East Lancashire Hospitals
NHS Trust
A University Teaching Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

Personal

Effective

East Lancashire Hospitals NHS Trust
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TRUST BOARD MEETING (OPEN SESSION)
13 JULY 2022, 13.00
VIA MS TEAMS
AGENDA

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

OPENING MATTERS				
TB/2022/078	**Chairman's Welcome**	Chairman	v	
TB/2022/079	**Apologies** To note apologies.	Chairman	v	
TB/2022/080	**Declarations of Interest** To note the directors register of interests and note any new declarations from Directors.	Chairman	v	Information/ Assurance
TB/2022/081	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 11 May 2022.	Chairman	d✓	Approval
TB/2022/082	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2022/083	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2022/084	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2022/085	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Interim Chief Executive	d✓	Information
QUALITY AND SAFETY				
TB/2022/086	**Staff Story** To receive and consider the learning from a patient story.	Executive Director of Nursing	p	Information/Assurance
TB/2022/087	**Corporate Risk Register** To receive an update on the Corporate Risk Register and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Executive Medical Director	d✓	Assurance/ Approval
TB/2022/088	**Board Assurance Framework Review** To receive an update on the Board Assurance Framework and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Executive Medical Director	d✓	Information/ Assurance
TB/2022/089	**Patient Safety Incident Response Assurance Report**	Executive Medical Director	d✓	Information/ Assurance

ACCOUNTABILITY AND PERFORMANCE				
TB/2022/090	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed, with items being raised by exception: a) Introduction (Interim Chief Executive) b) Safe (Executive Medical Director and Executive Director of Nursing) c) Caring (Executive Director of Nursing) d) Effective (Executive Medical Director) e) Responsive (Chief Operating Officer) f) Well-Led (Executive Director of HR and OD and Executive Director of Finance)	Executive Directors	d✓	Information/ Assurance
TB/2022/091	**Staff Health and Wellbeing Summary Report**	Executive Director of HR & OD	d✓	Information/ Assurance
STRATEGIC ISSUES				
TB/2022/092	**Clinical Strategy**	Executive Medical Director / Interim Executive Director of Service Development	d✓	Information/ Approval
GOVERNANCE				
TB/2022/093	**NHS Improvement Annual Board Self-Certification**	Director of Corporate Governance	d✓	Information/ Approval
TB/2022/094	**Ockenden Final Statement**	Executive Director of Nursing	d✓	Information/ Assurance
TB/2022/095	**Ratification of Board Sub-Committee Terms of Reference** a) Trust Charitable Funds Committee b) Remuneration Committee	Director of Corporate Governance	d✓ d✓	Approval Approval
TB/2022/096	**Finance and Performance Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2022/097	**Quality Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2022/098	**Audit Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information

TB/2022/099	**Trust Board (Closed Session) Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
TB/2022/100	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
	FOR INFORMATION			
TB/2022/101	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2022/102	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2022/103	**Board Performance and Reflection** To consider the performance of the Trust Board, including asking: 1. Have we, as the Board, via the agenda and our discussions fulfilled our objective of supporting our: a. Communities b. Staff c. Stakeholders 2. Have we, as the Board fulfilled our statutory obligations	Chairman	v	
TB/2022/104	**Date and Time of Next Meeting** Wednesday 14 September 2022, 1.00pm, via MS Teams	Chairman	v	

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TRUST BOARD REPORT

Item	**81**
Purpose	Approval

13 July 2022

Title	Minutes of the Previous Meeting
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The minutes of the previous Trust Board meeting held on 11 May 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

East Lancashire Hospitals
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EAST LANCASHIRE HOSPITALS NHS TRUST
TRUST BOARD MEETING, 1.00PM, 11 MAY 2022
MINUTES

PRESENT

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

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Director of Corporate Governance/ Company Secretary	
Mr D Byrne	Corporate Governance Officer	Minutes
Mrs E Davies	Deputy Director of HR and OD	
Mrs D Gee	Charity Manager	Item: TB/2022/059
Mr J Hawker	Senior Responsible Officer, New Hospitals Programme	Item: TB/2022/068
Mr M Pugh	Corporate Governance Officer	

APOLOGIES

Mr S Barnes	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))
Mrs F Patel	Associate Non-Executive Director
Mrs K Quinn	Operational Director of HR and OD

TB/2022/051 CHAIRMAN'S WELCOME

Professor Fairhurst welcomed attendees to the meeting. She informed Directors that Mrs Davies was in attendance in place of Mrs Quinn and that Mr Hawker would be joining the meeting to present the quarter 4 update for the New Hospitals Programme (NHP).

TB/2022/052 APOLOGIES

Apologies were received as recorded above.

TB/2022/053 DECLARATIONS OF INTEREST REPORT

Professor Fairhurst requested confirmation from Directors that they were content for the Register of Interests Report to be included in the Trust's Annual Report for 2021/22.

Mrs Brown stated that she had an additional declaration to be added regarding her spouse's role at North West Ambulance Services (NWAS).

Mrs Atkinson advised that she had taken up a role as Parent Governor at Blacko Primary School from April 2022 and requested that this was added to the Register.

RESOLVED: **The additional declarations of interest from Mrs Brown and Mrs Atkinson will be added to the Register of Interest prior to its inclusion in the Annual Report for 2021/22.**

TB/2022/054 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 9 March 2022 were approved as a true and accurate record.**

TB/2022/055 MATTERS ARISING

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

TB/2022/056 ACTION MATRIX

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

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

TB/2022/057 CHAIRMAN'S REPORT

Professor Fairhurst's informed Directors that she had continued to attend the Pennine Lancashire (PL) Senior Leaders Advisory Group, the Provider Collaboration Board (PCB), Pathology Services Board and the Lancashire and South Cumbria (LSC) Health Equity Commission. Professor Fairhurst also advised that she had attended the opening of a 'hideaway garden' at Burnley General Teaching Hospitals and explained that this was intended to be a place where either staff or patients could go for some 'time out' if needed.

Professor Fairhurst reported that the Trust had recently received a visit from the newly appointed Chair of NHS England (NHSE), Richard Meddings MBE, and Amanda Pritchard, Chief Executive of NHSE. She stated that both Mr Meddings and Mrs Pritchard had been impressed by what they had seen from Trust colleagues despite the significant pressures they were under, particularly in its emergency pathways. She noted that this should provide assurance not only to the Board but also to members of the public.

Professor Fairhurst concluded her update by informing Directors that an MBE investiture event had been held the previous day for Ms Douglas and extended her congratulations to her. She commented that it was key to remember how crucial Ms Douglas' role had been in turning around the morale of nursing colleagues when the Trust was placed in Special Measures in 2013.

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

TB/2022/058 CHIEF EXECUTIVE'S REPORT

Mr Hodgson provided updates on national headlines and explained that the Trust would be considering its infection prevention and control (IPC) measures, and relaxing a number where appropriate, in line with the 'Living with COVID-19' guidance recently published by the Government. He reminded Directors that the final report from the Ockenden review of maternity services had been published in March 2022 and that the Board had been apprised on what this would mean for the Trust in practical terms. Mr Hodgson referred to the section of his report regarding the Elective Recovery Programme and confirmed that the Trust had already undertaken same-day hip replacements and had recently held an improvement event around cataract work.

Mr Hodgson informed Directors that a number of developments had also taken place at an LSC level. He reported that the Integrated Care System had now achieved the national standards identified in the NHS Long Term Plan for its Two-Hour Urgent Community Response, providing rapid intervention to patients in their own homes and in care homes, and explained that the focus would now shift to meeting the requirements laid out in the 2022/23 National Planning Guidance. He added that there were currently no areas of concern for any of the services provided by the Trust. Mr Hodgson confirmed that progress continued to be made by the LSC Pathology Collaborative but explained that the decision had been taken to pause the move to a single managed clinical network after a number of concerns had been expressed by clinical staff and union representatives. Directors noted that a revised engagement process had been agreed at the most recent meeting of the PCB.

Mr Hodgson went on to provide a summary of the developments taking place at a Trust level, including the recent publication of the staff survey results for 2021. He advised that the 90 new Wellbeing and Engagement champions were now in place across the Trust and explained that this was linked to the implementation of its Behavioural Framework which had been launched in 2021. Mr Hodgson went on to inform Directors that the numbers of COVID-19 positive inpatients continued to fall both nationally and within the Trust but stressed that this should not diminish what staff and patients had experienced over the previous two-year period, adding that the Trust had recently taken time to mark the second anniversary of its first COVID-19 admission. He confirmed that good progress was being made with the implementation of the Trust's new Electronic Patient Record (EPR) system and that it had recently achieved a major milestone which would allow it to move into the next stage of its development.

Mr Hodgson advised that the Trust's Surgical Admissions and Day Case Unit and Burnley East District Nurses had achieved their first three consecutive green Nursing Assessment

Performance Framework (NAPF) outcomes and had presented at Safe, Personal and Effective Care Panel (SPEC) level. He also advised that ward B14 had achieved a further green NAPF outcome. Mr Hodgson requested confirmation from Directors that they were content for all three areas to be awarded silver status for continuing to deliver Safe, Personal and Effective Care at all times.

Ms Douglas added that an additional request had been received from Acute Medical Unit A to also be awarded silver status and asked for this to be approved along with the other areas.

Directors confirmed that they were content to award 'Silver' status to all four areas.

Professor Fairhurst extended her congratulations and thanks to the colleagues involved for their efforts in achieving these results.

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

The Board agreed to award the four areas 'Silver' status.

TB/2022/059 STAFF STORY

Ms Douglas explained that the story would be presented by Denise Gee, Charity Manager for the Trust.

Mrs Gee extended her thanks to Directors for her invitation to the meeting and explained that she currently managed the Trust's official charity, ELHT&me. She advised that the Charity was made up of a relatively small team but made a substantial difference to the Trust's patients and its staff. Mrs Gee explained that the manner of the Charity's fundraising efforts had changed drastically when the COVID-19 pandemic had started, as face-to-face interactions were no longer possible, but reported that there had been a substantial amount of donations received from the public. She advised that the Charity's strategy had had to change in other ways and that more work had taken place within the Trust to provide aid, including delivering goods to wards and the provision of iPad's to enable patients to talk with their families. Mrs Gee noted that much of this work would not have been possible if not for the Charity reaching out to other organisations in the area.

Mrs Gee informed Directors that the Charity was now looking forward to its next steps, including the development of a new Charity Hub and retail outlet at the front of the Royal Blackburn Teaching Hospital (RBTH) site. She reported that a number of appeals were in place to raise funds for other developments, including improvements to the Trust's chemotherapy department, and highlighted the efforts being made by colleagues running marathons climbing mountains and taking on other challenges to raise money and make their departments better.

Mrs Gilligan extended her thanks to all Charity staff who had worked on site during the pandemic as they consistently delivered whatever had been asked of them.

Miss Wright commented that her work with Mrs Gee and the rest of the ELHT&me team was one of the highlights of her role at the Trust and stated that its importance had never been clearer than it had been during the pandemic. She informed Directors that coming year would be an exciting time for the Charity and that the planned outlet and retail hub would be a huge positive addition to the RBTH sit for both staff and patients.

Mr Hodgson also extended his thanks to Mrs Gee and the Charity team and noted that they carried out a lot of activity outside of normal working hours.

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

TB/2022/060 CORPORATE RISK REGISTER (CRR)

Mr Husain referred Directors to the previously circulated report and requested that it be taken as read. He highlighted that there had been a full review of the risks on the CRR since the previous meeting, resulting in a reduction in the number of open risks from 20 down to 16. Mr Husain also informed Directors that risk ID 9439 (Failure to meet internal and external financial targets for 2022-23) had been added to the CRR in place of risk ID 8652 (Failure to meet internal and external financial targets for 2021-22), which had now been stood down. He reported that the number of overdue risks had now come down from 197 to 169 and that this credit to the efforts of divisional and governance colleagues.

Mr Husain concluded his update by confirming that any risks scoring 15 or above had been reviewed and that governance colleagues continued to work with Divisions regarding any associated scoring and recommendations.

Directors confirmed that they were content with the assurance provided by the CRR and that relevant processes and outcomes were being adequately attended to.

RESOLVED: Directors received the report and assurance given.

TB/2022/061 BOARD ASSURANCE FRAMEWORK (BAF)

Mr Hodgson informed Directors that a significant piece of work had been undertaken to assess the current version of the BAF and update it to reflect the national strategic position. He explained that it had been clear from recent meetings which had taken place that more work was needed around the current formatting of the BAF and the numbers of risks currently included on it to provide more clarity.

Mr Hodgson requested confirmation from Directors that they were content for the revised iteration of the BAF to be taken through the Board Sub-committees in June, with a view to presenting it to the Board in July 2022. Directors confirmed that they were content with this approach.

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

The first finished draft of the revised Board Assurance Framework will be presented to the Trust Board meeting taking place in July 2022.

TB/2022/062 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) ASSURANCE REPORT

Mr Husain referred Directors to the previously circulated report and requested that it be taken as read. He explained that the PSIRF Assurance Process Reports would include more information regarding lessons learned from incidents than the previous Serious Incidents Requiring Assurance reports and would include maternity specific incidents as per the recommendations made in the final Ockenden report.

Mr Husain confirmed that the Trust's patient safety investigative team were now fully in place and were working with patients and their families around the ten investigations that were currently open.

Directors noted that the first Patient Safety Incidents Requiring Investigation (PSIRI) panel was due to be held on the 18 May 2022 and would review incidents and outcomes and agree any lessons learned. Mr Husain clarified that any incidents which did not meet the threshold for presentation at the PSIRI Panel would be managed within the relevant Divisions and that any incidents where harm had been classed as 'moderate' or above would feed into the Patient Safety Group (PSG) which would, in turn, feed into the Trust's Lessons Learned Group (LLG).

Mr Husain reported that a total of six Never Events had been declared the previous year, adding that two had now been stood down, three had been confirmed to have resulted in no harm to patients and one was still under investigation. He informed Directors that one new Never Event had been declared in April 2022 and related to the insertion of a chest drain. He stressed that although no harm had been caused to the patient involved, Duty of Candour and all other relevant activities had been undertaken since. He also confirmed that various points had been highlighted which would require further investigation, including issues around Local Safety Standards for Invasive Procedures (LocSSIPs).

Mr Husain concluded his update by advising that, as an early adopter of the PSIRF, the Trust had recently provided guidance not only to neighbouring Trusts in LSC but also in Cheshire and Merseyside and Greater Manchester.

Professor Fairhurst enquired if it would be possible for a diagram to be included in future reports to provide more clarity around the relationship between any new groups established following the move to the PSIRF. Mr Husain stated that he would ensure that a diagram was circulated after the meeting to more clearly show how these groups fed into each other.

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

A diagram showing the relationship between new groups set up following the move to PSIRF to be included in future reports and circulated to Directors outside the meeting.

TB/2022/063 INTEGRATED PERFORMANCE REPORT (IPR)

a) Introduction

Mr Hodgson introduced the item and confirmed that it covered the period to the end of March 2022. He stated that there had been a number of challenges at this time, particularly the numbers of patients waiting 12 hours or more in the Trust's Emergency Department (ED) and cancer performance falling short but stressed that these should be considered in the context of having to manage ongoing COVID-19 infections, elective recovery efforts and significant pressures on the workforce.

b) Safe

Mr Husain requested that the safe section of the report be taken as read and provided a summary of highlights. He reported that the numbers of Clostridium difficile (C. diff) Pseudomonas bacteria cases had remained well under trajectory in the previous 12-months. He noted that the Trust had recorded a greater number of Escherichia coli (E. coli) than its trajectory target. Mr Husain advised that the E. coli outbreak on the Trust's Neonatal Intensive Care Unit (NICU) had now been formally closed but confirmed that support was still being provided to the unit by IPC nurse colleagues. He reported that Venous Thromboembolism assessment rates were at 99% against a trajectory target of 95%.

Ms Douglas requested that the staffing section of the report be taken as read and stressed that March had remained a very challenging month as a consequence of the spread of the Omicron variant of COVID-19. She advised that the actions taken to mitigate any shortages were listed in the report and highlighted that the recruitment of internal nursing colleagues was proceeding well, with around 10 new colleagues joining the Trust per month. In response to a query raised by Mr Rehman regarding the rise in the numbers of pressure ulcer investigations taking place over recent months, Ms Douglas clarified that there had been a change in national reporting mechanisms and that all pressure ulcers were now recorded, rather than just those of higher severities. She provided assurances that each pressure ulcer report was thoroughly investigated through the PSIRF process discussed earlier in the meeting.

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

c) Caring

Ms Douglas referred Directors to the Caring section of the report and requested that it be taken as read. She advised that all Divisions were being encouraged to review feedback provided by patients and that every effort was being made to collect data from all patients attending the ED via a text messaging service. Ms Douglas highlighted that work was taking place to ensure that more complaints were responded to in a timely manner, whilst also ensuring that thorough investigations had taken place and that families had the opportunity to meet with divisional colleagues to discuss any concerns that they may have.

Professor Fairhurst noted the ongoing deterioration in Friends and Family Test (FFT) scores in Accident and Emergency (A&E) areas and requested clarification on whether the physically and emotionally distressed state of patients was considered when feedback was provided. Ms Douglas explained that information was collected both during patients' stay and post discharge in order to provide a clearer picture of whether anything had changed, adding that some patients elected to wait until they had returned home before submitting their responses.

RESOLVED: **Directors noted the information and assurance 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 104.6, adding that it had further reduced to 103.8 as of the time of the meeting. He reported that the Trust's Summary Hospital Mortality Indicator (SHMI) had similarly reduced, down to 1.05, and commented that this was also a positive development. Mr Husain informed Directors that crude mortality for the Trust was down to 2.2%, compared to 2.6% during the same period in 2020 and 2.4% in 2021, and, when COVID-19 deaths were removed, stood at 1.9%. He went on to advise that two groups were currently raising concerns, specifically sepsis and acute cerebrovascular disease, and provided assurances that these were being closely monitored by the Trust's Sepsis Steering Group and Stroke Steering Group respectively. Mr Husain confirmed that the Trust's Medical Examiner team continued to review all deaths in the organisation and advised that the size of the team had been increased in preparation for them reviewing deaths in community settings from July 2022 onwards.

Directors confirmed that they were content with the level of assurance provided under the Effective section of the report.

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 reiterated that emergency pathways remained under significant pressure but highlighted that there had been a slight improvement in performance in March 2022, with 71.1% of patients either being treated, discharged or admitted within four hours of arrival. Despite this improvement, Mrs Gilligan acknowledged that a significant number of patients, 809 in total, had waited in the ED for over 12 hours following a Decision to Admit (DTA), with 798 of these due to physical health concerns and 11 due to mental health concerns. She explained that the volume and complexity of the patients coming into the Trust were the main contributing factors to the issues being seen, as well as the complexity of pathways themselves and ongoing staff shortages. Mrs Gilligan stressed that a significant amount of work was being done to improve the Trust's position and advised that a paper was due to be presented at the next meeting of the Finance and Performance Committee outlining the actions currently being taken. Directors noted that despite the Trust having the highest number of ambulance conveyances in the North West, it had kept its turnaround times to an absolute minimum, with an average of 22 minutes in March 2022.

Mrs Gilligan went on to provide a brief update on elective performance to Directors. She reported that the number of patients on open pathways continued to rise but stressed that this was expected to reduce over the coming months as additional validation was completed. Mrs Gilligan informed Directors that the Trust was currently ahead of trajectory for reducing the number of patients waiting 52 weeks or more treatment and was aiming to reduce the number of patients waiting 104 weeks or more to zero by the end of June 2022. In response to a query from Mr Smyth regarding cancer waiting times, Mrs Gilligan clarified that that just over 600 patients had breached in total, 266 of which had gone over 104 days, and that the system was working to get back to pre-pandemic levels by the end of the year.

Mr Hodgson reiterated that a significant amount of work was taking place to reduce the numbers of patients staying in the ED for over 12 hours and advised that the Trust's Executive team was considering how to put further escalation measures in place in the future.

Mrs Anderson stated that she was assured by the information that had been provided and that it was clear that good progress was being made in a number of areas despite the impact from COVID-19. She requested further clarification on whether there had been an increase in the number of patients presenting in the ED with greater acuity. Mrs Gilligan stated that the Trust was working with its primary care partners to educate the public about more appropriate places to access care. She reported that, on average, it was receiving 55 more patients in A&E per day then it had at the same time in 2019. She advised that she had received anecdotal evidence that the Trust was seeing more acutely unwell patients and evidence of long-term conditions that had worsened during the pandemic but explained that the full health cost of COVID-19 would not be fully understood for some time yet.

Mr McDonald informed Directors that across LSC there were estimated to be around 24,000 outstanding patients with long-term health conditions such as diabetes, hypertension and asthma and that a sizeable proportion of them would have already come through urgent and emergency care pathways due to delays in primary care. He confirmed that a plan was being developed with primary care and commissioning colleagues to address the situation.

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

f) Well-Led

Mr Davies reiterated that nursing and midwifery staffing had been challenging but reported that the Trust had managed to fill 72,000 hours through the staff bank in March, compared to its usual average of 60,000. She added that this was linked to the work taking place around international nurse recruitment. Mrs Davies explained that retention would form an important part of the Trust's Workforce Strategy and that the first survey for later career nurses and midwives had just been completed. Directors noted that discussions were now taking place around extending this retention survey out to other areas in the Trust where it was expecting staffing challenges in the future. She reported that sickness and absence rates in the Trust were still above threshold and had stood at 7.08% in March, 1.63% of which had been attributed to COVID-19 related illness. Mrs Davies advised that these numbers had slowly started to decline over recent days and weeks.

Responding to a query raised by Mr Wedgeworth regarding the support available for any newly recruited international nursing colleagues, Mrs Davies explained that a robust plan was in place to support them and confirmed that the Trust followed the nationally agreed framework for best practice in this area.

Ms Douglas added that pastoral support had always been available for international nursing recruits and that they were encouraged to make connections with any existing international colleagues already in the organisation.

Mrs Brown confirmed that the Trust had had met all of its financial expectations and was expecting a surplus of £17,000 in line with previous forecasts. She reported total capital spend £30,000,000 for the year, with a £2,000,000 underspend due to some remedial work required on the roof of one the buildings at the RBTH site. Mrs Brown also confirmed that the Trust had met all of its Better Payment Practice Tariffs (BPPTs) for the year and had paid over 95% of its bills within 30 days.

Mrs Brown went on to inform Directors that, along with other providers, the Trust had agreed to bridge the system financial gap for the 2022-23 financial year with a 5% efficiency programme, resulting in a total expected cost of £28,800,000. She acknowledged that this would require a significant amount of work both organisationally and as a system to achieve this target and stated that she would provide a further update at the next meeting, including a more substantial update on the Trust's Waste Reduction Programme (WRP).

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

An update on the work taking place to meet the financial targets, including WRP will be provided as part of the IPR at the next meeting of the Board.

TB/2022/064 BEHAVIOUR FRAMEWORK IMPLEMENTATION UPDATE

Mrs Davies referred Directors to the previously circulated report and explained that it provided an overview of the progress made with the implementation of the Trust's Behavioural Framework since its launch in September 2021 and the plans for it to be further embedded over the coming 12-month period. She highlighted the importance of the framework and the widely accept benefits of culture changes improving the staff and patient experience, as well as supporting the Trust's aspirations to be outstanding and its efforts to support recruitment and retention. Mrs Davies advised that there had already been a number of successes since September 2021, including the launch of a new Communications and Engagement plan with support from colleagues in the Communications Team. She stated that the plans to further embed the framework into wider procedures would be the next crucial piece of work taking place over the coming months.

Mr Wedgeworth requested clarification on how Directors' adherence to the Behavioural Framework would be monitored. Professor Fairhurst clarified that this would come under her purview as Chairman but stressed that it would also be the collective responsibility of the Board to ensure that it was observing the principles laid out in the framework.

Mr Rehman referred to section 6 of the report regarding measures of success and enquired whether any plans were in place to tie the Behavioural Framework into the Trust's appraisal process. Mrs Davies stated that work was already taking place to look at incorporating elements of the Behavioural Framework into the next round of appraisals and to also tie it into the associated documentation processes.

Mrs Atkinson advised that discussions had also recently taken place around how the Behavioural Framework could be incorporated into the Trust's improvement practices and how to strengthen the links between the two.

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

A further progress report on the implementation of the Trust's Behavioural Framework will be provided to the Board in 12 months' time.

TB/2022/065 NATIONAL STAFF SURVEY REPORT 2021/22

Mrs Davies presented a series of slides to Directors summarising the results and findings from the 2021-22 NHS Staff Survey, the actions taken since and the next steps.

Mrs Davies informed Directors that the survey for 2021-22 had been completely refreshed to align the questions to the NHS People Promise. She highlighted that a total of 5,265 staff had completed the survey and pointed out that this was a clear sign that staff engagement had continued to improve despite the significant pressures that the Trust had been working under.

Mrs Davies reported that the Trust had scored above average' for seven of the nine themes outlined in the survey, average for the theme of 'we are a team' and below average' for the theme of 'we are always learning'. Directors also noted that 65% of those staff who had completed the survey had stated that they would recommend the Trust as a place to work. Mrs Davies concluded her update by advising that the agreed corporate and divisional action plans developed in response to the survey results were due to be discussed and approved at the June 2022 Employee Engagement Sponsor Group.

Mrs Atkinson noted that colleagues had reported that they felt they had the opportunity to show initiative in the Trust but not to actually take their ideas and turn them into action. She confirmed that one of the future priorities of the improvement team would be to think about how this could be built into the core activities of staff to empower them to do this.

Mr Rehman commented that it was not surprising to see that some areas had worsened over the previous year and that this reinforced the need for the Trust to improve the situation as a priority. He suggested that it may be worth considering carrying out a ‘deep dive’ into the broader workforce challenges at a later date. Mrs Davies confirmed that this was one of the areas that she and her colleagues were most focused on and stated that this was why the ‘Big Conversation’ process currently taking place was so important, as it would allow greater understanding of the reasons behind these results.

RESOLVED: Directors received the report and noted the assurance provided.

TB/2022/066 QUALITY STRATEGY

Mr Husain informed Directors that work had started the previous year to develop a new Quality Strategy for the Trust and confirmed that external stakeholders and Executive colleagues had been involved in this process. Mr Husain requested confirmation from Directors that they were happy to approve the contents of the document, adding that the final touches in terms of formatting and pictures would be added at a later date.

Mrs Atkinson explained that the Trust had sought to embed its improvement practices across a number of its strategies, including the Quality Strategy. She advised that a detailed plan was in place that underpinned much of this work and that she will look into sharing this information with Board members at a future date.

Mr Wedgeworth commented that he felt the strategy made clear that the Trust was determined to provide the best quality of care that it could but suggested that more information was needed around the prevention aspect of healthcare as well as treatment.

Professor Fairhurst suggested that delegated authority was granted to the Chair of the Quality Committee, Mr Hodgson and herself to review and approve the final version of the document before it went into the public domain. Mr Hodgson agreed that this would be a sensible way to proceed and would follow the same process used for the Department of Education, Research and Innovation (DERI) strategy discussed at the previous meeting.

RESOLVED: **Directors received the report and noted its content.**
Mrs Atkinson to provide an update on the work underpinning the Trust's improvement practices at a future meeting.
Delegated authority to be granted to Professor Fairhurst, Mr Hodgson and Mrs Anderson to review and approve the final version of the Trust's Quality Strategy before it is circulated into the wider public domain.

TB/2022/067 CLINICAL STRATEGY DEVELOPMENT – PROGRESS UPDATE

Mr Husain advised that a number of workshops had been held with stakeholders to develop the Trust's Clinical Strategy and that comments and feedback had been requested from external partners before proceeding further. He also confirmed that clinical and operational leadership teams had gone through a robust engagement process with Divisions. Mr Husain explained that the primary ambitions of the strategy were to ensure that the Trust had first class emergency and elective services and stated that it would form the basis of what it was intending to deliver over the coming years.

Mrs Atkinson informed Directors that the detailed proposals underpinning some of the ambitions outlined in the Clinical Strategy had been collated and presented at the Trust's Senior Leadership Group meeting and at a recent Board Development Session. She extended her thanks to the Trust colleagues who had participated and advised that it would be presented at the Trust Board meeting in July 2022 for formal approval. Directors confirmed that they were content with this proposal.

RESOLVED: **Directors noted the update provided.**
The Trust's Clinical Strategy will be presented at the meeting in July 2022 for formal approval.

TB/2022/068 NEW HOSPITALS PROGRAMME QUARTER 4 BOARD REPORT

Mr Hawker introduced himself to Directors in his role as Senior Responsible Officer for the New Hospitals Programme (NHP) and requested that the paper be taken as read. He highlighted that the shortlisting options process for the NHP had now been completed and that these were now being worked through in detail to make it clearer what they would mean in practical terms for patients. Mr Hawker also advised that work had been taking place with the wider LSC system over recent months to start a parallel programme of work to look at developing a strategy for primary and community services, as this would form an important part of ensuring that region would have the right hospitals delivering the right services.

Mr Hodgson stated that it was becoming increasingly clear through discussions at the PCB that a coherent hospital strategy was needed and noted that the NHP would play a pivotal role in the Trust's own clinical strategy as it was developed.

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

TB/2022/069 RATIFICATION OF BOARD SUB-COMMITTEE TERMS OF REFERENCE

The revised Terms of Reference for the Audit Committee, Quality Committee and Finance and Performance Committee were presented to Directors for ratification, following their approval at the most recent meetings of each.

Directors confirmed that they were content to ratify the revised Terms of Reference presented.

RESOLVED: **Directors confirmed that they were content to ratify the revised Terms of Reference for the Audit Committee, Quality Committee and Finance and Performance Committee.**

TB/2022/070 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/2022/071 QUALITY COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

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

TB/2022/072 AUDIT COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

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

TB/2022/073 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/2022/074 ANY OTHER BUSINESS

No additional items were raised for discussion.

TB/2022/075 OPEN FORUM

Professor Fairhurst informed Directors that a question had been submitted prior to the meeting by Unite and Unison colleagues regarding the planned reintroduction of car parking charges on the Trust's sites. The following response was provided:

"All NHS organisations are affected by the Government's announcement about the reintroduction of parking charges to staff. We accept and understand your concerns connected to the wider rising cost of living and the further impact this will have on colleagues. Whilst we're not able to decline this instruction we want to assure you that within the Lancashire and South Cumbria system, NHS organisations are working together to do it in the fairest way possible.

Despite the announcement in April, we have been able to delay charges until July. We are committed to working with staff side colleagues to consider all options in relation to parking charges to help colleagues. I want to be clear also that the Trust will only cover the costs of times we're required to charge for. There will be no profit from it.

The Trust welcomes feedback and suggestions from all patients and their families and all colleagues and staff side representatives. Your question and concerns are appreciated, and we hope this response provides some assurance around our approach."

TB/2022/076 BOARD PERFORMANCE AND REFLECTION

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

Mr Hodgson stated that he felt the discussions had had a strong focus on Trust staff and the communities which it served and that the Board had fulfilled its statutory duties.

Mrs Gilligan commented that she felt it had been a good meeting, with appropriate levels of debate on the items discussed.

RESOLVED: Directors noted the feedback provided.

TB/2022/077 DATE AND TIME OF NEXT MEETING

Professor Fairhurst informed Directors that the next Trust Board meeting would be taking place on Wednesday, 13 July 2022 at 13:00, via MS Teams.

Mr D Byrne, Corporate Governance Officer

TRUST BOARD REPORT		**Item**	**83**
13 July 2022		**Purpose**	Information

Title	Action Matrix
Director sponsor	Mrs A Bosnjak-Szekeres, Director of Corporate Governance/ Company Secretary

Summary: The outstanding actions from previous meetings are presented for discussion. Directors are asked to note progress against outstanding items and agree further items as appropriate

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

(83) Action Matrix

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
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
TB/2022/053: Declarations of Interest Report	The additional declarations of interest from Mrs Brown and Mrs Atkinson will be added to the Register of Interest prior to its inclusion in the Annual Report for 2021/22.	Corporate Governance Team	May 2022	Complete: The Directors Register of Interests was updates as per the requests made.
TB/2022/061: Board Assurance Framework	The first finished draft of the revised Board Assurance Framework will be presented to the Trust Board meeting taking place in July 2022.	Director of Corporate Governance	July 2022	Agenda Item: July 2022
TB/2022/062: Patient Safety Incident Response Framework Assurance Report	A diagram showing the relationship between new groups set up following the move to PSIRF to be included in future reports and circulated to Directors outside the meeting.	Executive Medical Director	July 2022	Complete: A flowchart of reporting groups for the PSIRF will be included in all future assurance reports provided at Trust Board meetings.

Item Number	Action	Assigned To	Deadline	Status
TB/2022/063: Integrated Performance Report (Well-led)	An update on the work taking place to meet financial targets, including WRP will be provided as part of the IPR at the next meeting of the Board.	Executive Director of Finance	July 2022	An update will be provided as part of item 90 (Integrated Performance Report) at the Trust Board meeting in July.
TB/2022/064: Behaviour Framework Implementation Update	A further progress report on the implementation of the Trust's Behavioural Framework will be provided to the Board in 12 months' time.	Executive Director of HR & OD	May 2023	Agenda Item: May 2023
TB/2022/066: Quality Strategy	Mrs Atkinson to provide an update on the work underpinning the Trust's improvement practices at a future meeting. Delegated authority to be granted to Professor Fairhurst, Mr Hodgson and Mrs Anderson to review and approve the final version of the Trust's Quality Strategy before it is circulated into the wider public domain.	Interim Executive Director of Service Development and Improvement Chairman/Chief Executive/Quality Committee Chair	September 2022 July 2022	Update: Future updates on the improvement work taking place in the Trust will be provided to the Board on a six-monthly basis. Update: following approval of the foreword by the Executive Director of Nursing and Executive Medical Director the Strategy will be published on the Trust website before the Trust Board meeting on 13 July 2022.

Item Number	Action	Assigned To	Deadline	Status
TB/2022/067: Clinical Strategy Development – Progress Update	The Trust's Clinical Strategy will be presented at the meeting in July 2022 for formal approval.	Executive Medical Director/ Interim Executive Director of Service Development and Improvement	July 2022	Agenda Item: July 2022

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

Miss K Ingham, Corporate Governance Manager

TRUST BOARD REPORT		**Item**	**85**
13 July 2022		**Purpose**	Information

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

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

CEO Report

July 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 125 million COVID vaccination doses have now been administered in England taking the percentage of people fully vaccinated to 75.3%.

The Government ended provision of free universal symptomatic and asymptomatic testing in England in April and is now managing the virus like other respiratory infections as set out in the Living with COVID-19 Plan. The legal requirement to wear a face covering no longer applies. Likewise, there is no requirement for the people to wear masks in healthcare settings unless there is a personal preference, they are at high risk of infection due to immunosuppression (oncology/haematology) or entering areas with patients who are immunosuppressed or have been positively tested for COVID-19.

Health and care colleagues should continue to wear facemasks as part of personal protective equipment required when working in COVID-19/respiratory care pathways, for any aerosol generating procedures and when caring for patients who are immunosuppressed.

The pandemic has been reclassified from a Level 4 (National) to a Level 3 (Regional) Incident. The NHS will continue to remain vigilant, and local health and care systems will continue to ensure their resilience and capability to re-establish to full incident responses in the event this is warranted.

Transitioning from COVID-19 response to recovery

Amanda Pritchard, NHS Chief Executive and Sir David Sloman, Chief Operating Officer for NHS England and NHS Improvement has published a letter setting out the next steps on transitioning from COVID-19 response to recovery.

While there are no additional expectations or priorities on local systems beyond those already set out in the 2022/23 priorities and operational planning guidance there is a call for immediate focus on delivering timely urgent and emergency care and discharge, providing more routine elective and cancer tests and treatments and improving patient experience.

Next steps for integrating primary care

In November 2021 Amanda Pritchard, NHS Chief Executive, asked Dr Claire Fuller, Chief Executive-designate Surrey Heartlands Integrated Care System and GP, to undertake a stocktake on integrated primary care, and assess how newly formed Integrated Care Systems and primary care could work together to improve care for patients.

The now published Next steps for integrating primary care: Fuller Stocktake report makes a series of recommendations for local and national leaders, and articulates important ideas about the future shape of urgent care and about the further development of neighbourhood teams.

At the heart of this report is a new vision for integrating primary care, improving the access, experience and outcomes for our communities, which centres around three essential offers:

- **streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
- **providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- **helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

All 42 NHS Chief Executive designates of the Integrated Care Systems have signed a letter in support to Amanda Pritchard, pledging to take forward the actions in their own systems and communities.

Checks for prostate cancer hit all-time high

Record numbers of men are getting checked for prostate cancer thanks to a lifesaving awareness raising campaign. Urgent referrals for urological cancers reached an all-time high in March this year, with almost 25,000 people (24,331) checked in just one month, following a campaign launched by the NHS and Prostate Cancer UK in February.

The NHS teamed up with Prostate Cancer UK to deliver a six-week campaign from mid-February, urging men to use the charity's online risk checker in a bid to reduce the shortfall in men starting prostate cancer treatment since the pandemic began. NHS figures show the campaign had an immediate impact as urological cancer referrals in March increased by more than a fifth (23%) compared to the previous month and are up by almost one third (30%) compared with the same month last year.

Symptoms of prostate cancer often do not show up during early stages but men who have higher risk are encouraged to come forward for checks.

One million checks delivered by NHS 'one stop shops'

NHS 'one stop shops' have delivered over one million checks and tests since the rollout began, as the biggest catch-up programme in health history gathers pace.

Over 90 community diagnostic centres are already freeing up hospital capacity by offering MRI, CT and other services closer to patients' homes, often in the heart of local communities. Tests and checks carried out at these sites help staff diagnose a range of conditions including cancer, heart and lung disease quicker to ensure patients get the care they need more quickly.

As set out in the NHS elective recovery plan earlier this year, around £2.3 billion will be used to expand diagnostics and £1.5billion for treatment, with a focus on cancer, to ensure wait times are addressed for everyone. The NHS will increase capacity to deliver over 10 million diagnostic tests over a three-year period.

GP surgeries to provide specialist mental health support

Thousands of new mental health experts will be on hand to support people in their local GP practice amid record demand for mental health services.

Fully trained experts from local NHS Trusts will offer people with severe mental health problems such as bipolar, psychosis or eating disorders, a consultation, treatment, peer support, or a referral to hospital teams without needing a GP appointment. The new service ensures people are offered appointments with mental experts which are up to three times longer than a standard GP appointment, meaning more time for their needs to be assessed.

The NHS is providing funding for two mental health practitioners for every group of GP practices in a local area, meaning up to 2,500 mental health experts will be providing additional support.

High street pharmacies play key role in new NHS early diagnosis drive

High street pharmacies will be funded to spot signs of cancer as part of a new drive to catch tumours early when they are easier to treat. Customers will then be sent for scans and other checks under the initiative, which is being trialled by pharmacies as part of radical NHS action that also includes roaming liver scan trucks and a targeted genetic testing programme.

The NHS Long Term Plan committed to increasing the proportion of cancers caught early, when they are easier to treat, from half to three in four. The community pharmacy pilot, to be carried out in areas across the country, will see staff spot signs of cancer in people who might not have noticed symptoms. Those with key symptoms linked to cancer will be referred direct for scans and checks without needing to see a GP.

Breakthrough in global battle against superbugs

The NHS is set to roll out two 'superbug' busting drugs through a world-first, pioneering subscription deal that will help tackle antimicrobial resistance.

These drugs will provide a lifeline to patients with life-threatening infections like sepsis, hospital or ventilator pneumonia and blood stream infection, with increasing numbers of people developing drug resistance as germs evolve to become resistant to current antibiotics.

A study from the University of Oxford published this year estimates that around 1.2 million deaths globally were caused by antibiotic resistance and experts predict this will only grow. This first-of-its-kind NHS scheme means pharmaceutical firms will receive a fixed yearly fee – capped at a level that represents value to taxpayers – to incentivise funding for innovation that can generate a pipeline of new antibiotics for NHS patients. It is hoped that this scheme will encourage investment in this critical area and promote good stewardship to limit the potential development of antimicrobial resistance.

NHS ConfedExpo

NHS Confederation, NHS England and NHS Improvement joined forces this year to bring together two long-standing conferences to create a new event -- NHS ConfedExpo. The event ran for two days and was held at ACC Liverpool.

Set to be one of the biggest and most significant healthcare conferences in the UK, it created a single point of focus for health and care leaders and their teams to come together at a time of transformation and recovery.

The conference programme contained a mixture of high profile and influential plenary speakers, theatre sessions, pop-up universities, feature zones and a range of networking opportunities that provide delegates with information, tools and fresh thinking to help take their organisation forward.

In her keynote speech Amanda Pritchard talked about her priorities as Chief Executive of NHSE, which she characterised of the 'four Rs' of recovery, resilience, respect and reform.

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.

Health and Care Bill receives Royal Assent to become part of UK law

The Health and Care Bill 2021 has completed the Parliamentary process and received Royal Assent, meaning it will form part of UK law.

This is a welcome and important step on the journey towards establishing Integrated Care Systems on a statutory footing, which will take place on 1 July 2022.

The new Act of Parliament introduces measures to tackle the COVID-19 backlogs and rebuild health and social care services from the pandemic. It also aims to tackle health inequalities and create safer, more joined-up services that will put the health and care system on a more sustainable footing.

Across Lancashire and South Cumbria, organisations have been working together for a number of years to join up services and improve the care that our communities receive. The new legislation supports this strengthening the joint working even more, through the establishment of a statutory Integrated Care System (ICS). ICSs are designed to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

Within an Integrated Care System, there are three levels: neighbourhood, place and system.

Neighbourhood level services are those outside of a hospital such as GPs, opticians, dentists and community pharmacies working together to deliver primary care.

Place covers a wider area and will include several neighbourhoods.

The **system**, also referred to as the Integrated Care System (ICS), is a key enabler for the integration of local services. The ICS is made up of two key bodies:

- **Integrated care partnership** – this links together all the wider health and care partners including the voluntary sector, employment and health across Lancashire and South Cumbria. Locally, we refer to this as Lancashire and South Cumbria Health and Care Partnership.
- **Integrated care board** - the newly passed legislation means that a new Integrated Care Board (ICB), known publicly as NHS Lancashire and South Cumbria, will be set up from 1 July 2022.

Provider Collaboration

During the COVID-19 pandemic, provider Trusts and the wider health and care system increasingly worked collaboratively with each other to ensure the maintenance of such good patient care.

This provided a great opportunity to build on the collaboration to further improve health and care and now the five provider NHS Trusts have come together as a Provider Collaborative to agree joint priorities and how to best deliver them for the benefit of people across Lancashire and South Cumbria.

In addition, the Lancashire and South Cumbria Health and Care Partnership has established a Mental Health, Learning Disability and Autism Provider Collaborative. This will be led by Lancashire and South Cumbria NHS Foundation Trust working with colleagues in health, social care and the voluntary, community, faith and social enterprise sector.

The combined aim is to drive up quality by sharing and standardising best practice to reduce unwarranted variation and duplication.

The Provider Collaborative wants to ensure patients have equal access to the same high-quality care wherever they live and for colleagues to have the same high-quality experience wherever they work. And importantly, the Provider Collaborative want to play a part in addressing the inequalities the combined communities experience.

This new venture is about strengthened partnership working and not about organisational change. All the Trusts remain as statutory bodies, and each chair and chief executive remain accountable for their own separate organisation.

This is the start of the journey for our Provider Collaborative and as part of that colleague from the hospital Trusts have been the invited to attend briefings which aim to introduce them to the provider collaboration and the work ongoing across all of the organisations.

The virtual events will be held in June and July and hosted by all five provider NHS Trust chief executives and Kevin Lavery, Designate Chief Executive Officer of the Lancashire and South Cumbria Integrated Care Board will be talking about system working and how provider collaboration fits into this.

Colleagues will be able to file questions for the expert panel in advance or via the chatbox function on the day. All Q&As will be collated and shared. More information can be found on the Lancashire and South Cumbria Provider Collaborative website.

New Hospitals Programme update

Following the announcement of the shortlist of proposals for new hospital facilities the current focus for the programme is the detailed work to understand the feasibility of the shortlisted options. This will include site footprint, land availability, planning considerations and financial affordability.

Recent activities for the programme include Rebecca Malin, Programme Director for the New Hospitals Programme, explaining how the shortlist of proposals for the New Hospitals Programme have been developed and discussing the merits of the proposals carried forward and the next steps for the programme.

Once completed, the brand-new facilities that the Lancashire and South Cumbria New Hospitals Programme will bring will be a huge boost to the region. Aaron Cummins, Chief Executive of University Hospitals Morecambe Bay NHS FT explains the impact that will have across the system in a piece on the New Hospitals Programme website. It also includes a piece from Kevin McGee, Chief Executive of Lancashire Teaching Hospitals NHS FT, talking about the collaborative approach to the New Hospitals Programme and how it is 'future-proofing health and social care for generations to come".

