the PFI partners at both sites.
7. The members were updated on the Corporate Risk Register, noting that work continued to review risks and that the Assistant Director of Health, Safety and Risk

Management was holding meetings with the Divisions to address any issues and determine what should be reported at the Risk Assurance Meeting.

At the meeting of the Finance and Performance Committee held on 25 April 2022 members considered the following matters:

1. Finance Reporting, including Financial Performance 2021/22, Financial Envelopes and Planning 2022/23
2. Improvement Update
3. ELHT H2 Planning Submission Summary
4. EPR Progress Report
5. Integrated Performance Report: Workforce and Operations Update
6. COVID-19 & Restoration Update
7. PFI Update
8. Corporate Risk Register

A more detailed report from this meeting will be provided at the next Board meeting.

Martyn Pugh, Acting Corporate Governance Team Leader, 4 May 2022

# TRUST BOARD REPORT

**Item** 71

## 11 May 2022

**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 30 March 2022 and 27 April 2022.

**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<br>Invest in and develop our workforce<br>Work with key stakeholders to develop effective partnerships<br>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.<br>Recruitment and workforce planning fail to deliver the Trust objectives<br>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.<br>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 |

(71) Quality Committee Information Report

**Quality Committee Update**

At the meeting of the Quality Committee held on 30 March 2022 members considered the following matters:

1. Members received an update on the numbers of COVID positive patients being cared for by the Trust and noted that there had a significant increase from the number reported at the previous meeting. Members were also informed that this increase was exacerbating the already significant pressures being seen on urgent and emergency care pathways.
2. An update was provided to members on the Trust's Safeguarding Children team and its response to a recent national review launched by the Government following two high profile child deaths that had occurred during the first national lockdown in 2020. Members noted that work was taking place to improve Safeguarding Children Supervision Level 3 training rates among relevant staff after a drop incurred by the pandemic.
3. Members received an update on the PLACE Lite Assessment process that had commenced on 22 November 2021 and the outcomes following its completion. Members were informed that 101 separate areas had been assessed across all five of the Trust's sites and that there had been a slight decline in some since the previous assessment due in large part to the pandemic.
4. An update was provided to the committee on the latest round of Professional Judgement Reviews of the Trust's nursing and midwifery staffing establishments. It was reported that an overall increase of nine whole time equivalent nursing posts, 44 healthcare support workers and four housekeepers was required and that individual business cases had been requested for each area due to the scale of financial investment that would be required. Members confirmed that they were content for these proposed staffing increases to be presented to the Board for formal approval at a later date.
5. A series of slides were presented to members summarising the changes to the Trust's incident reporting processes as a result of its full implementation of the Patient Safety Incident Response Framework (PSIRF). Members were informed that the current Serious Incidents Requiring Investigation (SIRI) panel would be replaced by a new Patient Safety Incidents Requiring Investigation (PSIRI) panel from the 4 May onwards.

6. Members considered an update version of the Trust's latest Quality Strategy and noted that it would be circulated to senior colleagues for further comments and feedback before it was formally presented to the Trust Board for approval in May.
7. A paper summarising an internal review of a selection of audits carried out by the Mersey Internal Audit Agency (MIAA) was presented to members. It was confirmed that the majority of actions outlined in response had been completed.
8. In addition to the above items the Committee also received updates on a number of standing agenda items, including Maternity Services, the Integrated Performance Report and the CQC Well-led Inspection Update.

At the meeting of the Quality Committee held on 27 April 2022 members considered the following matters, a full summary of the discussions that took place will be provided at the next meeting:

1. Patient / Staff Safety
2. CQC Update
3. Patient Safety Incident Response Framework Report
4. Floor to Board Report for Maternity Services
5. Getting It Right First Time (GIRFT) Update
6. National Staff Survey Results Report 2021-22
7. Complaints Update
8. Board Assurance Framework
9. Risk Reporting: Corporate Risk Register
10. Risk Reporting: Risk Assurance Meeting Minutes
11. Draft Quality Account Report 2021-22
12. Review of Committee Terms of Reference
13. Infection Prevention and Control Report
14. Mortality Report
15. Nursing Assessment Performance Framework Update
16. Integrated Performance Report
17. Trust Wide Quality Governance Update

Dan Byrne, Corporate Governance Officer, 3 May 2022.

# TRUST BOARD REPORT

**Item** 72

**11 May 2022**

**Purpose** Information

| | |
|---|---|
| **Title** | Audit Committee Information Report |
| **Author** | Mr M Pugh, Acting Corporate Governance Team Leader |
| **Executive sponsor** | Mr R Smyth, Non-Executive Director, Committee Chair |

**Summary:** The report details the agenda items discussed in the Audit Committee meeting held on 27 April 2022.

**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<br>Invest in and develop our workforce<br>Work with key stakeholders to develop effective partnerships<br>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.<br>Recruitment and workforce planning fail to deliver the Trust objectives<br>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.<br>The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework.<br>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 |

**Audit Committee Update**

At the meeting of the Audit Committee held on 27 April 2022, members considered the following matters:

1. Consultant Job Planning Update
2. Management Response to Internal Audit on Risk Management
3. Cyber Security Assurance Report
4. Internal Audit Progress Report including Internal Audit Charter
5. External Audit Update
6. Anti-Fraud Service Annual Report
7. Draft Annual Governance Statement
8. Draft Going Concern Statement
9. Draft Response from Those Charged with Governance
10. 2021/22 Annual Report and Accounts Timetable
11. Accounting Policies
12. Corporate Risk Register
13. Whistleblowing Assurance Report
14. Tender Waivers Report
15. Standing Financial Instructions (SFI) – EU Procurement Changes Update
16. Review of Committee Terms of Reference
17. Noting of Ratification of Policies by the Audit Committee
    a. Standards of Conduct Policy
    b. Anti-Fraud, Bribery and Corruption Policy

A more detailed report from this meeting will be provided at the next Board meeting

Martyn Pugh, Acting Corporate Governance Team Leader, 11 May 2022

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

| **TRUST BOARD REPORT** | **Item** | **73** |
|---|---|---|
| **11 May 2022** | **Purpose** | Information |

| | |
|---|---|
| **Title** | Trust Board (Closed Session) Information Report |
| **Author** | Mr D Byrne, Corporate Governance Officer |
| **Executive sponsor** | Professor E Fairhurst, Chairman |

**Summary:** The report details the agenda items discussed in closed session of the Board meetings held on 9 March 2022.

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<br>Invest in and develop our workforce<br>Work with key stakeholders to develop effective partnerships<br>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.<br>Recruitment and workforce planning fail to deliver the Trust objectives<br>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.<br>The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework.<br>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 9 March 2022, the following matters were discussed in private:
    a) Round Table Discussion: ICB / PCB
    b) Round Table Discussion: Elective Recovery Update and COVID-19 Backlog
    c) Round Table Discussion: Annual Planning
    d) Round Table Discussion: Lancashire and South Cumbria Pathology Collaboration Agreement
    e) Renew of Microsoft Licencing Agreement 2022-25
    f) Department of Education, Research and Innovation (DERI) Strategy 2022-27
    g) National Staff Survey Results 2021
    h) Nosocomial Infections Update
    i) Industrial Action Update
    j) Fire Safety Update
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.