Chatbot helps people move up NHS waiting lists

Chatbot is an automated call system being piloted by Lancashire and South Cumbria NHS, which guides patients through a series of questions designed by NHS consultants and healthcare experts. It enables patients to let their hospital know if they no longer require treatment, if their condition has worsened and, where necessary, speed up their treatment.

Thanks to Chatbot, 15 per cent of people on waiting lists in the Morecambe Bay and Preston areas have been removed, meaning quicker access to services for those remaining patients who need to be seen, in particular, the 10 per cent of patients who indicated they needed an appointment sooner. The pilot will now be extended to patients in Blackpool and East Lancashire.

The pilot saw 2,282 waiting list patients in the Morecambe Bay and Preston areas receive an automated call asking them about their health condition. Three quarters (75 per cent) of patients responded to either the automated call, or a follow-up call from a member of staff.

On the back of this success, another 2,000 people in Blackpool and East Lancashire will now be contacted by the automated system. Patients will receive an SMS text message beforehand to warn them to expect the call.

Hundreds of patients benefit from heart scan push

Almost 750 patients in Lancashire and South Cumbria benefitted from a weekend drive which provided 800 extra appointments for echocardiography (ECHO), a scan used to look at the heart and blood vessels.

The push to reduce waiting lists was made possible due to a digital passporting scheme which allowed staff to move between the four acute hospital Trusts in the ICS, over two weekends.

To support patients and to promote post-COVID ECHO recovery, the hospital Trusts came together through cross-site working to offer additional capacity as a system-wide workforce. This collaborative work has decreased waiting lists substantially and has successfully returned a number of sites back to pre-COVID levels.

Anyone waiting for a diagnostic test, treatment or surgery, can visit myplannedcare.nhs.uk/nwest/ to find out more about their hospital and treatment.

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. Since the decision was taken to pause the process, further listening and engagement with those colleagues who are affected by the proposed changes has begun.

The collaboration has also received notification from NHS England and NHS Improvement which placed it in the ‘DEVELOPING’ stage within the national pathology network maturity matrix. This acknowledges the progress made to date and makes clear the target of reaching ‘MATURING’ by 2024/25.

Within that progress the following key milestones must be achieved:

- A collaborative approach to point of care Testing
- Improve network governance around quality assurance
- A network approach to continuous improvement
- Developing a network-wide approach to Digital Pathology
- A collaborative approach to workforce strategy, planning and training
- Achieving all the key elements of a mature network

These are broadly consistent with the priorities identified after the April Pathology Board meeting. The collaboration will continue to move forward with delivering the milestones above as it progresses towards providing a single service for the Lancashire and South Cumbria integrated health and care system.

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 not been used since the last report to the Board.

Chief Nurse receives MBE for services to nursing

Christine Douglas (formerly Pearson), Chief Nurse and Executive Director of Nursing at the Trust, was presented with the honour at a ceremony at Royal Blackburn Teaching Hospitals, where she has led the nursing team and been a member of the Trust Board for more than eight years.

Chris received the Member of the order of the British Empire (MBE) in recognition of her services of over more than 40 years. She was joined by colleagues from the Trust, family and friends at the ceremony and received the award from the Lord-Lieutenant of Lancashire the Rt Hon Lord Shuttleworth.

Chris began as a student nurse day at North Manchester General Hospital, qualifying as a registered general nurse in 1984. With a keen interest in patient safety, she completed the Institute of Health Improvement Patient Safety Officer Course in 2009 in Boston USA and took the lead on several patient safety initiatives. Chris's passion for ensuring safe, personal and effective care is delivered harm-free and of the highest quality, is something she has carried throughout her career and passed on to many colleagues that she has worked with.

New funding for online brain injury support scheme

A successful scheme to help brain injury and stroke survivors is being rolled out through Lancashire and South Cumbria, thanks to new funding from a national charity.

The Neuro Rehabilitation OnLine (NROL) programme, which is jointly run by the Trust and the University of Central Lancashire, has received nearly £180,000 from brain injury recovery charity SameYou to expand the pilot project. SameYou was awarded funding from The National Lottery Community Fund, which will enable the scheme to be rolled out through Lancashire and South Cumbria.

eLancs programme hit major milestone

The Trust is just six months away from rolling out its revolutionary digital programme eLancs which has been designed to improve patient care and safety.

The planned go-live date is in November when the Trust will officially switch from paper-based records to an electronic patient record (EPR) in a move that will transform the way staff work and provide lasting benefits for patients and their families. Once live, it will provide doctors and nurses with more information about patients at their fingertips helping them to make better, more effective decisions

Operational colleagues will have the ability to ensure patients are moved effectively around the system using a new, advanced patient flow technology from Alcidion that links directly to the Cerner EPR.

The foundation work of what is a huge 10-year programme has been gradually progressing since July 2021 alongside a major project to upgrade the IT network infrastructure, improving capacity, speed and resilience. Recent months have also seen a steady introduction of a suite of new digital tools and technologies, like the BadgerNet system for parents-to-be and Patientrack for recording patient observations.

Parliamentary award recognition

The Macmillan Cancer Information and Support Service (MCISS) at the Trust has been named as a regional champion in this year's Parliamentary Awards for increasing access to cancer services and support in the community. The submission was shortlisted from 700 other entries.

The MCISS has been working hard to encourage more people from Asian communities to access services and support for themselves or a family member with a cancer diagnosis. This has included a programme of outreach work in partnership with a local mosque, other teams in cancer service and Macmillan to raise awareness of signs and symptoms of cancer and highlighting support available.

Regional champions have been selected by panels of senior regional NHS representatives for their dedication to the health service and to people they care for in their communities. The MCISS will join the other regional winners at the national awards ceremony on 6 July in Westminster, a day after the NHS's 74th birthday, where the overall winners will be announced.

Red Rose Awards 2022

More than 1,000 guests celebrated in Blackpool at the return of the Red Rose Awards, 2022. The awards are the County's biggest business celebration which receives hundreds of nominations from companies big and small.

This year the Trust's charity, ELHT&Me, entered the Not-for profit Award, and while they didn't take home the trophy on this occasion, it was a great success to be shortlisted. The ELHT&Me team had to present their case in person to a panel of hand-picked, independent judges and sponsors. During the presentation, they demonstrated how the charity works like a business should – even under the most trying of circumstances.

The work carried out by ELHT&Me is commendable, they are committed to improving the Trust's hospital facilities and supporting projects that fall outside core NHS funding. The charity has funded projects which enhance the physical environment of the hospitals namely the children's play area and garden of memories and has also provided state-of-the-art medical equipment, such as surgical robots and defibrillators.

Trust gains UNICEF UK Baby Friendly award

The Trust has been awarded the prestigious Baby Friendly Award and is the latest UK health care facility to gain recognition from the UK Committee for UNICEF (UNICEF UK) Baby Friendly Initiative.

The Baby Friendly Initiative, set up by Unicef and the World Health Organisation, is a global programme which provides a practical and effective way for health services to improve the care provided for all mothers and babies. The award is given to organisations after an assessment by a Unicef team has shown that recognised best practice standards are in place.

The Trust began working towards the UNICEF Neonatal Baby Friendly Initiative accreditation seven years ago and the journey has been incredibly important for the Trust to ensure it is providing excellent care and support around infant feeding and relationship building to families and involving parents as partners in care.

Stakeholder event

The Trust will be holding its very first virtual stakeholder event on Thursday 7 July, following their postponement during to the pandemic.

This are not a public facing event as such but targeted mainly at our core stakeholders including health and social care partners, third sector providers, community organisations, local authorities and education organisations.

The purpose of this event is to provide a platform for the Trust Board to give an update about the services provided by the Trust, the challenges it faces and an opportunity to share good news.

Attendees will be able to pose live questions to the board through the chatbox function of the virtual platform.

Star Awards

The highlight of our recognition calendar is the STAR Awards. The last time the awards were held physically was back in 2019. Since then, the hugely popular annual in-person event has been postponed to keep everyone safe during the pandemic. In 2021, an in-house virtual event was produced to ensure those nominated in 2020 were recognised.

This year the awards have returned in a new virtual format. On Thursday 14 July at 7pm, the ceremony will be live streamed from a professional broadcast studio, where Executive and Non-Executive Directors will announce the winners and BBC Radio presenter Graham Liver will anchor the programme. The benefit of changing the format is that as many colleagues as wish to attend will be able to join live and enjoy the event. And for those who can’t join live, the event can be viewed later via catch-up.

Almost 300 nominations were received for the 14 awards which includes a brand-new inclusivity category. Judging panels, which included Executive Directors, Non-Executive Directors and senior managers, selected three finalists, and a winner, in each of the categories, celebrating Trust values, innovation and team members who have gone the extra mile.

To create a celebratory atmosphere around the Trust and make sure as many people as possible feel involved, goody and party bags have been distributed with larger hampers of treats provided to colleagues nominated to enjoy on the night. A series of raffles will also be drawn for all those nominated in each category on the night.

The results of awards will be shared live on the night via the Trust's social media platforms, which can be found by searching @ELHT on Twitter and Facebook. Information about the winners will also be published on the Trust's website after the event.

Car parking charges reinstated

In early 2020, the Government took the decision to introduce free staff parking at NHS sites as part of the national COVID-19 pandemic response.

Earlier this year, the Secretary of State for Health and Social Care, Sajid Javid, announced that staff parking fees were to be reintroduced from April 2022.

However, alongside other Trusts across the Lancashire and South Cumbria Integrated Care System, the Trust agreed to provide a further grace period to colleagues until 1 July 2022.

Discussions remain on-going for a possible single colleague parking fee structure to be adopted by all hospitals across Lancashire and South Cumbria. However, this is a long-term aspiration and until that time the Trust will continue to work collaboratively to address existing car parking problems and look at effective ways to manage this.

Cost of living

The cost of living has been increasing across the UK since early 2021. In May 2022, the annual rate of inflation was the highest it has been since 1982, affecting the affordability of goods and services for households.

The Trust is committed to doing all it can to support colleagues to help reduce the impact of the cost of living rises. HR colleagues from across the system meet fortnightly at the Cost of Living Group to discuss current support offered in individual organisations, share good practice and to consider what other opportunities could be provided at both local and system level.

Amongst a number of initiatives deployed at ELHT, a Financial Wellbeing booklet has been produced and distributed which contains advice, guidance and discounts on offer to colleagues. These include the tax-free childcare scheme, Ask Bill a website which provides advice on how to combine financial sustainability with environmental sustainability and Vivup the health and wellbeing portal.

Four – Communications and Engagement

This report aims to demonstrate how the communications team at ELHT has been engaging, involving and informing our patients and our communities about key healthcare initiatives, Trust news and awareness events through external coverage on our digital platforms.

There is also a section which reports how communications takes a part and supports colleagues with the operational delivery of key strategic projects across the organisation.

This is a new format for illustrating the work carried out. Due to the way data is captured, this report will highlight activity for the month of May 2022 only. In the subsequent reports, we will share activity spanning two months, starting with June and July.

The report does not include the day-to-day support work ongoing by the team which includes things like:

- Regular bulletins
- Media management
- Proactive public relations
- Support for divisional communications requirements
- Management of social media channels or the website
- Development of the colleague app or private Facebook group
- The CEO blog or Teams Brief
- The ELHT audio podcasting channel

The list above is not exhaustive but gives examples of business-as-usual activity, albeit this is continuously improving and evolving in content and reach.

In addition, the team continues to provide support to ongoing areas of work including the EPR, well team initiatives, the NHS Staff Survey results etc.

If you would like to know more about the work carried out or have feedback on the report, please get in touch by emailing communications@elhs.nhs.uk

Digital Communications

Headline statistics

Social Media

- 529,696 total social media impressions (the number of times our social media posts have been seen)
- 42,818 total social engagements with our accounts including likes, shares, retweets, mentions, comments
- Women aged 25-44 continue to be the largest demographic engaged on social media. Men contribute to 16.1% of the audience on Facebook and 14.2% on Instagram.

Website

- **64,317** unique users (the number of people who have viewed our website at least once)
- **172,420** page views (the total number of pages viewed)
- Most viewed webpage* was the [Star Awards finalists] with **2,933** unique page views.
- We had **3,596** referrals from social media (mainly Facebook which accounted for 3,247) which led to **4,558** page views. The most popular was the Star Awards (**818** views).

*This is excluding the homepage, contact us and about us.

Facebook	Twitter	Instagram	LinkedIn	Website
19,768 Likes ↑2%	9,743 Followers ↑1%	3,378 Followers ↑1%	6,320 Followers ↑3.9%	172,420 Page views ↑1%
178 Posts ↑12%	178 Tweets ↑15%	2 Posts ↔0%	5 Posts ↑25%	98,864 Sessions ↑0.1%
25,626 Engagement ↑14%	565 Mentions ↑45%	323 Interactions ↔0%	158 Engagements ↓34%	2mins 11sec Time on site ↔
	15,700 Profile visits ↑48%	323 Profile visits ↑40%		55,940 New users ↑2%

Safe | Personal | Effective

Please join us on our digital platforms like, comment, post and share!

Podcasts
We published **3** podcasts this month on ELHT Audio.

VIDEO
9 videos were produced in May, including Dr Jawad's fortnightly vlog and the opener for the Star Awards.

Follow us here @ELHT_NHS

WEBSITE
The guidance for attending surgical procedures page received 1,856 hits in May.

Like us here @ELHT_NHS

TEAMS BRIEF
139 colleagues joined May's live briefing.

Follow us here ELHT

ELHT PEOPLE
Our private colleague Facebook group is growing in strength and engagement.

We now have **1,743** followers, with more people joining every month.

Interactions on the **73** posts during May reached **2,678**.

The top post was the first post for our 'Where's the Queen' competition. It had a reach of **1,524** and **407** engagements!

Follow us here @ELHT_NHS

Visit us here www.ELHT.nhs.uk

MEDIA ACTIVITY
This month we have issued **7** press releases and dealt with **4** media enquiries, with sentiment at **74%** for positive or neutral coverage.

Key Strategic Projects

Draft Clinical Strategy

Colleagues are being encouraged to share their views on the draft 5-year clinical strategy which has been developed by our clinical teams. The key themes to the strategy are around building back our services as we come out of the pandemic, building on our strengths, managing challenges and getting the fundamentals of clinical care right for our patients.

The ambition is to create a hospital without walls over the next 5 years, where we work with all partners to have one fully joined up service, with patients at the heart of what we do.

The Communications Team is supporting the engagement of colleagues to have their say, bringing the draft strategy to life with a series of podcasts. Focusing on the hospitals without walls concept, each episode highlights a different theme of the strategy.

Key internal experts were invited to be part of the conversation which created meaningful context to compliment the strategy overview. The podcasts are being used as a hook to motivate listeners to read the strategy and learn more about the work taking place to put ELHT at the forefront of care and treatment.

ED Pressures

We are working with colleagues in the Emergency Department to help reduce the number of people who come into A&E, with a particular focus on the Jubilee Weekend.

Additional social media activity and video messages in advance of the Bank Holiday concentrated on simple things patients could do to prepare for the weekend such as collecting prescriptions in good time and alternative options to consider before visiting A&E such as NHS 111 online or pharmacies that could offer support and prevent unnecessary A&E visitors.

Internally, consistent messages reminded colleagues of steps that could be taken to ensure as many people could go home as possible to maximise flow over the bank holiday. This was supplemented with messages encouraging patients to ask what could be done to get them home as soon as possible.

Communication was also distributed in ELHT bulletins, video bulletins and on the internal Facebook Group to ensure as many colleagues as possible saw it.

Recruitment

Key roles have been promoted in several ways to increase applications and encourage people to consider a career with at ELHT. Alongside promoting job adverts on social media, personal experiences have also been shared to provide a greater insight into roles that we have open on a regular basis.

This has included podcasts for International Nurses Day, International Day of Midwives and Dying Matters Week which all featured team members who talked about their careers and experiences and helped showcase different career pathways with the Trust. Podcasts featured new colleagues, nurses with experience and international nurses giving a perspective about coming to the UK to work.

Social media activity reinforced this message with photos and quotes from colleagues and information about skills needed for key roles.

Posts have also focused on ELHT being an employer of choice by highlighting positive work taking place to improve the Trust and being a workplace to be proud of such as being awarded the Rainbow Badge and media activity showcasing the Macmillan Cancer Information and Support Service winning a Parliamentary Award.

A programme of work is currently underway to support recruitment to the Medicine and Emergency Care Division. A series of video messages about 'our ELHT Family' are being developed with team members where they talk about what their role means to them, why they enjoy doing what they do and how all teams ‘work together as a family’.

Star Awards

To support retention and improve morale across the Trust, colleagues have been recognised through communications for their contribution and achievements.

Promotion of the Star Awards across all communication channels has led to almost 300 nominations being made, with many judges on shortlist panels commenting on the strength of entry being submitted.

Preparation is underway for a virtual Oscars-style awards ceremony to celebrate success.

In addition, the communications team have used national awareness events to say thank you to teams. In particular, they encouraged patients and our communities to share details of their nursing heroes for International Day of the Midwife and International Nurses Day and after receiving 40 nominations for nurses and midwives, 10 were presented with flowers.

Digital Transformation

Face-to-face communication has been taking place to highlight the implementation of EPR and digital transformation. This has included four Trust-wide eLancs Q&A webinars and roadshows across all sites where colleagues could see EPR system in action.

More recently, ward visits have been organised to speak directly to teams and show them the new system. All questions raised during these ward walkarounds are being captured and shared on SharePoint for further learning, as they may be relevant to other teams.

The face-to-face activity is in addition to the broadcast communication that is now embedded as part of ongoing communication regarding digital transformation, including digital screen messaging, dedicated social media activity, updates in the Trust-wide bulletin and Teams Live.

The digital communications team is playing a key role in supporting the implementation of new digital systems and also the change management programme.

Forward view

STAR AWARDS

Don't forget to join us for the live streamed event on Thursday 14 July 2022. You can read about all our amazing finalists and how to join in the celebrations here.

NHS BIRTHDAY
The NHS is 74 on Tuesday 4 July! Make sure you follow us on our social media platforms for all the celebration messaging focused on thanking our colleagues and highlighting the NHS as a career option.

WHY NOT HOME? WHY NOT TODAY?
The communications team will continue to support this year-round campaign but with a particular focus on preparations for the August Bank Holiday and using internal communication channels to encourage clinical teams to do all they can to improve flow.

SOUTH ASIAN HERITAGE MONTH
Working with colleague networks, the Communications Team will be promoting South Asian History Month. This will promote diversity within the organisation and provide an opportunity to share lived experiences.

FESTIVAL OF INCLUSION
A week-long celebration, to include promotion of events, guest speakers, a family fun day and social media take over day. Welcoming banners will be displayed on the Blackburn and Burnley sites representing multiple languages and nationalities. Follow us on social media for regular updates.

Five - Chief Executive's Meetings

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

June 2022 Meetings

Date/Frequency	Meeting
Weekly – Tuesday	Executive Team
Weekly – Tuesday	Chairman/Chief Executive Briefing
Bi-Weekly – Tuesday	Senior Leadership Group (Full group)
Bi-Weekly – Tuesday	Senior Leadership Group (Triumvirates)
1 June	Team Brief
7 June	STAR Award
8 June	Trust Board Development
8 June	LSC CEO Briefing
9 June	Task and Finish Group in preparation for CQC Well Led Visit
9 June	LSC Head and Neck Network Programme
10 June	BAF Review
14 June	PL Chair and Chief Officers Advisory Group
14 June	Audit Committee
15/16 June	NHS Confed
21 June	LSC ICB/Provider CEOs/Chairs
23 June	Provider Collaboration Board
23 June	Executive Risk Assurance Group
24 June	LSC Pathology Service Board
27 June	Finance and Performance Committee

27 June	Civic Gathering in respect of Council Leader Mohammed Khan CBE
27 June	Consort introductory meeting
29 June	Provider Collaboration live comms event
30 June	Chief Executive visit to the Quality and Safety directorate
30 June	Consultant interviews

July 2022 Meetings

Date/Frequency	Meeting
Weekly – Tuesday	Executive Team
Weekly – Tuesday	Chairman/Chief Executive Briefing
Weekly – Tuesday	Teams Brief
Bi-Weekly – Tuesday	Senior Leadership Group (Full group)
Bi-Weekly – Tuesday	Senior Leadership Group (Triumvirates)
4 July	Head and Neck Network
4 July	Euro Garages presentation
4 July	NW Regional Roadshow
6 July	EPR Strategic Committee
7 July	ELHT Stakeholder Event
8 July	LSC System Feedback
11 July	LSC and Wigan Vascular Network Board
12 July	Trust Board
12 July	PL Chair and Chief Officers Advisory Group
13 July	Extraordinary Board Meeting
13 July	Provider Collaboration live comms event
14 July	STAR Awards

15 July	Transformation Guiding Board
20 July	System Leaders Executive
21 July	Provider Collaboration Board
21 July	Population Health Board
25 July	Finance and Performance Committee
26 July	Combined NW System Leaders and Chairs Call
27 July	LSC CEO Briefing
28 July	Trust Board Development
29 July	LSC Pathology Service Board

Mrs E-L Cooke, Joint Deputy Director Communications and Engagement

TRUST BOARD REPORT

13 July 2022

Item	**87**
Purpose	Information Action Monitoring

Title	Corporate Risk Register
Executive sponsor	Mr J Husain, Executive Medical Director

Summary: The purpose of this report is to provide the Board with an overview of risk management performance activity and of risks presented onto the Corporate Risk Register

Recommendation: Board members are asked to note and approve the contents of this report and seek assurances the Corporate Risk Register 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 Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to 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:

Executive Summary

1. The purpose of this report is to provide the Board with an overview of risk management performance activity and of risks presented onto the Corporate Risk Register (CRR).
2. Key points of note since the last meeting.
   a) Total numbers of open risks held on the risk register continue to reduce.
   b) Work remains continuous in improving the quality of risks held on the CRR, increasing awareness of the operating risk management framework and of compliance with the process regarding escalation of risks.
3. Board members are asked to note and approve the contents of this report.

Introduction

4. East Lancashire Hospitals NHS Trust operates a risk management framework that reflects the basic principles of risk management as summarised below.

Principle	Description
Proportionate	Risk management activities must be proportionate to the level of risk faced by the organisation
Aligned	Risk management activities need to be aligned with other activities in the organisation
Comprehensive	Risk management approach must be comprehensive in order to be fully effective
Embedded	Risk management activities need to be fully embedded within the organisation
Dynamic	Risk management activities must be dynamic and responsive to emerging and changing risks

Risk Management Performance Activity

5. Key points of note since the last meeting.
   a) There continues to be a reduction in total numbers of open risks held on the risk register. This is due to ongoing improvements works being undertaken to avoid unnecessary duplication, improve standardisation and quality of risks held.
   b) Out of the 1,512 open risks held on the risk register, 19 remain on the CRR.
   c) Challenging and improving risk profiles is helping steer the movement of levels of risk from being moderate and or significant to low.

d) Highest numbers of open risks by risk type relate to clinical risks, comprising 48% of the total number, followed by health and safety risks with a percentage of 27%.
e) Work to improve health and safety risk sub type categories and their assimilation that will act as a benchmark of performance against all risk types has been completed.
f) Work has commenced with members of the Finance and Performance Committee to review all open financial risks and with the Information Governance Team in reviewing all information governance risks held.
g) All services have been supported to ensure risks of coronavirus have been reviewed and accurately reflect the level of risk and scoring against changes in legislation, guidance and recovery and restoration stages.
h) There has been a 41% reduction in total numbers of overdue risks as a result of challenging the quantity and quality of risks, the validity and or risk scoring.

Risks removed from the CRR

6. Although no risks have been presented for removal since the last meeting, one risk has seen a positive movement that has resulted in a downward risk scoring from 20 to 15 which relates to the risk of coronavirus outbreak (DATIX ID 8441). This risk is due for further review which may result in its removal from the CRR.

Risks presented at RAM for approval onto the CRR

7. A total of four risks were presented for discussion and review. It was agreed de-escalation of risk scores and or further work was required before any of the risks were considered for inclusion on the CRR.

Executive Risk Assurance Group (ERAG)

8. The newly established ERAG held its first meeting at the end of June 2022 whereby it approved its Terms of Reference and reviewed all risks on the CRR.
9. Key points of note from this meeting.

a) A review of all risk leads and executive leads has been completed for all risks held on the CRR and reflected in DATIX.
b) Consideration is to be given to merging DATIX ID 8061 the management of the holding list and DATIX ID 6190 insufficient capacity to accommodate the volume of patients requiring to be seen in clinical within the specified timescales (ophthalmology).
c) DATIX ID 9222 has been renamed to more accurately describe the risk of implementing the NHS Green Plan.
d) Consideration is to be given of merging DATIX ID 7764 and DATIX ID 8808 relating to breaches in fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke.
e) A further review of the risk score for DATIX ID 8267 regarding the loss of transfusion service and subsequent removal from the CRR.
f) Consideration is to be given to merging DATIX ID 7067 failure to obtain timely mental health treatments and DATIX ID 4932 patients who lack capacity to consent to placements in hospital may be unlawfully detained.
g) DATIX ID 7008 failure to comply with 62 day cancer waiting times is a Trust Wide risk not just SAS.

Conclusion of report

10. The importance of prioritising, reviewing and improving the quantity and quality of risks held, increasing awareness of the operating risk management framework and of compliance with the process regarding escalation of risks remains a key focus area. This has been reaffirmed across all divisions.

Next actions

11. A summary of key focused activity due for completion before the next meeting.
   a) Work with specialisms and or subject matter experts across the clinical risk sub types i.e. medical devices, infection control, medication and radiation in reviewing the quantity and quality of risks held remains a key priority and area of focus.

b) Continuous review and update of the Mersey Internal Audit Agency Risk Management Action Plan to reflect completion of improvement works and the different workstreams taking place in reviewing the integrity of risks held.
c) Review of all open risks held across the Estates and Facilities Division.
d) Addressing significantly high numbers of risks overdue and or due for review over the next three months.
e) Strengthening strategic and operational risks in line with organisational strategy, the business assurance framework, objectives and targets etc.
f) Review of the RAM terms of reference following the newly established ERAG.

How the decision will be communicated internally and externally

12. Progress in monitoring the quality and integrity of open risks held, in particular, those scoring fifteen and above, is undertaken at the monthly RAM and newly established Executive Risk Assurance Group (ERAG) meeting.

Appendices

13. Summary of risks on the CRR
14. Detailed information of risks on the CRR

J Houlihan, Assistant Director of Health, Safety and Risk Management
13 July 22

Summary of risks held on the Corporate Risk Register

Corporate Risk Register						
No	**ID**	**Where is the risk being managed**	**Title**	**Rating (current)**	**Effectiveness of Controls (taken from Datix)**	**Changes since last report**
1	9439	Trust Wide	Failure to meet internal and external financial targets for the 2022-23 financial year	**20**	**Limited**	↔
2	9336	MEC	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery	**20**	**Limited**	↔
3	8126	Corporate	Risk of compromising patient care due to lack of an advanced Electronic Patient Record (EPR) System	**20**	**Limited**	↔
4	8061	Trust Wide	Management of Holding List	**20**	**Limited**	↔
5	9222	Trust Wide	Failure to implement the NHS Green Plan	**16**	**Limited**	↔
6	8941	Trust Wide	Delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology	**16**	**Limited**	↔
7	6190	SAS	Insufficient capacity to accommodate patient volumes required to be seen in clinic within specified timescales	**16**	**Limited**	↔
8	8960	FC	Risk of undetected foetal growth restriction and preventable stillbirth due to non-compliance with pulsatility index ultrasound guidance	**15**	**Limited**	↔
9	8839	SAS	Failure to achieve performance targets	**15**	**Limited**	↔
10	8441	Trust Wide	Managing the risk of coronavirus (COVID-19) outbreak	**15**	**Adequate**	↓
11	7764	Corporate	Royal Blackburn Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke	**15**	**Adequate**	↔
12	8808	Corporate	Burnley General Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke	**15**	**Adequate**	↔
13	8257	DCS	Loss of transfusion service	**15**	**Limited**	↔
14	7165	Corporate	Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)	**15**	**Limited**	↔
15	7067	MEC	Failure to obtain timely mental health treatment impacts on patient care, safety and quality	**15**	**Adequate**	↔
16	7008	Trust Wide	Failure to comply with 62 day cancer waiting time target	**15**	**Limited**	↔
17	5791	Corporate	Failure to adequately recruit to substantive nursing and midwifery posts may adversely impact on patient care and finance	**15**	**Adequate**	↔
18	4932	Trust Wide	Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained	**15**	**Limited**	↔
19	2636	DCS	Inability to maintain establishment of consultant histopathologists	**15**	**Limited**	↔

Corporate Risk Register Detailed Information

<table>
<tr><th>No</th><th>ID</th><th colspan="5">Title</th></tr>
<tr><td>1</td><td>9439</td><td colspan="5">Failure to meet internal and external financial targets for the 2022-23 financial year</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Charlotte Henson
Exec Lead: Michelle Brown</td><td>Current score</td><td>20</td><td>Score Movement</td><td>↔</td></tr>
<tr><td colspan="2">Description</td><td colspan="2">Failure to meet the Trust financial plan and obligations, together with the wider Lancashire and South Cumbria Integrated Care Systems financial plan and obligations, is likely to lead to imposition of special measures, limiting the ability to invest in services. Continued failure to meet financial targets may lead to the Trust being acquired by another provider.

The financial risk is made up of:
1. A lack of control. In the current financial regime monies are allocated to Integrated Care Systems to agree how they are allocated to other system partner organisations.
2. A 5% efficiency target set for the 2022-23 financial year to reduce costs by £28.8 million - a level that has never been achieved.
3. The unknown extent of increased living costs and inflation rates.
4. The unknown impact of Covid within the 2022-23 financial year.
5. A system financial gap that still has to be closed.</td><td rowspan="2">Actions</td><td colspan="2" rowspan="2">1. Higher efficiency target than has ever been achieved in the past to ensure all services across the Trust are fully engaged and playing their part in reducing inefficiencies.
2. Financial regime is managed at a system level now in addition to the Trust.
3. Financial gap is across the system not just the Trust.</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.
2. Financial performance reports distributed across the Trust to allow senior and service managers to monitor financial performance against financial plans, supported by the Finance Department.
3. Enforcement of Standing Financial Instructions through financial controls to ensure expenditure commitments incurred are made in accordance with delegated limits.
4. Arrangements to monitor and improve delivery of the Waste Reduction Programme.
5. Training and guidance for budget holders.
6. A senior finance presence in internal and external conversations influencing the direction of travel.
7. Frequent, accurate and robust financial reporting and challenge by the way of:
a. Trust Board Report
b. Finance and Performance Committee Finance Report
c. Audit Committee Reports
d. Integrated Performance reporting
e. Divisional and Directorate Finance reports
f. Budget Statements
g. Staff in Posts Lists
h. Financial risks
i. External Reporting and Challenge</td></tr>
<tr><td colspan="2" rowspan="4">Update since the last report</td><td colspan="2" rowspan="4">Update 13/06/2022
Final financial plans for 2022-23 show a breakeven plan. Amount of system risk held presented for approval at the Finance and Performance Committee and Trust Board.

Other than the system risk, the Trust has met its financial plan. This variant is reported internally and externally. The Trust has forecast a breakeven plan will be met at the end of the financial year.

Next Review Date 13/07/2022</td><td>Date Last reviewed</td><td colspan="2">13/06/2022</td></tr>
<tr><td>Risk by Quarter 2022</td><td colspan="2">Q1: 20 | Q2: 20 | Q3: | Q4:</td></tr>
<tr><td>8-week score projection</td><td colspan="2">20</td></tr>
<tr><td>Current issues</td><td colspan="2">System wide external influences</td></tr>
</table>

<table>
<tr><th>No</th><th>ID</th><th colspan="6">Title</th></tr>
<tr><td>2</td><td>9336</td><td colspan="6">Lack of capacity across the Trust can lead to extreme pressure resulting in a delayed care delivery</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Michelle Montague
Exec Lead: Sharon Gilligan</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">Lack of capacity can lead to extreme pressure resulting in delayed delivery of optimal standard of care. At times of extreme pressure increasing patient numbers across the emergency pathway make care difficult and impacts on clinical flow. The staffing requirement is not calculated as standard to care for increased patient numbers with increased complexity with inadequate capacity within specialist areas such as cardiology, stroke etc. to ensure adequate flow and optimum care.

There is also an increased risk of nosocomial infection spread as a result of overcrowding and poor patient experience leading to complaints.</td><td rowspan="2">Actions</td><td colspan="3" rowspan="2">1. Ongoing discussions taking place with Commissioners for health economy solutions and to help attendance avoidance.
2. Incidents with harm noted.
3. Improved ambulance turnaround times. All over 60-minute breaches reviewed.
4. High observation beds in place on AMUB to support patients requiring higher levels of care.
5. Further in reach to help decrease admissions.
6. Patient experience strategy in place with complaints trends and themes monitored.
7. Gold command in place to support.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. Operational Pressures Escalation Levels (OPEL) triggers and actions completed for Emergency Department (ED) and Acute Medical Units (AMU).
2. Code black standard operating process reviewed and redesigned.
3. All divisions have a divisional flow rep so escalation of ‘pull through’ can be much clearer, along with actions.
4. Bed meetings held x4 daily with divisional flow reps.
5. Escalation trolleys implemented for extreme pressure.
6. ED, AMU and Urgency Care Centre (UCC) taking stable assessed patients out of trolley space/bed to facilitate putting unassessed patients into bed/trolley.
7. Corridor care standard operating procedure embedded.
8. Hourly rounding by nursing staff embedded in ED.
9. Review of processes across acute and emergency medicine in line with coronial process and incidents.
10. Established 111/GP direct bookings to UCC.
11. 111 pathways from GP/North West Ambulance Service (NWAS) directly to Ambulatory Emergency Care Unit (AECU).
12. Pathways in place from NWAS to Surgical Ambulatory Emergency Care Unit (SAECU), Children’s Observation and Assessment Unit (COAU), Mental Health, Gynaecology and Obstetrics and the Community.
13. Segregation of ED in line with COVID-19 risk to reduce likelihood of cross contamination. Risk assessments completed.
14. Daily staff capacity assessments completed.
15. Workforce redesign aligned to demands in ED.
16. Full recruitment of established consultants.
17. Safe Care Tool designed for ED.
18. Daily consultant ward rounds done at cubicles so review of care plans are undertaken.
19. Matrons have undergone coaching and development on board rounds.
20. Daily ‘every day matters’ meetings with head of clinical flow and all patient flow facilitators.</td></tr>
<tr><td colspan="2" rowspan="6">Update since the last report</td><td colspan="2" rowspan="6">Update 01/06/22

The risk score has been reviewed and remains the same. Though 12 hour breaches appear to be reducing and overcrowding easing over the summer months, service demand continues.

Next Review Date 01/07/22</td><td>Date last reviewed</td><td colspan="3">01/06/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2022</td><td>Q1</td><td>Q2</td><td>Q3</td></tr>
<tr><td>20</td><td>20</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">Impact of COVID-19 pandemic and restoration pressures</td></tr>
</table>

Note: the Q4 column header and its empty cell appear to the right of Q3.

No	ID	Title
3	8126	**Aggregated Risk** - **Potential to compromise patient care due to the lack of a Trust-wide advanced Electronic Patient Record (EPR) System**

Lead	Risk Lead: Mark Johnson Exec Lead: Michelle Brown	Current score	20	Score Movement	

Description	The absence of an EPR system, the reliance on paper case notes, assessments, prescriptions and multiple minimally interconnected electronic systems in the Trust could compromise patient care and patient outcomes, lead to poor data quality and management and increased organisational costs.	**Actions**	1. The WinDIP Electronic Document Management System does not cover all specialities and case note groups. 2. EMIS system only supports community activity, with no significant system within an Acute setting. 3. Not all systems are registered or known 4. Contracts for current systems being ‘rolled over’ annually cannot identify specific ‘switch over’ dates. 5. Inability to rapidly flex the current system to emerging demands from NHS Improvement for additional information. 6. Limited capital budget to invest in additional hardware or software as clinical requirements develop.
Top Controls	1. Stable Patient Admission System (PAS) albeit 25+ years old. 2. Extra-med patient flow software which includes the capture of nursing documentation. 3. Use of Integrated Clinical Environment (ICE) and EMIS Group healthcare software systems and information technology. 4. The use of the Winscribe Digital Dictation System allows clinicians to quickly streamline and automate dictation and transcription workflow. 5. The WinDIP Electronic Document Management System assists with the digitalisation of paper records 6. The Orion Health and Social Care Clinical Portal provides a single view of patient information across different IT systems. 7. 24/7 system support services and additional administrative staff. 8. Paper contingencies in place for data capture. 9. All critical systems managed by informatics or services with direct links to Informatics. 10. Register of non-core systems capturing patient information (feral systems) in place. 11. Improved infrastructure (including storage) to maintain and manage existing systems.		

Update since the last report	**Update 14/04/2022** 1. Consistent monitoring of current clinical systems and support via helpdesks and informatics service. 2. Significant amount of business intelligence system data quality and usage reports. 3. Whilst many reports are produced the Trust does not always have enough administrative or clinical resource to action. 4. Unable to plan infrastructure as new technologies and clinical techniques develop in isolation from the main EPR system. **Next Review Date 26/05/22** Reminder Issued to Risk Lead to review risk in line with Risk Management Assurance Framework. The EPR system still remains on track to go live in November 2022 at which point this risk will then be removed from the Corporate Risk Register.	**Date Last reviewed**	**14/04/2022**			
		Risk by Quarter 2022	Q1	Q2	Q3	Q4
			20	20		
		8 week score projection	20			
		Current issues	Work remains ongoing with Cerner on implementation.			

Safe | Personal | Effective

<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>Risk Lead: Victoria Hampson
Exec Lead: Sharon Gilligan</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 are waiting past their intended date for review appointments and subsequently coming to harm due to a deteriorating condition or from suffering complications as a result of delayed decision making or clinical intervention.</td><td rowspan="2">Actions</td><td colspan="4" rowspan="2">1. Holding list remains high due to backlog from COVID-19.
2. Patients currently booked into appointments not RAG rated will drop onto the holding list if appointments are cancelled and do not have a RAG rating identified.
3. Patients added to the holding list from other sources such as theatres, wards etc. will not have a RAG identified.
4. Specialities continue to review patients waiting over 6 months and those rated as red to ensure they are prioritised appointments.
5. General lack of capacity across many specialities impacting on reducing holding list numbers.
6. Not all staff follow the standard operating procedures for RAG rating of patients leaving some patients without a rating.
7. Updates provided weekly to Executive Team.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. Suitable Red, Amber, Green (RAG) ratings included on all outcome sheets in outpatient clinic.
2. Daily holding list report circulated to all Divisions to show the current and future size of the holding list.
3. Updates provided at weekly Patient Transfer List (PTL) meetings.
4. Restoration plan in place to restore activity to pre-covid levels.
5. Individual specialities undertaking their own review of the holding list to identify if patients can be managed in alternative ways.
6. Meetings held between Divisional and Ophthalmology Triads to discuss current risk and agree next steps.
7. Requests sent to all Directorates requesting all patients on holding list 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.
8. RAG status for each patient to be added to the comments field on the patient record in Outpatient Welcome Liaison Service (OWLS) to capture current RAG status. This will allow future automated reports to be produced.
9. Meetings held with Directorate Managers from all Divisions to understand position of all holding lists.
10. All patients where harm is indicated or flagged as a red rating to be actioned immediately. Directorates to agree plans to manage these patients depending on numbers.
11. A process has been agreed to ensure all follow up patients in the future are assigned a RAG rating at the time of putting them on the holding list. Process has been rolled out and is monitored daily.
12. Underlying demand and capacity gaps must be quantified and plans put in place to support these specialities in improving the current position and reducing the reliance on holding lists in the future.</td></tr>
<tr><td colspan="2" rowspan="5">Update since the last report</td><td colspan="2" rowspan="5">Update 27/05/22
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.

12, 462 patients are on the holding list. 5,790 patients are currently on the surgical holding list. 2, 045 patients are unknown or uncoded. 1,327 patients are over 6 months.

Next Review Date 24/06/22
Reminder Issued to Risk Lead to review risk in line with Risk Management Assurance Framework.</td><td>Date last reviewed</td><td colspan="4">27/05/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2022</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>20</td><td>20</td><td></td><td></td></tr>
<tr><td>8 week score projection</td><td colspan="4">20</td></tr>
<tr><td>Current issues</td><td colspan="4">Impact of COVID-19 pandemic and restoration pressures</td></tr>
</table>

No	ID	Title
5	9222	**Failure to implement the NHS Green Plan**

Lead	Risk Lead: Sue Chapman Exec Lead: Michelle Brown	Current score	16	Score Movement	

Description	The Health and Social Care Act has been amended to support existing environmental legislation and the NHS England sustainability strategy which places duties on NHS Trusts in meeting carbon reduction strategies as part of the NHS Green Plan.	**Actions**	1. Buildings will need resources to bring them up to standard e.g. insulated walls and adequate windows etc. 2. Long term target of reaching carbon neutral targets will require huge investment to buildings to meet minimum standards under BREEAM. 3. Review of staff resources, knowledge, skills, experience and training etc. to be able to deliver actions required. 4. Review of energy efficiency equipment e.g. gas boilers before 2032, heating and ventilation units etc. 5. Funds for capital projects and increased costs of materials and services required to meet NHS sustainability strategy needs. 6. Budget commitments to deliver zero carbon plan is significant but will need to be factored into wider plans. 7. Lack of full carbon emissions monitoring. 8. Lack of compliance with Greenhouse Gas Emissions Trading Scheme Order 2020.
Top Controls	1. Full review of legislative requirements, organisational arrangements, processes, equipment and competences. 2. Development and implementation of a new Green Plan. 3. Link of Green Plan with other necessary plans e.g. travel plan, care plans etc. 4. All building work done to Building Research Establishments Environmental Assessment Method (BREEAM) standards 5. Purchase of EV fleet vehicles where possible. 6. Review of energy and waste processes for reduction / greener strategies. 7. Local leadership, raised awareness of actions, understanding and inspiring action. 8. Working with neighbouring Trusts to identify improvement and compliance strategies.		

Update since the last report	**Update 01/07/2022** No change to risk scoring. Green Plan data, NHS England data reporting processes, UK ETS emissions reporting management and Estates Returns Information Collection (ERIC) returns will provide a baseline for the Trust. First step implemented on 01 April 2022 by means of 10% weighting of sustainability requirement in procurement contracts. **Next Review Date 01/08/22**	**Date last reviewed**	**01/07/2022**			
		Risk by Quarter 2022	**Q1**	**Q2**	**Q3**	**Q4**
			16	16		
		8 week score projection	16			
		Current issues	Commitment of adequate resources to deliver the NHS Green Plan			

No	ID	Title				
6	8941	**Potential delays to cancer diagnosis due to inadequate reporting and staff capacity in cellular pathology**				
Lead	Risk Lead: Neil Fletcher Exec Lead: Kevin Moynes	**Current score**	**16**	**Score Movement**	⟷	
Description	The cellular pathology department is not able to meet existing turnaround times (TAT's) due to inadequate consultant reporting capacity and laboratory staffing levels with difficulties in recruitment of appropriately skilled staff causing potential delays to patient diagnosis and treatment of serious illnesses such as cancers.		**Actions**	1. Lack of equipment is being partially addressed by capital funding. 2. COVID19 related absences. 3. Continuing difficulties in recruiting highly skilled, permanent consultant staff. 4. Increasing TAT due to volume and complexity of work.		
Top Controls	1. Monthly monitoring of TATs against targets. 2. Locum laboratory biomedical staff members in post. 3. Locum consultants in post. 4. Sample tracking software installed. 5. Ongoing recruitment of additional substantive and locum histopathologists. 6. Risks monitored via Quality Assurance and Operations meetings. 7. Increasing volume of tests sent to external providers at additional cost.					
Update since the last report	**Update 22/06/2022** No change to risk score. There continues to be a national shortage of histopathologists. TATs continue not to be met. There is a risk that potential delays to patient diagnosis and treatment of serious illnesses such as unexpected cancers may be waiting in backlogs. **Next Review Date 22/07/2022**		**Date last reviewed**	**22/06/2022**		
			Risk by Quarter 2022	**Q1**	**Q2**	**Q3** / **Q4**
				16	**16**	
			8 week score projection	**16**		
			Current issues	National shortage of histopathologists		

<table>
<tr><th>No</th><th>ID</th><th colspan="6">Title</th></tr>
<tr><td>7</td><td>6190</td><td colspan="6">Insufficient Capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescale</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Victoria Hampson
Exec Lead: Sharon Gilligan</td><td>Current score</td><td>16</td><td colspan="2">Score Movement</td><td>↔</td></tr>
<tr><td colspan="2">Description</td><td colspan="2">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.

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.

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><td rowspan="2">Actions</td><td colspan="3" rowspan="2">1. Insufficient staff to provide capacity.
2. Insufficient estates capacity and outpatient space to provide required clinics and comply with social distancing.
3. Ability to flex theatres to outpatient departments and vice versa but opportunities are limited.
4. Funding and difficulties recruiting additional medical staff and equipment so as to be able to increase activity e.g. medical, nursing, admin etc.
5. Locums introduced but only a short term fix as there is a tendency to bring patients back for further review which impacts longer term on increasing the holding list.
6. Getting It Right First Time (GIRFT) report not yet created for patient waiting times above 25% within recommended timescales for review.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. A failsafe officer is in place who validates the holding list and focuses on appointing red rated patients and those longest waiting.
2. Capacity sessions held where doctors are willing and available.
3. Increased flexibility of staff and constant review and micro management of each sub specialty.
4. Integrated Eye Care Service in place for specific pathways, keeping relevant patients out of hospital eye services where possible.
5. Use of clinical virtual pathways where appropriate.
6. Expanded non-medical roles e.g., orthoptists, optometrists, specialised nurses etc.
7. Action plan and ongoing service improvements identified to reduce demand.
8. All holding list patients are reviewed weekly by administrative staff, with patients highlighted where required to clinical teams.
9. Weekly operational meetings challenge outpatient activity and recovery.</td></tr>
<tr><td colspan="2" rowspan="5">Update since the last report</td><td colspan="2" rowspan="5">Update 14/06/2022
No change in risk scoring. 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.

Next Review Date 14/07/2022.</td><td>Date last reviewed</td><td colspan="3">14/06/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2022</td><td>Q1</td><td>Q2</td><td>Q3 | Q4</td></tr>
<tr><td>16</td><td>16</td><td></td></tr>
<tr><td>8 week score projection</td><td colspan="3">16</td></tr>
<tr><td>Current Issues</td><td colspan="3">Impact of COVID-19 pandemic and restoration pressures</td></tr>
</table>

<table>
<tr><th>No</th><th>ID</th><th colspan="4">Title</th></tr>
<tr><td>8</td><td>8960</td><td colspan="4">Risk of undetected foetal growth restriction and possible preventable stillbirth given non-compliance with national Ultrasound guidelines</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Tracy Thompson
Exec Lead: Julie Molyneaux</td><td>Current score</td><td>15</td><td>Score Movement</td></tr>
<tr><td colspan="2">Description</td><td>Diagnosis of intrauterine growth restriction could be missed due to inability to report/action pulsatility index on uterine artery doppler measurement.

The introduction of national/international recommendations will require investment of resources including the obstetric reporting package, increase in sonography and midwife sonography hours currently allocated and an update of ultrasound machines within maternity services.</td><td rowspan="2">Actions</td><td colspan="2" rowspan="2">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).
2. There is currently no resources to allow trained staff the hours required to fulfil this task.
3. No capacity to increase current workload within midwife sonography or general ultrasound.</td></tr>
<tr><td colspan="2">Top Controls</td><td>1. Additional funding and implementation of ultrasound machine.
2. Staff trained in measuring and interpreting pulsatility index.
3. Rollout of viewpoint reporting software allowing interpretation and reporting of pulsatility index.
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.
5. Women at very high risk of early-onset growth restriction are seen within placenta clinic.
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.
7. Audit to assess pulsatility index within midwife sonography services to understand potential volumes of demand going forward has now been completed.</td></tr>
<tr><td colspan="2" rowspan="4">Update since the last report</td><td rowspan="4">Update 27/06/2022
Discussed at Obstetric Triad Meeting. Audit completed which is intended to quantify future capacity needs of the foetal growth restriction service.

The existing system allows for detection of some cases of foetal growth restriction. Of the women who pass through general sonography, there will be a cohort of women who develop undetected foetal growth restriction, or it will be detected late. This has the potential for stillbirth that could have otherwise been prevented.

Risk scoring remains unchanged. No change to current practice.

Next Review Date 27/07/2022</td><td>Date Last reviewed</td><td colspan="2">27/06/2022</td></tr>
<tr><td>Risk by Quarter 2022</td><td colspan="2">Q1: 15   Q2: 15   Q3:   Q4:</td></tr>
<tr><td>8-week score projection</td><td colspan="2">12</td></tr>
<tr><td>Current issues</td><td colspan="2">Capacity issues and operational pressures have impacted on the mitigation of the risk.</td></tr>
</table>

<table>
<tr><th>No</th><th>ID</th><th colspan="5">Title</th></tr>
<tr><td>9</td><td>8839</td><td colspan="5">Failure to meet performance targets (SAS)</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Victoria Hampson
Exec Lead: Sharon Gilligan</td><td>Current score</td><td>15</td><td>Score Movement</td><td>↔</td></tr>
<tr><td colspan="2">Description</td><td>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.

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.

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 rowspan="2" colspan="3">1. Exploration of options for mutual aid where possible and outsourcing capacity.
2. Monthly meetings held with Clinical Commissioning Group regarding demand management.
3. Miss match between capacity and demand.
4. Reluctance of patients attending clinic or theatre due to COVID-19 leading to delays and cancellations.
5. Volume of backlog causing significant gaps to fill.</td></tr>
<tr><td colspan="2">Top Controls</td><td>1. Strong monitoring at Trust, Divisional and Directorate Level.
2. Weekly Patient Treatment List (PTL) meeting within division to ensure awareness of current position and to ensure controls are continuously put in place to focus on achievement of the standard.
3. Bi-weekly performance meeting with Directorate Managers led by the Director of Operations.
4. Planning & information produced for trajectories.
5. Monitoring at Directorate meetings and Divisional Management Board (DMB).
6. Recovery plans being updated weekly by Directorate Managers.
7. Attendance of Divisional Information Manager at directorate meetings to provide information regarding current position.
8. Strong management of standard at DMB and performance meeting with Exec. Team.
9. Exception reports provided where standards are not met.
10. Monthly performance meeting with exec team and DMB where divisional position is reported, discussed and challenged.
11. Regular 1:1s between Divisional Manager and Deputy Director of Operations to review current position.
12. Recent addition of priority code monitoring now part of PTL meetings. This control means all clinically urgent patients are tracked for dates.
13. Additional waiting list initiatives for theatres and clinics to maximise capacity.</td></tr>
<tr><td colspan="2" rowspan="4">Update since the last report</td><td rowspan="4">Update 27/05/2022
No change in risk scoring. No patients are over 104 weeks in the pathway. Mutual aid offered to partners across Lancashire and South Cumbria for urology, vascular and general surgery. 45 patients over 75 weeks, 27 of which are dated. 419 patients currently over 52 weeks. All patients over 52 weeks are tracked weekly by the Deputy Directorate Manager.

Next Review Date 24/06/2022
Reminder Issued to Risk Lead to review risk in line with Risk Management Assurance Framework.</td><td>Date Last reviewed</td><td colspan="3">27/05/2022</td></tr>
<tr><td>Risk by Quarter 2022</td><td colspan="3">Q1: 15 | Q2: 15 | Q3: | Q4:</td></tr>
<tr><td>8 week score projection</td><td colspan="3">15</td></tr>
<tr><td>Current issues</td><td colspan="3">Increased COVID-19 prevalence has impacted on workforce across the elective pathway and patient availability for surgery</td></tr>
</table>

<table>
<tr><th>No</th><th>ID</th><th colspan="5">Title</th></tr>
<tr><td>10</td><td>8441</td><td colspan="5">Manging the risk of coronavirus (COVID-19) outbreak</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Alison Whitehead
Exec Lead: Tony McDonald</td><td>Current score</td><td>15</td><td>Score Movement</td><td>↓</td></tr>
<tr><td colspan="2">Description</td><td colspan="2">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.</td><td rowspan="2">Actions</td><td rowspan="2" colspan="2">1. Change of isolation rules for staff.
2. Changes in government legislative requirements and guidance.
3. Risk anticipated to reduce further as back to normal processes are further implemented.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. Increased staffing during core hours to alleviate pressures including outcome of winter pressure measures.
2. Regular communications about next steps and working group outcomes to keep staff and patients informed.
3. Co-ordination centre set up at Trust HQ to enable the management and implementation of plans, processes and procedures, with daily / regular update meetings taking place.
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.
5. Regular Trust-wide Covid-19 Bulletin implemented (previously daily / weekly).
6. NHS 111 referral measures - including home testing and support to alleviate Urgent Care Centre and ED pressures.
7. Plans and processes in place to relocate staff to provide additional support in those areas most in need.
8. Implementation of internal vaccination programme for staff
9. Establishment of vaccination centres and deployment of mobile vaccination units across local regional for public and staff including walk ins.
10. Senior Leadership Group established to maintain oversight and governance.
11. Asymptomatic testing i.e., use of LFT / LAMP etc.
12. All population groups offered vaccination (at least one dose) and boosters.
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.
14. Weekly / regular Management and Exec. team meetings.
15. COVID-19 wards mobilised across acute and community settings.
16. Why not home why not today campaign to maximise discharges, patient flow and bed capacity.</td></tr>
<tr><td colspan="2" rowspan="4">Update since the last report</td><td colspan="2" rowspan="4">Update 25/05/2022
Risk scoring has been reduced to reflect changes in government legislative requirements and guidance, a reduction in national incident level (reduced to Level 3), a reduction in numbers of inpatients and the relaxation of restrictions where appropriate. This risk is anticipated to reduce further as ‘back to normal’ processes are further introduced.

Next update 01/07/2022
Reminder Issued to Risk Lead to review risk in line with Risk Management Assurance Framework.</td><td>Date Last reviewed</td><td colspan="2">25/05/2022</td></tr>
<tr><td>Risk by Quarter 2022</td><td colspan="2">Q1: 20 | Q2: 15 | Q3: | Q4:</td></tr>
<tr><td>8 week score projection</td><td colspan="2">12</td></tr>
<tr><td>Current issues</td><td colspan="2">Impacted by COVID-19 pandemic. Infection rates continuously monitored</td></tr>
</table>

<table>
<tr><th>o</th><th>ID</th><th colspan="6">Title</th></tr>
<tr><td>11</td><td>7764</td><td colspan="6">Royal Blackburn Teaching Hospital (RBTH) Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: John Houlihan
Exec Lead: Tony McDonald</td><td>Current score</td><td>15</td><td colspan="2">Score Movement</td><td>↔</td></tr>
<tr><td colspan="2">Description</td><td>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 colspan="4" rowspan="2">1. Monthly Executive and Senior Management meetings held with Finance, PFI Partners, Estates and Facilities and Health and Safety (Fire) to review position and activity.
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 colspan="2">Top Controls</td><td>1. Fire alarm system throughout building providing early warning of fire.
2. Evacuation procedures in place.
3. Staff fire wardens are in most areas.
4. All staff trained in awareness of alarm and evacuation methods.
5. Fire safety awareness training modules are a core and statutory training requirements for all staff.
6. Fire safety policy and performance monitoring regularly reviewed by the Health and Safety Committee.
7. Provision of on-site fire safety team response.
8. Agreement of external response times with Lancashire Fire and Rescue Service (LFRS).
9. External monitoring, servicing and maintenance of fire safety alarm system and suitable fire safety signage in place.
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.
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.
12. Total Fire Safety Ltd have commenced program of work on phases 1-4 with Balfour Beatty undertaking work in phase 5.
13. Project team established to manage passive fire protection remedial works throughout phase 5.
14. Random sampling and audit of project works of fire stop door surrounds in phase 5 and phases 1-4.
15. ELHT Estates and Facilities team working closely with Consort and third parties to address high risk areas e.g., plant rooms etc.
16. Additional fire wardens provided by ENGIE to patrol common areas of hospital, maintain extra vigilance and undertake basic fire safety checks.
17. All before and after photographic evidence of remedial works being recorded and appropriately shared.
18. Independent advice established to oversee process, materials and methods used.</td></tr>
<tr><td colspan="2" rowspan="6">Update since the last report</td><td rowspan="6">Update 21/06/2022

No change to risk scoring. Enforcement Notice issued by LFRS.

Next Review Date 21/07/2022</td><td>Date Last reviewed</td><td colspan="4">21/06/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2022</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>15</td><td>15</td><td></td><td></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 coronavirus pandemic</td></tr>
</table>

No	ID	Title
12	8808	**Burnley General Teaching Hospital (BGTH) - Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke.**

Lead	Risk Lead: John Houlihan Exec Lead: 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.
Top Controls	1. Fire alarm system throughout building providing early warning of fire. 2. Evacuation procedures in place. 3. Staff fire wardens are in most areas. 4. All staff trained in awareness of alarm and evacuation methods. 5. Fire safety awareness training modules are a core and statutory training requirements for all staff. 6. Fire safety policy and performance monitoring regularly reviewed by the Health and Safety Committee. 7. Provision of on-site fire safety team response. 8. Agreement of external response times with Lancashire Fire and Rescue Service (LFRS). 9. External monitoring, servicing and maintenance of fire safety alarm system and suitable fire safety signage in place. 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. 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. 12. Total Fire Safety Ltd have commenced program of work on phases 1-4 with Balfour Beatty undertaking work in phase 5. 13. Project team established to manage passive fire protection remedial works throughout phase 5. 14. Random sampling and audit of project works of fire stop door surrounds in phase 5 and phases 1-4. 15. Estates and Facilities team working closely with Consort and third parties to address high risk areas e.g., plant rooms etc. 16. Additional fire wardens provided by ENGIE to patrol common areas of hospital, maintain extra vigilance and undertake basic fire safety checks. 17. All before and after photographic evidence of remedial works being recorded and appropriately shared. 18. Independent advice established to oversee process, materials and methods used.
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. 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
Update since the last report	**Update 21/06/2022** No change to risk scoring. Enforcement Notice issued by LFRS. **Next Review Date 21/07/2022**

Date Last reviewed	**21/06/2022**			
Risk by Quarter 2022	**Q1**	**Q2**	**Q3**	**Q4**
	15	**15**		
8 week score projection	**15**			
Current issues	Impacted by coronavirus pandemic			

<table>
<tr><th>No</th><th>ID</th><th colspan="6">Title</th></tr>
<tr><td>13</td><td>8257</td><td colspan="6">Loss of Transfusion Service</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Handler: Lee Carter
Exec Lead: Jane Oakey</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">Denial of the laboratory premises at Royal Blackburn Teaching Hospital (RBTH), especially blood transfusion, due to:

1. Planned evacuation due to fire alarm test.
2. Unplanned evacuation, in response to local fire alarm activation.
3. Evacuation due to actual fire within the laboratory.
4. Evacuation due to flooding within the laboratory.

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:

1. Routine transfusions.
2. Blood for surgical procedures.
3. Blood for major haemorrhages.

In the latter of the two instances, this would have a profound clinical, organisational and reputational impact.</td><td rowspan="2">Actions</td><td colspan="3" rowspan="2">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.
2. 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</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. Meetings held with project lead for haemonetics.
2. Emergency bloods can be stored in temporary insulated boxes for a period of time.
3. The Bio-Medical Scientist (BMS) would station themselves outside the entrance to the laboratory where they could issue emergency units out.
4. If level 0 was out of bounds, clinical flow room would be the point of contact for skilled staff.
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.
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.</td></tr>
<tr><td colspan="2" rowspan="5">Update since the last report</td><td colspan="2" rowspan="5">Update 06/06/2022
No change to risk scoring. No change has been made regarding the storage sites of blood. All bloods are still held within the laboratory.

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.

Next Review Date 11/07/2022</td><td>Date Last reviewed</td><td colspan="3">06/06/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2022</td><td>Q1</td><td>Q2</td><td>Q3 | Q4</td></tr>
<tr><td>15</td><td>15</td><td></td></tr>
<tr><td>8 week score projection</td><td colspan="3">10</td></tr>
<tr><td>Current issues</td><td colspan="3">Risk scoring will reduce as the blood track system is being rolled out</td></tr>
</table>

East Lancashire Hospitals NHS Trust
A University Teaching Trust

o	ID	Title
14	7165	**Failure to ensure legislative compliance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013**

Lead	Risk Lead: John Houlihan Exec Lead: Tony McDonald	**Current score**	15	**Score Movement**	⟷

Description	Failure to provide quality assurance of legislative compliance regarding duties to report certain types of injuries, diseases and dangerous occurrences to the HSE within set timescales	**Actions**	1. Process of determining RIDDOR reportable incidents and ensuring legislative compliance is let down by deficiencies in the incident management process and of utilising specialists more effectively. 2. There is no evidence of assurance cases of medically diagnosed occupational disease, infections or ill health are being identified or reported. 3. More in depth review of incidents and their investigation is highlighting gaps in risk management systems e.g. sharps, patient falls, manual handling, violence and aggression etc. 4. Demonstrable evidence of increasing awareness and activity from external bodies i.e. HSE, CQC etc. 5. Time spent completing investigations, some of which are very complex, and delays from services in responding to requests in a timely manner due to competing priorities, increased demand and service delivery pressures is having a major impact on ensuring legislative compliance.
Top Controls	1. Full review of legislative requirements and measuring and reviewing performance. 2. Inclusion of RIDDOR reporting requirements within the scope of the incident management policy and or procedures 3. Review of historical incidents to provide qualitative assurance actions taken remain effective. 4. Better utilisation of the incident reporting and investigation module of DATIX 5. Training provided to members of the Health and Safety Committee, Quality and Safety Divisional Leads and Teams, Occupational Health and cascade training across Groups etc. 6. Increased management and staff awareness and understanding of RIDDOR i.e. what is and what is not reportable, consequences and timescales involved in reporting externally to the HSE, relevant work examples and the issue of guidance. 7. Improved working relationships with clinical services and other specialisms e.g. human resources, occupational health, infection prevention control, manual handling, security, falls, legal, estates and facilities etc. should any significant trends be identified. 8. Increased management and staff awareness of health surveillance programmes and utilisation of occupational health services and 'fast-physio'. 9. More in depth investigation, thematic review, monitoring of all incidents undertaken by health and safety team. 10. Escalation processes in place to improve service responses. 11. RIDDOR performance included as a standalone agenda item of the Health and Safety Committee, with escalation and or exception reporting to Trust Wide Quality Governance and Quality Committee.		

Update since the last report	**Update 15/06/2022** No change in risk scoring. Total numbers of RIDDOR reportable incidents for the financial year 2020/21 surpassed all previous historical totals recorded with higher than average figures in 2021/22. This is expected to continue into the new financial year. Since the impact of coronavirus, legislative compliance in relation to response times have significantly reduced from 75% in 2019/20 to currently 15% in 2022/23. **Next Review Date 15/07/2022**	**Date Last reviewed**	**15/06/2022**			
		Risk by Quarter 2022	Q1	Q2	Q3	Q4
			15	15		
		8 week score projection	15			
		Current issues	Impacted by coronavirus pandemic			

Safe | Personal | Effective

No	ID	Title
15	7067	Aggregated Risk - **Failure to obtain timely mental health (MH) treatment impacts adversely on patient care, safety and quality**

Lead	Risk Lead: Alison Brown Exec Lead: Jawad Husain	**Current score**	**15**	**Score Movement**	

Description	ELHT is not a specialist provider or equipped to provide inpatient mental health services. Patients with mental health needs present and may require physical and mental health assessments, treatment and referral to specialist services. Due to a lack of specialist knowledge this may cause a deterioration in patient condition.	**Actions**	1. Process of registration with the Care Quality Commission (CQC) as a mental health service provider remains ongoing. 2. Risks for patients needing admission can only be based on availability of staff (AMHP, MH Consultant), in-patient bed availability and secure available transport (where required). 3. Ring fencing of beds only where there is bed availability. 4. Limited performance data for mental health patients in attendance. 5. ELCAS only commissioned to provide weekday service. There is a gap in children and young people who present with mental health issues with the pathway requiring review. 6. Documentation of shared care not always clear, concise, present, at the required standard. 7. Increasing numbers of Community Development Trust Associations being advised of attendance at ED due to mental health need. 8. Escalation of adverse incidents through internal and external governance processes. 9. Ongoing monitoring of patient feedback through a variety of sources.
Top Controls	1. Frequent meetings between Lancashire and South Cumbria Foundation Trust (LSCFT), East Lancashire Hospitals NHS Trust (ELHT) senior managers, specialist and urgent care commissioners to discuss issues and develop pathways to mitigate risk. 2. 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 the environment. 3. Monthly performance monitoring via Accident and Emergency Delivery Board (AEDB) to provide a system wide response. 4. Bi-monthly Mental Health Clinical Working Group (MHCWG) meetings between ELHT and LSCFT. 5. Daily Gold Command System in place to support. 6. Monthly performance activity monitored by Board. 7. Shared approach to searching patients who consent. 8. Ongoing progress with digitalisation of section 136. 9. Anti-ligature cubicles in place to support higher risk mental health patients. 10. Expanded Mental Health Liaison Team Service (MHLTS) based in the Emergency Department (ED) with 24 hr provision, including shared care and in parallel with the ED triage nurse. 11. Triage risk assessment toolkit in place alongside shared mental health and physical documentation between LSCFT and ED. 12. Regular monitoring and review of near misses and concerns discussed bi-monthly as part of the MHCWG. 13. Cluster review of 12 hr breaches presented at AEDB. 14. Themes from timelines/cluster reviews discussed weekly with CCG, NHS England and LSCFT. 15. Meetings held with LSCFT and Lancashire Constabulary to improve management of patients who abscond.		

Update since the last report	**Update 01/06/2022** Risk scoring remains unchanged. Significant delays are still being experienced when transferring patients to mental health beds. **Next review date 01/07/2022** Reminder Issued to Risk Lead to review risk in line with Risk Management Assurance Framework.	**Date last reviewed**	**01/06/2022**			
		Risk by Quarter 2022	**Q1**	**Q2**	**Q3**	**Q4**
			15	**15**		
		8 week score projection	**15**			
		Current issues	Clinical model pathways and design improvements to be embedded			

<table>
<tr><th>No</th><th>ID</th><th colspan="6">Title</th></tr>
<tr><td>16</td><td>7008</td><td colspan="6">Failure to comply with the 62 day cancer waiting time targets.</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Matthew Wainman
Exec Lead: Sharon Gilligan</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">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 colspan="3" rowspan="2">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.
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.
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.
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.
4. External Funding – Regular investment of the Lancashire and South Cumbria (L&SC) Cancer Alliance & NHS England funding into problem areas.
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.
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.
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 01/06/2022
Increased COVID-19 prevalence has impacted on the workforce across the elective pathway and patient availability for investigation and surgery. Significant challenges within endoscopy, lower gastrointestinal demand, clinical oncology, pathology and outpatient capacity across all specialities. Weekly micro-management undertaken at specialty level.

Next review date 11/07/2022</td><td>Date Last reviewed</td><td colspan="3">01/06/2022</td></tr>
<tr><td rowspan="2">Risk By Quarter 2022</td><td>Q1</td><td>Q2</td><td>Q3 / Q4</td></tr>
<tr><td>15</td><td>15</td><td></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>

<table>
<tr><th>No</th><th>ID</th><th colspan="5">Title</th></tr>
<tr><td>17</td><td>5791</td><td colspan="5">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>Risk Handler: Julie Molyneux
Exec Lead: Chris Douglas</td><td>Current score</td><td>15</td><td>Score Movement</td><td></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 colspan="2" rowspan="2">1. Regular dashboard review of good rostering compliance.
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.
2. Appointment of Lead Recruitment Nurse with focus on ongoing local, national and international recruitment of registered nurses and healthcare support workers.
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.
4. The use of e-rostering, both planned and actual nurse staffing numbers recorded daily and formally reported monthly following quality assurance processes.
5. Use of Safe Care Tool within Allocate to support decision making regarding acuity and dependency.
6. Senior nursing staff authorisation of agency usage
7. Robust system implemented to manage and monitor utilisation of temporary staff including overtime worked.
8. Establishment of internal bank staff arrangements.
9. Business continuity plan available in response to the pandemic with escalated bank and agency rates offered.
10. Monitoring of red flags, incident reporting (IR1's), complaints and other patient experience data.
11. Monthly financial reporting and non-medical agency group reviews of spending.</td></tr>
<tr><td colspan="2" rowspan="4">Update since the last report</td><td colspan="2" rowspan="4">Update 30/06/2022
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.

Next review date 29/07/2022</td><td>Date Last reviewed</td><td colspan="2">30/06/2022</td></tr>
<tr><td>Risk by Quarter 2022</td><td colspan="2">Q1: 15 | Q2: 15 | Q3: | Q4:</td></tr>
<tr><td>8 week score projection</td><td colspan="2">15</td></tr>
<tr><td>Current issues</td><td colspan="2">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>18</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>Risk Lead: Howard Stanley
Exec Lead: Chris Douglas</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">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 DoLS is in effect unauthorised. The Supervisory Body is aware but has not been able to process the assessments within the statutory timescales.</td><td rowspan="2">Actions</td><td colspan="3" rowspan="2">1. Resourcing issue of the Supervisory Body not being able to meet the requirement for the assessment of patients remains outside the control of ELHT who consequently are unable to extend urgent authorisations beyond the minimum time permitted of 14 days.
2. In the absence of assessments undertaken by the Supervisory Body patients will not have their DoLS authorised and will not have had relevant checks undertaken to ensure they are legally detained.
3. Increasing DoLS applications adding to pressures on safeguarding team to manage the process.
4. Plans to change from DoLS to Liberty Protection Safeguards (LPS) still open for consultation until July 2022.</td></tr>
<tr><td colspan="2">Top Controls</td><td colspan="2">1. The Mental Capacity Act Policy and DoLS procedure has been updated to reflect the 2014 Supreme Court ruling.
2. The policy and procedure are being adhered to by wards with applications made in a timely manner.
3. Support is provided by the Adult Safeguarding Team.
4. Mental Capacity Act DoLS training is available to all employees.
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.
6. Applications are tracked by the Adult Safeguarding Team, with changes in patient status related back to the local authority as the supervisory body.
7. The ability to extend urgent authorisations for all patients up to 14 days in total provides some defence to the Trust.
8. Legal advice and support are readily available.
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.
10. Quarterly review of risk by Internal Safeguarding Board.</td></tr>
<tr><td colspan="2" rowspan="5">Update since the last report</td><td colspan="2" rowspan="5">Update 12/05/22
No change in risk score. All cases are routinely referred and responses chased. Patients are detained without authorisation as not doing so would create a higher risk than not doing so.

Next review date 13/06/22
Reminder Issued to Risk Lead to review risk in line with Risk Management Assurance Framework.</td><td>Date Last reviewed</td><td colspan="3">12/05/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2022</td><td>Q1</td><td>Q2</td><td>Q3</td></tr>
<tr><td>15</td><td>15</td><td></td></tr>
<tr><td>8-week score projection</td><td colspan="3">15</td></tr>
<tr><td>Current issues</td><td colspan="3">External influences regarding mitigation of risk beyond the control of ELHT</td></tr>
</table>

Note: the Risk by Quarter row also has a Q4 column (empty).

<table>
<tr><th>No</th><th>ID</th><th colspan="6">Title</th></tr>
<tr><td>19</td><td>2636</td><td colspan="6">Inability to maintain establishment of consultant histopathologists</td></tr>
<tr><td colspan="2">Lead</td><td>Risk Lead: Pamela Henderson
Exec Lead: 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">A national shortage of histopathologists and increasing service demand is leading 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).
2. Process mapping and pathways being reviewed.
3. Demand outstripping capacity with position on meeting turnaround times very challenging.
4. Recruitment ongoing with potential success of at least 1 consultant if not 2 to commence in post early September 2022.
5. Delayed turnaround time inevitable consequence exacerbated 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;
- Urgent i.e. cases marked urgent or with a specific target e.g. two week rule.
- Allocated i.e. surgical cancer resections allocated to a named pathologist.
- Routine i.e. cases reported on site but not in the above categories.
- Referred i.e. cases of a non-urgent nature which can be sent to an external reporting service.
2. Workloads over capacity are reported via capacity lists on weekends, or sent to an external reporting service dependent on clinical need.
3. Medical staffing looking to fill all vacancies on a permanent or locum basis.
4. 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.
5. Capacity provided by external reporting services has reduced over the summer months but has picked up again with a scheduled plan in place to export work.
6. Since January 2022 the entire gynae / cancer pathology workload is now reported by Lancashire Teaching Hospital (LTH) and the entire breast cancer pathology workload now shared by LTH and University Hospitals Morecambe Bay (UHMB).
7. The new Clinical Director from LTH and Trust Divisional Director are continuously monitoring situation.
8. Weekly consultants meeting chaired by new histopathology lead.
9. New overseas locum started end February 2022 and is 'bedding' in, with another overseas locum commencing post in May 2022.
10. Continued use of outsourcing companies to keep up with backlog.</td></tr>
<tr><td colspan="2" rowspan="6">Update since the last report</td><td colspan="2" rowspan="6">Update 21/06/2022
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, LTH and UHMB.

Outsourcing companies struggling to cope with national shortages, sickness and annual leave amongst their own pathologists.

Next Review Date 21/07/2022</td><td>Date last reviewed</td><td colspan="3">21/06/2022</td></tr>
<tr><td rowspan="2">Risk by Quarter 2022</td><td>Q1</td><td>Q2</td><td>Q3</td></tr>
<tr><td>15</td><td>15</td><td></td></tr>
<tr><td>8 week score projection</td><td colspan="3">20</td></tr>
<tr><td rowspan="2">Current Issues</td><td colspan="3" rowspan="2">National shortages in recruitment and COVID19 restoration pressures adding to demand</td></tr>
<tr></tr>
</table>

Note: Risk by Quarter 2022 also has column Q4 (blank).

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

Mrs A Brown, Associate Director of Quality and Safety

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

13 July 2022

Item	**88**
Purpose	Information Action

Title	Board Assurance Framework
Executive sponsor	Mr J Husain, Executive Medical Director

Summary: The revised BAF and risk appetite statement are presented to the Board for a discussion and ratification.

The Committees have received the BAF at their respective meetings and agreed to recommend the revised Risk Appetite Statement to the Board. The Quality Committee did not have an opportunity at its last meeting to review in detail the new BAF risks, but it has been agreed to allocate a significant amount of time at the next meeting to this item.
The BAF has also been shared with the Audit Committee members for their feedback in advance of the Board meeting.

The cover report sets out the review journey and the methodology used for the annual review of the BAF. The new BAF is closely aligned to the key organisational strategies and Trust goals outlined in the Strategic Framework.

Recommendation: The Board is asked to review and approve the new BAF risks for 2022-23, including the risk scores and the Risk Appetite Statement and the allocation of the individual BAF risks to the Committees as set out in section 7.

Report linkages

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

(88) Board Assurance Framework

The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework.

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

Executive Team, March, May and June 2022

Trust Board Workshop, May 2022

Finance and Performance Committee, June 2022

Quality Committee, June 2022

Audit Committee (via email), June 2022.

Introduction

1. The Board have undertaken the annual review of the Board Assurance Framework (BAF), which commenced in March 2022. The review has been carried out utilising the Improving Safe, Personal and Effective Care (SPE+) Improvement Methodology which emphasises the need to take a co-design and continuous improvement approach. The Executive Team have met together on a number of occasions to progress the work, including dedicated sessions on 8 March, 6 May and 10 June 2022. In addition, the Executive Directors with BAF risks assigned to them have met individually with the Director of Corporate Governance and the Interim Director of Service Development and Improvement to develop the content of the individual risks.
2. The Board also met collectively on 10 May 2022 to review, discuss and provide feedback on the newly developed draft framework.
3. As part of the review, a new Executive Risk Assurance Group (ERAG) has been established and the inaugural meeting took place on Thursday 23 June 2022. The Group is Chaired by the Trust's Chief Executive and has been constituted to provide assurance to the Chief Executive, as the Accountable Officer, and the Trust Board about the effectiveness of the Trust's Risk Management System with specific reference to the Corporate Risk Register (CRR) and the BAF. The ERAG will ensure delivery of strategy and effective management of the Trust's key risks through interrogation of evidence about the effectiveness of risk treatment actions. The ERAG will also provide a corporate view on Trust-wide issues of current concern ensuring co-ordination between clinical divisions and corporate services.
4. The Group will advise Board members of its work via the CRR and BAF reports presented to the Committees and the Board.

Development of BAF risks

5. Following discussions held with Executive Directors and review of exemplar Trusts' BAF documents, the proposal was made to increase the number of strategic risks from five to twelve. The new risks are set out below:
    a) **Risk 1: (Risk Score 12, Consequence (C) 4 x Likelihood (L) 3)** The partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, including the Provider Collaboration Board and the Place-based partnership for Pennine Lancashire do not deliver the anticipated benefits resulting in improved health and wellbeing for our communities.

b) **Risk 2a: (Risk Score 15, C5 x L3)** The Trust is unable to deliver on safe, personal and effective care in line with the requirements of the NHS Constitution and relevant legislation, and Patient Charter.

c) **Risk 2b: (Risk Score 15, C3 x L5)** The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as Health and Safety Executive.

d) **Risk 3: (Risk Score 12, C4 x L3)** The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities.

e) **Risk 4a: (Risk Score 16, C4 x L4)** The volume of activity that the Trust is able to deliver is insufficient to achieve the required targets and eradicate backlogs.

f) **Risk 4b: (Risk Score 20, C4 x L5)** The Trust is unable to see, treat and discharge/admit/transfer patients within the prescribed timeframes due to:

  i. the volume and complexity of their needs
  ii. the unavailability of alternative consistent services in the community
  iii. lack of workforce (links to BAF 5b)
  iv. lack of flow within the organisation

g) **Risk 5a: (Risk Score 20, C5 x L4)** Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce.

h) **Risk 5b: (Risk Score 20, C4 x L5)** Recruitment, retention and workforce planning/redesign fail to deliver the Trust objectives and strategies (including the Clinical Strategy).

i) **Risk 6: (Risk Score 20, C5 x L4)** The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.

j) **Risk 7: (Risk Score 20, C5 x L4)** The Trust fails to deliver the strategic objectives set out in its NHS Green Plan.

k) **Risk 8: (Risk Score 16, C4 x L4)** The Trust's transition towards increased digitisation of records and communication disrupts the current clinical and operational service delivery to such a degree that it increases the risk of harm to patients, The reliance on digital systems also increases the impact upon the services should the Trust be subject to a Cyber-attack or significant infrastructure failure.

l) **Risk 9: (Risk Score 16, C4 x L4)** The Trust's Improvement Practice and Management System (including strategy deployment framework and associated key delivery and improvement programmes) do not sufficiently build improvement capability and support delivery on agreed outcomes.

6. The above BAF risks have replaced the risks included within the 2021-22 document, which were the following:

   a) **Risk 1 (Risk Score 16, C4 X L4):** Service Development and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care.
   b) **Risk 2 (Risk Score 20, C5 X L4):** Recruitment, retention and workforce planning fail to deliver the Trust objectives.
   c) **Risk 3 (Risk Score 16, C4 X L4):** 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.
   d) **Risk 4 (Risk Score 20, C4 X L5):** The Trust fails to achieve a recurrent sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to achieve financial balance, at the end of H2.
   e) **Risk 5 (Risk Score 16, C4 X L4):** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements.

7. From September 2022 onwards the full BAF will be presented to the Committees for completeness and information, however, the Committees will be asked to only discuss the risk scores and the mitigations and actions for the risks that are within their remit as follows:

   a) **Finance & Performance Committee:** BAF 1, BAF 3, BAF 4a and 4b, BAF 5b, BAF 6, BAF 8 and BAF 9.
   b) **Quality Committee**: BAF 2a and 2b, BAF 3, BAF 5a.
   c) **Audit Committee**: BAF 7.

8. For ease of reference and comparison we have produced the heat map of the BAF risks for 2021-22 and for 2022-23 below. The heat map for the new BAF risks will be included in future reports.

BAF Risk Scores 2021-22 Heat Map

CONSEQUENCE	LIKELIHOOD →	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
	Catastrophic 5					
	Major 4				BAF 1 BAF 3 BAF 5	BAF 2 BAF 4
	Moderate 3					
	Minor 2					
	Negligible 1					

BAF Risk Scores 2022-23 Heat Map

CONSEQUENCE	LIKELIHOOD →	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
	Catastrophic 5			BAF 7		
	Major 4			BAF 1 BAF 5a	BAF 4a BAF 5b BAF 8 BAF 9	BAF 4b BAF 6
	Moderate 3				BAF 3	BAF 2a BAF 2b
	Minor 2					
	Negligible 1					

Proposed Risk Appetite Statement 2022-23

9. The Board also agreed to undertake a review of the Trust's Risk Appetite Statement for 2022-23. The statement below has been agreed by the ERAG and the Committees and Board is asked to review and approve it.

The long-term sustainability of ELHT depends on the delivery of the strategic objectives and relationships with patients and service users, staff, public and strategic partners. We do not accept risks that materially impact on patients care, health and safety or compliance and regulatory objectives, but we have a higher risk appetite relating to our pursuance of innovation and transformation objectives.

The response to the risk should be in proportion to the level of risk identified and in accordance with the risk appetite and tolerance levels set by the Board of Directors.

*As a provider of healthcare services, the Trust generally has a **'minimal'** appetite for risks to the quality and safety of patient care. This also applies to any risks to the health and safety and wellbeing of patients, staff, contractors and visitors.*
When any risks to the quality and safety of patient care and health and safety and wellbeing are identified the objective should always be to reduce the risk to as low a level (tolerance) as is practicable before it is accepted, or to avoid it altogether where that is an option.

*The appetite of the Trust where risks to its finances, resources or the continuity of its services are concerned is described as **'cautious'**, which means that safe options are preferred. The aim should still be to reduce the risk as far as is practicable, but it is possible that a **'moderate'** level of risk may be tolerated when all circumstances are considered. This would be particularly relevant when balancing these types of risks with safety risks as part of the same decision.*

*The appetite category of **'open' / 'high'** is applicable where the Trust is prepared to accept a higher level of residual risk than usual in pursuit of potential benefits when considering risks and decisions relating to collaboration, innovation and transformation objectives.*

10. In addition to the overarching Risk Appetite Statement, the Executive Directors have worked with the Director of Corporate Governance to suggest risk appetite statement

ratings for their individual risks and these have been included below and will be reviewed bi-monthly:

BAF Risk	Risk Appetite Statement Rating
BAF 1: Integrated Care / Partnerships / System Working	Open/High
BAF 2a: Quality and Safety	Minimal
BAF 2b: Health and Safety	Minimal
BAF 3: Health Inequalities	Open/High
BAF 4a: Elective Recovery	Minimal
BAF 4b: Emergency Care Pathway	Minimal
BAF 5a: Culture	Open/High
BAF 5b: Workforce Planning/Redesign	Cautious/Moderate
BAF 6: Financial Sustainability	Cautious/Moderate
BAF 7: Wider Sustainability	Cautious/Moderate
BAF 8: Digital Agenda	Cautious/Moderate
BAF 9: SPE+ Improvement Practice and Key Delivery Programmes	Open/High

Connection with the CRR

11. Following feedback from the Board we are connecting the BAF risks with those on the CRR. The table below shows the individual CRR risks and their links to the BAF.

BAF Risk	Linked CRR Risks	CRR Score
1: Integrated Care/ Partnerships/ System Working	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 1.	N/A
2a: Quality and Safety	**ID 9336:** Lack of capacity across the Trust can lead to extreme pressure resulting in delayed care. **ID 8126:** Risk of compromising patient care due to lack of electronic patient record (EPR) system. **ID 8960:** Risk of undetected foetal growth restriction and preventable stillbirth due to non-compliance with pulsatility index ultrasound guidance.	20 20 15

BAF Risk	Linked CRR Risks	CRR Score
	ID 8441: Managing the risk of coronavirus (COVID-19) outbreak. **ID 7067:** Failure to obtain timely mental health treatment impacts on patient care, safety and quality. **ID 4932:** Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained.	15 15 15
2b: Health and Safety	**ID 9222:** Failure to implement the NHS Green Plan. **ID 8808:** Burnley General Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke. **ID 7764:** Royal Blackburn Hospital breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke. **ID 7165:** Failure to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).	16 15 15 15
3: Health Inequalities	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 3.	N/A
4a: Elective Recovery	**ID 8061:** Management of Holding Lists. **ID 8941:** Delays to cancer diagnosis due to inadequate reporting and staffing capacity in cellular pathology. **ID 6190:** Insufficient capacity to accommodate patient volumes required to be seen in clinic within specified timescales. **ID 8257:** Loss of transfusion service. **ID 7008:** Failure to comply with 62-day cancer waiting time target.	20 16 16 15 15
4b: Emergency Care Pathway	**ID 8839:** Failure to achieve performance targets.	15
5a: Culture	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 5a.	N/A
5b: Workforce Planning/Redesign	**ID 5791:** Failure to adequately recruit to substantive nursing and midwifery posts may adversely impact on patient care and finance.	15

BAF Risk	Linked CRR Risks	CRR Score
	ID 2636: Inability to maintain establishment of consultant histopathologists.	15
6: Financial Sustainability	**ID 9439:** Failure to meet internal and external financial targets for the 2022-23 financial year	20
7: Wider Sustainability	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 7.	N/A
8: Digital Agenda	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 8.	N/A
9: SPE+ Improvement Practice and Key Delivery Programmes	Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 9.	N/A

Mapping of Trust Key Delivery Programmes to BAF Risks

12. A part of refreshing the ELHT Strategic Framework for 2022-23, a number of key delivery programmes have been identified to ensure there is a robust approach to supporting delivery of Trust goals. Each of the BAF risks has been linked to these key delivery programmes which, in turn, are linked to the Trust goals outlined on its Strategic Framework.

Key Delivery Programmes mapped to Trust Goals from revised Strategic Framework 2022-23

Key Delivery Programmes	Deliver Safe, high quality care	Secure COVID Recovery and Resilience	Compass-ionate and Inclusive Culture	Improve health and tackle inequalities in our community	Healthy, diverse and highly motivated people	Drive sustain-ability
Urgent and emergency care improvement	●	●				
Elective pathway improvement	●	●				
People Plan priorities		●	●		●	●
Quality and safety improvement priorities	●			●		
Electronic Patient Record	●				●	●
Care closer to home/place-based partnerships	●	●		●		
Provider Collaborative	●			●		●
Tackling health and care inequalities			●	●		●
R&D, Education and Innovation	●				●	
Waste Reduction Programme	●					●
Sustainability						●

SPE+ Approach and Improvement Hub Team support

13. The new BAF summary table above shows the alignment of BAF risks to the key organisational strategies and Trust goals outlined in our Strategic Framework. The table below shows the alignment of the Key Delivery Programmes to the BAF. The gaps in controls/assurances and their associated actions can therefore be addressed within each of the Key Delivery Programmes.

BAF Risk	Key Delivery Programme
BAF 1: Integrated Care/Partnerships/System Working	Care closer to home/Place-based partnerships Provider Collaboration
BAF 2a: Quality and Safety BAF 2b: Health and Safety	Quality and Safety improvement priorities
BAF 3: Health Inequalities	Tackling health and care inequalities
BAF 4a: Elective Recovery	Elective pathway improvement
BAF 4b: Emergency Care Pathway	Urgent and Emergency Care improvement
BAF 5a: Culture	People Plan priorities
BAF 5b: Workforce Planning/Redesign	People Plan priorities R&D, Education and Innovation
BAF 6: Financial Sustainability	Waste Reduction Programme
BAF 7: Wider sustainability	Waste Reduction Programme Sustainability
BAF 8: Digital	eLancs programme/EPR

14. BAF 9: SPE+ Improvement Practice and Key Delivery Programmes, has been developed specifically to ensure that there is a link between planning and programme delivery and the development of a supporting improvement practice.

Recommendation

15. The Board is asked to review and approve the new BAF risks for 2022-23, including the risk scores and the Risk Appetite Statement and the allocation of the individual BAF risks to the Committees as set out in section 7.

Mrs A Bosnjak-Szekeres, Director of Corporate Governance

Mrs K Atkinson, Interim Director of Service Development and Improvement

Miss K Ingham, Corporate Governance Manager

BOARD ASSURANCE FRAMEWORK - SUMMARY PAGE

Ref	Trust Strategy	Risk Summary	Risk Descriptor	Lead Executive	Monitoring Committee Finance and Performance Committee - FPC Quality Committee - QC	Trust Goals Impacted Deliver safe, high quality care	Secure COVID recovery and resilience	Compassionate and inclusive culture	Improve health and tackle inequalities in our community	Healthy, diverse and highly motivated people	Drive sustainability	Initial Risk Score	Current Risk Score 2022-23 Q1	Q2	Q3	Q4	Effectiveness of Controls and Assurance	Change	Risk Appetite	Target Risk Score
BAF 1	ELHT Strategic Framework (SPE+ Improvement Practice and Key Delivery Programmes)	Integrated Care / Partnerships / System Working	The partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, including the Provider Collaboration Board and the Place-based partnership for Pennine Lancashire do not deliver the anticipated benefits resulting in improved health and wellbeing for our communities.	MH/KA	FPC	✔	✔		✔		✔	12	(L3 x C4) 12				P	◄►	Open/High	8
BAF 2a	Quality Strategy	Quality and Safety	The Trust is unable to deliver on safe, personal and effective care in line with the requirements of the NHS Constitution and relevant legislation, and Patient Charter.	JH/CP	QC	✔	✔					15	(L3 x C5) 15				P	◄►	Minimal	5
BAF 2b	Quality Strategy	Health and Safety	The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as Health and Safety Executive	TMcD	FPC	✔						15	(L3 x C5) 15				P	◄►	Minimal	10
BAF 3	Clinical Strategy	Health Inequalities	The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities.	SG/TMcD	FPC	✔	✔		✔			12	(L3 x C4) 12				P	◄►	Open/High	8
BAF 4a	Clinical Strategy	Elective Recovery	The volume of activity that the Trust is able to deliver is insufficient to achieve the required targets and eradicate backlogs.	SG	FPC	✔	✔		✔		✔	16	(L3 x C4) 16				P	◄►	Minimal	12
BAF 4b	Clinical Strategy	Emergency Care Pathway	The Trust is unable to see, treat and discharge/admit/transfer patients within the prescribed timeframes due to: •the volume and complexity of their needs •the unavailability of alternative consistent services in the community •lack of workforce (links to BAF 5b) •lack of flow within the organisation	SG/TMcD	FPC	✔	✔		✔		✔	20	(L5 x C4) 20				P	◄►	Minimal	12
BAF 5a	People/ Workforce Strategy	Culture	Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce.	KQ/KM	QC	✔		✔	✔	✔		20	(L3 x C4) 12				P	▼	Open/High	6
BAF 5b	People/ Workforce Strategy	Workforce Planning / Redesign	Recruitment, retention and workforce planning/redesign fail to deliver the Trust objectives and strategies (including the Clinical Strategy)	KQ/KM	FPC	✔	✔		✔	✔	✔	20	(L4 x C4) 16				P	▼	tious/Mode	12
BAF 6	Finance Strategy	Financial Sustainability	The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.	MB	FPC	✔	✔				✔	20	(L5 x C4) 20				P	◄►	tious/Mode	12
BAF 7	NHS Green Plan	Wider Sustainability	The Trust fails to deliver the strategic objectives set out in its NHS Green Plan.	MB/KA	FPC QC	✔					✔	20	(L3 x C 5) 15				P	▼	tious/Mode	10
BAF 8	Digital Strategy	Digital Transformation	The Trust's transition towards increased digitisation of records and communication disrupts the current clinical and operational service delivery to such a degree that it increases the risk of harm to patients. The reliance on digital systems also increases the impact upon the services should the Trust be subject to a Cyber-attack or significant infrastructure failure.	MB	FPC	✔					✔	16	(L4 x C 5) 16				P	◄►	tious/Mode	12
BAF 9	ELHT Strategic Framework (SPE+ Improvement Practice and Key Delivery Programmes)	SPE+ Improvement Practice and Key Delivery Programmes	The Trust's Improvement Practice and Management System (including strategy deployment framework and associated key delivery and improvement programmes) do not sufficiently build improvement capability and support delivery on agreed outcomes.	KA	FPC	✔	✔	✔	✔	✔	✔	16	(L4 x C4) 16				P	◄►	Open/High	8

Key:

✔		Alignment to Strategic Objective (main goal impacted)
✔		Alignment to Strategic Objective (other goals impacted)
▲		Risk Increasing
◄►		No Change to Risk
▼		Risk Decreasing
E		Effective - Controls are effective, no additional assurance required
P		Partially Effective - Controls are partially effective, further monitoring by management is required
I		Insufficient - Controls are ineffective, may require immediate action to remediate

Table 1 Consequence scores

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	1	2	3	4	5
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

BAF Risk 1

Risk Description: The partnership arrangements across the Integrated Care System (ICS) for Lancashire and South Cumbria, including the Provider Collaboration Board and the Place-based partnership for Pennine Lancashire do not deliver the anticipated benefits resulting in improved health and wellbeing for our communities.

Executive Director Lead: Interim Chief Executive

Strategy: ELHT Strategic framework (Partnership Working)

Date of last review: 16 June 2022

Links to Key Delivery Programmes: Care Closer to Home Place-based Partnerships

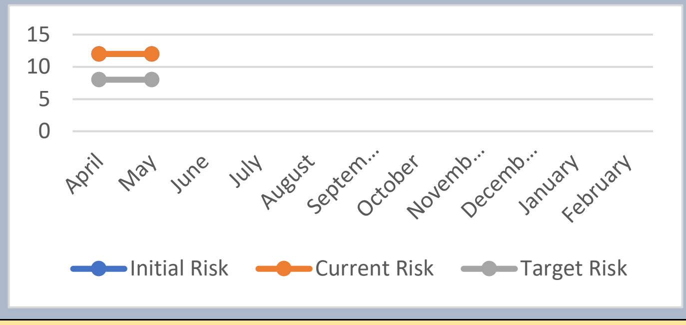
Lead Committee: Finance and Performance Committee

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

Initial Risk Rating: C4 x L3 = 12

Current Risk Rating: C4 x L3 = 12

Target Risk Rating: C4 x L2 = 8



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite:

Open/High

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

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

- ELHT has strong representation at all levels across existing ICS and emerging ICB structures and working groups. This is inclusive of Executive, senior clinical and operational representation at ICS working groups for key programmes, tactical co-ordination groups and planning groups to ensure alignment of plans.

Provider Collaborative Board (PCB):

- The PCB is developing a robust governance and delivery structure, with investment from all partners, and has developed key aims and objectives and PCB Business Plan.
- ELHT plays a key role in the PCB including Chief Executive and Chair at PCB Provider Collaborative Board, lead Director Senior Responsible Officer (SRO) roles at PCB Co-ordination Group, representation at all other functional Director co-ordination groups and senior clinical and operational staff represented at clinical and non-clinical programme and working groups.
- The PCB is developing a Quality Management System to ensure a consistent approach to planning, a consistent approach to system-level improvement work via a single overarching improvement model and co-ordination of key operational and service development work streams e.g. Elective Recovery, Pathology Collaborative etc
- A PCB Clinical Strategy is in development.

Pennine Lancashire Place-Based Partnership (PBP):

- A strong PBP delivery model has been established with Partnership Leader's Forum, Chairs and Chief Officers Advisory Group and an overarching Delivery Co-ordination Group.
- The PBP has formal place-based Collaborative Delivery Boards, with responsibility for planning and delivery of an integrated approach to key workstreams with identified priorities for 2022-23. There is strong leadership and representation from ELHT and all partners on the Delivery Boards.

ELHT:

- ELHT Strategic framework has been developed to ensure clear alignment of organisational aims to wider system aims.
- Key organisational strategies have been developed/in development to clearly outline ELHT priorities for development as a partner in the wider system.
- Key delivery programmes have been identified to ensure delivery against organisational aims and objectives and aligned to wider system programmes.
- Strategy deployment framework/process will support development and delivery of organisational plans aligned to wider system.

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

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

- ICS/PCB/PBP Updates are a standing agenda item at Executive meeting and Senior Leadership Group.
- Reports from PCB SROs. Programme Update reports to the PCB Co-ordination Group and PCB Board.
- PBP Programme Boards workplans and progress reports developed and signed off by PBP and monitored via Programme Delivery Co-ordination Group.

Specialist support, policy and procedure setting, oversight responsibility:

- Standing agenda item at Trust Board where approvals will be established, and permissions are provided by the Board to let Executives progress the generation of ideas and options with external stakeholders.
- Board Chief Executive Officers (CEO) report including updates on system developments and engagement.
- Pennine Lancashire ICP Memorandum of Understanding (MoU) agreed by stakeholders workplan in place after Tripartite Board session. Revised governance and delivery standards.

Independent challenge on levels of assurance, risk and control:

- Provider Collaborative Board Business Plan signed off by all partners. Ongoing assurance on delivery provided via PCB Board and oversight groups.
- Trust, PBP, PCB plans feed into ICS-level plans as part of the national operational planning processes and are scrutinised by NHS Improvement/England.
- Regular communication with NHS England, NHS subsidiaries, Commissioners and Senior/Executive Management between teams.

• ELHT is a provider of community and primary care services and well represented at Primary Care Networks.	

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	System delivery plans developed are yet to deliver tangible outcomes and progress not always consistently clear.	Work with partners to ensure plans improve assurance on action, progress, outcomes, inter-dependencies and risk and build into ELHT Key Delivery Programme Reporting arrangements (refer to BAF 9).	Interim Director of Service Development and Improvement with SRO leads	End July 2022	PCB delivery plans are being updated to include actions/impact. Pennine Lancashire plans for 2022-23 in process of being updated and signed off through delivery boards. Further work required to quantify impact and monitoring arrangements. Unable to fully incorporate into ELHT Key Delivery Programmes until complete.	A
2.	PCB Clinical Strategy development process needs clarifying to ensure clear alignment to wider ICS, New Hospitals programme, organisational strategies.	Work with PCB via Clinical Integration Group and Directors of Strategy Group to clarify plans for development.	Executive Medical Director/ Interim Director of Service Development and Improvement	End July 2022	Initial draft strategy currently being shared via PCB working groups and boards. Draft version to be shared with wider staff groups in July for consultation.	G
3.	ICB review of place-based partnerships boundary review may impact on current Pennine Lancashire PBP arrangements/ progress.	Participate in review to ensure opportunities and risks appropriately identified.	Interim Chief Executive/ Executive Director of Integrated Care, Partnerships and Resilience	July 2022	Review underway, and due to be ratified in July at ICB.	A
4.	Community service provision in Pennine Lancashire sits across 2 providers which can impact equity of provision.	Continue to engage with ICB and PBP leaders to mitigate inequities so far as possible and reunify provision.	Interim Chief Executive/ Executive Director of Integrated Care, Partnerships and Resilience	No date yet agreed Position to be reviewed in September 2022	Secure agreement to be sole provider of urgent community response service across Pennine Lancashire.	A
5.	ICB Programme(s) for community, discharge and intermediate care including virtual wards and hospital at home.	Continue to lead and engage in programmes to support transformation and mobilisation of pathways.	Executive Director of Integrated Care, Partnerships and Resilience	March 2023	Work programmes either in development or on track as expected.	G
6.	Quality Management System in early stages of development. System Improvement Model developed and in early stages of testing.	Active participation in development of QMS and Model for Improvement. Testing of Improvement Model on Frailty/Respiratory.	Interim Director of Service Development and Improvement	March 2023	Work plan in place for development of Model for Improvement. Recruitment of teams underway. External support from David Fillingham and University of Cambridge.	G
7.	Capacity to support all workstreams both for ELHT staff, due to system architecture changes and emerging delivery structures at PCB.	Continue to review demand and capacity and shape discussions on best way to configure system resources to support delivery	Senior Responsible Officers	End July	Discussions ongoing to verify programme priorities and resources required to support delivery and agreed outcomes. Capacity requirements not yet fully understood.	A

BRAG	Explanation
	Complete / Business as Usual - Completed: Improvement / action delivered with sustainability assured.
	On Track or not yet due - Improvement on trajectory
	Problematic - Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement
	Delayed - Off track / trajectory – milestone / timescales breached. Recovery plan required.

BAF Risk 2a

Risk Description: The Trust is unable to deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter.

Executive Director Lead: Executive Medical Director, Executive Director of Nursing

Strategy: Quality Strategy

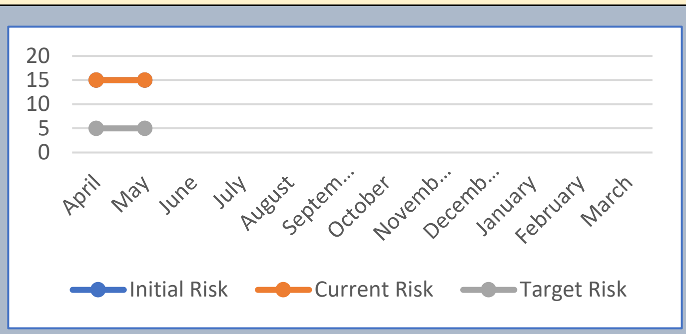
Date of last review: 16 June 2022

Links to Key Delivery Programmes: Quality and Safety Improvement Priorities

Lead Committee: Quality Committee

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

Initial Risk Rating:	C5 x L3 = 15
Current Risk Rating:	C5 x L3= 15
Target Risk Rating:	C5 x L1 = 5



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite:

Minimal

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

Strategy and Planning:

- The Quality Strategy contains 14 core priorities which are routinely reported and monitored through the Quality Committee. These will be reviewed and updated annually through workshops with key partners.

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

- The Trust has an established quality assurance process supported through a formal Committee Structure. This provides the golden thread enabling reporting and escalation between the Divisions and the Board.
- The Trust Board, Quality Committee, Finance and Performance Committee and Audit Committee all receive reports on risk/quality as part of their annual workplan, or as escalation where indicated
- Escalation required outside of standard Committee processes is enabled through a weekly Senior Leadership Group, chaired by the Chief Executive or other Executive member to enable timely decision making and trust wide focus where required.
- All Divisions (including Estates and Facilities) have Quality and Safety meetings which coordinate Directorate assurance reports and escalation. Divisional reports are provided to the Trust Wide Quality Governance (TWQG) Group and escalated to the Quality Committee through standard reporting and/or as patient/staff safety escalation points.
- Statutory requirements are monitored specifically through Trust Wide assurance meetings including, but not limited to Mortality Steering Group, Patient Safety and Experience, Clinical Effectiveness Committee, Infection Prevention and Control Steering Group, Safeguarding Board, Medicines Management Committee, Trust Wide Quality Governance Group, All of which report to the Trust's Quality Committee, which is a sub-committee of the Board.
- The Professional Standards Group and Employee Relations Case Review Group monitor professional/staff behaviours and all referrals to professional bodies.
- The Risk Assurance Meeting coordinates and monitors all risks reported as potentially scoring 15 or above and escalates to the Executive Risk Assurance Group before inclusion onto the Corporate Risk Register.
- The Patient Safety Incident Response Framework, Patient Experience Framework, Risk Management Framework and Clinical Effectiveness Framework coordinate the operational implementation of the priorities which are reported and monitored through respective assurance groups, and exceptions reported to Quality Committee via TWQG.

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

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

- Monitoring against Model Hospital, Getting it Right First Time (GIRFT), National Institute for Health and Care Excellence (NICE) guidelines, Internal and Clinical Audits (local and national), specialist commissioning, CQC insight data (monthly)
- Quality Walk rounds including Executive and Non-Executives
- Complaints review process which is chaired by a Non-Executive Director
- Nursing Assessment Performance Framework (NAPF) Process ongoing and reports to Quality Committee
- Safe, Personal, Effective Care (SPEC) process and the ratings of green/silver wards/areas (mapped to the CQC Key Lines of Enquiry)

Specialist support, policy and procedure setting, oversight responsibility:

- Clinical Commissioning Group Quality Assurance Meetings – awaiting Integrated Care Board (ICB) reporting structure
- Health Safety Incident Board (HSIB) reports – review deaths and Health and Safety incidents
- Engagement meetings with Care Quality Commission (CQC) in place monitoring performance against the CQC standards. The Trust is preparing for its next Well-Led review, via Task and Finish Group working.
- Patient Safety Incident Response Framework (PSIRF) supported through regular contact with NHS England Implementation Team
- Early adoption of Parliamentary and Health Service Ombudsman (PHSO) Complaints Standards supported through regular contact with PHSO Local Safeguarding Childrens Board (LSCB)/Safeguarding Adults Board (SAB) reporting on Care Act and Children Act Standards.

Independent challenge on levels of assurance, risk and control:

- Annual organisational appraisal report.
- CQC inspections and preparation/evidence gathering ongoing.
- Mersey Internal Audit Agency (MIAA) audits (Risk/Incidents/Duty of Candour) and improvement actions plan reporting to Audit Committee.
- Engagement meetings with General Medical Council (GMC) and e-Learning Anaesthesia (e-LA).
- Coroner reviews of care provided through Inquest Processes.
- Public Participation Panel (PPP) involvement in improvement activities and walk rounds.
- PHSO complaints monitoring and external reports.

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

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

BAF Risk 2a

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
Progress update/Impact: Update by exception and effectiveness of impact on address gap in control/assurance						
1	Fragility and availability of the workforce (medical and nursing). Health and wellbeing of the workforce (Refer to BAF 5a and BAF 5b)	To strengthen the Patient Safety Culture in line with the Workforce Plan and a Just Culture Approach.	Executive Medical Director/ Executive Director of Nursing/ Director of HR and OD	September 2022	Patient Safety Specialist roles introduced to liaise with HR and introduce staff safety metrics reporting and monitoring.	G
2	Provision of histopathology within the Trust (medical and healthcare scientists)	Work is taking place across providers via mutual aid and exploration of outsourcing and open recruitment. Ongoing improvement work to identify internal efficiency opportunities.	Executive Medical Director/ Executive Director of Nursing/ Director of HR and OD	September 2022	Advertised for recruitment to the vacant posts (consultants). Task and Finish Group with Diagnostics and Clinical Services (DCS) team and Chief Operating Officer. Early evidence of improvement work having impact on Histopathology turnaround times, this will be reported to the Quality Committee in June 2022.	A
4	Lack of electronic governance management system	Implement RADAR as new governance system.	Executive Medical Director	September 2022	RADAR purchased and implementation plan under development.	G
5a	Continued requirement to manage patients who are waiting for placement under the Mental Health Act (MHA) Sections 2/3	Continued working with Integrated Care System (ICS) partners to commission mental health provision (refer to BAF 4b).	Executive Director of Nursing/ Executive Medical Director/ Executive Director of Integrated Care, Partnerships and Resilience	October 22	Interaction at local level with mental health teams.	A
5b	Increased requirement to manage patients who require detention under section 5 2 of the MHA, or who display challenging behaviour	Application to the CQC for the Trust to provide assessments and detain for patients under Section 5.2 of the MHA.	Executive Director of Nursing/ Executive Medical Director/	September 2022	Mental Health Urgent Assessment Centre (MHUAC) service implemented. Mental Health Liaison nurses supporting ED. Urgent and Emergency Care (UEC) MH admission pathway. Need to develop a formal agreement with Lancashire and South Cumbria Foundation Trust (LSCFT) re support available to assist our staff to safely manage patients who may be a risk to themselves or others in an acute setting.	G
6	Unprecedented demand on the Quality Governance team	Co-ordinate GIRFT through Audit and Effectiveness Team to identify Trust wide efficiency and effectiveness gains.	Executive Medical Director	November 2022	Linkage with Model Health System, PLICS & GIRFT (MPG) Group to capture historic/ongoing action plans to reduce duplication and following up work already completed during the pandemic. All received action plans are currently being captured and transposed into a standardised format to allow for monitoring of actions. 18/30 local specialty action plans have been received following observational visits, from which 376 actions have been identified and they are being progressed. 23 National Reports with recommendations, 12 received in 2021 of which 5/13 reviews have been confirmed and 8/13 are being progressed. Newly published reports are added and circulated for review and response in line with Clinical Effectiveness Framework.	A
		Implement PSIRF and PHSO Complaints standards as an early adopter.	Executive Director of Nursing/ Executive Medical Director/	November 2022	**PSIRF** Resources to support PSIRF implementation will be reviewed in July/August 2022. Links made with Leeds Early Adopter Trust to share good practice and Learning.	A

					PSII and PSR investigations now taking place and assurance being provided at Patient safety Group, Lessons Learnt Group, Quality Committee, Trust Board. RADAR Governance system due to be implemented September 2022. **PHSO** The recommendations for the implementation of the PHSO Complaints Standards Framework were agreed at the May 2022 Quality Committee and an update will be provided to the Quality Committee in November 2022.	
		COVID-19 Independent Inquiry will require significant resource to co-ordinate.	Executive Director of Nursing/ Executive Medical Director/	September 2022	Terms of Reference confirmation awaited. Indication likely significant focus on ELHT and likely significant assurance evidence required to be coordinated and checked prior to submission.	R
		Introduction of Liberty Protection Safeguards.	Executive Director of Nursing/ Executive Medical Director/	Before April 2023	Awareness raising ongoing. Project manager required to scope Liberty Protection Safeguards (LPS) and MHA 5 2 implementation impact – yet to be funded. Potential significant workload associated to cover approx. 260 annual applications.	A
7	Need to increase patient/public engagement and influence	Introduction of Patient Safety Partners.	Executive Director of Nursing	July 2022	Allocation of funding for Patient Safety partners to be considered. Role Descriptions currently being agreed. Project Lead allocated.	A

BAF 2b

Risk Description: The Trust fails to meet the required statutory requirements and compliance associated with health and safety legislation and is therefore subject to formal legal action via regulatory bodies such as Health and Safety Executive

Executive Director Lead: Executive Director of Integrated Care, Partnerships and Resilience

Strategy: Quality Strategy / Health and Safety Framework as enabler to the Safe priorities

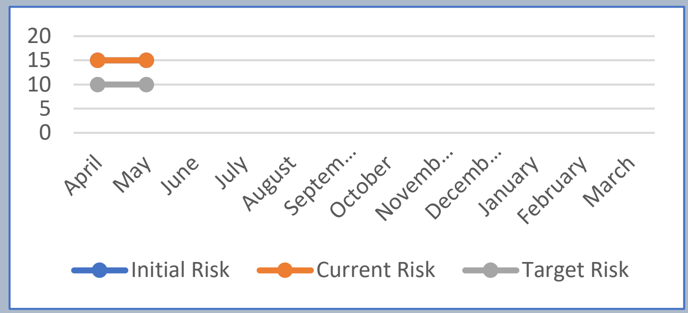
Date of last review: 22 June 2022

Links to Key Delivery Programmes: Quality and Safety Improvement Priorities

Lead Committee: Quality Committee

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

Initial Risk Rating:	C5 x L3 = 15
Current Risk Rating:	C5 x L3 = 15
Target Risk Rating:	C5 x L2 = 10



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite:

Minimal

Controls: (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the risk)

Strategy and Planning:

- New Health and Safety at Work policy, developed and ratified in March 2022 by the Health and Safety Committee, that provides the organisational strategy and operational framework for health and safety management for the Trust.

Health and Safety Governance Arrangements:

- The Trust has a well-established Health and Safety Committee which reports to the Quality Committee via the Trust Wide Quality Governance Group (TWQG) providing strategic direction to the Trust regarding the management of health and safety. Reports are routinely provided to TWQG every other month.
- Key health and safety risk areas (e.g. Safe Working Spaces, Control of Substances Hazardous to Health, Reporting of Injuries Diseases and Dangerous Occurrences Regulations) are identified and discussed at Trust Health and Safety Committee to ensure organisational approach to management is agreed
- Risk assessment process developed and agreed to support identification of health and safety risks and agreement of mitigating actions.
- Health and Safety Awareness, Fire Safety Awareness, Moving and Handling training are part of the Core Mandatory Training which ensures staff are aware of key obligations and requirements/actions and compliance is monitored and reviewed at the Health and Safety Committee and within divisional Core Skills Training monthly reports.
- Risk Management and Violence and Aggression and Conflict Resolution training available for staff via Learning Hub to develop skills to support effective health and safety management.
- Robust incident investigation process for Health and Safety related incidents to ensure identification of themes/trends. All incidents are reviewed by the incident team via daily triage processes. Health and Safety incidents are escalated to a Health and Safety Officer who requests clarification from the reporter regarding any indication of an immediate safety concern or a statutory reporting threshold having been met. If identified the notification to regulatory bodies is made by the Health and Safety Officer following notification to the Accountable Officer. Timeframes for reporting are monitored via electronic systems and reported to the Executive along with activity themes every two weeks, as part of the Quality Governance data pack.

Assurances: (Evidence that the controls/ systems which we are placing reliance on are effective)

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

- The Trust has nominated the Executive Director of Integrated Care, Partnerships and Resilience to be the responsible lead for health and safety at Board level.
- The Assistant Director of Health, Safety and Risk Management is the named lead person to provide strategic and operational direction as required by statutory legislation.
- Key risks identified and risk assessments developed and reviewed via Health and Safety Committee which report to the Quality Committee.

Specialist support, policy and procedure setting, oversight responsibility:

- The Trust has a robust overarching corporate Health and Safety at Work policy and statement of intent outlining the strategic and organisational arrangements for the effective management of health and safety, how this is to be delivered and how it will be performance managed, supported by the Board and the Accountable Officer demonstrating organisational commitment in achieving this purpose.
- Health and Safety Committee meets bi-monthly and reports to Trust-wide Quality Governance group bi-monthly.
- Health and Safety Core Mandatory Training requirements met.

Independent challenge on levels of assurance, risk and control:

- Health and Safety Executive (HSE) oversight and review arrangements in place. Updates on the implementation of the improvements indicated in the recent Improvement notice received April 2022 are provided to the HSE and visible at Board. There is an Extraordinary Board meeting scheduled for 12 July 2022 to receive assurance regarding fire safety.
- Lancashire Fire and Rescue Service (LFRS) regulate the fire safety requirements of the Trust and have recently issued an Improvement Notice with regard to physical improvements required across the Trusts main hospital sites.
- Health and Safety arrangements reviewed as part of CQC fundamental standards which are assessed as part of regular inspection processes.
- Environment Agency reviews of health and safety environment issues e.g. waste.
- Medicines and Healthcare Products Regulatory Agency (MHRA) oversight of safety alerts, medical devices and equipment.

BAF 2b

Gaps in controls and assurance: Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level or to improve evidence that the controls are effective

Mitigating actions: Plans to improve controls/assurance

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	No overarching Health and Safety Framework currently in place.	Develop organisational Health and Safety Framework in line with Quality Strategy	TMcD	December 2022	Framework agreed and development underway	G
2	No evidence of assurance that Trust Board have received training in relation to key Health and Safety responsibilities.	Utilise approved toolkit to benchmark current performance	TMcD	Sept 2022	Early planning underway to agree actions and timescales	G
3	Leadership Training to support effective delivery of the Health and Safety at work policy	Senior Management leadership training for health and safety	TMcD	December 2022	Identification of external accredited courses underway	G
4	Further assurance required that all identified health and safety risks have been fully assessed and mitigation plans are optimised consistently across the organisation	Prioritisation of key actions via Health and Safety Committee	TMcD	March 2023	Key issues identified, ongoing discussions about how best to recourse and support delivery of priority risks	A
5	Lancashire Fire and Rescue Service have issued an Enforcement Notice with regard to improvements required across the Trusts main hospital sites.	Implementation of required mandatory improvement plans in partnership with Consort and Albany for a) Burnley General Hospital - Renal suite b) Burnley General Phase 5 c) Royal Blackburn Hospital Phase 5	TMcD	a) Sept2022 b) May 2024 c) Apr 2023	Incident Management Team established and meeting weekly to co-ordinate Consort/Albany and the Trust action plans to complete required improvements. Identified need for increased resource to support implementation being outlined for consideration.	A

BAF Risk 3

Risk Description: The Trust cannot fulfil the requirements of the NHS Constitution, relevant legislation, Patient Charter and the recommendations of the Lancashire and South Cumbria ICS Health Equalities Commission in relation to reducing health inequalities.

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

Strategy: Clinical Strategy

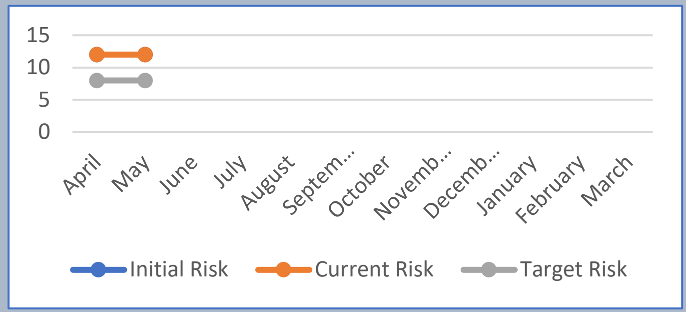
Date of last review: 16 June 2022

Links to Key Delivery Programmes: Tackling Health and Care Inequalities

Lead Committee: Finance and Performance Committee and Quality Committee

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

Initial Risk Rating:	C4 x L3 = 12
Current Risk Rating:	C4 x L3 = 12
Target Risk Rating:	C4 x L2 = 8



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite:

Open/High

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

At Trust and System level there is a sign up to reducing health inequalities which has been endorsed by the Trust Board and Provider Collaborative Board. At present, reliance is placed upon existing systems and processes which have not been designed to intentionally introduce health inequalities, but which can be further developed.

To further strengthen our position, the following controls, systems and processes are being established:

- Development of a Trust-wide Health Equity strategy, which will focus on reducing health inequalities affecting patients and/or care pathways.
- Development of a 'Delivery Group', who will oversee specific workstreams that are prioritised through the strategy - establishing systems and processes, including terms of references, delivery plans and control processes.
- Development of a communications sub-strategy to raise the appropriate awareness amongst staff, patients and relevant stakeholders.
- Creation of systems and processes for screening waiting lists for health inequalities
- Integration of 'personalised care' into the outpatients' improvement programme in key areas such as 'patient-initiated follow-up' (PIFU) and virtual consultations (VC).
- Creation of operational delivery processes and controls to support five clinical areas identified in the national 'Core20PLUS5' approach to reducing health inequalities. These are:
    a. Maternity
    b. Severe mental illness
    c. Chronic respiratory disease
    d. Early cancer diagnosis
    e. Hypertension case finding
- Integration of continuous improvement methodology processes into each specific area to support deliver of key priorities
- Monitoring and controlling key deliverables through established reporting mechanisms for operational performance
- Creation of mechanisms to ensure patient and staff feedback is gained and reacted upon where applicable.
- Inter-Divisional working groups such as Weekly Operations, Outpatients Steering Group, Elective Recovery Board amongst others.

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

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

- By targeting specific population groups, the Trust will monitor, and support actions intended to overcome inappropriate variations in service delivery
- Appropriate screening of patient waiting and holding lists for health inequalities in relation to the Trust's elective recovery and outpatients' improvement programmes

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

- Formation of a Pennine-Lancashire, Health Equity Board, which includes key stakeholders across the health and care, council, education, research, voluntary and patient groups.
- Consideration of a Public Health Registrar (PHR), In partnership with Blackburn with Darwen Unitary Authority (BWDUA), to work with the Trust on tackling wider determinants of health equity
- Funding of a Programme Manager post has been funded to work with the Trust, in partnership with the ICS.

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

- Outputs and decisions from the Health Equity Board, will devolve to respective steering groups for actioning and follow-up, then fed back to the Board for ongoing monitoring and peer-led review
- Progress in the form of policy reviews, pathway (re)development and research will be shared for system-wide learning and peer-led review.

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Health Equity strategy is not yet developed	Draft a Health Equity Strategy for Board/Integrated Care Partnership (ICP)/ICS approval	Executive Director of Integrated Care	January 2023	Strategy is currently in its development stage	G

			Partnerships and Resilience			G
2	Pennine-Lancashire, Health Equity Board is not yet established	Set-up the inaugural meeting of Health Equity Board	Executive Director of Integrated Care Partnerships and Resilience	July 2022	Key members have been contacted and a meeting scheduled in June 2022.	G
3	Operational Delivery Group is not yet established	Assemble key members for an Operational Delivery Group	Executive Director of Integrated Care Partnerships and Resilience	September 2022	Will be created once the HE Board is underway and objectives have been created	G
4	Operational plans for Core20PLUS5 are not yet formulated	Draft deliverable plans to reduce inequalities based on the five key areas	Executive Director of Integrated Care Partnerships and Resilience / Chief Operating Officer	September 2022	These will be formulated based on the outputs of the Health Equity Board	G
5	Process to screen waiting lists for inequalities is not yet formulated	Work with business intelligence leads and clinical staff to create an inequalities screening tool	Chief Operating Officer	September 2022	ICP business intelligence colleagues approached – further discussions needed	G
6	Patient-centred feedback for PIFU has not been gathered	Patient survey to be finalised and sent out to a cohort of patients to explore personalised care element	Chief Operating Officer	August 2022	Survey finalised and to be distributed in May 2022. Results to be collated and analysed in July 2022.	G
7	Communications sub-strategy has not yet been developed	Create a communications sub-strategy to promote the Trust's vision for health equity	Executive Director of Integrated Care Partnerships and Resilience	November 2022	To be conceptualised, but this be a key strand of the Board, in conjunction with system partners	G
8	Public Health Registrar support has not yet been established	Recruitment to this post in partnership with BWDUA	Executive Director of Integrated Care Partnerships and Resilience	August 2022	Initial conversations and prospective candidate shortlisted. Possible July/August start	G
9	Programme Management support has not yet been established	Recruitment to this post in partnership with ICS partners	Executive Director of Integrated Care Partnerships and Resilience	August 2022	Funding secured, job description and advert finalised – awaiting financial instruction	G

BAF Risk 4a

Risk Description: The volume of activity that the Trust is able to deliver is insufficient to achieve the required targets and eradicate backlogs.

Executive Director Lead: Chief Operating Officer

Strategy: Clinical Strategy

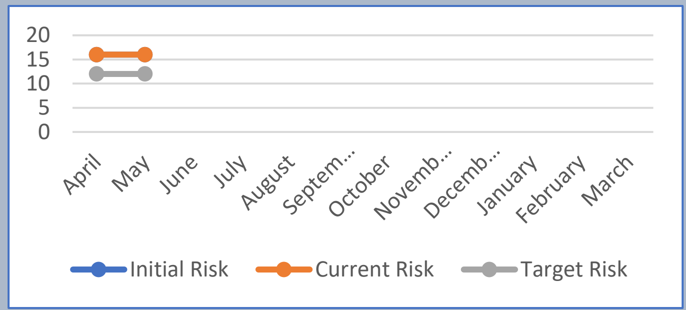
Date of last review: 21 June 2022

Links to Key Delivery Programmes: Elective Pathway Improvement

Lead Committee: Finance and Performance Committee

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

Initial Risk Rating:	C4 x L4 = 16
Current Risk Rating:	C4 x L4 = 16
Target Risk Rating:	C4 x L3 = 12



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite:

Minimal

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

Overall planning and delivery processes:

- Robust annual planning processes and ongoing review processes in place to continually assess clinical and operational demand and capacity across all specialities, modalities and points of delivery
- Elective pathway improvement identified as a Key Delivery Programme as part of the Trust Strategic Framework and a supporting Pennine Lancashire wide elective care improvement plan inclusive of theatres, diagnostics, cancer, endoscopy and outpatient improvement plan has been developed
- Trust clinical strategy developed to identify key developments required over 5-year period to support ongoing delivery and development of elective care services.
- Development of systems and processes to support reduction in risk to Health Equity (refer to BAF 3)
- Development of system and processes to assess and reduce risk of clinical harm potential for patients on elective waiting lists and support delivery of safe, personal and effective care (refer to BAF 2a)
- Collaborative working across Lancashire and South Cumbria on delivery and development of all elective care services via Elective Care Recovery Group with system-level plans in place and programmes of work identified.
- Additional capacity provided through insourcing, Independent Sector contracts and Mutual Aid arrangements within Lancashire and South Cumbria Integrated Care System (ICS).

Operational Management processes:

- Robust daily operational management processes in place to support ongoing monitoring of activity, demand and performance.
- Weekly monitoring of activity delivery to plan and effectiveness of remedial actions at divisional and specialty level by point of delivery (PoD)
- Weekly Patient Tracking List (PTL) meetings with specialty leads including for cancer to ensure tracking at individual patient level
- Ongoing implementation and monitoring of elective improvement plans including theatre productivity, diagnostic clearance plans etc. to ensure effective support to delivery of overall activity level.
- Implementation of chatbot for an accurate waiting list status for prioritised treatment based on clinical need and chronological wait
- Additional support secured for waiting list validation to ensure reporting of accurate waiting list position.

Oversight arrangements:

- Pennine Lancashire Elective and Outpatient improvement board co-chaired by Chief Operating Officer (COO) and Interim Director of Service Development and Improvement overseeing delivery of performance and improvement plan
- Monthly elective care steering group chaired by Deputy COO overseeing elective/diagnostic/cancer plan
- Monthly outpatient steering group chair by Deputy COO overseeing outpatient improvement plan
- Weekly Operational performance meetings focusing on high-risk areas and delivery of agreed improvement trajectories
- Weekly monitoring of Referral to Treatment (RTT) and cancer wait time position using performance dashboard at specialty/tumour site level

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

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

- Achievement of zero 104 week waits by July 2022 in line with submitted plans.
- Clear trajectories for other key targets for Referral to treatment Times, Cancer, Diagnostics and Activity levels in place and monitored via reporting to weekly operational team meeting, executive team meeting, senior leadership group.

Specialist support, policy and procedure setting, oversight responsibility:

- Benchmarking data available from Getting It Right First Time (GIRFT), Model Hospital
- Cancer Alliance support on focussed areas requiring improvement
- Integrated Performance Report and remedial and improvement plans reviewed at Senior Leadership group, Quality Committee, Finance and Performance Committee and Trust Board
- Lancashire and South Cumbria oversight and co-ordination via Elective Activity Co-ordination Team, Elective care Recovery Group, Lancashire and South Cumbria Chief Operating Officers meetings.

Independent challenge on levels of assurance, risk and control:

- Elective recovery and annual plans signed off by Lancashire and South Cumbria Integrated Care Board (ICB), regional and national teams.
- Elective recovery plans reviewed by KPMG (Audit Company) as part of 2022-23 annual planning process
- High Volume Low Complexity (HVLC) procedures review currently underway to identify opportunities for improvement.

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

BAF Risk 4a

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Activity at 104% of 2019-20 levels not achieved consistently	Development and implementation of Specialty level plans for demand and capacity Focus on 5 high-risk RTT specialties	Chief Operating Officer	End July 2022	Teams reviewing and updating plans for re-submission on 20 June 2022.	G
2	Diagnostic clearance to 95% <6 weeks at 95% by March 2025	Implementation of Modality level delivery plans	Chief Operating Officer	End July 2022	Ongoing implementation of delivery plans.	G
3	Increased >62-day backlog in colorectal	Joint work with the Cancer Alliance on colorectal tumour site improvement	Chief Operating Officer	End June 2022	**Action completed:** The Trust has met with the Cancer Alliance to review the current improvement plan and agree joint priorities as part of the ICS work plan. This is in addition to specific local interventions to address the backlog in Colorectal, Urology, Lung and Head & Neck tumour sites	B
4	Pennine Lancashire Elective and Outpatient Improvement Board has been reformed but needs to mature and further develop processes in order to be able to provide full assurance on delivery of plans.	Programme management and reporting processes fully established.	Chief Operating Officer/ Interim Director of Service Development and Improvement	End September 2022	Initial board meeting held to review plans. Meeting in June will have a focus on work required to improvement assurance.	G
5	Improvement Hub team support identified for key projects but detailed delivery plans still in development	Completion of scoping and agreement of detailed timescales and plans for agreed areas of focus.	Interim Director of Service Development and Improvement	End July 2022	Scoping underway and on course for delivery to agreed timescales.	G
6	Clinical Strategy ambitions need translating into multi-year delivery plans and aligning to Lancashire and South Cumbria Provider Collaboration Board (PCB)/ICS plans.	Finalisation of Clinical Strategy and detailed delivery plans. Ongoing work to align to wider Lancashire and South Cumbria plans	Executive Team	End September 2022	Clinical strategy currently being consulted upon. Draft delivery plans in place and year 1 priorities agreed.	G

BAF Risk 4b

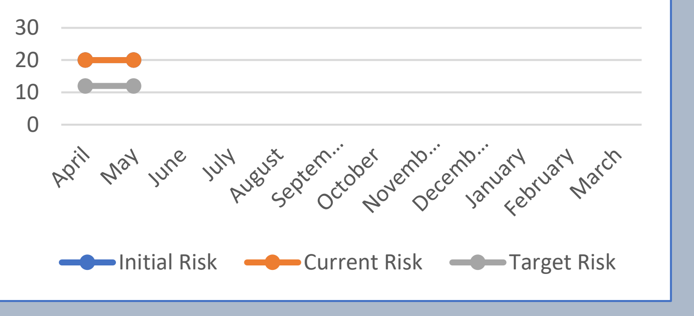
Risk Description: The Trust is unable to see, treat and discharge/admit/transfer patients within the prescribed timeframes due to: • the volume and complexity of their needs • the unavailability of alternative consistent services in the community • lack of workforce (links to BAF 5b) • lack of flow within the organisation	**Executive Director Lead:** Chief Operating Officer, Executive Director of Integrated Care, Partnerships and Resilience
Strategy: Clinical Strategy	**Date of last review:** 21 June 2022
Links to Key Delivery Programmes: Urgent and Emergency Care Improvement	**Lead Committee:** Finance and Performance Committee

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

Initial Risk Rating: C4 x L5 = 20

Current Risk Rating: C4 x L5 = 20

Target Risk Rating: C4 x L3 = 12



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite:

Minimal

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

Overall planning and delivery processes:

- Annual planning processes and ongoing review processes in place to assess demand and capacity and anticipated performance trajectories for Urgent and Emergency Care including out of hospital, front door services, same day emergency care and in-patient care with in-house bed modelling system in development.
- Urgent and Emergency Care Improvement identified as a Key Delivery Programme as part of the Trust Strategic Framework and key priority for wider Pennine Lancashire Integrated Care Partnership (ICP). A joint delivery and improvement plan (Accident and Emergency Delivery Board (AEDB) plan on a page) developed as a system to address demand management for urgent and emergency care (UEC) including primary care access and ELHT specific plan agreed as part of wider system plan.
- Links made to other Key Delivery Programmes e.g. Care Closer to Home/place-based partnership and Pennine Lancashire Delivery Groups to ensure consistency of plans.
- Robust planning arrangements in place for winter and Bank Holidays to ensure appropriate capacity planning for demand forecasts.

Operational Management processes:

- Robust flow management system and processes in place with flow team and bed meetings for ongoing Situation Reports (SitRep) reporting and agreement of actions over 24/7 period and ongoing plans to strengthen discharge matron and patient flow facilitator role for supporting timely 7-day discharges
- Ongoing implementation of ambulance handover improvement plans to sustain ambulance handover performance and improve on the current baseline including direct admission to Same Day Emergency Care (SDEC) areas.
- Ongoing collection of key data e.g. not meeting criteria to reside and production/use of Inpatient Patient Tracking List to support high quality daily operational management processes e.g. Every Day matters meetings
- Data collection to identify target themes and services from the high intensity service users' group to inform the system demand management schemes for UEC. Specific focus around Mental Health pathways with Lancashire and South Cumbria Foundation Trust (LSCFT).
- Operational and Improvement plan to continue to strengthen internal ED processes to manage maximum time in department to 12-hours from arrival to discharge
- Implementation of plans to further develop the Same Day Emergency Care model to include the acute frailty pathway via Older Peoples Response Area (OPRA)
- Manage length of stay (LoS) over 3 days on the Acute Medical Unit (AMU) and Emergency Surgical Unit (ESU)
- Improve ward discharge process based on the best practice discharge bundle and monitoring board round effectiveness
- Clinical engagement with the required change ensuring ownership for discharge planning on admission

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

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

- Close monitoring of total time in department within 12-hours from arrival to discharge/transfer/admit
- Site meetings 7 days a week ensuring timely escalation of delays (potential and actual) with corrective actions
- Clear roles and responsibilities within Emergency Department (ED) ensuring grip and control with identified doctor and nurse in charge accountable for the department flow
- Monitoring of ambulance handover times, time to triage, first assessment time and time to bed from decision to admit ensuring preventative measures in place to reduce any delays

Specialist support, policy and procedure setting, oversight responsibility:

- Integrated Performance Report and remedial and improvement plans reviewed at Senior Leadership group, Quality Committee, Finance and Performance Committee and Trust Board
- System level plan monitoring at Pennine Lancashire via AEDB and Integrated Care Board (ICB) level via relevant system forums

Independent challenge on levels of assurance, risk and control:

- Annual plans signed off by Lancashire and South Cumbria Integrated Care Board, regional and national teams.
- CQC Transitional Monitoring Approach (TMA) review of urgent and emergency care at ELHT to give assurance on areas of best practice and opportunities for improvement
- CQC UEC system-level review will independently identify areas of best practice and opportunities for improvement

• Continued development of community response services for both step up (admission/attendance avoidance) and step down (timely discharge facilitation) care to maximise opportunities for admission avoidance and reduce demand for inpatient beds. • Manage Not Meeting Criteria to Reside (NMC2R) to less than 5% of bed base in line with national requirements to maximise acute bed capacity for appropriate acute needs. Oversight arrangements: • Daily, weekly and monthly performance reports for UEC in place to focus on performance improvement. • Daily 'Pressure of Emergency Pathways' meeting with Executive Team and key leads from Emergency Pathway to provide oversight and support • ELHT Emergency Care Improvement Steering Group meets every 2 weeks to monitor the implementation of the UEC improvement plan across ELHT covering inflow, flow and outflow • AEDB meets every 2 weeks to oversee the implementation of the system UEC improvement plan across the system	

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	System plan on demand management in the community for preventing UEC attendances	Agreed system plan for demand management schemes in the community with increased primary care access.	Executive Director of Integrated Care Partnerships and Resilience	End September 2022	Plan in development across partners.	A
2	Mental Health pathways further developed with LSCFT to minimise time in ED	Agreed system plan with LSCFT to manage patients with MH needs outside of ED for patients who are assessed as medically fit.	Executive Director of Integrated Care Partnerships and Resilience	End October 2022	Pathways agreed but capacity not yet available. Refer to BAF 2a actions 5a/b.	R
3	Improved ED processes for managing to a maximum of 12-hours total time from arrival	Review and improve internal ED processes to ensure alternative pathways and a stronger focus on reducing delays for patients on non-admitted pathways.	Executive Director of Integrated Care Partnerships and Resilience / Chief Operating Officer	End September 2022	Progress being made including reconfiguration of ED/UCC flows.	A
4	Consistent daily flows into SDEC areas by 07:30 am including OPRA	Review and strengthen compliance against agreed Standing Operating Procedures consistently to decongest ED and ensure timely, safe and effective pathways for patients requiring Emergency Care.	Executive Director of Integrated Care Partnerships and Resilience / Chief Operating Officer	End August 2022	SDEC group established, reinforcing consistent use of pathways.	A
5	Strengthen ward discharge bundle and clinical ownership for timely discharges	Embed the discharge bundle across all wards with clinical champions to promote best practice.	Executive Medical Director/ Executive Director of Nursing	End August 2022	Re-enforcing agreed discharge care bundle.	A
6	Total understanding of bed requirements required.	Completion of bed modelling to consider required capacity.	Chief Operating Officer	End September 2022	Support to further develop bed modelling tool currently being scoped.	A

Risk Description: Failure to develop a compassionate inclusive, wellbeing and improvement focused culture will impede our ability to attract and retain the right workforce.

Executive Director Lead: Executive Director of HR and OD, Operational Director of HR and OD

Strategy: People/Workforce Strategy

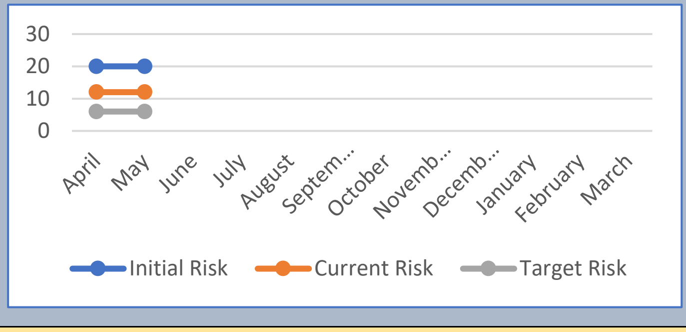
Date of last review: 14 June 2022

Links to Key Delivery Programmes: People Plan Priorities

Lead Committee: Quality Committee

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

Initial Risk Rating:	C5 x L4 = 20 (as part of old BAF 2)
Current Risk Rating:	C4 x L3 = 12
Target Risk Rating:	C3 x L2 = 6



Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite:

Open/High

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

- Employee Engagement Sponsor Group – Chaired by Chief Executive with representation from across Divisions/Trust to oversee and hold Divisions to account on employee engagement and experience (eg staff survey).
- Black, Asian and Minority Ethnic (BAME) Strategic Oversight Group – formulated from Executives, Non-Executive Directors (NEDs) and BAME Network Chairs in order to hold the Trust to account for progress on its anti-racist ambition, Workforce Race Equality Standards (WRES) progress and wider race inclusion agenda.
- Inclusion Group – brings together Chairs from staff networks along with Executive and NED sponsors to support the delivery of the Trust's inclusion agenda.
- Leadership Strategy Group – exists to develop a leadership and talent management approach to meet the needs of the organisation. Chaired by the Director of HR and OD and reports to the Quality Committee and Trust Board. The leadership strategy was approved at Executive Team and Senior Leadership Group in May 2022 for presentation at the Quality Committee and Board in September 2022.
- Joint Local Negotiating Committee (JLNC) and Joint Negotiating Consultative Committee (JNCC) to support partnership working with our Trade Union colleagues.
- Staff Safety Group – Chaired by the Executive Director of Integrated Care, Partnerships and Resilience. The purpose of the group is to enable staff to address issues of concern in relation to staff safety in the workplace.
- Freedom to Speak Up (FTSU) Guardian and Champions – in line with the national FTSU agenda. They report to the Staff Safety Group, Quality Committee and Trust Board.

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

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

- The Trust's Staff Safety Group oversees the day to day operational risks and interventions to ensure staff safety matters are addressed.
- Five Staff Networks, each are supported by an Executive Lead and reporting through the Inclusion Group:
  - BAME,
  - Women's,
  - Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+),
  - Disability and Wellness,
  - Mental Health
- Freedom to Speak-Up (FTSU) – the Trust has FTSU Champions embedded across the organisation to support the FTSU Guardian in enabling staff to raise concerns.
- Implementation of the Team Engagement and Development (TED) Tool across the organisation will enable teams to manage team culture.
- The Trust's Behaviour Framework will be embedded across the organisation and integrated into the recruitment and appraisal processes.
- The Trust's Big Conversation programme, following publication of the Staff Survey results enables the Trust to respond and improve staff experience.
- Flexible working manifesto in place to assist staff and managers in exploring opportunities to work flexibly.

Specialist support, policy and procedure setting, oversight responsibility:

- Director of HR and OD is involved in a national staff experience forum.
- Integrated Care System (ICS) Equality, Diversity and Inclusion (EDI) collaborative is in place to support the development and sharing of best practice.
- NED EDI lead is a member of the regional BAME Assembly.
- We are participating in a new national rainbow badge programme which will enable us to develop a robust action plan and achieve accreditation as a Trust.
- The Trust has a Partnership Officer (link between the Unions and Trust) who works with the Director of HR and OD to ensure that employee relations between the Trust and Trade Unions colleagues is effective.

Independent challenge on levels of assurance, risk and control:

- WRES and Workforce Disability Equality Standard (WDES) standards are monitored nationally and reported to the Trust Board on an annual basis.
- National Staff Survey reports and benchmarks the Trust's performance against other organisations at a national and regional level.
- Required to work within the national FTSU framework and are accountable to the National Guardian for delivery.

BAF Risk 5a

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	The need for a refreshed Leadership Strategy	The Leadership Strategy will be presented to the Quality Committee and Board in September 2022.	Director of HR and OD	September 2022	The Strategy has been to Executive Team and Senior Leadership Group.	G
2	Workforce Committee to be established	Membership and Terms of Reference (ToR) to be agreed and a meeting cycle established.	Director of HR and OD	September 2022	Draft ToRs have been prepared.	G
3	Full roll out of the behaviour framework	Additional communications and OD support with individual teams.	Director of HR and OD	March 2023	Appointed an Associate Director of OD who will be progressing the implementation.	G
4	Capacity of staff network members to support the delivery of the inclusion agenda	Explore the option for some protected time.	Director of HR and OD	September 2022	Business case to be developed	A
5	Further alignment of leadership and Organisational Development (OD) activities to the Safe, Personal, Effective Plus (SPE+) Improvement Practice as part of Trust Improvement Continuum required	Cross-correlation of plans and training/development offers to maximise benefits and consistency of message	Director of HR and OD/ Interim Director of Service Development and Improvement	September 2022	Scoping discussions underway. Organisational Development and Culture being built into Improvement Practice Development Plan.	G

BAF Risk 5b

Risk Description: Recruitment, retention and workforce planning/redesign fail to deliver the Trust objectives and strategies (including the Clinical Strategy)

Executive Director Lead: Executive Director of Human Resources and Organisational Development

Strategy: Workforce / People Strategy

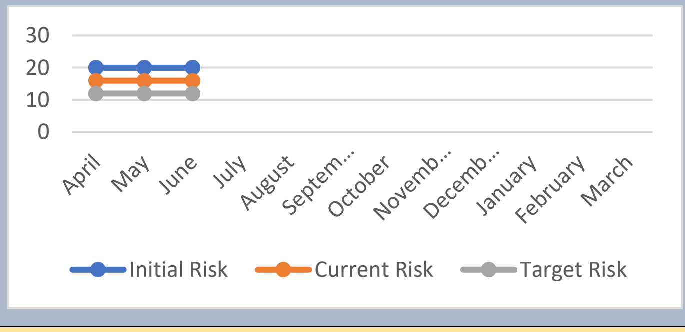
Date of last review: 21 June 2022

Links to Key Delivery Programmes: People Plan Priorities / R&D, Education and Innovation

Lead Committee: Finance and Performance Committee

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

Initial Risk Rating:	C4 x L5 = 20 (old BAF 2)
Current Risk Rating:	C4 x L4 = 16
Target Risk Rating:	C3 x L4 = 12



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite:

Cautious / Moderate

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

- Agreed Integrated Care System (ICS), place-based workforce plans and Trust People Plan 2022-23 – The ICS plan stratifies actions to be delivered at organisation, place and system level. The plan is monitored through the Provider Collaboration Board (PCB) Workforce Steering Group and the ICS People Board. Operational issues from these forums are picked up through the Executive team and reporting on progress is provided through the quarterly workforce report. The place-based workforce plan will be managed through the Pennine Lancashire People Board and accountable through Chairs and Chief Executives. This will be reported through Executives and the quarterly workforce report. The Trust People plan is operationally delivered through the Senior Leadership Group (SLG) and Divisional Management Boards (DMBs) and delivery is accountable through Finance and Performance Committee (FPC) as part of the quarterly workforce report. This also forms part of the workforce section of the Integrated Performance Report (IPR).
- International Nurse Recruitment Plan 2022-23 – aiming to have zero nursing vacancies by March 2023 (initial plan was October 2022 but due to international developments affecting visas this was revised). The plan is being monitored through the Recruitment and Retention Group – reported through quarterly workforce report to FPC. Also monitored through the IPR which is presented to the Board at each meeting.
- Health and Wellbeing – have comprehensive health and wellbeing offer and are leading the ICS Enhanced Health and Wellbeing and occupational health workstream. This is monitored through the PCB workforce steering group, regular updates are provided to the Board on wellbeing and a NED wellbeing guardian is in post. A Health and Wellbeing Strategy is also in place – this was approved by the Board in January 2022.
- Department of Education, Research and Innovation (DERI) Strategy – newly developed and discussed by the Board – clearly articulates the ambition of the Trust to support workforce, research and innovation to make the Trust a more attractive place to work. Have just agreed that DERI will produce a bi-annual report for FPC Committee.

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

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

- Recruitment and Retention Group have oversight of the vacancies and risks associated with nurse staffing – overseen by Senior Nurse Leadership of the Trust.
- Job planning panels – have established a job planning scrutiny panel who review medical job plans to ensure that they are all compliant with regulatory guidance. Also inform delivery against the clinical strategy.
- Medical Recruitment and Retention Steering Group
- Workforce Innovation team – looking at how we can improve what we offer as an employer at a Trust level to enable us to retain people (flexible working, redesign).
- Trust Well Team – lead on engaging with the workforce and developing the Trust response to emerging wellbeing needs.
- Operationally this is delivered through the DERI and Educational Delivery Board.

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

- Recruitment, retention and staff in post data monitored through IPR and Quarterly Workforce Report to FPC Committee.
- Policies and procedures at a workforce level are done through engagement at divisional level and with staff networks, work with staff side colleagues and through agreement via the policy group and ratification at a Trust Board and Sub-Committee level.
- Human Resources (HR) Directors Group across the ICS inform and monitor delivery of the system level workforce agenda but also direct Trust activity where collaboration has been agreed or where opportunities have been identified.

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

- Workforce Plan submission – there is an annual workforce plan submission to the national regulator which is triangulated internally with finance and activity data and aligned to our clinical strategy. This is monitored through the Integrated Care Board (ICB).
- Workforce Race Equality Standard (WRES) and Workforce Diversity Equality Standard (WDES) action plans with timelines in place. Regular reporting to the Board on progress. Ongoing monitoring of workforce diversity through the re-establishment of the Diversity and Inclusion Steering Group and Trust staff networks.

BAF Risk 5b

	• Monitored by NHS England / Improvement on our bank and agency spend – have been identified as good practice – drives recruitment strategies for the Trust. • Workforce Audit Plan – translates to Annual Internal Audit Plan – escalated to Sub-Committees.

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Reducing the Trust vacancy gap	Develop recruitment plan to support delivery of the 2022-23 workforce plan	Director of HR and OD	October 2022	Plan has been agreed but required refinement based on current workforce transformation activity.	G
2	Achieve zero nurse vacancy position	Delivery of plan focused on nurse recruitment and retention	Director of HR and OD	March 2023	Workforce Innovation Team are undertaking a focused piece of work specifically on retention.	G
		Delivery of international recruitment campaign – further 71 new starters	Director of HR and OD	October 2022	International Nurse pipeline is continuing to deliver against this trajectory with some minor delays due to visa processing.	G
3	Improve Trust retention levels / Develop Retention Strategy	Implementation of targeted plan to deliver the national People Promise of Flexible Working and development of a Trust Retention Strategy. The first milestone is to agree the strategy.	Director of HR and OD	September 2022	Delivered flexible working manifesto and are working with teams to deliver flexible working pilots. Trust retention strategy to be developed	A
4	Regional/national shortage of roles	Explore opportunities for collaborative working/system-wide roles through Lancashire and South Cumbria ICS e.g. Diagnostic Network	Director of HR and OD	September 2022	ICS Clinical Strategy and Trust Clinical Strategy will start to identify where wider system opportunities exist.	A
5	Risk of staff leaving the NHS due to post COVID19 burnout	Delivery of the Enhanced Health & Wellbeing offer to the ICS. Next steps are to revised the model and proposition.	Director of HR and OD	December 2022	Exploration phase is almost complete with a model expected by December 2022. A wellbeing website has been delivered providing consistency across the ICS.	G

BAF Risk 6

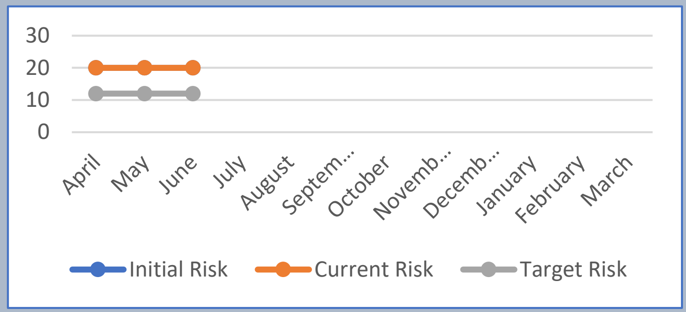
Risk Description: The Trust is unable to achieve a recurrent sustainable financial position. The Trust fails to align its strategy to the wider system and deliver the additional benefits that working within the wider system should bring.	**Executive Director Lead:** Executive Director of Finance
Strategy: Finance Strategy	**Date of last review:** 21 June 2022
Links to Key Delivery Programmes: Waste Reduction Programme	**Lead Committee:** Finance and Performance Committee

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

Initial Risk Rating: C5 x L4 = 20

Current Risk Rating: C5 x L4 = 20

Target Risk Rating: C4 x L3 = 12



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite:

Cautious/Moderate

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

Organisation
- Financial plans for 2022-23 developed via annual planning process and signed off by the Trust Board.
- The Trust Standing Financial Instructions (SFI's) are reviewed annually and updated for any national guidance and regulations. The last review was completed in April 2022.
- The financial position, forecasting for the year, capital spend against programme and progress towards achievement of the Waste reduction programme are reported and scrutinised through the monthly Finance Assurance Board with Executive and cross-Divisional team representation, Capital Planning Board chaired by the Director of Finance, and Finance and Performance Committee, sub-committee of the Board.

System
- System finances monitored through System Finance Group (includes representation of all providers and Integrated Care Board (ICB) to facilitate understanding and actions associated with the overall system financial position.
- System Corporate Collaboration group oversees potential savings and other benefits of corporate collaboration opportunities including strengthening fragile services.
- System Financial Recovery Board has been established with the aim of ensuring financial sustainability across all Integrated Care System partners.

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

Service delivery and day to day management of risk and control:
- 2021-22 financial targets achieved in accordance with agreed plan.
- Financial plan submitted to System and Regional team in line with all national planning deadlines/timetable and opening plans have been issued to budget holders
- Financial plan and delivery of ongoing performance scrutinised via Finance and Performance Committee with key risks identified
- Corporate Risk Register updated for latest financial risks facing the organisation with action plans in place to mitigate risks which are regularly reviewed and updated
- Divisional Waste reduction programmes in development
- Forecast deficit against plan likely for Quarter 1 against the plan
- Additional financial controls being put in place Quarter 1 to reduce spend

Specialist support, policy and procedure setting, oversight responsibility:
- Benefits realisation team part recruited to support development of a robust benefits realisation framework for the organisation and to support delivery of key projects associated with wate reduction programme.
- Corporate collaboration – full participation in all areas and opportunities identified

Independent challenge on levels of assurance, risk and control:
- Internal and external audit – agreed internal audit plan for 2022-23, clean Head of Internal audit opinion received, clean external audit of annual accounts for 2021-22 received, counter fraud workplan for 2022-23 agreed.
- Mersey Internal Audit Agency (MIAA) audit of Care Quality Commission (CQC) Well-led evidence underway
- Re-accreditation at Finance Staff Development (FSD) level 3 (the highest level) for financial management within the finance team and supporting the wider organisation. High level of qualified staff in department (53%) with a further 35% in training.

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Medium term financial strategy to be developed (financial recovery)	Finalise and sign-off through Finance and Performance Committee	Executive Director of Finance	End of July 2022	Draft strategy currently in development and will be taken through Finance and Performance Committee in July 2022	A

BAF Risk 6

2	Fully identified Waste Reduction Programme 2022-23	Continue work with Divisions and central to develop plan for 2022-23	Executive Director of Finance	End of July 2022	Partially completed and reviewed in detail at FABs with cross divisional support to enable, Conversations and challenge to continue in July. Current gap circa 35% of total.	A
3	Board sign-off of financial plans.	To be approved via operational planning paper to Trust Board in May 2022.	Executive Director of Finance	May 2022	**Action Completed:** The Financial Plans were presented to the Board at their meeting in May 2022 and approved. The updated revenue breakeven financial plan was presented to Junes Finance and Performance Committee, with risks highlighted.	B
4	ICS system finance governance to be determined/clarified.	Directors of Finance (DoFs)/ Chief Finance Officers (CFOs) to work with ICB leads to ensure robust governance.	System leads	No date set yet but will be reviewed in September 2022.	Work continues through the System finance groups.	A
5	Benefits Realisation team establishment.	Lead post to be recruited to.	Executive Director of Finance/ Interim Director of Service Development and Improvement	End of July 2022	Project team staff in post; lead post recruited – start August 2022.	G
6	Accountability Framework to be ratified.	Redevelopment of Trust Accountability Framework to reflect principles of Improvement Practice and management system developments.	Executive Director of Finance	End of July 2022	To go through Executive Team and Senior Leadership Group in July 2022.	A
7	Deficit against plan reported at month 1.	Additional financial controls in place for 2022-23 until assurance on the achievement of the financial position is gained.	Executive Director of Finance	End of July 2022	Systems in place are being reviewed for additional authority for spend.	A

BAF Risk 7

Risk Description: The Trust fails to deliver the strategic objectives set out in its NHS Green Plan

Executive Director Lead: Executive Director of Finance

Strategy: Wider sustainability (NHS Green Plan)

Date of last review: 16 June 2022

Links to Key Delivery Programmes: Waste Reduction Programme / Sustainability

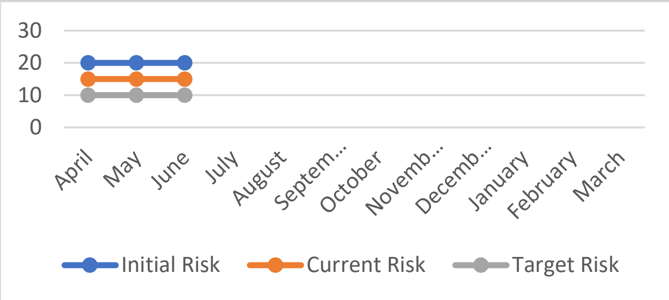
Lead Committee: Audit Committee

Risk Rating (Consequence x likelihood):

Initial Risk Rating: C5 x L4 = 20

Current Risk Rating: C5 x L3 = 15

Target Risk Rating: C5 x L2 = 10



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite:

Cautious / Moderate

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

Strategy Development:

- ELHT's Green plan 2022-2025, which sets out the road map to achieve the Net Zero goals of the NHS and other sustainability requirements outlined in the NHS Long Term Plan and NHS Standard Contract, has been developed and signed off by the Trust Board in March 2022 to ensure the Trust is able to meet its required obligations.
- NHS Green plan published on Trust website to facilitate public access to commitments made and the monitoring of the achievement of the objectives.

Strategy Delivery:

- A 3-year measurement contract has been agreed and is in place with an external provider to support monitoring of anticipated benefits as outlined in the agreed Green Plan. Annual assessment will take place once a year in November to undertake measurement and document progress against key plan objectives.
- There is Lancashire and South Cumbria Integrated Care System (ICS) oversight arrangements in place via ICS Estates and Facilities team and Estates Infrastructure Group to monitor delivery against the agreed plan. The Trust Green plan also forms part of wider ICS plan.

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

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

- Green Plan target setting achieved in accordance with agreed timescales
- Green Plan submission to ICS achieved in accordance with agreed timescales
- Divisional Waste reduction programmes in development

Specialist support, policy and procedure setting, oversight responsibility:

- Benefits realisation team recruited to who will assist in monitoring of plan
- Corporate collaboration – full participation in all areas to maximise benefits for collaborative working and sustainability (refer to BAF 1)
- Clinical pathways ICS – full participation in all current identified work programmes (refer to BAF 1)

Independent challenge on levels of assurance, risk and control:

- Independent oversight arrangements in place with annual review over 3 years

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1	Green Plan governance arrangements to be established	Governance to be agreed through Executive Team and Senior Leadership Group	Executive Director of Finance	End of July 2022	In development – to go to Executive Team Meting/Senior Leadership Group.	A
2	Benefits Realisation team establishment	Lead post to be recruited to	Executive Director of Finance/ Interim Director of Service Development and Improvement	End of July 2022	Project team staff in post; lead post recruited – start 1st August 2022.	A

3	Fully identified Waste Reduction Programme 2022-23	Continue work with Divisions and central to develop plan for 2022-23	Executive Director of Finance	End of July 2022	Partially completed and reviewed at Finance Assurance Board (FAB). Current gap is around 35% of total.	R
4	Fully identified programme to meet annual targets for NHS Green plan	Underway – linked to governance in point 1	Executive Director of Finance	August 2022	In process of being pulled together.	A

BAF Risk 8

Risk Description: The Trust's transition towards increased digitisation of records and communication disrupts the current clinical and operational service delivery to such a degree that it increases the risk of harm to patients, The reliance on digital systems also increases the impact upon the services should the Trust be subject to a Cyber-attack or significant infrastructure failure.

Executive Director Lead: Executive Director of Finance

Strategy: Digital Strategy

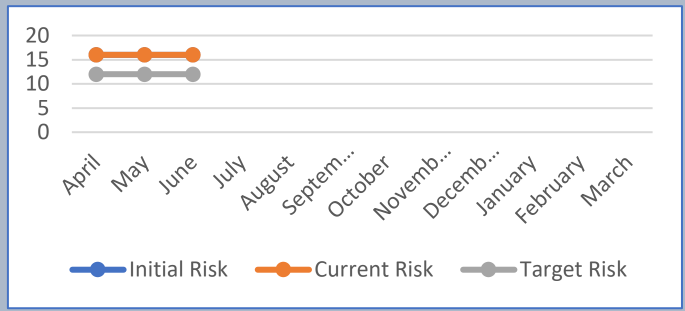
Date of last review: 22 June 2022

Links to Key Delivery Programmes: eLancs Programme / EPR

Lead Committee: Finance and Performance Committee

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

Initial Risk Rating:	C4 x L4 = 16
Current Risk Rating:	C4 x L4 = 16
Target Risk Rating:	C4 x L3 = 12



Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite:

Cautious/Moderate

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

<u>eLancs/ePR programme</u>

- Detailed eLancs and ePR programme plans in place which are constantly monitored and evaluated by the Informatics ePR Team with supporting delivery team structure in place to ensure appropriate mobilisation of resources.
- Daily meetings with senior team leaders to discuss progress and address upcoming work programmes and issues.
- Detailed risk and Issues logs, constantly monitored and updated and reported via ePR governance structure.
- Regular updates provided to Senior Leadership Group and Monthly meetings with the Executive.
- Stop / Start / Continue workshops to explore transformation changes in the clinical and operational field to ensure operational readiness and deliver safe and effective transition to the new ways of working and overseen by Interim Director of Service Development and Improvement.
- Operational readiness phase preparations underway and overseen by the Chief Operating Officer. Organisational readiness group set up in line with ePR Governance structure.

<u>ICS strategic ePR developments:</u>

- ELHT presents to and is fully engaged in single ePR convergence programme for Lancashire and South Cumbria. The Integrated Care System (ICS) is building upon the work ELHT is doing to implement ePR.
- Working with the ICS the digital teams recently completed a population health management solution appraisal and plans are in place to undertake a full business case for such a solution before the end of the financial year.

<u>Core infrastructure and Cyber defences</u>

- ELHT has significantly upgraded its networks, core infrastructure and cyber defences utilising the latest technology and tools in accordance with best practice and in coordination with ICS colleagues.
- ELHT has been joint authors and contributors to the development of the 'Northern Star' digital strategy which set out the strategic goals for key digital services (infrastructure / personnel / systems and corporate services). The strategy sets out a common set of principles for future digital services.
- ELHT is a core contributor to ICS wide strategic groups, focussing particularly on Cyber defences and Information Governance. Congruence in procurement and deployment of systems has been attained for key defence and support tools.

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

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

- Regular formalised ePR Gateway reviews undertaken to ensure programme is meeting all quality indicators and deliverables, also ensuring resources are lined up for the next phase of the programme.
- ELHT has representation on all key strategic digital governance groups including Core ePR Group, Digital Design Authority and Digital Portfolio Board.
- ELHT continue to attend all supplier pre-engagement events, supports the formulation of all business cases and output-based specifications for a consolidated ePR system across the region.
- ELHT are signatories to the Common Systems Roadmap whose main themes are to support the development of shared core hospital ePR, shared specialty systems and the development of a data orchestration ecosystem.

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

- ICS wide, Information Governance and Information Security Boards set up ensuring best practice is maintained and lessons learnt identified and disseminated.
- 5 Core Infrastructure teams set up to explore key corporate digital areas: Printers, End User Devices, Unified Communications, Service Desk, Managing patient records.
- Digital Northern Star paper has been produced, presented to the ICB and signed off by the Provider Collaborative Board which extends the previous Memorandum of Understanding between providers into a formal arrangement to collaborate and develop.
- £5m has been secured at ICS level to support the development of a shared data warehouse and Trusted research environment, ELHT has been instrumental in supporting this bid and has already built the infrastructure necessary to take the solution forward.
- Finance and Performance committee receive regular reports on progress of eLancs and ePR programme and will oversee benefits realisation.
- Weekly updates provided to Senior Leadership Group.
- Monthly face / face with Trust Executive including St Vincent's (external oversight group).

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

- Employment of an external outside expert group to monitor progress and advise on corrective actions if required.

	• ELHT attends bi-weekly meetings with all Chief Information Officer's (CIO) and senior digital leaders in the ICS to monitor progress and set activities to support the digital northern star. • MIAA Data Security Protection Toolkit (DSPT) assessments prior to submission. • External Penetration Testing of Systems. • External Audit of programme and spend (Mazars).

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update/Impact	BRAG
1	Resource constraints in Cyber teams across the region	Address local vacancies and skill set deficits and coordinate with regional leads to centralise functions where possible	Executive Director of Finance	August 2022	Posts to be advertised once banding confirmed.	A
2	Capacity of digital senior leaders at ELHT to fully contribute to ICS strategic initiatives due to pressure of ePR workload	Ensure senior leaders coordinate activity and share pressure, triage meetings to remove less significant meetings and duplication.	Chief Information Officer	July 2022	Meetings shared and most important have ELHT representation, offline contributions to others maintained.	G
3	Requirement to have independent readiness assessment nearer to Full Dress Rehearsal	Engage third party to undertake organisational readiness assessment	Chief Information Officer	August 2022	Discussed with previous Cerner sites and NHS England – a number of suppliers have been highlighted.	G
4	Policies / procedures / SOP's and Locsips not yet updated to reflect change in systems.	Coordinate prioritisation, updates and ongoing revision of all documents.	Associate Director of Quality and Safety	November 2022	Paper re process being developed and working groups being set up.	G
5	Updated Digital Strategy to reflect current changes	Update ELHT Digital Strategy to reflect Integrated Care Board changes, ePR delivery, NHS England focus and emerging national strategies	Chief Information Officer	January 2022	Document in development, regularly updated, final version to be published on completion of ePR go live.	G
6	Business Case completion for consolidated ePR across Lancashire and South Cumbria	Blackpool Teaching Hospitals need to complete and gain approval for their business case for ePR which will facilitate procurement across the ICS for which ELHT will be a part.	Chief Information Officer, Blackpool Hospitals NHS Foundation Trust	September 2023	Business case in preparation.	A

BAF Risk 9

Risk Description: The Trust's Improvement Practice and key delivery programmes do not sufficiently build improvement capability and support delivery on agreed outcomes.

Executive Director Lead: Interim Executive Director of Service Development

Strategy: ELHT Strategic framework (SPE+ Improvement Practice and Key Delivery Programmes)

Date of last review: 15 June 2022

Links to Key Delivery Programmes: Overarching all Key Delivery Programmes

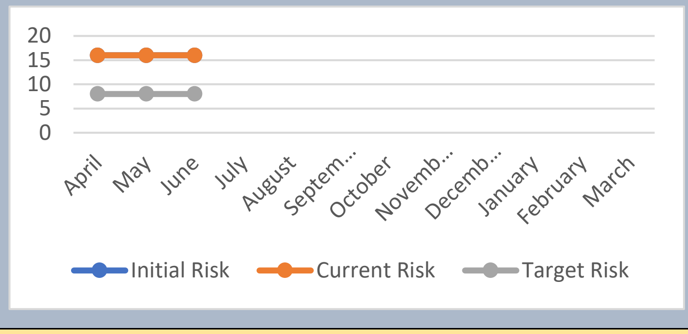
Lead Committee: Finance and Performance Committee

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

Initial Risk Rating: C4 x L4 = 16

Current Risk Rating: C4 x L4 = 16

Target Risk Rating: C4 x L2 = 8



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite:

Open/High

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

Improvement Practice:

- Established and evidence-based Improvement Methodology and Practice (Improving Safe, Personal and Effective Care (SPE+)), led by Interim Director of Service Development and Improvement to ensure delivery of more reliable improvements and outcomes.
- Development of Lancashire and South Cumbria (LSC) system-level method of improvement and agreed testing on one system priority during 2022-23 to support single approach to system improvement work.
- Established Improvement Hub team to support delivery of Improvement priorities within Key Delivery Programmes
- SPE+ Improvement Practice Development Objectives 2022-25 agreed as part of Trust Strategy refreshes (to be built into all strategies but currently signed off as part of Quality Strategy via Trust Board) to ensure organisational sign up to Improvement and development of improvement capacity and capability across the organisation
- Detailed Improvement Practice Development Plan 2022-25 and 1-year delivery plan in development (due for completion in June 2022) to support embedding of improvement across the organisation.
- Alignment of Improvement Hub team resources to support improvement priorities within key delivery programmes (draft plan agreed, final plan in June 2022)

Strategy Deployment:

- Strategy deployment framework designed to ensure clear alignment of Trust vision, values, goals to key delivery programmes and business plans that meet national and local planning requirements
- Key delivery programmes being reviewed/established internally and across Place Based Partnerships (PBP) / Provider Collaboration Board (PCB) / Integrated Care System (ICS) as appropriate with clear programme/project plans and benefits realisation framework aligned to SPE+

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

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

- ELHT Key Delivery Programme Boards, Pennine Lancashire Place-Based Partnerships Boards and PCB/ICS Programme Boards established or in process of being established to monitor delivery of programme and improvement plans
- Trust Improvement Register has 371 improvement projects registered (March 2022) and status monitored at Divisional Transformation Boards and Clinical Effectiveness Committees.

Specialist support, policy and procedure setting, oversight responsibility:

- Key Delivery and Improvement Programmes monitored at Senior Leadership Group and relevant Trust Board sub-committees
- Pennine Lancashire Delivery Boards and PCB/Integrated Care Board (ICB) Programme Boards report through relevant Pennine Lancashire, PCB/ICB governance structures
- External Executive Sensei support on development of Improvement Practice in place

Independent challenge on levels of assurance, risk and control:

- Mersey Internal Audit Agency (MIAA) audit of financial sustainability and improvement practice underway and due to be completed in Quarter 2 of 2022-23
- MIAA audit of CQC Well-led evidence underway
- Peer to peer challenge and reviews by LSC Improvement Leads

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

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

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

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update/Impact	BRAG
1	Final SPE+ Improvement Practice Development Plan	Finalise and sign off final detailed plan 2022-23 including key performance indicators and monitoring plan	Interim Director of Service Development and Improvement	August 2022	In development and on course for completion and sign off at Senior Leadership Group (SLG) and Finance and Performance Committee (FPC) in July/August 2022.	G

BAF Risk 9

2	Resource alignment to Improvement Priorities	Complete Improvement Hub alignment to improvement priorities in key delivery programmes	Interim Director of Service Development and Improvement	July 2022	In development and on course for completion and sign off at SLG and FPC in July 2022.	G
3	SPE+ capacity and capability development plan	Finalise training delivery plan and associated communication plan to ensure uptake of training in line with agreed training numbers	Interim Director of Service Development and Improvement	August 2022	Level 2 and 3 training complete and available. Level 1 and 4 training in development.	G
4	System Improvement Model developed and in early stages of testing (refer to BAF1).	Active participation in development of Model for Improvement. Testing of Improvement Model on Frailty/Respiratory.	Interim Director of Service Development and Improvement	March 2023	Work plan in place for development of Model for Improvement. Recruitment of teams underway. External support from David Fillingham and University of Cambridge.	G
5	Ongoing Strategy deployment framework development required to mature approach	Closure of planning for 2022-23 (completion of key strategies, agreement of final Divisional/ Directorate plan of a page), review and agreement of ongoing development plans	Interim Director of Service Development and Improvement	End July 2022	Quality strategy complete, draft clinical strategy complete and due for sign off at Trust Board 13 July 2022, timeline for completion of all strategies being reviewed. Closure of annual planning round underway and on track.	G
6	Key Delivery programmes to be fully established and provide assurance of delivery through agreed reporting arrangements	Full mapping of all key delivery programmes (ELHT/PBP/PCB) and finalisation of clear delivery plans and associated measurement plan	Executive Directors allocated for each programme	End July 2022	In development and on course for completion and sign off. Leadership Wall under construction to give oversight of all key delivery programmes	G
7	Executive Wall and Visual Management	Development of executive leadership wall to enable oversight of all key delivery programmes	Interim Director of Service Development and Improvement	End July 2022	Initial scoping work commenced in line with key delivery programme development work	G

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item	89
Purpose	Information Decision

13 July 2022

Title	Patient Safety Incident Response Assurance Report
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 Trust 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 Invest in and develop our workforce Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: No formal Committee

Safe | Personal | Effective

1. Incidents reported under the Patient Safety Incident Response Framework (PSIRF) from 1st December to 30th June 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 4th July 2022 the Trust has reported a total of:

- 3 Incident investigations have been fully completed and approved by Patient Safety Incident Requiring Investigation (PSIRI) panel
- 1 Incident investigation has been completed and awaiting PSIRI approval
- 10 Incidents are currently being investigated by the PSII team of which 2 are expected to be presented to PSIRI on 13th July
- 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 A meeting has taken place with Cancer services to identify six 104 breaches to investigate under local priorities by the PSII team.

1.1.3 The PSII Team are currently reviewing 9 incidents that meet the criteria under a local priority for investigation for consideration of a PSII.

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. The Divisions also complete PSR investigations where clear lessons learnt need to be identified on low harm incidents. See appendix 2 for the types and numbers of PSRs undertaken as of 4th July 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 (LLG). Since the last report there has been one meeting of Lessons Learnt Group, two divisions each presented an incident action plan and provided assurance of their completion.

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 CCG for final closure. As of 4th July 2022, there are 32 open investigations:

- 17 are awaiting feedback from division following queries from the CCG made in May/June 2022
- 3 are awaiting amendment from Trust feedback
- 9 are awaiting a response from the CCG
- 3 are being investigated by HSIB

2.2 Since the last report 15 investigation reports have been approved and closed by the CCG.

2.3 Quality Governance continue to work with Divisions to manage the number of outstanding investigations. Divisions have submitted several reports that were outstanding following Trust feedback. The position is discussed in the each PSIRI meeting and meeting has been requested with the CCG to discuss their timeline for reviewing outstanding reports.

3 Never Events

3.1 The Trust currently has 2 Never Events under investigation:

3.1.1 Overdose of insulin due to incorrect device, the investigation is underway, interviews have taken place with staff and a meeting has been held with the patient's family.

3.1.2 Guidewire left in situ, the investigation is complete and the PSII report is due to be presented to PSIRI on 13th July 2022 for Trust approval and agreement of safety improvements.

4 Patient Safety Incident Requiring Investigation (PSIRI) Panel Overview

4.1 The first meeting of PSIRI took place on 18th May 2022, this meeting was used to give the panel an overview of the PSII process and the associated documentation. The panel now meet on a fortnightly basis and have reviewed 4 completed PSII reports to date:

- 3 reports were approved by the panel with minor amendments required

- 1 report requires some further information and to be presented to PSIRI following the completion of an updated report.

4.2 Two reports are due to be presented to the panel on 13th July 2022.

4.3 The PSII reports have been positively received by the panel, who have commented on the style of structure of the reports, the level of detail and the investigation methods used. The reports have also generated detailed discussions with a focus on the learning and subsequent safety actions.

5 Lessons Learnt from Patient Safety Incident Investigations

5.1 Incident involving a patient fall identified Trust wide learning and raising awareness of the importance of post falls medical assessment and examination being completed and documentation in patient notes in line with national guidance. This is being reviewed and managed by the Trust's Falls Steering Group

5.2 Incident involving the sad death of a patient found on the floor in ICU. Key recommendations have been made and safety actions developed with regards to buddy cover when staff take allocated breaks. Another issue identified problems with alarms not being heard on monitoring equipment. This is being picked up with Biomedical and Clinical Engineering Team and with manufacturer

5.3 The reported Never Event (guidewire left in situ) has highlighted issues with regards to the compliance of the use of LocSSIPs. A ELHT Patient Safety Alert for LocSSIPs is being developed to highlight the learning from the investigation and provide clear guidance on the requirements of LocSSIPs being used for all invasive procedures undertaken with the Trust. This is due to be published and sent out to all appropriate staff in July.

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 43 maternity related incidents have been reported on StEIS of which:

- 20 have been closed by the CCG
- 13 have been agreed for de-escalation from StEIS by the CCG
- 5 are currently being investigated by HSIB
- 1 is awaiting feedback from division following queries from the CCG

- 1 is awaiting completion of SIRI feedback
- 1 is awaiting a response from the CCG
- 1 investigation underway by PSII team
- 1 does not meet HSIB criteria, however due to PMRT grading will be investigated as a PSII, using the PMRT review as the investigation report.

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

7.1 In the last 4 months the Assistant Director of Patient Safety and Effectiveness has provided an overview presentation of PSIRF implementation to 19 other Trusts and/or Northwest committees and another 3 overview presentations are booked for July.

7.2 ELHT have met with Leeds Teaching Hospital NHS Trust who are another early adopted of PSIRF, to sharing learning. Unfortunately, Leeds did not go live until the 1st April 2022 and are currently in the process of evaluating their internal processes. Another meeting has been arranged for later this year to share learning.

7.3 A meeting has been arranged with Divisional Quality and Safety Teams to review and further develop the Patient Safety Response templates in line with new National templates which have been recently published.

7.4 The PSII Team have recently completed training in Incident Investigation with Human Factors and are booked on the Train the Trainer for Human Factors with Advancing Quality Alliance (AQuA). AQuA has agreed to support the Trust develop an inhouse investigation training course for staff completing PSRs, this will hopefully be made available to Trust staff in October 2022.

7.5 Training is being restarted and dates made available on the Trusts Learning Hub for Introduction for Human Factors, all staff will be able to book on the training starting in September 2022.

8 Incident Management Structure and Assurance

8.1 With the introduction of PSIRF the Quality Governance Team has reviewed and further developed the incident management structure, the process of identifying incidents for high level investigations and how assurance is provided with regards to the standard of investigations and the development and management of safety improvements.

8.1.1 Appendix 3 provides a flowchart of the Incident Management Triage process for identification of level of investigation required in line with PSIRF.

8.1.2 Appendix 4 provides an overview of the Patient Safety Investigation Response Process for possible PSIIs

8.1.3 Appendix 5 provides a flowchart of Groups and Committees where incident investigations are either discussed in full or assurance is provided against PSIRF.

Lewis Wilkinson – Incident and Policy Manager

Jacquetta Hardacre – Assistant Director of Patient Safety and Effectiveness

Date: 4th July 2022

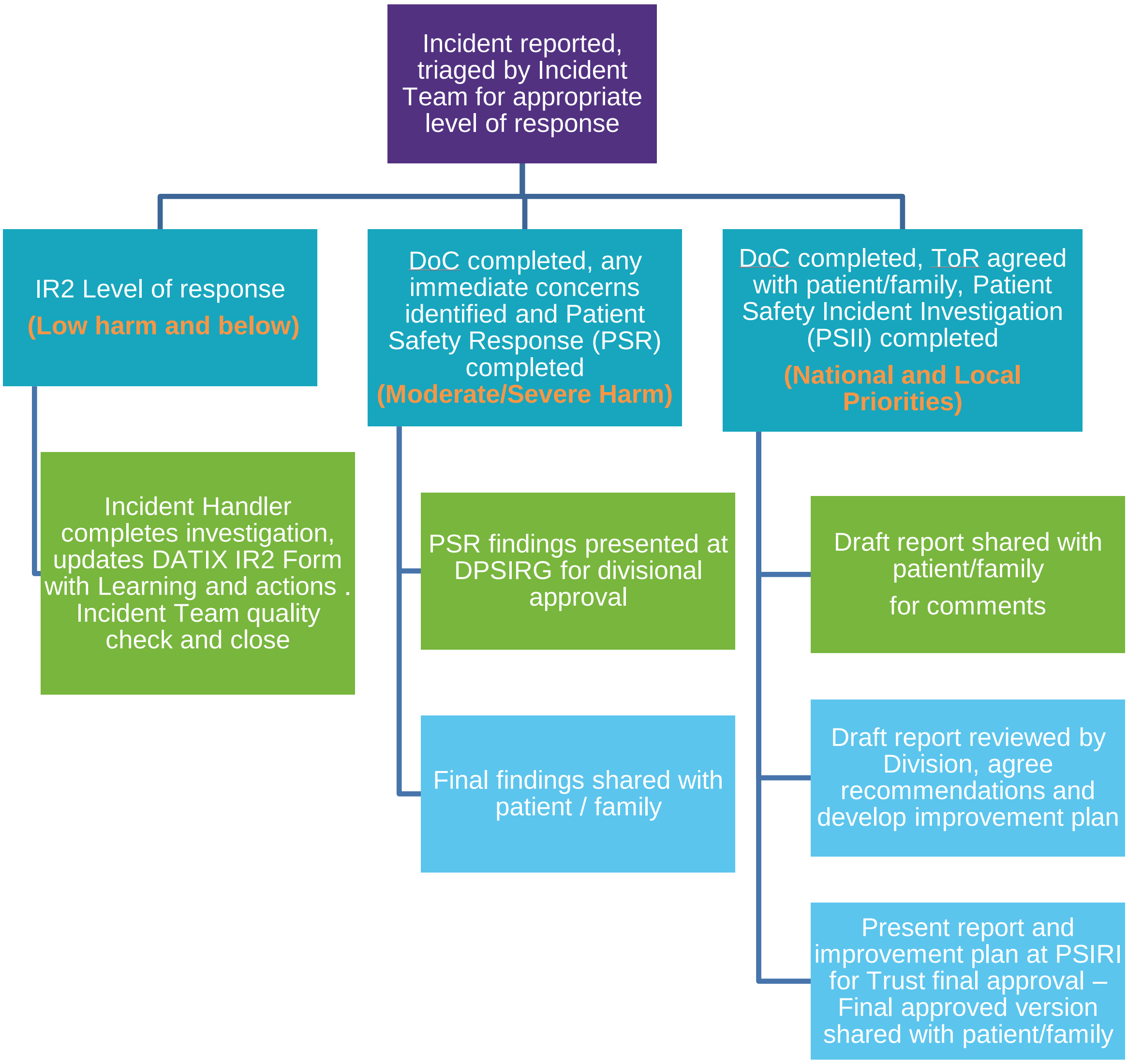
Appendix 1: Priority and category of incidetns accepted for Patient Safety Incident Investigations as of 4th July 2022

PSIIs (National or Local Priority)	Categories (report since 1st Dec 2021 to 17th June 2022)	No: of Incidents reported	No: under investigation	No: awaiting approval	No: of incidents closed
National	Never Events Learning from Deaths (due to problems in care) Death or long-term severe injury of a person in state care or detailed under the MHA	2 6 0	2 5 0	0 0 0	0 1 0
National priorities to be referred to another team	Maternal Death (HSIB) Neonatal Death (HSIB) Unexpected term admission to NICU (HSIB)	2 1 1	2 1 1	0 0 0	0 0 0
Local	Fall leading to #NOF DNACPR communication with patient/family Nil by mouth in venerable adult (6 days) ED internal transfer / problems / issues 104 Cancer Breach causing moderate or above harm	3 1 1 1 0	2 0 0 1 0	0 0 1 0 0	1 1 0 0 0
Total		**18**	**14**	**1**	**3**

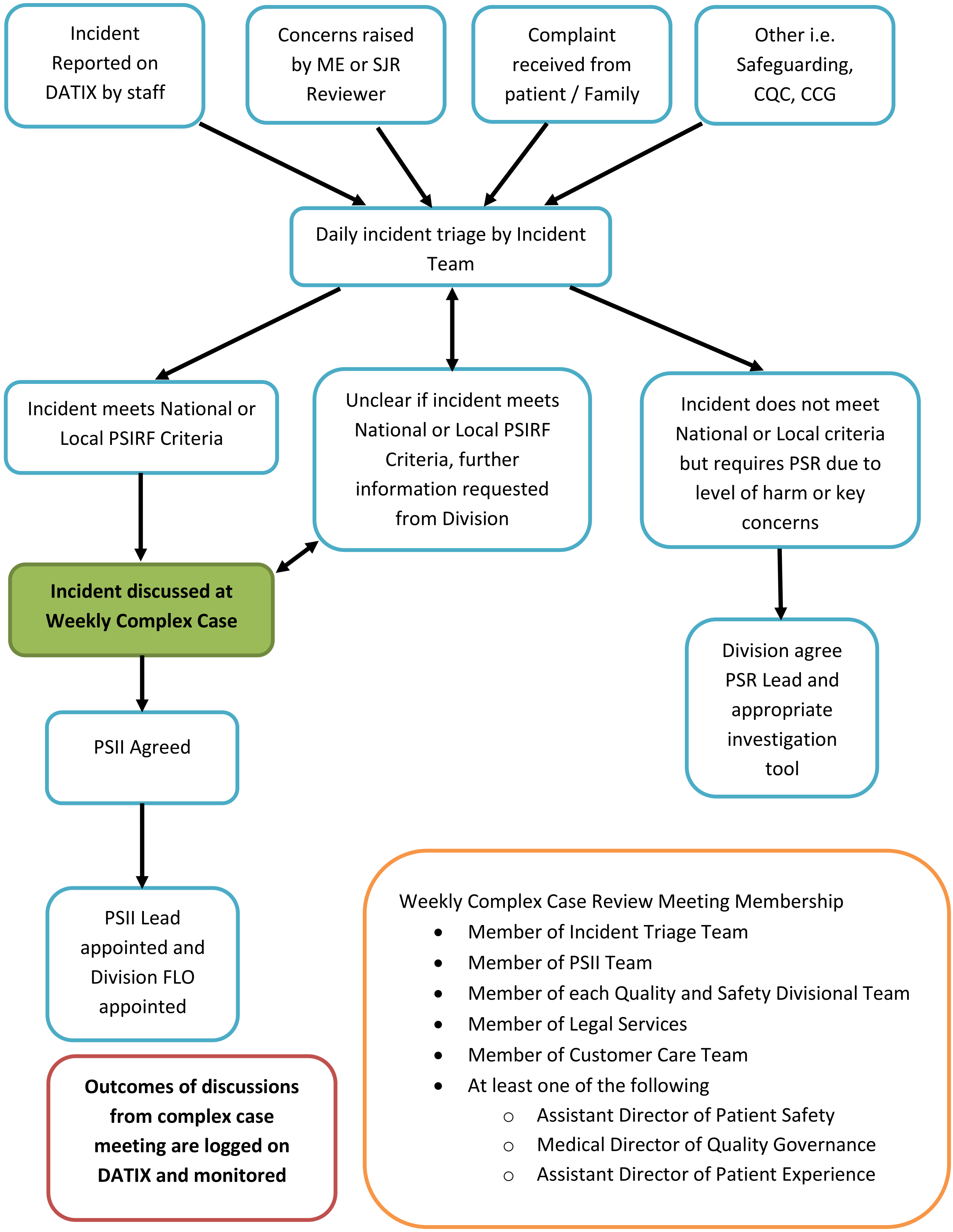
Appendix 2: Patient Safety Response tools used as of 4th July 2022

No. of PSRs	
Investigation tool	**No.**
Immediate actions	1
Open discussion	5
Rapid review	86
Risk assessment	1
Falls checklist	10
Pressure checklist	371
Clinical/Peer review	25
Cluster review	5
Concise report	38
SJR	1
Specialised reviews	48
Timeline mapping	9
Round table	7
Awaiting to be assigned	24
Total	**631**

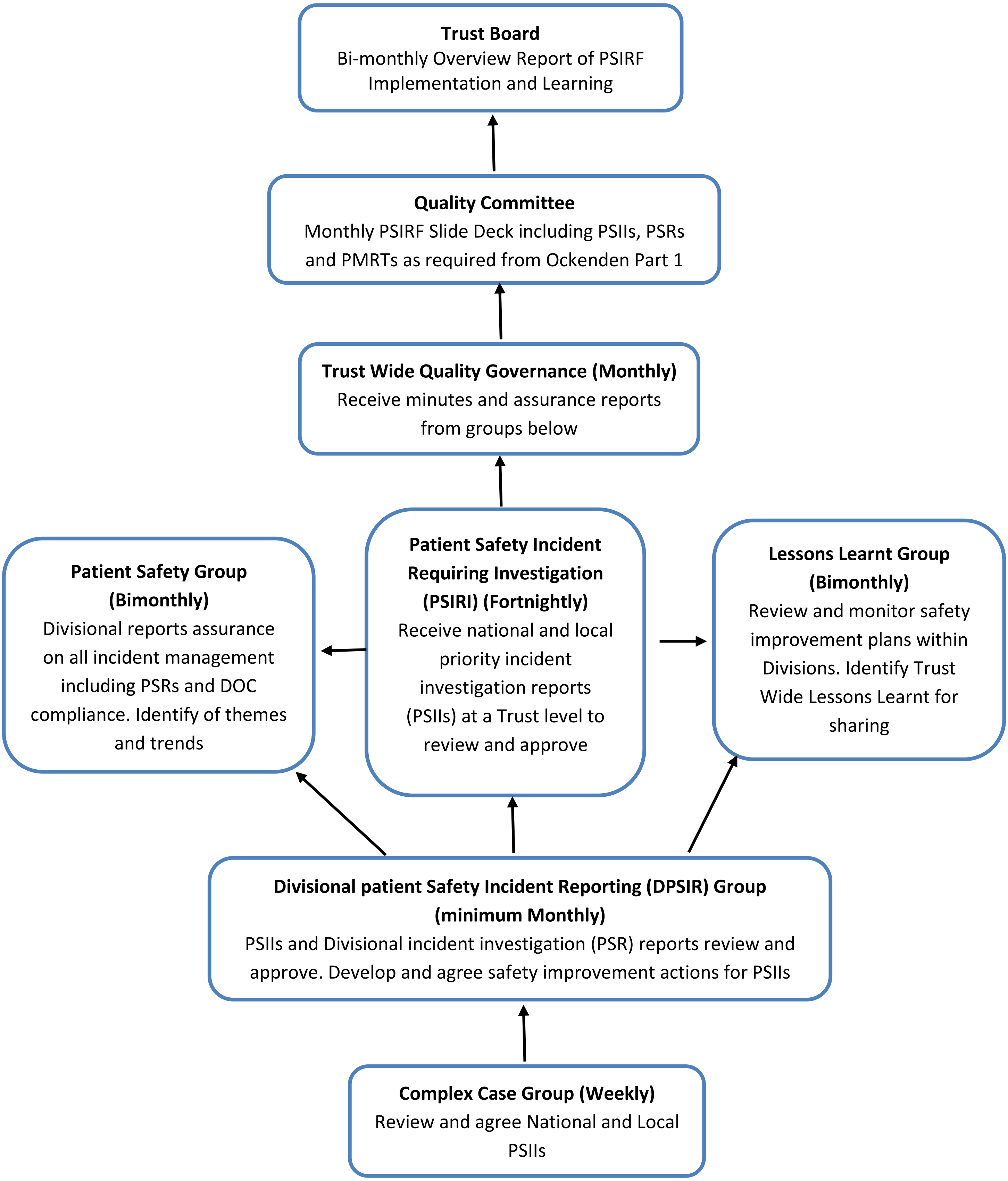
Appendix 3: Incident Management Flowchart



Appendix 4: Patient Safety Investigation Response Process



Appendix 5: Assurance Committees and Groups



East Lancashire Hospitals
NHS Trust

QUALITY COMMITTEE REPORT

Item 90

13 July 2022

Purpose Information
Monitoring

Title	Integrated Performance Report
Executive sponsor	Mrs S Gilligan, Chief Operating Officer

Summary: This paper presents the corporate performance data at May 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 Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

Board of Directors, Update

Corporate Report

Executive Overview Summary

Positive News

- 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 showed significant deterioration in May.
- The complaints rate remains below threshold, and is showing significant improvement in May.
- The Hospital Standardised Mortality Ratio (HSMR) has decreased and is 'within expected levels'.
- The 28 day faster diagnosis standard was met in April at 75.0% but is still showing significant deterioration from normal variation.
- The emergency readmission rate is within the normal range.
- The Trust is reporting an adjusted deficit of £4.4m in month 2, £1.8m behind plan.

Areas of Challenge

- There were two incidents reported in month which met local or national priorities and were reported onto steis.
- There were 6 healthcare associated clostridium difficile infections, 14 post 2 day E.coli bacteraemia, and 2 Klebsiellas detected in month.
- 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 May at 73.47%.
- There were 487 breaches of the 12 hour trolley wait standard (29 mental health and 458 physical health), which is a significant deterioration.
- There were 543 ambulance handovers > 30 minutes and 17 > 60 minutes. Following validation, 3 of the 17 were ELHT breaches and 14 were all due to non-compliance with the handover screen. The trend is showing significant improvement.
- Performance against the cancer 31 and 62 day standards has deteriorated and the standards were not met in April at 95.1% and 62.3%.
- There were 11 breaches of the 104 day cancer wait standard.
- The 6wk diagnostic target was not met at 14.35% in May.
- In May, the Referral to Treatment (RTT) number of total ongoing pathways has increased on last month to 42,587, and the number over 40 weeks has increased to 1,722.

- In May, there were 477 breaches of the RTT >52 weeks standard due to COVID-19.
- In May, there were 3 breaches of the 28 day standard for operations cancelled on the day.
- Length of stay – non-elective is showing deteriorating performance this month.
- The Trust vacancy rate is above threshold at 6.1%.
- Sickness rates are above threshold at 7.2% (April)
- Trust turnover rate is showing a significant increase, but remains below threshold.
- Compliance against the Appraisal (AFC staff) remains below threshold. Appraisals were on hold until March 21.
- Compliance against the Information Governance Toolkit remains below the 95% target at 92%
- Temporary costs as % of total pay bill remains above threshold at 11%.
- Most areas of core skills training are above threshold, with the exception of information governance, fire safety, basic life support, and infection prevention l2.

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 - elective is within normal levels.
- There were 68 operations cancelled on the day (non-clinical). This has returned to pre-covid levels.
- CQUIN schemes have been reintroduced for 2022/23, though for CCGs the CQUIN value will be included in block payments with no adjustment based on achievement levels.

Introduction

This report presents an update on the performance for May 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	5		No target set to provide assurance against
M64.3	Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)'	n/a	1		
M64.4	Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA)	67	11		
M65	MRSA	0	0		
M124	E-Coli (HOHA)	n/a	5		
M155	P. aeruginosa bacteraemia (HOHA)	n/a	0		
M157	Klebsiella species bacteraemia (HOHA)	n/a	2		
M66	Never Event Incidence	0	0		
M67	Medication errors causing serious harm (Steis reported date)	0	0		
M68	Maternal deaths	0	1		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)	No Threshold Set	17.2		
M69	Serious Incidents (Steis)	No Threshold Set	2		
M70	Central Alerting System (CAS) Alerts - non compliance	0	2		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	98%		

Caring

	Indicator	Target	Actual	Variation	Assurance
C38	Inpatient Friends and Family - % who would recommend	90%	96%		P
C31	NHS England Inpatients response rate from Friends and Family Test	No Threshold Set	49%		
C40	Maternity Friends and Family - % who would recommend	90%	90%		P
C42	A&E Friends and Family - % who would recommend	90%	65%		F
C32	NHS England A&E response rate from Friends and Family Test	No Threshold Set	9%		
C44	Community Friends and Family - % who would recommend	90%	94%		P
C38.5	Outpatient Friends and Family - % who would recommend	90%	94%		P
C15	Complaints – rate per 1000 contacts	0.40	0.20		?
M52	Mixed Sex Breaches	0			

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Within Expected Levels	1.06		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at Feb-22)	Within Expected Levels	104		
M74	Hospital Standardised Mortality Ratio - Weekday (as at Feb-22)	Within Expected Levels	102.7		
M75	Hospital Standardised Mortality Ratio - Weekend (as at Feb-22)	Within Expected Levels	107.6		
M73	Deaths in Low Risk Conditions (as at Feb-22)	Within Expected Levels	N/A		
M159	Stillbirths	<5	1		?
M160	Stillbirths - Improvements in care that impacted on the outcome	No Threshold Set	n/a		
M89	CQUIN schemes at risk	CQUIN schemes have been reintroduced for 2022/23			

Responsive

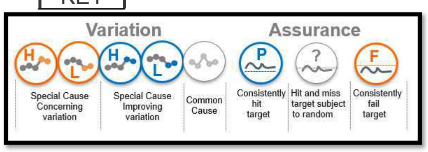
	Indicator	Target	Actual	Variation	Assurance
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95.0%	71.9%		
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95.0%	73.5%		
M62	12 hour trolley waits in A&E	0	487		
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	543		
M84	Handovers > 60 mins (Arrival to handover)	0	17		
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	47.8%		
C3	Referral to Treatment (RTT) non- admitted pathways: percentage within 18 weeks	No Threshold Set	74.9%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	No Threshold Set	42,587		
C4.2	Referral to Treatment (RTT) waiting times Incomplete pathways -over 40 wks	No Threshold Set	1722		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	478	477		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1.0%	14.4%		
C18	Cancer - Treatment within 62 days of referral from GP	85.0%	62.3%		
C19	Cancer - Treatment within 62 days of referral from screening	90.0%	80.0%		
C20	Cancer - Treatment within 31 days of decision to treat	96.0%	95.1%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98.0%	99.2%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94.0%	77.8%		
C36	Cancer 62 Day Consultant Upgrade	85.0%	90.2%		
C25.1	Cancer - Patients treated > day 104	0	11		
M9	Urgent operations cancelled for 2nd time	0	0		
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	3		
M138	No.Cancelled operations on day	No Threshold Set	68		
M55	Proportion of delayed discharges attributable to the NHS	New reporting in development			
C16	Emergency re-admissions within 30 days	No Threshold Set	11.0%		
M90	Average length of stay elective (excl daycase)	No Threshold Set	3.4		
M91	Average length of stay non-elective	No Threshold Set	5.3		

Well Led

	Indicator	Target	Actual	Variation	Assurance
M77	Trust turnover rate	12.0%	8.3%		
M78	Trust level total sickness rate	4.5%	7.2%		
M79	Total Trust vacancy rate	5.0%	6.1%		
M80.3	Appraisal (Agenda for Change Staff)	90.0%	65.0%		
M80.35	Appraisal (Consultant)	90.0%	98.0%		
M80.4	Appraisal (Other Medical)	90.0%	91.0%		
M80.2	Safeguarding Children	90.0%	95.0%		
M80.21	Information Governance Toolkit Compliance	95.0%	92.0%		
F8	Temporary costs as % of total paybill	4%	11.0%		
F9	Overtime as % of total paybill	0%	0%		
F1	Variance to H1 financial performance surplus / (deficit) (£m)	£0.0	-£1.8		
F2	Variance to H1 Waste Reduction Programme (WRP) achieved (£m)	£0.0	£0.00		
F3	Liquidity days	TBC	-12.5		
F4	Capital spend v plan	85.0%	72.0%		
F18a	Capital service capacity	0.7	0.4		
F19a	H1 Income & Expenditure margin	-2.7%	-4.0%		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	93.9%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	98.6%		
F14	Better Payment Practice Code (BPPC) NHS No of Invoices	95.0%	96.3%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	99.6%		

NB: Finance Metrics are reported year to date.

KEY

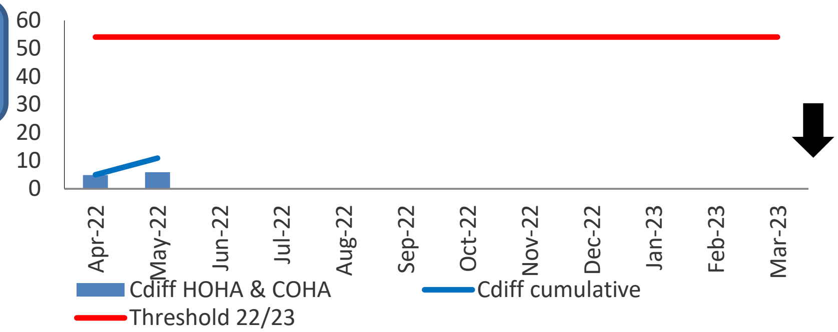


SPC Control Limits

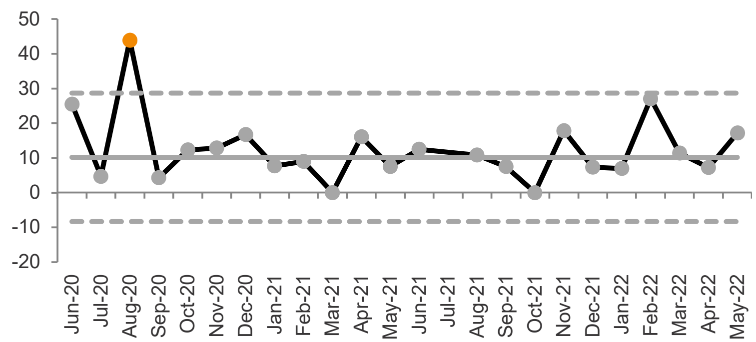
The data period used to calculate the SPC control limits is Apr 18 - Mar 20.

SAFE

C Difficile (HOHA &



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



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

The objective for 2022/22 is to have no more than 54 cases of 'Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)'. The final figure for cases reported in 2021/22 was 57.

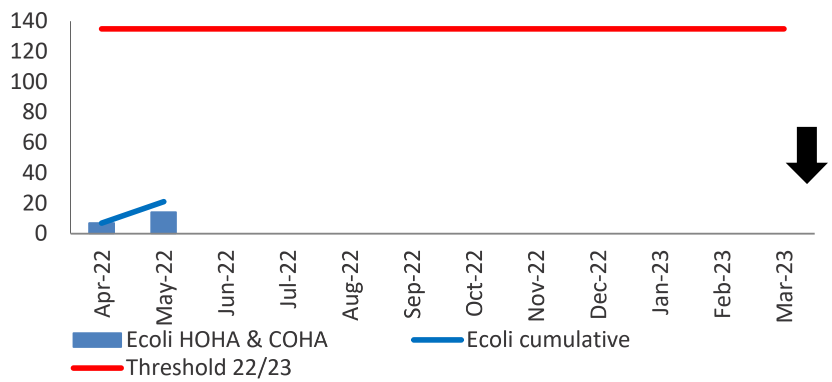
There were 6 healthcare associated Clostridium difficile toxin positive isolates identified in the laboratory in April. 5 of which were HOHA and 1 was COHA.

The year to date cumulative figure is 11 (HOHA & COHA). The detailed infection control report will be reviewed through the Quality Committee.

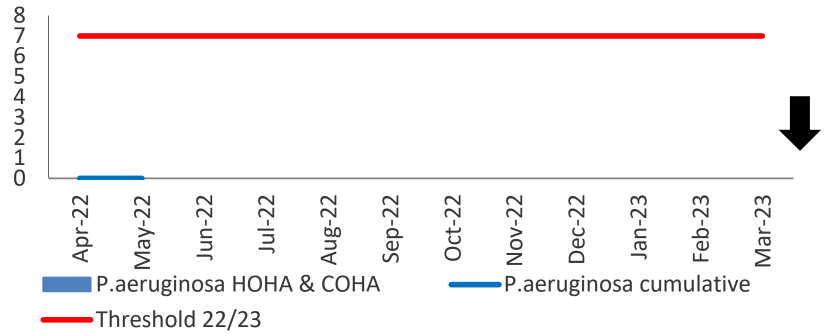
The rate of HOHA infection per 100,000 bed days is still within the normal range in May.

SAFE

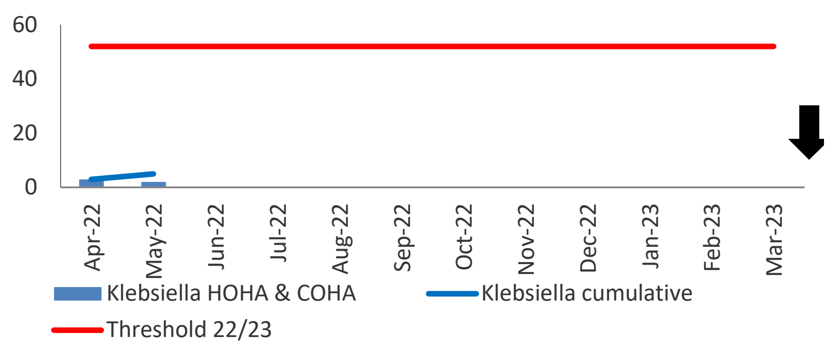
E. Coli (HOHA & COHA)



P.aeruginosa



Klebsiella



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

This year's trajectory for reduction of E.coli is 135 HOHA & COHA.

There were 14 reportable cases of E.coli bacteraemia identified in May. 5 of which were HOHA and 9 were COHA.

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 a trajectory was been introduced for Klebsiella and Pseudomonas. The Trust should have no more than 7 cases for Pseudomonas and 52 cases this year for Klebsiella.

There were 0 reportable cases of Pseudomonas identified in May.

There were 2 reportable cases of Klebsiella identified in May, both of which were HOHA.

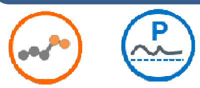
Surveillance will be undertaken in line with current requirements (e.g. E. coli bacteraemia). This surveillance will be carried out by the Infection Prevention and Control Team.

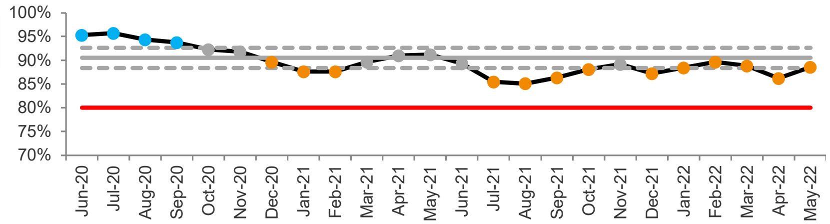
The work on catheter care, prevention of line infections, sepsis and improving hydration will help prevent healthcare associated bloodstream infections.

SAFE

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

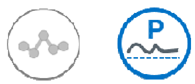
Registered Nurses/ Midwives - Day

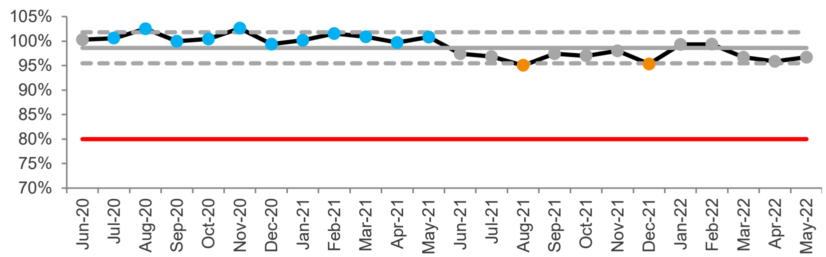




The average fill rate for registered nurses/ midwives during the day is showing a significant reduction in May, however based on current variation will consistently be above threshold.

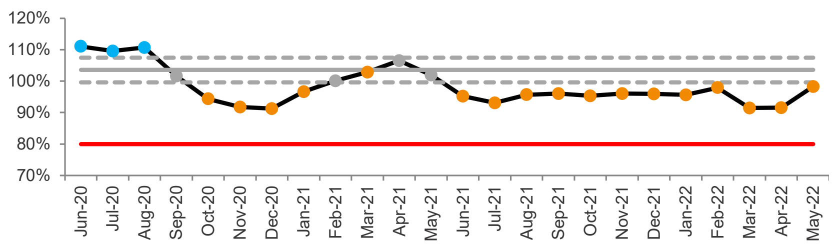
Registered Nurses/ Midwives - Night





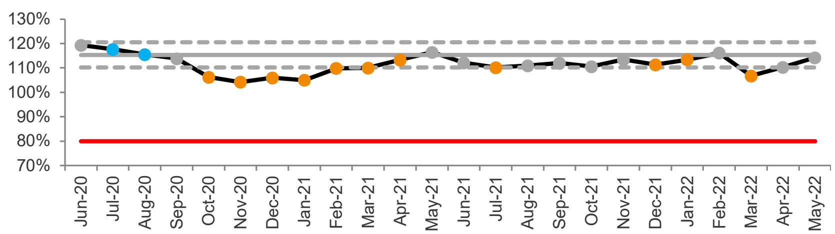
The average fill rate for registered nurses/ midwives at night is showing no significant variation in May, and based on current variation will consistently be above threshold.

Care Staff - Day



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

Care Staff - Night



The average fill rate for care staff at night is showing no significant variation in May and based on current variation will consistently be above threshold.

SAFE

Staffing in May 2022 has been slightly less challenging than previous month for nursing staff but remains as challenging in midwifery. Covid isolation absences are still impacting on staff sickness 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. The escalated bank rates for ED and Maternity remain in place and due for review at the end of June.

In May, 2 wards in total fell below the 80% for Registered Nurses/Midwives for the day shift. 1 in MEC and 1 in Family Care. This is a significant improvement from last month's 8 wards. In saying this, the impact of the OMNICRON variant, shielding, sickness and vacancies remains. The filling of Health Care Support Worker shifts has improved and work to recruit more HCSW staff is on-going

MEC <80% fill rate

Ward C7- This is currently a Covid ward and not always full. On these occasions surplus staff have been redeployed to support other areas.

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

For the month of May there were 2 nursing red flags reported

National Nursing Red Flags

MEC
CCU - A bariatric patient required 1:1 care (based upon their Enhanced Care Score). However, no additional staff to provide 1:1 care. The patient fell during this night shift, no harm or injury to the patient. No shortfalls in regular staffing establishment that night. All the appropriate equipment in place to support patient safer handling and the need for 1:1 care was escalated through the trust processes.

SAS
No red flags

CIC
CCH Ribblesdale Ward - due to 1 x RN short staffed and increased acuity of patients, unable to reliable carry out intentional rounding. This was supported with additional HCSWs. No harm to patients

Anecdotally staff resilience remains 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

Commenced plans for 'one stop shop' recruitment drive for HCAs and bank staff.

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

Recruitment Strategy, this is now an internal QI project, with regular monthly meetings monitoring progress

Nurse recruitment lead continues to work 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 in identified areas (currently ED and maternity), regularly reviewed.

Achieved the target to recruit 122 international nurses by April 2022. Aiming to recruit a further 71 by the end of the year. 4 of these arrived at the end of April and a further 11 in May. Planned 14 for June and 10 for July. There are 2 international midwives in the pipeline, these will be the first internationally recruited midwives at ELHT.

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
May-22	88.5%	98.2%	96.7%	114.3%	29,023	8.57	2	0	1	1

SAFE

Monthly Trend

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Sum of Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
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
Apr-22	86.2%	91.5%	95.8%	110.3%	27,446	8.48	8	5	1	0
May-22	88.5%	98.2%	96.7%	114.3%	29,023	8.57	2	0	1	1

SAFE

Family Care Staffing Summary – May 2022

There were no National Midwifery Staffing Red Flag events.

Maternity (Midwife to Birth Ratio)

Month	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Staffed to full Establishment	01:28	01:27	01:26	01:26	01:28	01:26	01:27	01:27	01:26	01:27	01:27	01:28	01:27
Excluding mat leave	01:29	01:27	01:27	01:27	01:29	01:27	01:28	01:29	01:27	01:27	01:27	01:29	01:29
With gaps filled through ELHT Midwife staff bank Per week	Bank Usage 24.14wte	Bank Usage 17.98wte	Bank Usage 17.40wte	Bank Usage 18.54wte	Bank Usage 21.84wte	Bank Usage 16.71wte	Bank Usage 23.40 wte	Bank Usage 17.43	Bank Usage 42.28	Bank Usage 17.33	Bank Usage 18.76	Bank Usage 14.79	Bank Usage 15.8

SAFE

Maternity - May bank filled hours were covering vacancies/ pregnancy shielding, extensive short, long-term sickness, extended staff isolation periods. A specialist midwife rota to cover day gaps for redeployment was reinstated. Maternity leave remains high with 15.5 WTE staff off. Escalated bank rates remained in place for May.

Antenatal ward fell below 80% fill rate once due to sickness. On this occasion the bed occupancy was reduced, acuity was low and the ward was safely staffed.

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; birth centres internally diverted patients on several occasions to support safe staffing, midwives were redeployed to other areas to support acuity and activity as and when required, bank uptake was in great demand as reflected in the monthly figures, highest recorded. Additional staffing huddles scheduled in times of additional pressures. Local flags are closely monitored to ensure any common themes are addressed point prevalent.

Daily and weekend bespoke staffing plans are summarised with a further review of skillset and experience for each midwife prior to be redeployed. This has been most days in the month of May. 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 at the weekend. Close monitoring with a proactive approach to breaks particularly in times of shortfalls being supported by the CBS coordinator and duty manager.

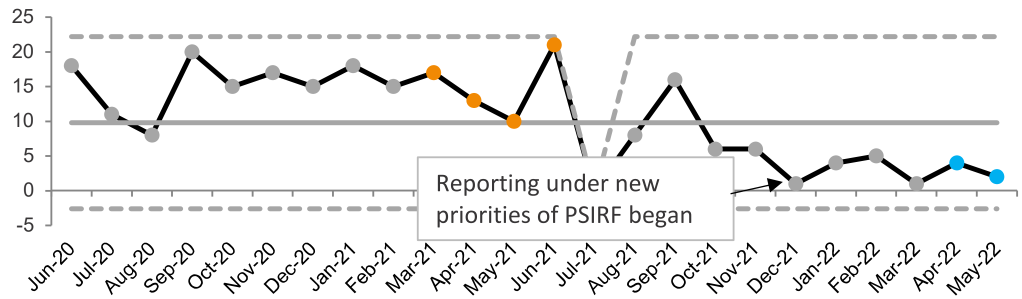
Neonatology – All Nursing duties were covered for safe staffing aligned with the x 3 daily staffing NW connect tool. No closures of NICU for the month of May. Cross divisional working with paediatrics to cover any nursing gaps in view of an increase in staff isolation periods, primarily in the nursery room 5.   Enhanced pay has now ceased hence the ask for agency has increased along with a spike in sickness and backfill for substantive duties in place to cover staffing gaps with request for agency where required as not been able to cover with internal bank shifts. Two international recruitment nurses have joined the NICU team as HCSWs until achieving their OSCE’s .

Paediatrics- Cross divisional support sought when required to support room 5 in NICU. Staffing managed within safe levels

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

SAFE

Serious Incidents



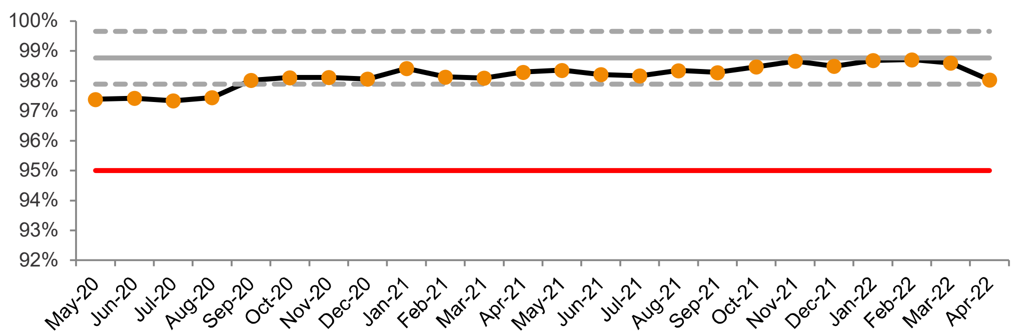
PSIRF Category	No. Incidents
HSIB national priority - unexpected term admission to NICU	1
HSIB national priority - maternal death	1

There were no never events reported in May.

Two incidents meeting a national or local priority and whereby a patient safety incident investigation (PSII) is underway, have 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



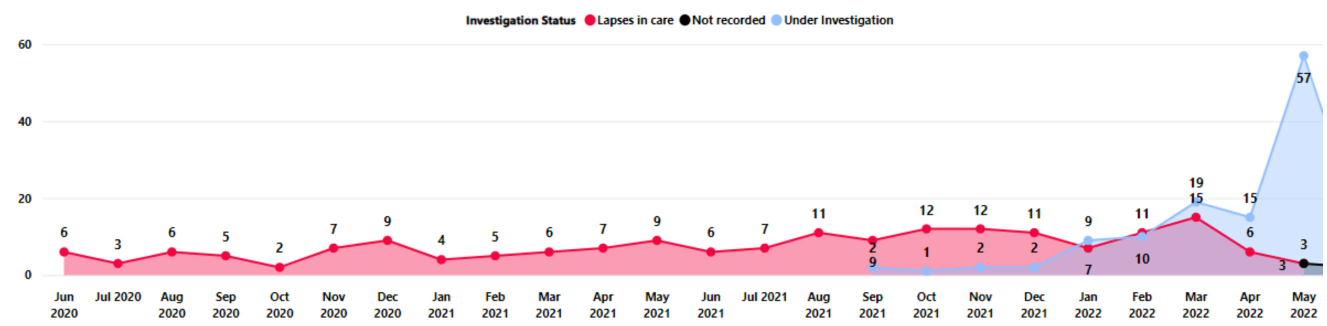
The Venous Thromboembolism (VTE) assessment trend continues to be below previous levels, however is still above the threshold.

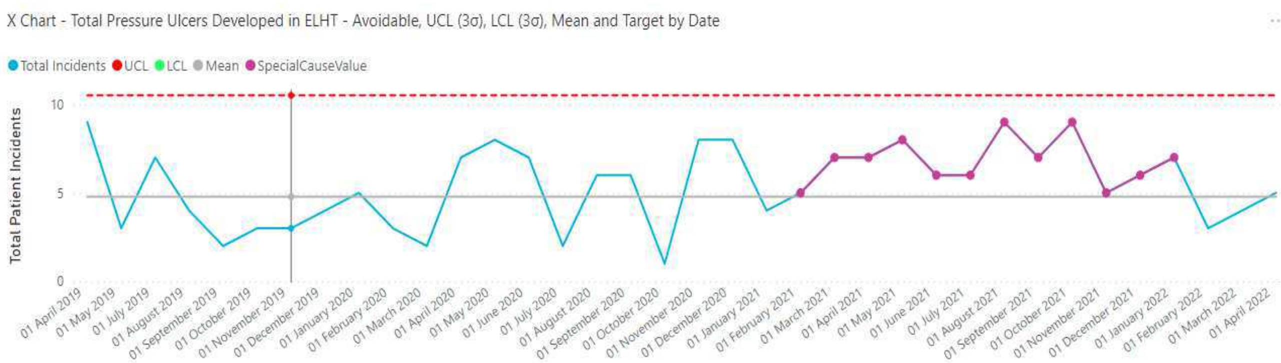
SAFE

Pressure Ulcers

For May 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 Sep 21-May 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.

Although we are consistently above the mean, this is typically only 3 to 4 above the mean each month.

The pressure ulcer collaborative refresh has commenced from May. This will be looking at the reoccurring themes from the PURLP process and using a QI methodology to achieve improvement.

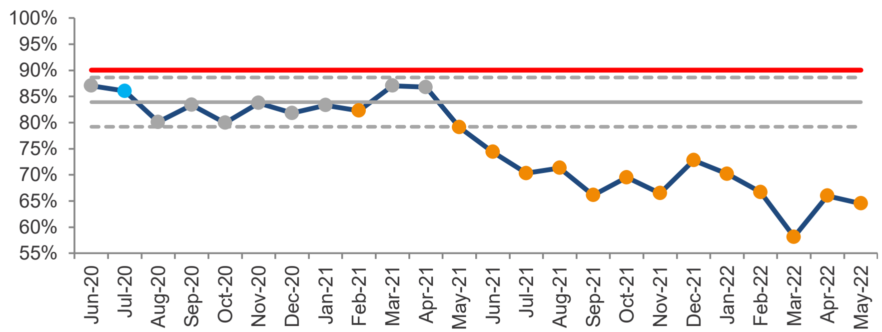
There is a full action plan available and reported into theTrust 'Lessons learned' group.

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.

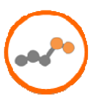
Inpatient data collection was suspended April 20 - Sep 20 due to COVID

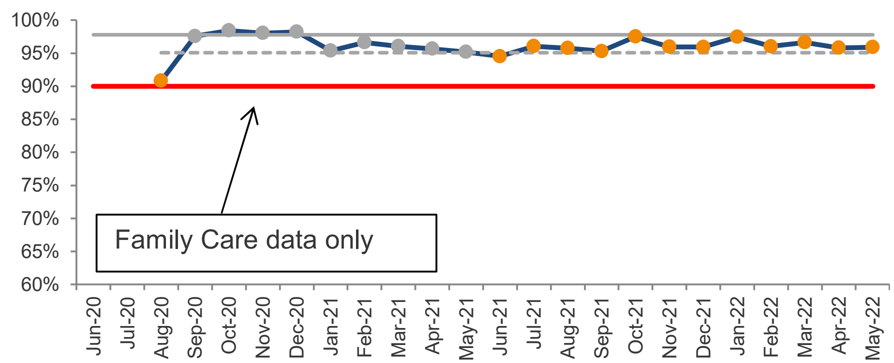
Friends & Family A&E



A&E scores are showing a significant deterioration in the last 12 months. Based on current variation this indicator is not capable of hitting the target routinely.

Friends & Family Inpatient



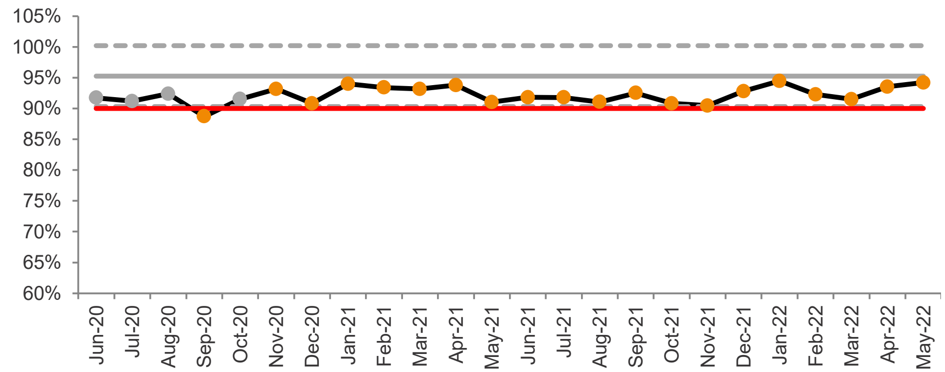


Inpatient data was suspended April - September 20 due to the COVID pandemic. Paper surverys were resumed in Family Care from 1st August 20 and across all areas from 1st September 20.

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

CARING

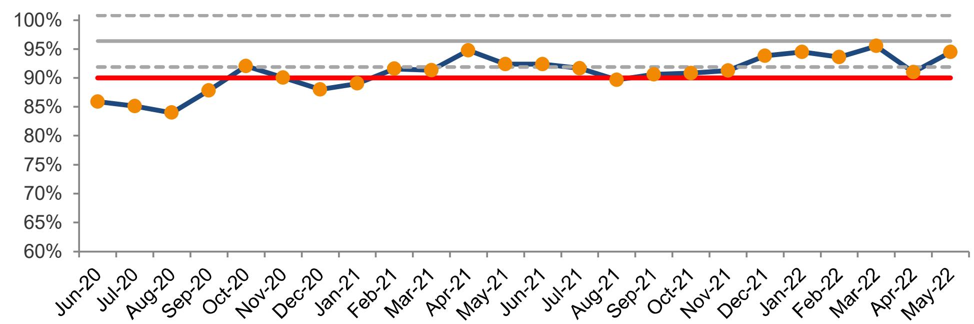
Friends & Family Outpatients



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

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

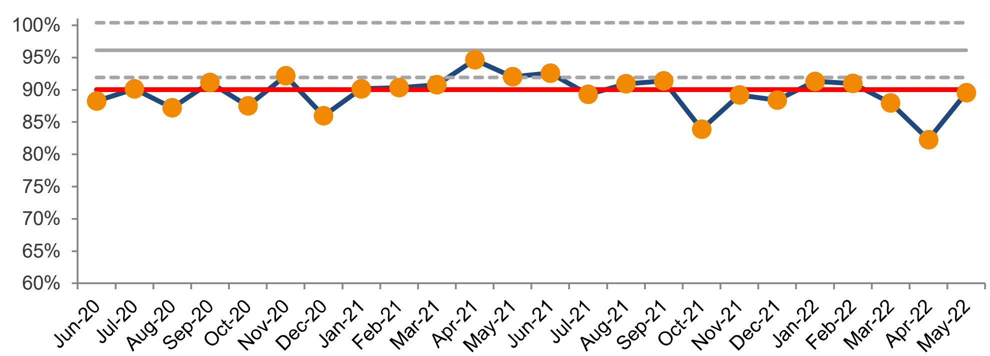
Friends & Family Community



Community scores are 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.

Friends & Family Maternity

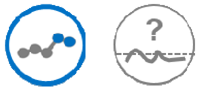


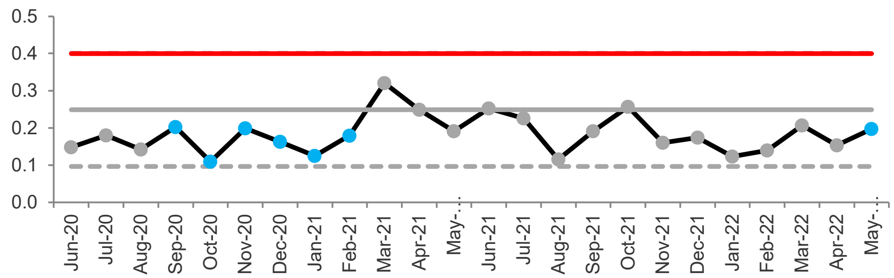
Maternity scores continue to show a reduction, which is significantly lower than usual variation, and is below the threshold.

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

CARING

Complaints per 1000 contacts





The Trust opened 21 new formal complaints in May.

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 May the number of complaints received was 0.20 Per 1,000 patient contacts.

The trend is showing significant improvement but based on current variation is at risk of not meeting the standard.

Patient Experience

Type	Division	Dignity Average Score	Information Average Score	Involvement Average Score	Quality Average Score	Overall Average Score
Antenatal	Family Care	94.74	100.00	75.00	92.50	92.75
Community	Community and Intermediate Care Services	98.11	94.66	95.55	93.39	95.55
Community	Diagnostic and Clinical Support	98.15	88.49	93.55	100.00	91.86
Community	Family Care	100.00	-	-	97.06	97.73
Community	Surgery	100.00	95.56	-	-	96.83
Delivery	Family Care	100.00	-	100.00	100.00	100.00
ED_UC	Medicine and Emergency Care	87.50	61.76	38.46	78.13	58.75
Inpatients	Community and Intermediate Care Services	89.84	86.03	85.42	88.60	87.19
Inpatients	Diagnostic and Clinical Support	100.00	85.00	98.04	97.93	98.51
Inpatients	Family Care	96.20	90.44	93.64	93.27	93.64
Inpatients	Medicine and Emergency Care	77.27	60.17	51.08	63.24	59.90
Inpatients	Surgery	97.98	90.10	92.93	95.88	93.80
OPD	Diagnostic and Clinical Support	98.36	96.12	98.46	97.83	97.26
OPD	Family Care	100.00	100.00	94.74	95.00	97.06
OPD	Medicine and Emergency Care	100.00	100.00	100.00	97.22	99.15
OPD	Surgery	99.40	93.30	97.49	99.25	97.25
Paediatric	Family Care	100.00	100.00	100.00	100.00	100.00
Postnatal	Family Care	97.22	97.01	100.00	96.19	97.12
SDCU	Family Care	97.22	94.79	100.00	90.28	96.43
	Total	**97.46**	**89.92**	**91.81**	**93.72**	**93.15**

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 May 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 3 of the 4 competencies.

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

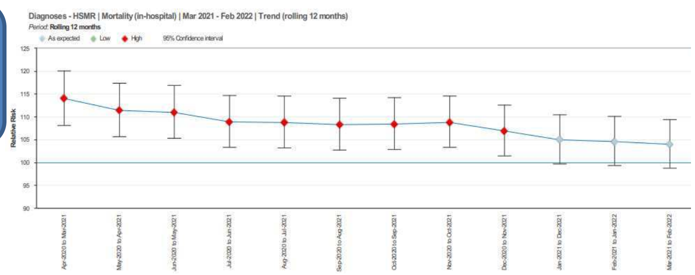
EFFECTIVE

SHMI Published Trend

Dr Foster HSMR rolling 12 month

	HSMR Rebased on latest month Mar 21 – Feb 22
	ALL
TOTAL	104
Weekday	102.7
Weekend	107.6
Deaths in Low Risk Diagnosis Groups	Not Available

Dr. Foster HSMR monthly trend



The latest Trust Summary Hospital-level Mortality Indicator (SHMI) value as reported by the Health and Social Care Information Centre and Care Quality Commission for the period Jan 21 to Dec 21 has remained within expected levels at 1.06, as published in May 22.

The latest indicative 12 month rolling Hospital Standardised Mortality Ratio (HSMR), (Mar 21 – Feb 22) has reduced from last month and is 'within expected levels' at 104.0 against the monthly rebased risk model.

The benchmark model has been adjusted this month to account for data upto November 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) is also currently also alerting on the nationally monitored SHMI groups.

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

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

Learning Disability Mortality Reviews

No update provided for May

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 - Mar 22	Apr-22	TOTAL
Deaths requiring SJR (Stage 1)	46	212	250	262	214	160	13	13
Allocated for review	46	212	250	262	214	159	13	13
SJR Complete	46	212	250	262	212	145	5	5
1 - Very Poor Care	1	1	0	0	1	0	0	0
2 - Poor Care	8	19	22	34	34	20	1	1
3 - Adequate Care	14	68	70	70	65	39	2	2
4 - Good Care	20	106	133	129	102	74	2	2
5 - Excellent Care	3	18	25	29	10	12	0	0
Stage 2								
Deaths requiring SJR (Stage 2)	9	20	22	34	35	20	1	1
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	1	4	1	1	0	0
Allocated for review	6	18	21	30	34	19	1	1
SJR-2 Complete	6	18	21	30	34	19	1	1
1 - Very Poor Care	1	1	1	2	0	0	0	0
2 - Poor Care	3	6	7	13	13	9	0	0
3 - Adequate Care	2	10	13	13	20	10	1	1
4 - Good Care	0	1	0	2	1	0	0	0
5 - Excellent Care	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 - Mar 22	Apr-22	Total
stage 1 requiring allocation	0	0	0	0	0	1	0	0
stage 1 requiring completion	0	0	0	0	2	14	8	8
Stage 1 Backlog	0	0	0	0	2	15	8	8
stage 2 requiring allocation	0	0	0	0	0	0	0	0
stage 2 requiring completion	0	0	0	0	0	0	0	0
Stage 2 Backlog	0	0	0	0	0	0	0	0

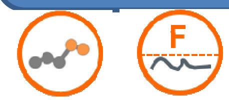
EFFECTIVE

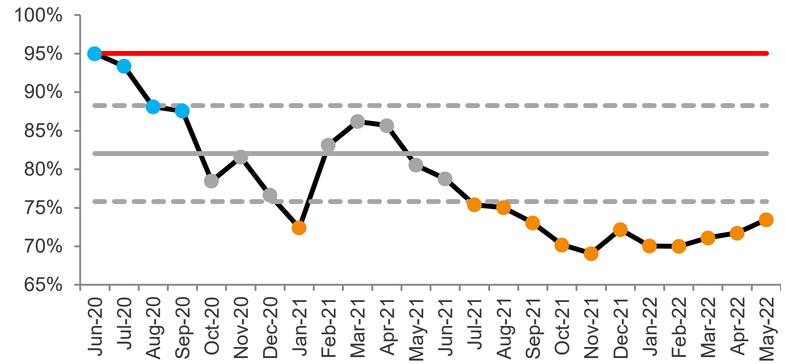
Commissioning for Quality and Innovation (CQUIN)

CQUIN schemes have been reintroduced for 2022/23, though for CCGs the CQUIN value will be included in block payments with no adjustment based on achievement levels. For Specialised Commissioning the CQUIN value is also included in block payments, though the current intention is for financial adjustment to be made based on achievement levels. This may be brought into line with the CCG approach when the contract is finalised, with discussions ongoing at an ICS level.

RESPONSIVE

A&E 4 hour standard % performance - Pennine

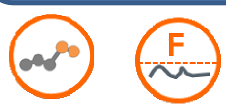


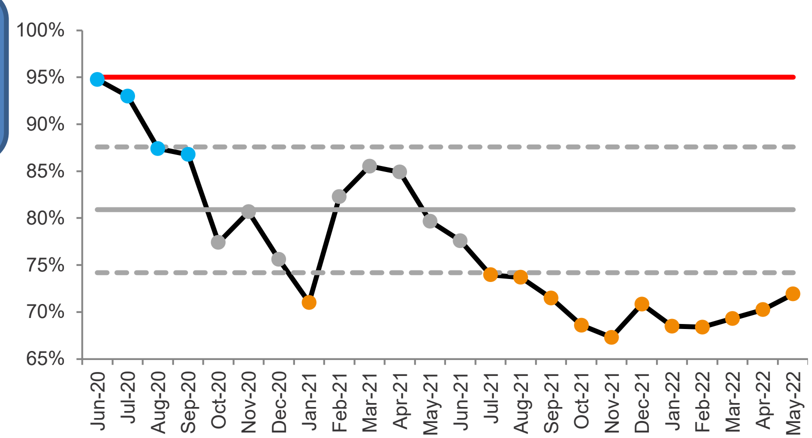


Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 73.47% in May, which is below the 95% threshold and the Trust trajectory (87%)

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

A&E 4 hour standard % performance - Trust

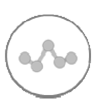


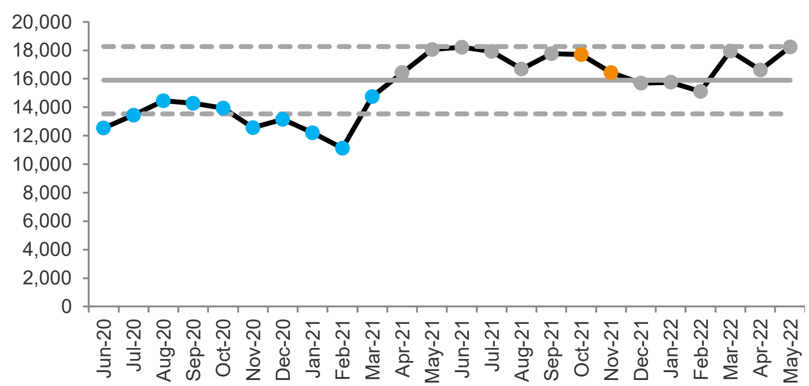


Performance against the ELHT four hour standard was 71.91% in May.

The national performance was 73.0% in May (All types) with none of the 108 reporting trusts with type 1 departments achieving the 95% standard.

A&E Attendances - Trust

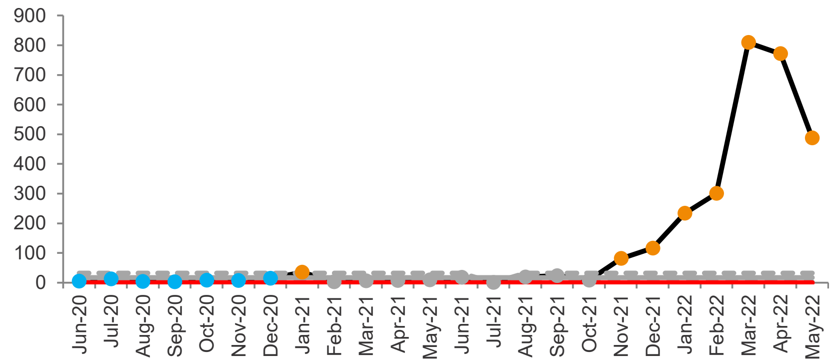




The number of attendances during May was 18,242, which is within the normal range.

RESPONSIVE

12 Hr Trolley Waits

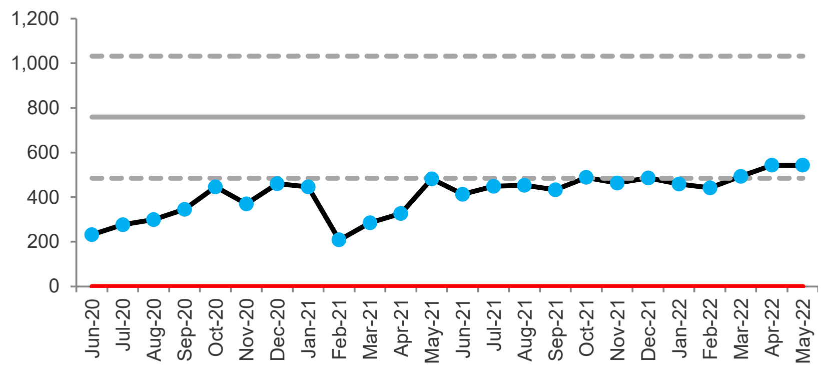


There were 487 reported breaches of the 12 hour trolley wait standard from decision to admit during May, which is higher than the normal range. 29 were mental health breaches and 458 were physical health.

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	29	458
Average Wait from Decision to Admit	28hr 44 min	15hr 45 min
Longest Wait from Decision to Admit	68hr 18 min	26hr 09 min

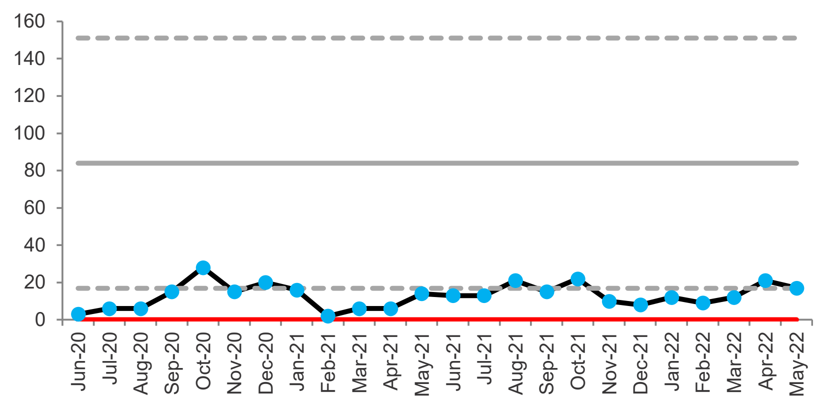
Ambulance Handovers -



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 543 ambulance handovers > 30 minutes in May. 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

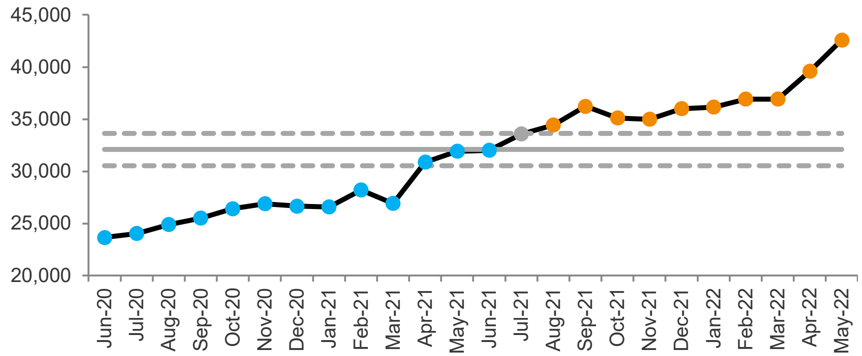


There were 17 ambulance handovers > 60 minutes in May, which continues to demonstrate a signifcant improvement. Following validation, 3 of the 17 were actual ELHT breaches and 14 were due to non-compliance with the handover screen.

The average handover time was 23 minutes in May and the longest handover was 1hr 45 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.

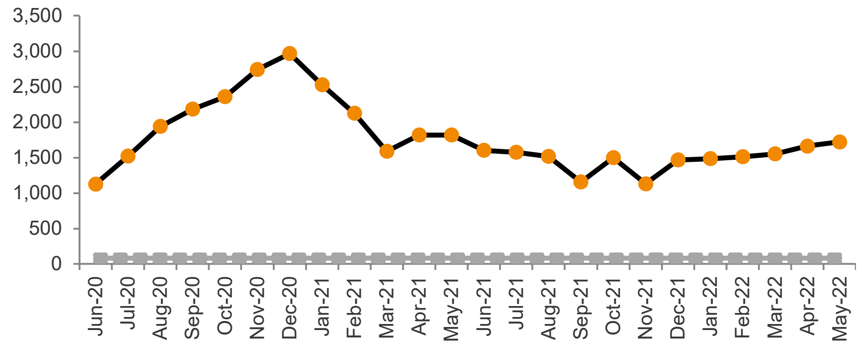
RESPONSIVE

Referral to Treatment (RTT) Total Ongoing



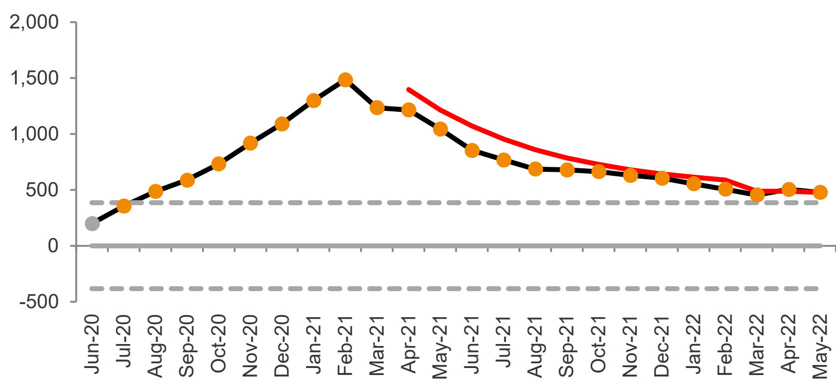
At the end of May, there were 42587 ongoing pathways, which has increased on last month and is above pre-COVID levels.

RTT Total Over 40 wks



The number of pathways over 40wks increased in May with 1722 patients waiting over 40 wks at month end.

RTT Total Over 52 wks



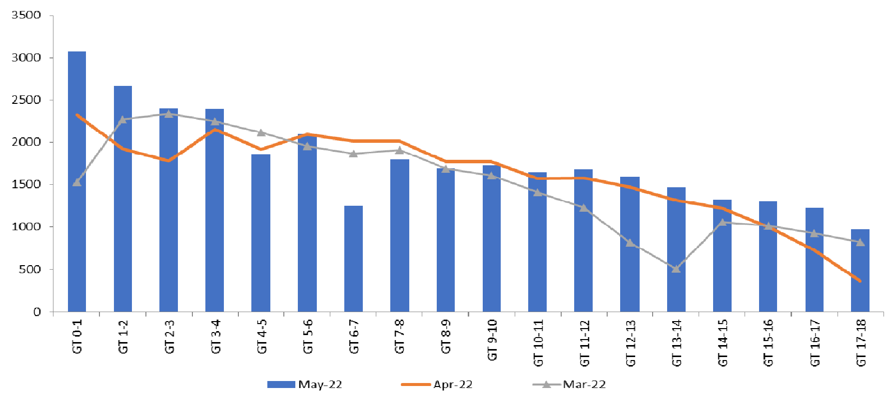
There were 477 patients waiting over 52 weeks at the end of May.

There was 1 patient waiting over 104 weeks.

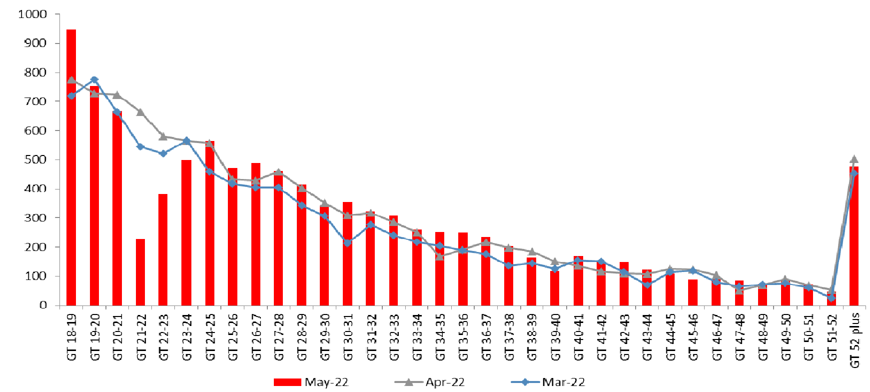
RESPONSIVE

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

RTT Ongoing 0-18 Weeks

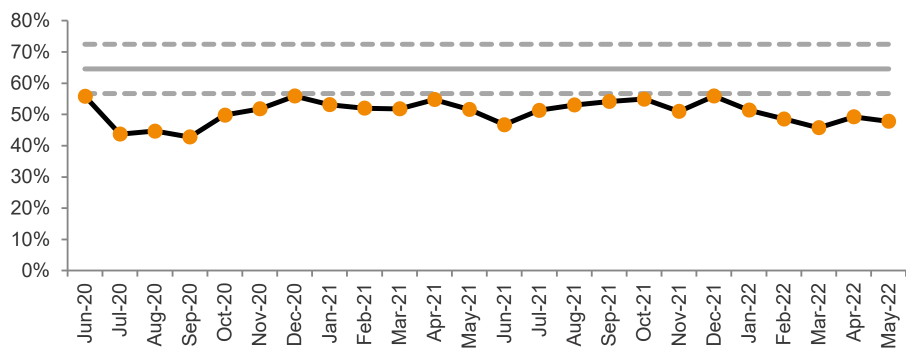


RTT Over 18 weeks

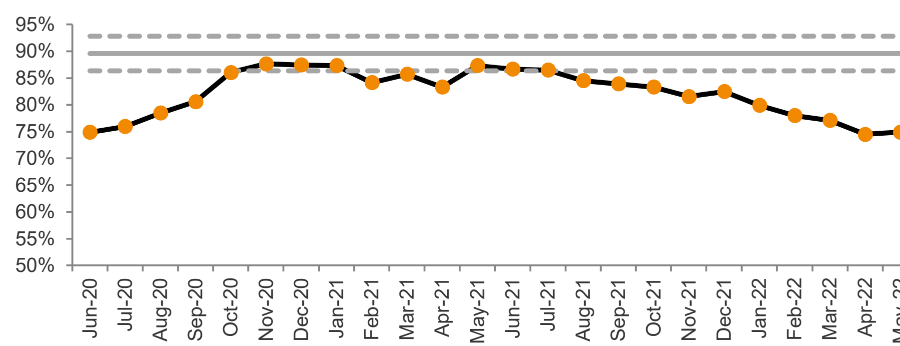


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information. During April 20 and May 20, only priority and urgent patients were admitted.

RTT Admitted

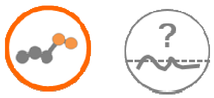


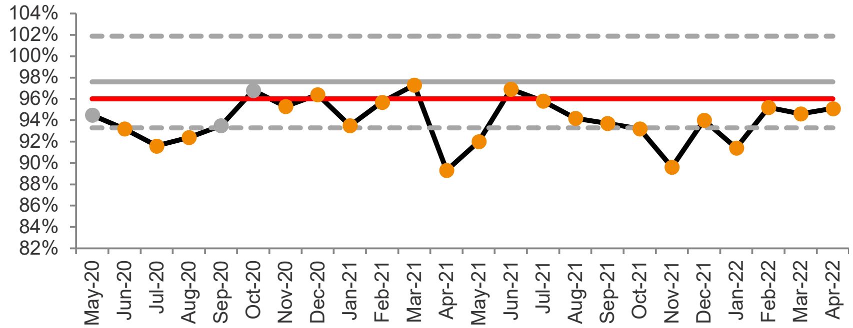
RTT Non-Admitted



RESPONSIVE

Cancer 31 day



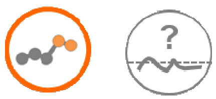


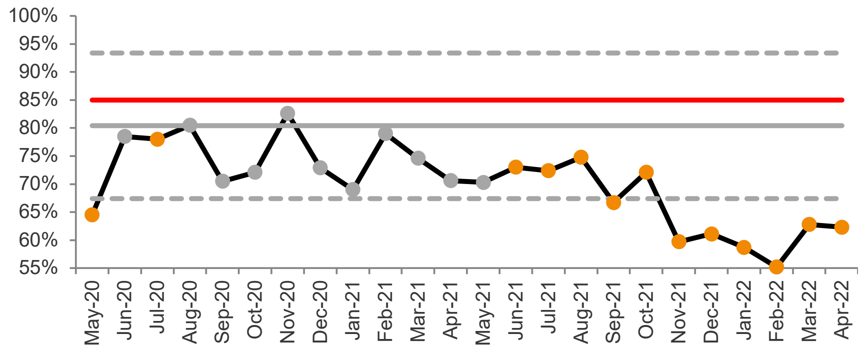
The 31 day standard was not achieved in April at 95.1%, below the 96% threshold.

Q4 was not achieved at 93.9%

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

Cancer 62 Day



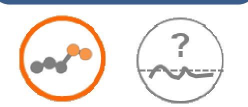


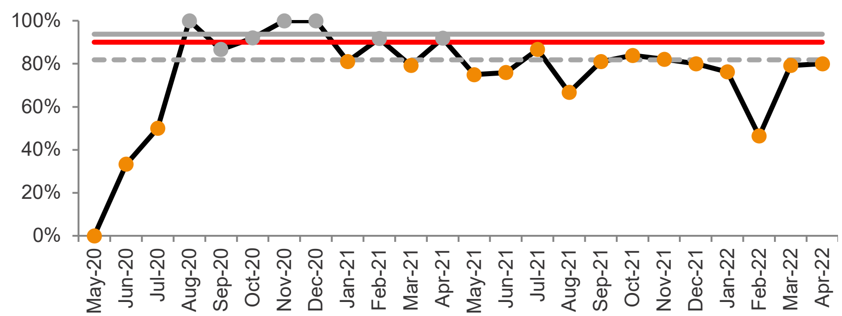
The 62 day cancer standard was not achieved in April at 62.3% below the 85% threshold.

Q4 was not achieved at 61.5%

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





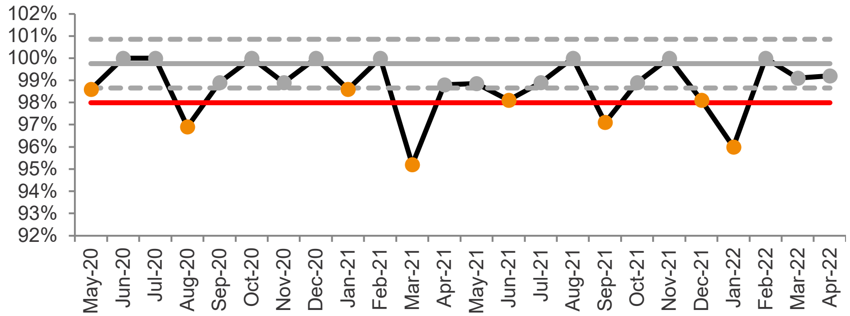
The 62 day screening standard was not achieved in April at 80.0%, below the 90% threshold.

Q4 was not achieved at 68.8%

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)



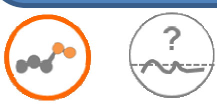
The subsequent treatment - drug standard was met in April at 99.2%, above the 98% threshold.

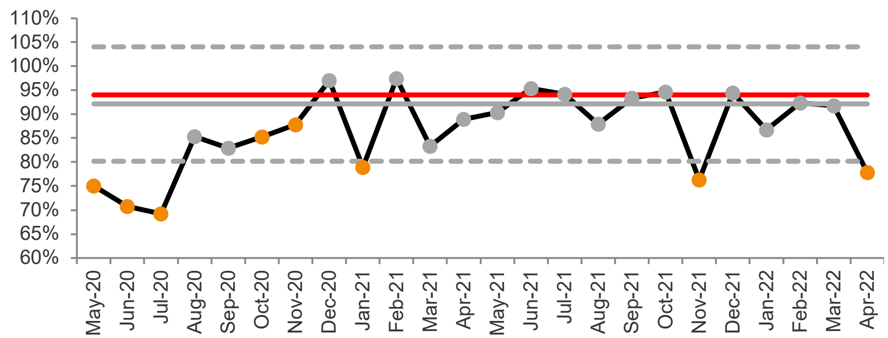
Q4 was achieved at 98.4%*

* 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)



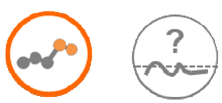


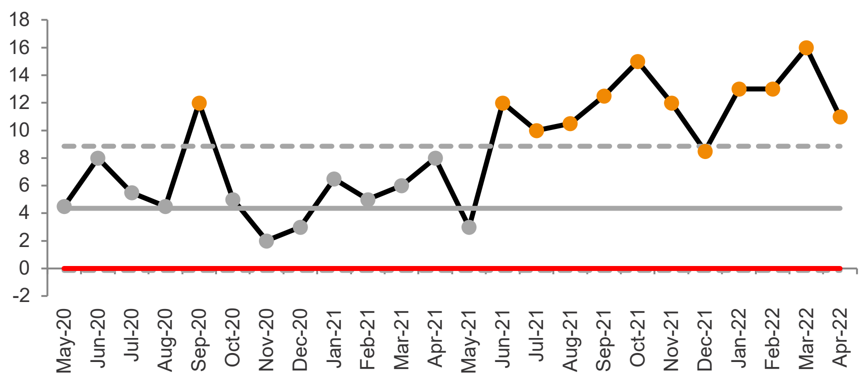
The subsequent treatment - surgery standard was not met in April at 77.8%, below the 94% standard.

Q4 was not achieved at 90.6%

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

Cancer Patients Treated > Day 104



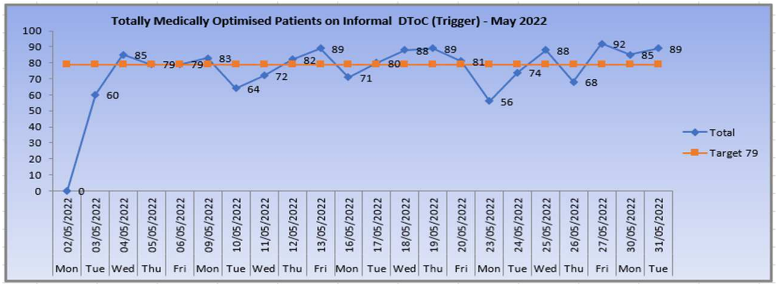


There were 11 breaches allocated to the Trust, treated after day 104 in April and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the consultants involved in the pathway as required.

The trend is showing a significant increase this month.

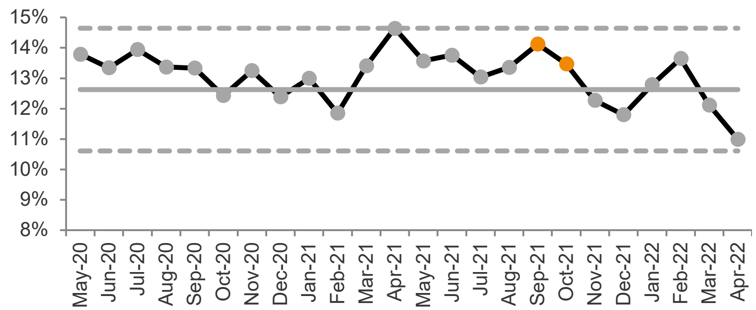
RESPONSIVE

Delayed Discharges



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

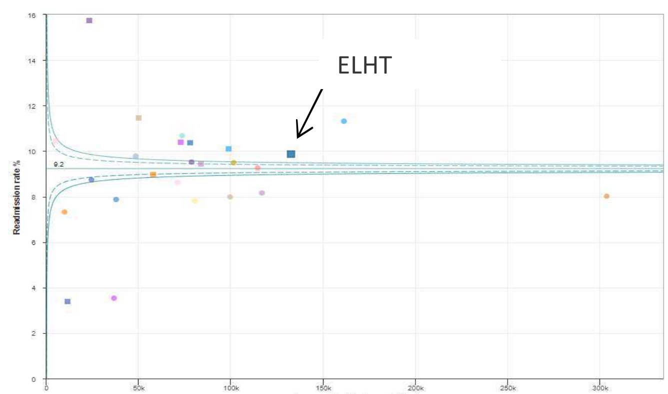
Emergency Readmissions



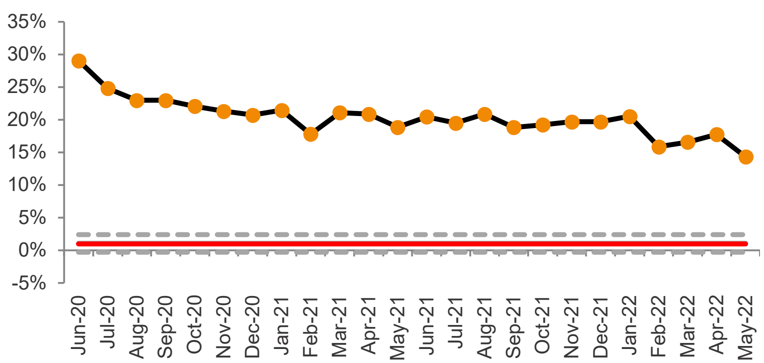
The emergency readmission rate trend is within the normal range.

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

Readmissions within 30 days vs North West - Dr Foster



Diagnostic Waits



In May, 14.35% 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 28.4% in April (reported 1 month behind).

RESPONSIVE

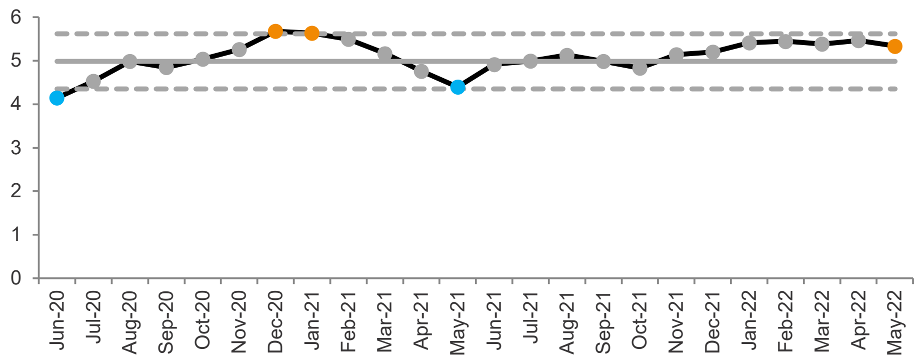
Average length of stay

Dr Foster Benchmarking March 21 - February 22

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	60,291	9,975	50,316	3.3	2.6	-0.7
Emergency	63,995	63,995	0	4.3	4.2	-0.1
Maternity/ Birth	13,343	13,343	0	2.3	2.2	-0.1
Transfer	224	224	0	9.3	25.1	15.9

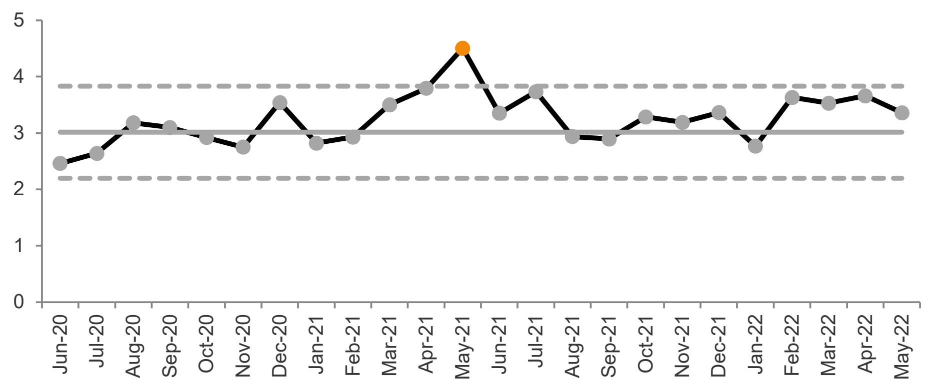
Dr Foster benchmarking shows the Trust length of stay to be below expected for emergency, elective, and maternity/birth when compared to national case mix adjusted, for the period March 21 - February 22.

Average length of stay - non elective



The Trust non-elective average length of stay is showing deteriorating performance this month.

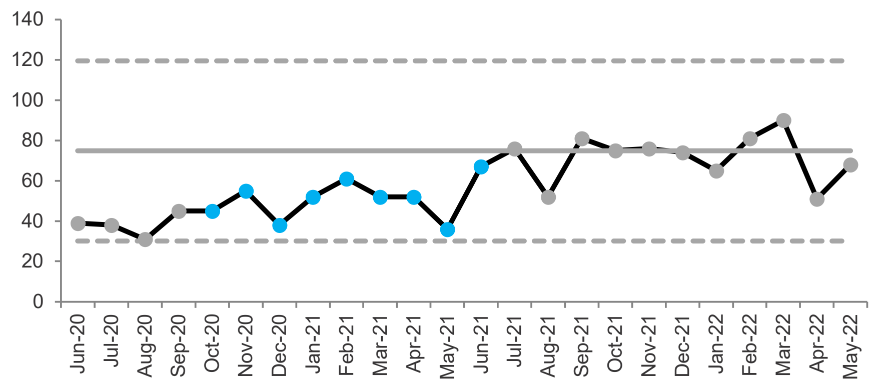
Average length of stay - elective



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

RESPONSIVE

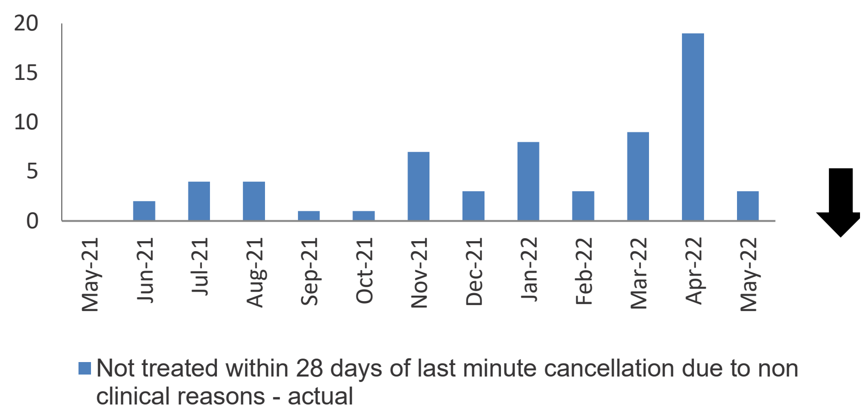
Operations cancelled on day



There were 68 operations cancelled on the day of operation - non clinical reasons, in May.

The trend is showing a return to normal variation.

Operations cancelled on day - breaches of 28 day

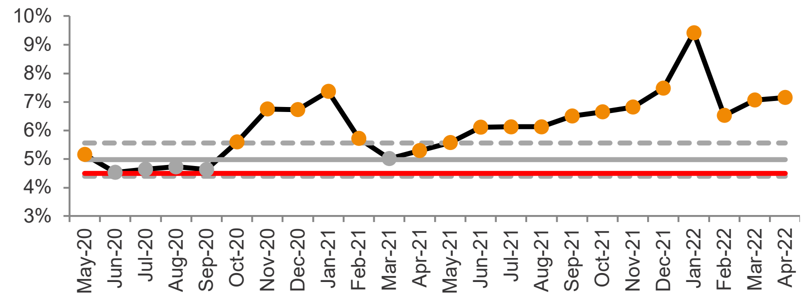


There were 3 'on the day' cancelled operations not rebooked within 28 days in May.
These will be provided to the Finance & Performance Committee.

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.

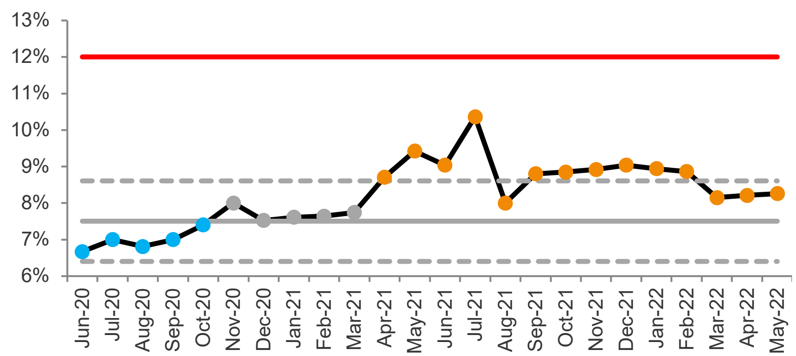
WELL LED

Sickness



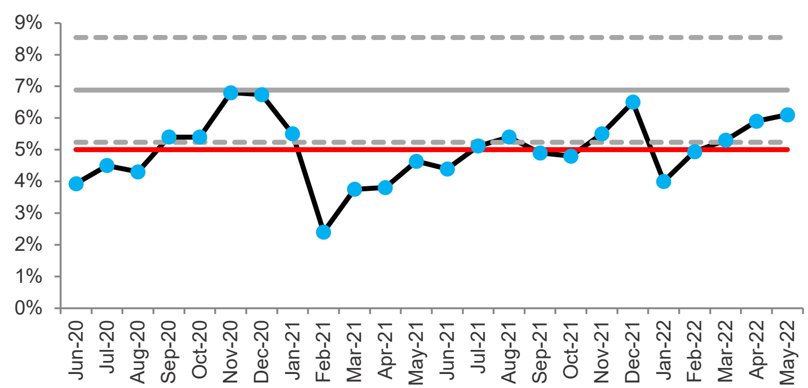
The sickness absence rate was 7.2% for April which is above the threshold of 4.5%. The trend is showing a significant increase and based on the current level of variaton, is at risk of being above threshold.

Turnover Rate



The trust turnover rate continues to be higher than normal at 8.3% in May, however remains below threshold. Based on current variation, the indicator will consistently be below the threshold.

Vacancy Rate



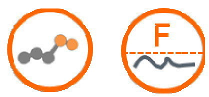
The vacancy rate is 6.1% for May which is above the 5% threshold.

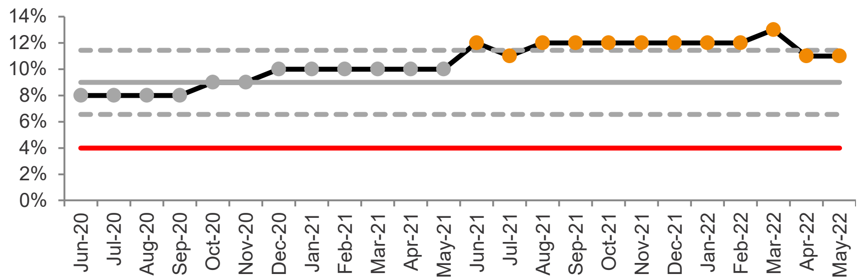
This is a significant improvement from normal variation but based on current variation this indicator is not capable of hitting the target routinely.

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

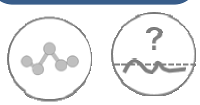
WELL LED

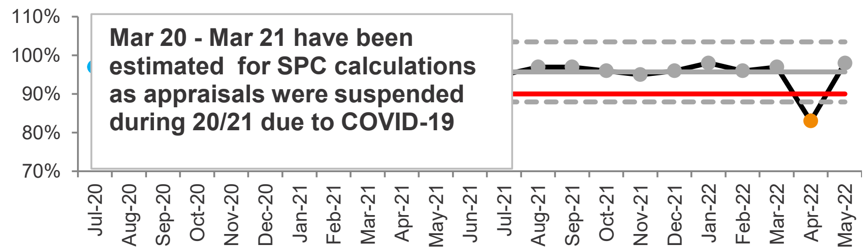
Temporary costs and overtime as %



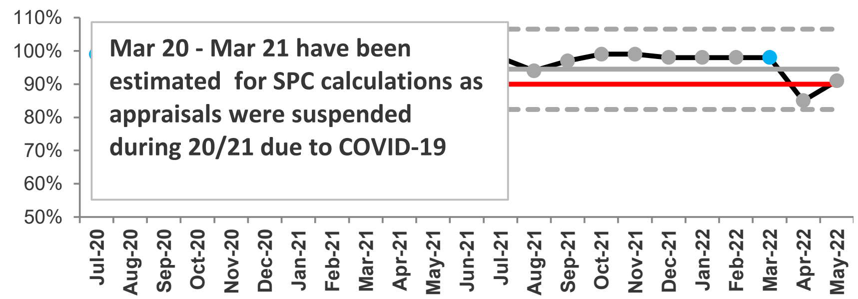


Appraisals, Consultant

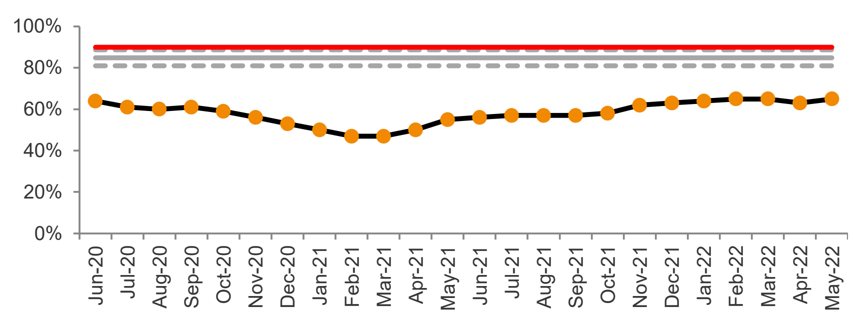




Appraisals, Other Medical



Appraisals Agenda for Change (AFC) Staff



In May 2022, £4.4m was spent on temporary staff, consisting of £1.5m on agency staff and £2.9m on bank staff.

WTE staff worked (9,269 WTE) was 121 WTE more than is funded substantively (9,390 WTE).

Pay costs are £0.1m more than budgeted establishment in May.

At the end of May 22 there were 551 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 May 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.

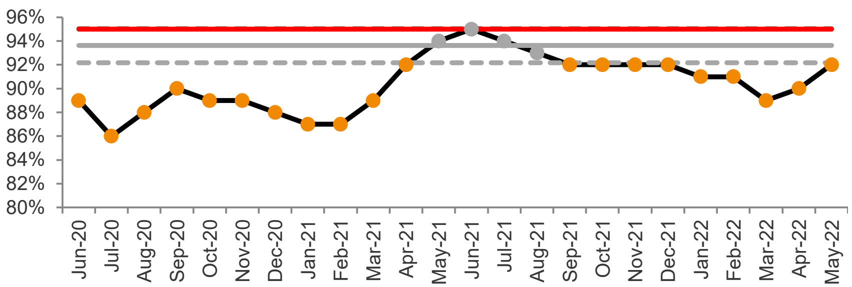
WELL LED

Job Plans

Stage	Consultant	SAS Doctor
Not Published	0	0
Draft	7	1
In discussion with 1st stage manager	157	29
Mediation	0	0
Appeal	0	0
1st stage sign off by consultant	46	5
1st stage sign off by manager	48	8
2nd stage sign off	33	6
3rd stage sign off	28	6
Signed off	42	16
Locked Down	0	1

As at May 2022, there were 361 Consultants and 72 Specialty Doctor/ Associate Specialist (SAS) doctors registered with a job plan on Allocate. The table shows the numbers in each stage of the job planning process.

Information Governance Toolkit Compliance



Information governance toolkit compliance is 92% in May 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 %

	Target	Compliance at end May
Basic Life Support	90%	89%
Conflict Resolution Training Level 1	90%	96%
Equality, Diversity and Human Rights	90%	95%
Fire Safety	95%	93%
Health, Safety and Welfare Level 1	90%	96%
Infection Prevention L1	90%	95%
Infection Prevention L2	90%	86%
Information Governance	95%	92%
Prevent Healthwrap	90%	94%
Safeguarding Adults	90%	95%
Safeguarding Children	90%	95%
Safer Handling Theory	90%	93%

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%

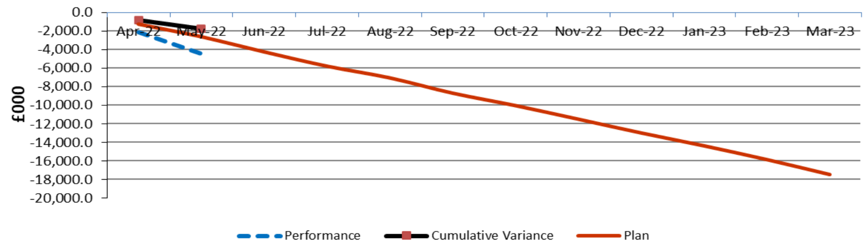
Four core training modules are below threshold; Basic Life Support, Fire Safety, Infection Prevention L2, and Information Governance.

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

WELL LED

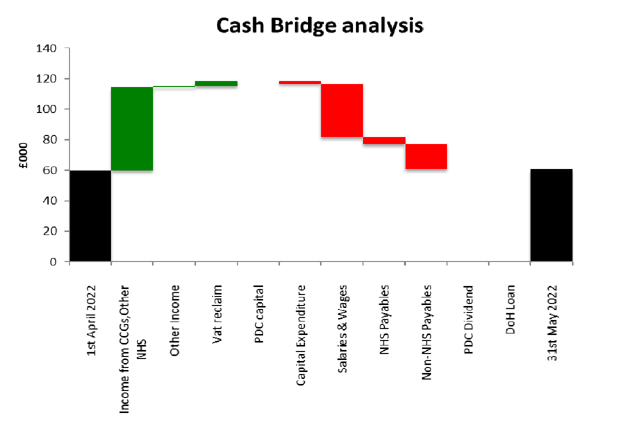
Adjusted financial

Adjusted financial performance surplus/ (deficit)



Cash

Cash bridge



Capital expenditure

Capital expenditure profile

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Revised Plan	1.92	2.72	3.53	5.33	6.14	6.94	10.19	13.79	17.40	20.60	31.81	43.18
Actual	1.22	1.97										

The Trust is reporting an adjusted deficit of £4.4m in month 2, £1.8m behind plan.

The cash balance on 31st May 2022 was £60.8m, an increase of £1.1m from the previous month largely due to the £2.3m unadjusted deficit for the month offsetting a £1.1m reduction in receivables and a £2.4m increase in payables.

The 2022-23 capital programme currently stands at £43.7m with £2.0m spent this month against a planned figure of £2.7m.

The WRP target at month 2 was £4.8m. The plan was equally phased to ensure that a disproportionate amount of risk was not pushed into later months of the year. It has been necessary to non-recurrently support the position by £4.5m at month 2.

East Lancashire Hospitals
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TRUST BOARD REPORT

13 July 2022

Item	**91**
Purpose	**Information**

Title	Staff Health and Wellbeing Summary Report
Executive sponsor	Mr K Moynes, Executive Director of Human Resources and Organisational Development

Summary: Board members are asked to note the staff health and wellbeing update report highlighting a summary of actions taken since the implementation of the ELHT staff health and wellbeing strategic action plan, key findings identified and next steps.

Report linkages

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

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by: - Trust Board part 1 Jan 2022

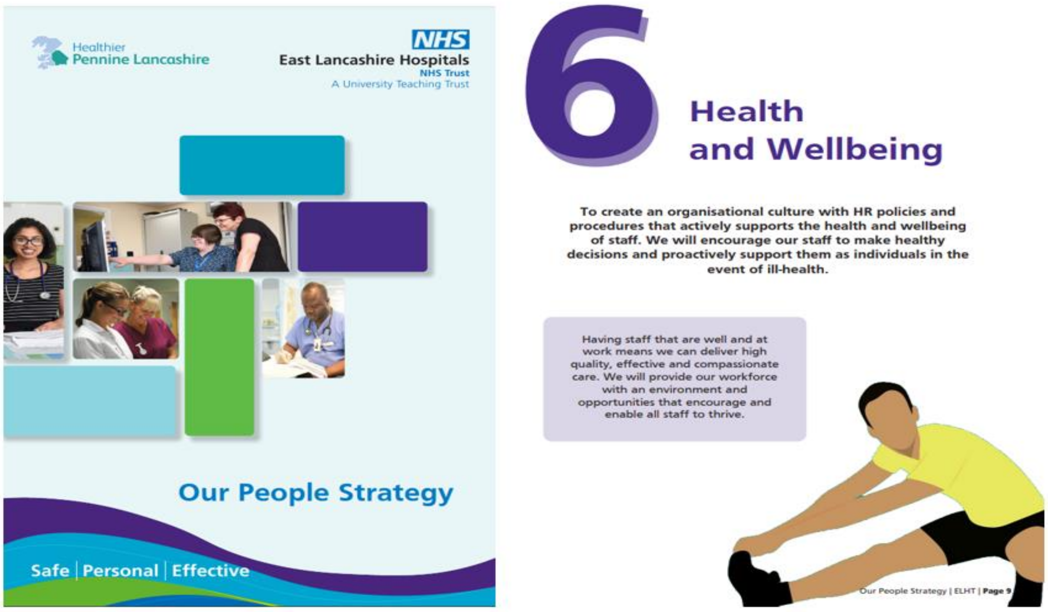
- Employee Engagement Sponsor Group June 2022
- Joint Quality, Finance and Performance Committee May 2022

Executive summary

1 This report summarises the progress made since the implementation of the East Lancashire Hospitals Trust (ELHT) Staff Health and Wellbeing Strategic Action Plan in January 2022. Board members are asked to note the 2022 update report, the key findings identified, actions taken since the implementation of the strategic action plan and support the next steps in our continuous drive to support and improve staff health and wellbeing throughout 2022.

Background

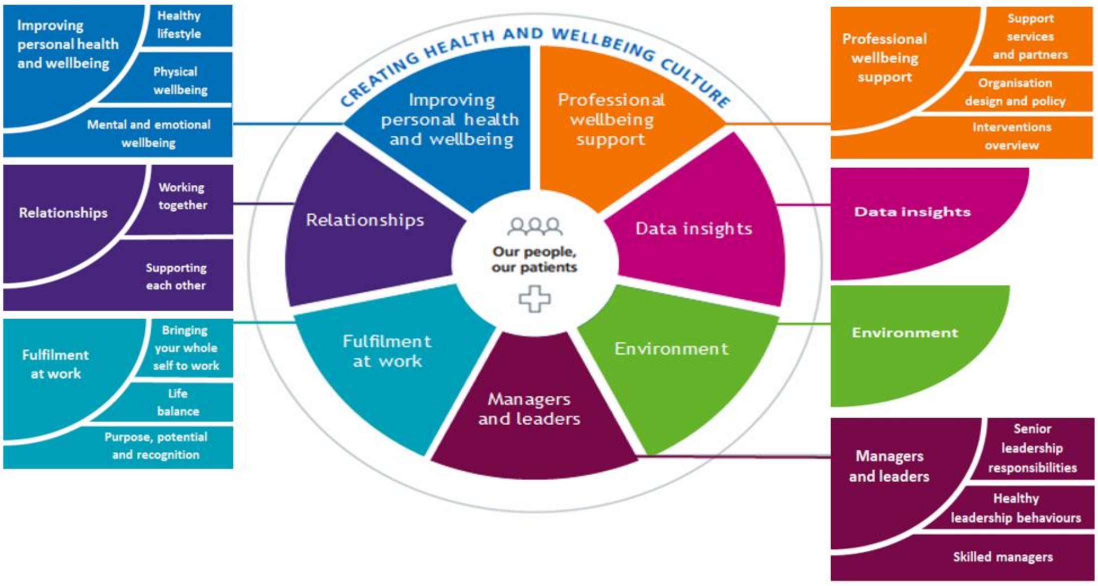
2 The 2022 Staff Health and Wellbeing Strategic Action Plan is underpinned by our vision, values, strategic aims and objectives. Deployment of our plan specifically focuses on enabling Staff Health and Wellbeing- priority 6 from our ELHT People Strategy.



3 Our plan is also congruent with the national programme of work to improve the health and wellbeing of our NHS people and the Lancashire and South Cumbria (LSC) programme of work to enhance Occupational Health and Wellbeing Services. Deployment of this programme specifically focuses on enabling looking after our people but also supports belonging in the NHS, new ways of working and delivering care and growing for the future.

Introduction to our ELHT 2022 Staff Health and Wellbeing Strategic Action Plan

4 The NHS Staff Health and Wellbeing Framework developed by NHSE/I and NHS Employers sets out the standards driven by the evidence base to support and improve staff health and wellbeing. ELHT uses the below model to organise our plan into 7 key themes with 66 high impact actions for 2022. A RAG status for each action can be seen in Appendix 1.



Summary of Themes

Data Insights

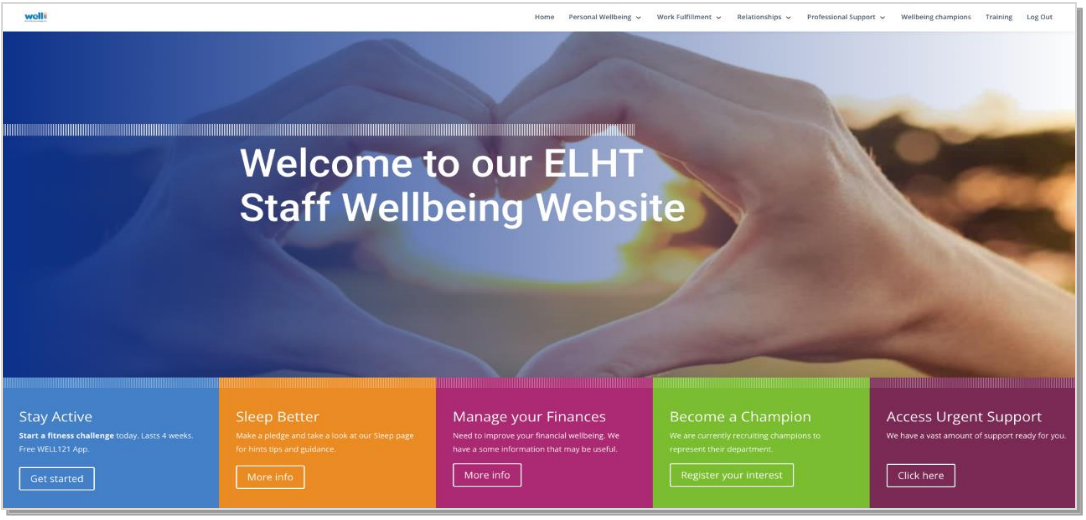
5 Our initial actions in relation to data insights has involved the triangulation of information to make more evidence-based decisions and target areas of greatest need. We know that the number one reason for sickness absence within the Trust is consistently mental health from our sickness absence data. However once this is triangulated with the underlying stressors from individuals via intelligence from interactions with colleagues and via our health needs assessment data in which 3004 staff responded, we have been able to pinpoint financial wellbeing, menopause, relationship breakdown, and Covid related mental health as crucial elements to support. As a result of data insights we have:

- Created and promoted a financial wellbeing booklet detailing help available to support staff concerns. (Please see Appendix 2)
- Promoted pensions webinars which have taken place across the last 6 months for all staff.
- Arranged on site drop ins by the credit union- Metro Money Wise and debt consolidation and financial education advice from Salary Finance.
- Deployed a cost-of-living working group to explore further solutions such as accessing daily and weekly pay, subsidised meals in the staff restaurants, free beverages and snacks/soups in staff rooms via the staff lottery funds, support for transport and mileage costs.
- Ran monthly menopause information support webinars which have proven to be very popular and promoted further support via the Balance App.
- Highlighted the additional mental health support available via the ICS Resilience Hub for Covid relation mental health.
- Reminded staff of the 24/7 Employee Assistance freephone line which offers support and advice during relationship breakdown along with talking therapy.
- Updated and circulated our Wellbeing Directory of Services to aid signposting and support.

Improving Personal Health and Wellbeing

6 To support personal health and wellbeing our new ELHT Staff Wellbeing website launched in May. The site is accessible for all staff, 24 hours a day, 7 days a week via www.LSCWellservice.co.uk, Username: ELHTWELL and used to access immediate support or to find out how staff can make positive healthy lifestyle changes.
The website has been designed in collaboration with the ICS and provides a holistic repository for staff health and wellbeing information, tools and resources including:

- Bitesize learning modules, webinars and training.
- A variety of hints and tips to help staff to make small but achievable health changes.
- Monthly challenges and pledges, aimed at improving health and wellbeing and access to a new and exciting tracking app.
- Useful videos helping staff to understand health topics and participate in healthier behaviours.
- Employee of the Month nomination forms and Appreciation Cards to send to colleagues.

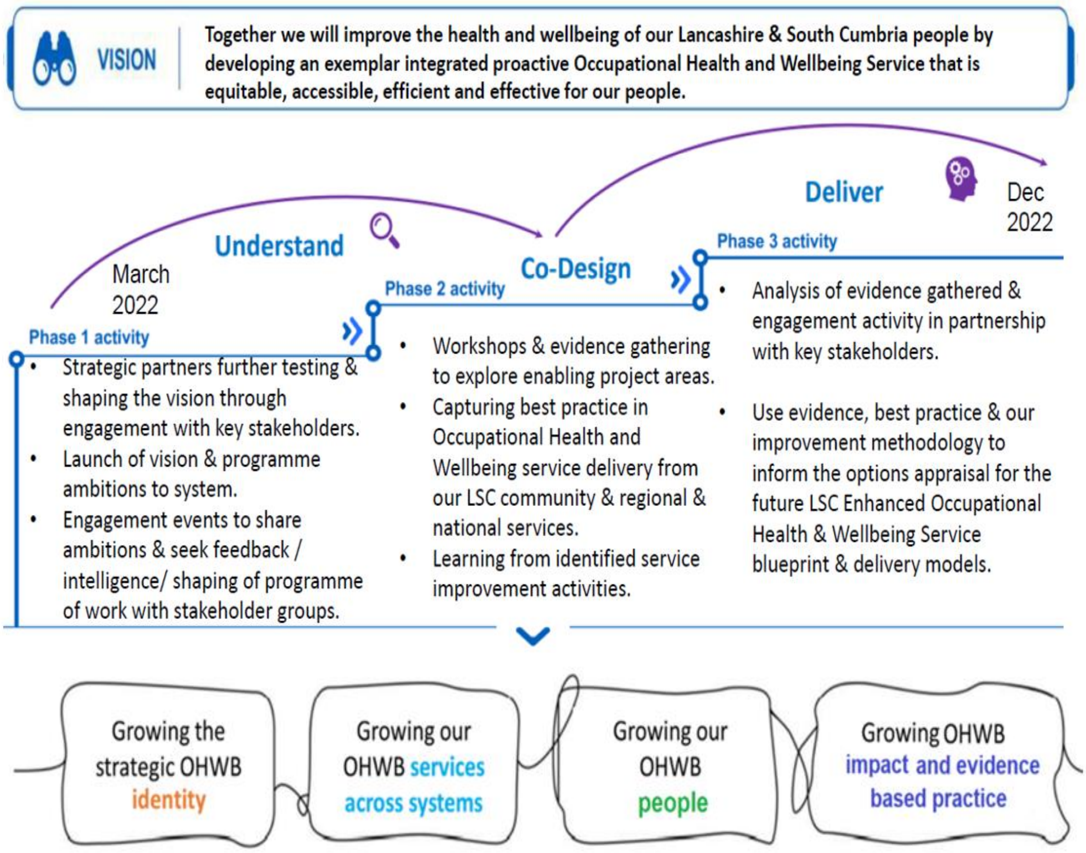


7 Throughout 2022 we have offered freely available on-site health checks for all staff. The health checks include: personal history and lifestyle questions, body mass index, blood pressure and cholesterol levels followed by a calculated individual risk factor score associated with coronary heart disease and a 'healthy heart' action plan with recommendations suggesting individual lifestyle changes along with a health coaching conversation. The total uptake of health checks in the last 12 months is 497 which is above 5% of the workforce knowing their numbers and taking a preventative approach to improve their health and wellbeing.

8 Over the last 6 months we have promoted a forward plan of events/information via our monthly calendar, which staff have advised they find useful. (See below example)

Professional Wellbeing Support

9 To target our high impact actions of further establishing collaborative relationships with external partners and reviewing the Occupational Health and Wellbeing Service & offer, along with unifying working practices & standards across the ICS as part of the "Growing our LSC Enhanced Occupational Health and Wellbeing Together", we have been working with our LSC Provider Trusts partners and the Resilience Hub to agree a vision for the future and a programme of collaborative work. Throughout 2022 the programme is applying the LSC improvement methodology phases of understand, co-design and deliver to create an options appraisal for the future LSC Enhanced Occupational Health & Wellbeing Service blueprint & delivery models by Dec 2022. The programme is currently in the co-design phase. The vision and phases can be seen below:



Our ELHT team is leading the way on this programme of work to ensure we have interventions that are both proactive & preventative as well as reactive & restorative, along with simplified pathways to appropriate internal and external support services to enable staff to find the best wellbeing support options based on their needs & choices.

So far, our Early Access to Support for Employees (EASE)- day 1 sickness absence service has been scaled up to provide a 12-month pilot of support for Lancashire and South Cumbria Foundation Trust staff since April 2022 and the service goes live at University Hospitals Morecombe Bay Trust on the 4th July 2022. Blackpool Teaching Hospitals will then go live in the autumn.

As the pilots progress we will be able to evaluate the impact of the service across the Provider Collaborative Group for the two biggest reasons for sickness absence-mental health and musculoskeletal absence.

Relationships

10 In our high impact action plan we committed to recruit, train and retain 100 active Wellbeing & Engagement Champions to support a team wellbeing culture throughout 2022. We currently have 147 active champions supporting teams across the Trust. Monthly champion development sessions along with weekly drop-in sessions support the champions work across the Trust. There is a dedicated section on the website for champions to access a wide range of resources and support including:

- Welcome pack
- Hints and tips document
- Information on Well spaces and starter pack
- Frequently asked questions
- 'Meet your champion' poster
- First sight of all upcoming events, resources and offers for staff including health checks, massage therapy, appreciation cards, etc...

Each month a champion is spotlighted in the Trust-wide Well newsletter highlighting the great work being done. See below for June's champion of the month:

Champion of the Month

"Hello everybody, my name is Lee and I just want to share a little information on my role as a Wellbeing and Engagement Champion. For me, the best thing about being a Champion is that I can pass on all the up-to-date relevant information to support and educate the members within my team. I have always been someone who likes to create good energy by using appropriate humour. Using the positivity of health and wellbeing does help me to fight away any negative atmospheres that at times we can experience. also find that it does help to boost moral during challenging times. I would like to encourage all Teams and Departments at East Lancashire Teaching Hospitals to recruit a Wellbeing and Engagement Champion.

Its easy being a Champion when you enjoy doing it".

well
Staff Wellbeing and Engagement
CHAMPION

11 Another high impact action identified was to launch a buddy scheme for all new starters in the Trust to support belonging and retention, as we know that the evidence base clearly demonstrates that the first 12 months is the most critical risk period for turnover and attrition. This action was successfully launched and implemented by the Directorate of Education, Research and Innovation (DERI) by the May deadline and the Buddy Scheme is co-ordinated by the induction team. All new starters are offered a buddy to support them in the first 12 months to help colleagues settle in, share tacit knowledge and provide informal support. As the scheme develops, we will evaluate the uptake and impact over the next 12 months.

12 To support relationships and early intervention with conflict in the workplace we continue to promote our internal Mediation Service which has completed over 150 mediations since its commencement and has a 95% reached settlement/agreement score. We also continue to promote our early resolution approach across the Trust which encourages all staff to take responsibility for nipping issues in the bud at the earliest opportunity without the need for formal processes which are time consuming, costly and have an impact on individual staff health and wellbeing. As a result of this change in approach we have seen the number of formal cases significantly reduce.

Fulfilment at work

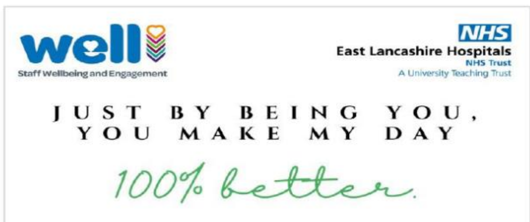
13 To support life balance, we committed to the high impact actions of reviewing the work life balance policy and flexible working options as we know that some colleagues go on to bank rotas, become locums, or leave us altogether because they are not offered the flexibility they need to combine work with their personal commitments. The NHS people plan is clear- to become a modern and model employer, we must build on the flexible working changes that have emerged through COVID-19. This is crucial for retaining the talent that we have. At ELHT, our agenda around flexible and agile working mirrors and yet goes beyond the expectations of the NHS People Plan and includes flexibility by default for all roles and normalising conversations about flexible working.

A suite of resources has been created which supports colleagues to understand our Flex & Agile agenda and the commitments we have made to this. It also provides additional, useful information, background reading, toolkits and resources to help colleagues not only understand, but to embed and embrace this new approach within teams. The Flexible Working Policy has been reviewed and updated and is available under Policies on OLI and further resources are available under Work Life Balance on the HR Portal. This new approach will be evaluated over the next 12 months to analyse the impact of the changes made.

14 To support bringing your whole self to work we continue to further embed staff networks for BAME, mental health and wellness, disability and wellness and LGBTQ+. We have also launched an additional network for Women which celebrated its first live webinar on International Women's Day in March 2022. One of the first actions the network committed to was the launch of free on-site sanitary products for staff thereby ending any potential background period poverty and enhancing staff health and wellbeing and dignity and respect in the workplace. The hampers are placed in all staff ladies' toilets and are topped up by our Estates and Facilities teams daily. The Women's network also committed to:

- Building inclusive workplaces through actively promoting conscious inclusion, psychological safety and belonging for all staff.
- Shining a light and celebrating the women who forge change, innovation and creative work.
- Gradually increasing consultant women's representation in specialties where they are significantly under-represented.
- Driving gender and ethnic parity across all pay bands.
- Advocating for more trees to be planted to support a greener environment.
- Support the efforts to embed a menopause friendly workplace.
- Strengthen workplace support for women and partners affected by pregnancy loss and other pregnancy and fertility related issues.

15 Purpose, potential and recognition continues to be targeted by various schemes such as Employee of the Month, STAR Awards and our Appreciation Cards, along with simple thank you's and spotlights in the Trust comms and the CEO blog when colleagues go the extra mile. A sample of our appreciation cards can be seen below.



Managers and Leaders

16 To support senior leadership responsibilities, we continue to schedule monthly Back to the Floors for Executives and Senior Managers throughout 2022. Back to the Floor is an initiative which gives the opportunity for the Executive Team and Senior Managers to spend time with staff who are 'on shift'. Getting back to the floor allows the Leader to experience a day in the life of staff members, to truly get to grips with what it is like to work in different parts of ELHT. They have proven to be well received by colleagues as staff feel they are able to discuss their role and highlight what they are proud of and any challenges directly to the Senior Leader. Below is an example of a recent back to the floor with Kate Atkinson in the Theatres Department at the Royal Blackburn Hospital site:

"Recently I had the privilege of spending a few hours in Theatres at the Royal Blackburn Hospital. I was welcomed by the theatres management team and then shown round the theatre complex by Sister Karen Copeland, Team Manager for Anaesthetics and Recovery. After walking the theatre corridor Karen arranged for us to spend some time in one of the theatres so we could follow a patient journey and talk to staff. We ended up in Theatre 9, an orthopaedic theatre, and were able to watch a patient come into theatre, have their procedure undertaken and then follow the patient out to recovery. During this time I was able to talk to the staff – many thanks to Rachel Holmes, Gary Smith, Tracey Mawdsley, Sarah Yankowski and Abigail Jacobs plus Mr Jugdey for answering my questions and showing us the ropes!

The team that day usually worked at Burnley but they had all willingly come over to help support the list going ahead at Blackburn. It was fantastic to see this team spirit with everyone supporting each other and working flexibly to ensure we continue to deliver safe, personal and effective care for our patients. As the Director for Service Development and Improvement it was also great to see our improvement work in action – I could see evidence of how work on theatres safety has really been embedded and was able to talk to staff about the efforts they go to ensure that patients operations do not get cancelled even if there are unexpected problems on the day.

I was also able to see first-hand the compassion and care shown to our patients. The patient we followed was awake for his procedure as it was undertaken under local anaesthetic and all staff engaged him in conversation to ensure that he was comfortable and managing OK. You could tell how each of the staff had a really positive impact on his experience. Team work in action and truly inspiring! Thanks to everyone I met and the whole of the theatres team!"

17 To enable and develop skilled manager's we continue to provide training opportunities for managers to understand the wellbeing offer and how/when to signpost and refer staff for support. Training to enable effective wellbeing conversations, workforce wellbeing and trauma support, de-stress "3 step pause", an introduction to resilience, soothing strategies and breathing techniques and menopause information sessions have been well evaluated by line managers over the last 6 months.

Environment

18 There has been progress with the Staff Safety Group meeting regularly to support violence reduction across the Trust to reduce incidents and improve staff safety from aggression and violence over the last 6 months.
The Lone workers policy is currently being reviewed and the transfer of security staff is underway to support the further development of our security services at ELHT.
One initiative that has had a high-profile impact has been the communications campaign where staff and their children are pictured with our zero-tolerance message. Please see the example below:

19 There has been little progress with a number of the other environment actions due to completing demands in the Estates and Facilities team. Further assurance and action is required to get these actions back on track in a timely manner.

20 Also, further focus needs to be placed on our efforts with the Smoke-Free environment & tackling smoking on site premises. Hotspots have been identified and actions are monitored via our Fire Safety Group. However, it is everybody's responsibility to drive this agenda and politely challenge when they see smoking on site as the standard you walk past is the standard you accept.

Next Steps

21 Assigned leaders will report progress made towards achieving their actions and sharing best practice and together we will commit to driving forward our objectives collectively to further improve staff health and wellbeing throughout 2022 and beyond.

22 We will continue to monitor and drive our Staff Health and Wellbeing Strategic Action Plan through the Staff Health and Wellbeing Steering Group and report on our progress at the September Employee Engagement Sponsor Group.

Recommendations

23 It is recommended that the Board members note the progress made in this crucial domain and that they receive a further update on progress across 2022 and plan of action for 2023 at the December 2022 Trust-board.

Lee Barnes

Associate Director Staff Wellbeing & Engagement ELHT 1.07.2022

East Lancashire Hospitals
NHS Trust
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TRUST BOARD REPORT

Item 92

13 July 2022

Purpose Approval

Title	Trust Clinical Strategy 2022-2027
Executive sponsor	Mrs K Atkinson, Interim Director of Service Development & Improvement

Summary: A draft clinical strategy for the Trust has been developed by clinical teams across the Trust. A period of engagement and consultation has been completed with staff, unions and external partners on our draft clinical strategy. As a result of this engagement and feedback some minor changes were made to the draft strategy. These changes are noted in this covering report. A final clinical strategy is attached for approval. Next actions are noted including delivery and monitoring of the strategy.

Recommendation: Members of the Trust Board are asked to

- note the process undertaken to both develop and engage on the Trust Clinical Strategy and proposed next steps to mobilise the strategy; and
- to approve the ELHT Clinical Strategy 2022-2027.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. 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.

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by:

- Senior Leadership Group 22 February 2022
- Senior Leadership Group 5 April 2022
- Trust Board Strategy Session – Clinical Strategy 13 April 2

Executive Summary

1. Our Clinical Strategy 'Fit for the Future' 2016-2021 set out our clinical services priorities against six transformational themes supporting the foundations of integration of care and the development of high-quality services. As we end the five-year period, we have delivered (or are in progress to deliver this year) all our key priorities and plans.
2. A new five-year 'ELHT Clinical Strategy 2022-27' has been developed by our clinical teams which expresses our collective purpose to provide safe, personal and effective care and our ambitions to develop our clinical services. The strategy is one of the cornerstones of the strategic framework (Trust Strategy), and one of our key enabling strategies to support the overall strategic aims and objectives of the Trust. The key themes of the clinical strategy are:
   a) To strive for the highest quality clinical services, building on our strengths and managing our challenges.
   b) Focus on improvement in all aspects of clinical care – elective surgical and medical care, emergency, urgent and community care and diagnostics.
   c) Population health is at the centre of our strategy, recognising that our role is wider than treating people when they are ill or injured, but also a wider role in supporting the wider health of our local population and tackling health inequalities.
   d) Developing a 'hospital without walls' – integrating clinical services locally, as well as networked services across Lancashire and South Cumbria.
3. The strategy has been developed by clinical teams through clinical Divisions, in addition to a Trust Board strategy session. It has been subject to engagement and consultation with staff and external partners.
4. Our final Clinical Strategy 2022-27, for approval and ratification by Trust Board Members, can be found at Appendix 1.

Process of Development and Engagement – Building the Clinical Strategy

5. The Clinical Strategy was developed through a series of workshops at Senior Leadership Group, in addition to a number of local divisional and directorate clinical planning meetings.
6. A Trust Board strategy session was held, and local Divisional strategy and planning meetings fed into the clinical priorities for improvement identified.

   Appendix 2 provides a detailed summary of how the clinical strategy was developed.

7. Our 'first cut' strategy was then shared through a focused engagement plan with key stakeholders. Included in our engagement plan were:
   a) presentations to key meetings across the Trust to ensure 'floor to board' involvement in the development of the strategy;
   b) a series of three podcasts to share information with a different theme and aspect of the strategy covered within each podcast;
   c) a focus spot within the Trust Team Brief and on the Chief Executive's blog;
   d) virtual drop-in sessions;
   e) sharing of the document with unions;
   f) sharing of the document and plans at our patient and public participation panel;
   g) sharing our draft strategy with key partners locally and at integrated care system level.

   Appendix 3 provides our detailed engagement plan.
8. Feedback from our engagement and consultation period has been largely positive, with no significant change or challenge to the content of our strategy. Those engaged felt that the strategy picked up the key priorities and focus of the organisation at the present time, whilst recognising the changing environment that ELHT will work within in coming years. Some changes were made to the Draft, which are noted in Appendix 4.

Conclusion

9. Our clinical strategy for 2022-2027 has been developed by and through detailed engagement with clinical teams.
10. A detailed operational delivery plan and strategic dashboard is being developed for years one and two of the strategy, which will be monitored quarterly through Divisional Management Boards and Senior Leadership Forum, and bi-annually at Trust Board.
11. By September 2022 we will have a plan and monitoring framework in place to deliver our strategy. Appendix 5 provides the detail to support delivery and monitoring of our strategy.
12. Within the next 2-3 months we will:
   a) Continue to engage and raise awareness of our clinical strategy with all staff through attendance at key staff meetings.
   b) Develop a short film summarising our Clinical Strategy to continue to raise awareness with staff and key partners and explain how it fits into our wider strategic framework and staff and departmental roles.

c) Mobilise our operational delivery plan for years 1 & 2 of the strategy, with noted leads and project plans for key improvements.

d) Develop a 'strategic dashboard' for the Trust that highlights key milestones, progress and associated outcomes within our strategy.

13. From September 2022 we will begin to deliver against our agreed improvement priorities and as Lancashire and South Cumbria Integrated Care Board/Provider Collaborative Board/Pennine Lancashire place-based plans are developed, we will work collaboratively with partners to maintain alignment of our plans.

Recommendation

14. The Trust Board are asked to:

a. note the process undertaken to both develop and engage on the Trust Clinical Strategy and proposed next steps to mobilise the strategy; and

b. to approve the ELHT Clinical Strategy 2022-2027.

Appendices

Appendix 1 – ELHT Clinical Strategy 2022-2027

Appendix 2 – Development of the Clinical Strategy

Appendix 3 – Engagement and Consultation Plan

Appendix 4 – Feedback from engagement and changes to the Clinical Strategy

Appendix 5 – Next Actions – Delivery & Monitoring Plan

Mrs C Vozzolo, Associate Director of Service Development

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Clinical Strategy 2022 - 2027

"Improving safe, personal, effective care together"

Foreword

Welcome to East Lancashire Hospital NHS Trust's Clinical Strategy.

Firstly may we start with a huge thank you to everyone who has taken the time to contribute to its development in recent months – including colleagues across the Trust, partners in the wider health and social care system in Pennine Lancashire and Lancashire and South Cumbria as a whole and, perhaps most importantly, patients and their advocates.

This document is the culmination of a great deal of work and has taken account of everything the Trust has already achieved, as well as our refreshed aims and objectives, learning and research and, of course, the need to restore our services following the pandemic.

We both feel incredibly proud of everything the Trust has achieved during this difficult and challenging time. Pennine Lancashire was particularly tested by Covid and we lost many people, including colleagues, to the virus.

It is always important to remember though that, thanks largely to the dedication, determination and sheer hard work of colleagues, we cared for many, many more people, who were able to return home to loved ones and recover.

The Clinical Strategy now and up to 2027 continues to focus on our aim to provide safe, personal and effective care for everyone.

This includes striving for excellence in urgent and emergency care, which continues to be a signficant pressure area for clinicians, as well as improving and transforming health and social care with partners across the area.

Despite the challenges that all hospital Trusts face in terms of workforce, finance and demand on services, we are proud that these plans are ambitious and focused. Our strategy is built on already well-developed, strong clinical services and our history of proud and caring staff, delivering excellent healthcare and outstanding performance.

We are confident this vision is right for the Trust, for colleagues, for patients and their families and the system as a whole and look forward to reporting on its successful delivery over the next five years – and especially the difference it makes to our services.

Professor Eileen Fairhurst
Chairman,
East Lancashire Hospitals NHS Trust

Mr Martin Hodgson
Chief Executive,
East Lancashire Hospitals NHS Trust

Where we are in 2022

East Lancashire Hospitals
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Our Clinical Strategy 'Fit for the Future' 2016-2021 set out our clinical services priorities against 6 transformational themes supporting the foundations of integration of care and the development of high-quality services. As we end the five-year period, we have delivered (or are in progress to deliver this year) all our of key priorities and plans. As part of our Clinical Strategy, we have built a strong, high performing clinical service for the population of East Lancashire.

Our key achievements were:

- Establishment of Robotic Surgery within ELHT
- Increased ED capacity – 13 additional cubicles and a further 8 ED cubicles
- Establishment of a new emergency village at the RBH site including a new AMU
- Development of the Mental Health Emergency Assessment Unit
- Development of expanded Children's Assessment Unit at the RBH Site
- 2 additional MRI scanners
- Pharmacy robot
- Rapid Diagnostic Centre
- Maternity EPR
- Ophthalmology EPR
- Fit for Purpose Chemotherapy Unit
- Tele triage for Dermatology
- Fast Track Delegated Service for end of life care
- 4th Endoscopy Room
- CT Scanner (RBH)
- Angiography Suite
- Point of Care Testing expansion
- ePMA electronic prescribing
- Sample Handling Transfer Tube System (BGH)
- B20 – Enhanced Care
- Critical care expansion – additional 8 enhanced care beds
- Expansion of SAECU
- 2-hour Urgent Care Response SPOA with ICAT
- IHSS - Telemedicine service / CVW model (HSJ Award)
- CAST service in IDS to enhance access to care homes across Pennine Lancs
- Paediatric HDU – 3 new isolation pods
- Simulation Suite (Spring 2022)
- The development of a Hybrid Theatre (due Spring 22)
- EPR Cerner Implementation (due Nov 22)
- Development of a HASU – hyper acute stroke unit (due Summer 22)

In 2020, the Covid pandemic impacted our 5-year plan with some developments delayed into 2022. Despite the difficulties the pandemic has posed, our clinical teams have sought to continue to adapt, develop and manage the challenges posed and continued to strive to improve clinical services during this time.

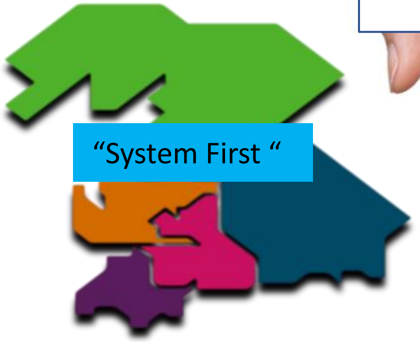
The pandemic has positively impacted on the development of community services and relationships across the system and allowed us to adapt and grow in different ways; but it also brought significant challenges never before experienced and thus resulted in elective care and diagnostic backlogs and further exacerbated health inequalities locally.

In addition to our challenge around elective recovery, we are still experiencing significantly altered and increased presentation for emergency demand on our services, that continue to put pressure on our clinical teams and infrastructure.

As a result, a large part of our new clinical strategy is focused primarily on building back our services (elective, non-elective and diagnostic) post-pandemic, getting the basics right, and building on the foundations that we have built since 2016. Our strategy has a strong focus on how we maintain and adapt what we do now - including what we do well and how we can improve. However, in some areas our clinical ambitions remain as we continue to develop innovative service models and specialist provision within the context of our developing relationships across place and wider system. Our clinical strategy is thus very much reflective of the environment in which we find ourselves in 2022.

Our key challenges remain as a focus of our effort - particularly workforce, but also infrastructure and transforming our ways of working to meet continued new pressures on our services. Our clinical teams remain resilient, ambitious and determined that within the next five years we will drive out the same high standards of care that we have achieved to date.

Key Principles of our Strategy



Our strategy expresses our collective purpose to provide safe, personal and effective care. It summarises our desire to achieve the highest standards in service delivery and improve health for local people - building on our history of proud and caring staff, delivering excellent healthcare and outstanding performance.

Our future is defined as a 'hospital without walls', networking as part of both a placed based partnership in Pennine Lancashire and within the wider Integrated Care System in Lancashire and South Cumbria.

We see ourselves as partners in a local and bigger integrated system of care - agile to the place and needs of our patients and acting as an anchor institution with the ability to influence and improve population health. Our 'offer' to the wider system will be to support integration locally and to support tackling inequalities across the Lancashire and South Cumbria ICS in a network and as a centre of excellence for Healthcare.

Our Clinical Strategy is a cornerstone of our Trust Strategic Framework (Trust Strategy), which along with other key strategies will collectively support delivery of our Vision and Goals.

Strategic Framework

Our Vision

To be widely recognised for providing safe, personal and effective care

Our Values

- We put patients first • We respect the individual • We act with integrity
- We serve the community • We promote positive change

Our Behaviours

- Taking responsibility • Building trust and respect • Working together
- Excellence • Keeping it simple

Our Goals

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

System Working

SPE+ Improvement Practice

Delivery Programmes

Supporting Strategies

Clinical Stategy
Quality Strategy
People Plan
Green Plan
Enabling strategies (Estates/Digital/Finance/Education, Research and Innovation)

Our Aims

Our aim over the next five years is to build on our strengths and manage our challenges and thus ensure that the fundamentals of care are right for our patients.

- **Ensure a 1st class emergency service**, so that patients are well cared for **in a fully integrated seamless way** through primary, community and social care, making clinical intervention meaningful, holistic and where possible within co-produced pathways.
- **Within elective care we will 'build back better' after covid**, so that patients receive their elective treatment in a timely, clinically optimal way, clearing elective backlogs to pre-pandemic levels, transforming the delivery of outpatient services and being a recognised centre for a range of specialist services.
- **To recognise and build on our clinical strengths** and thus our 'offer' at a local and ICS level, as a partner in health and care, providing services increasingly via networks.
- As a major employer and provider of healthcare, our focus goes beyond helping people to recover from episodes of ill health or injury and seeks **to play a part in addressing the health and wellbeing of our population and to reduce health inequalities.**
- **Be 'digital by default'** and sweat our digital capabilities to help clinicians provide safer, more effective care for patients.
- Have a **strong underpinning clinical workforce** plans that support our ambitions and be a preferred choice of employer for clinical teams across our services.
- **Productivity, efficiency and reduction in variation** are key threads of all of our clinical services.
- **Improvement, Education, Research and Innovation** underpin and support us to be the best that we can be.
- To ensure that **equality and diversity is a key thread throughout** our strategy.

What this means

Our key focus in the first part of our 5-year plan will be to re-establish our strong position pre-pandemic in both elective and non-elective care. From this foundation we will then extend and expand our goals to continue to drive up standards of care across our system.

Our ambitions will require strong workforce plans that underpin our goals and a change in focus from in-hospital service delivery to care in a 'hospital without walls'. Clinical teams will become more agile and flexible in the way that they work so are more responsive to 'place' and to patient, rather than patients following traditional pathways through primary to secondary care.

Within elective care, we will continue to develop our elective capacity, further developing our 'green' elective site, our centre of excellence for robotic surgery as well as expanding key areas of specialist skill – to the benefit of our local population and that of wider Lancashire and South Cumbria. We aim to fundamentally review the delivery of outpatient care, developing service delivery which is fit for the 21st Century. Similarly in non-elective care we will continue to develop our community offer in partnership with primary care networks including virtual wards and personalised case management alongside expansion of 'front door' provision/Same Day Emergency Care ensuring a home first approach wherever possible. Our acute in-patient services will ensure high quality specialist care when needed.

Diagnostic services are a fundamental part of our delivery strategy, underpinning our clinical services and development of therapy/diagnostic provision needs to continue alongside changes in clinical specialities. Our key priorities over the next 5 years are to build our diagnostic provision to match our ambitious clinical developments, in particular community diagnostic hub provision at Burnley General Teaching Hospital.

Making every contact count will be a key theme going forward, whether this is how we interact as partners at place and in the wider Integrated care system, or as contacts with our patients, relatives and carers.

As the largest employer locally and completing thousands of patient contacts every year, we are in a prime position to truly influence health equity, prevention work and ultimately population health.

Key 5-Year Priorities : Summary

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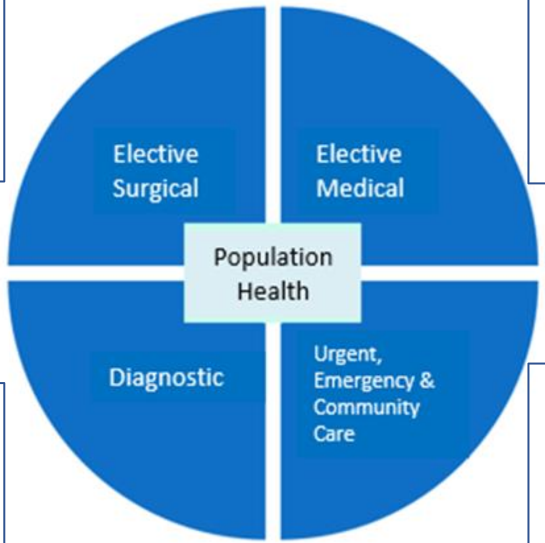
Our key priorities are identified through the quadrants of our healthcare provision, as elective medical and surgical care, diagnostics and urgent, emergency and community care. Central to all our work is our focus on wider population health.

- Elective Care Recovery post pandemic
- Build back better – Improvement in quality, productivity of care
- Development in some specialist areas – Robotic Surgery, Hybrid Theatre/Vascular Arterial Surgery, Head &Neck Cancer, Paediatric Surgery, Hepatobiliary (HPB) surgery

- Elective Care Recovery and clearance of backlogs
- Build on strengths and improve care in key specialist areas – Development of Heart Care Centre, Hepatology services, TB/Neurology services, Therapy /ACP support, Haematology/Chemotherapy Unit, Paediatric Oncology and young people’s mental health/SEND services



- Build diagnostic capacity / capability to support elective and emergency care
- Increase capacity for radiology (BGH site development), aseptic services, ERCP and specialist endoscopy and cardio-respiratory diagnostics (diagnostic hub model)

- Ensure a 1st class emergency service when our patients are at their most vulnerable
- Whole system improvement transferring care from in-hospital to more agile models of emergency care
- Improvements in acute stroke, medicine for older people / frailty, surgical assessment, same day emergency care, maternity and paediatric care and our level 3 NICU.

Population Health

- As an ‘anchor institution’ within the wider system, support health equity and access, whole system pathways including prevention and earlier support and care before patients access emergency services
- Integrated pathways with GPs, community and social care services

Key 5-year clinical services priorities

Elective Surgical

- Elective care recovery post pandemic and BGH elective site development
- Centre of excellence for robotic surgery
- Vascular arterial surgery/hybrid theatre – partner in Vascular Network
- Regional Head and Neck Cancer Centre
- Paediatric Surgery Centre
- HPB/general surgery expansion

Elective Medical

- Heart care centre/expansion of cardiology provision
- Gastroenterology hepatology service
- Explore opportunities for regional TB/neurology
- Cross-Division Therapy Team and ACP expansion – 7-day services/levelling up across Pennine Lancashire
- Mental health in schools
- Development of SEND
- Enhanced POSCU (paediatric oncology)
- Outpatient maternity ante-natal consultations
- Haematology/Chemotherapy Unit

Population Health

Diagnostics

- Phase 9 BGH radiology
- Aseptic Unit
- ERCP/specialist endoscopy
- Diagnostic hub for both endoscopy and cardio-respiratory
- Outpatient transformation

Urgent Emergency and Community Care

- Ensuring 1st class emergency services *(front door development – 111/bed base and workforce review/Pathways focus)*
- Acute Stroke Centre and stroke recovery (HASU)
- MFOP strategy, frailty pathway
- SAECU expansion
- Develop and improve ELHT's trauma services, working within the LSC Major Trauma network
- Expansion of out of hospital/agile care model (virtual wards/Hosp@Home)
- Urgent 2-hour response – single provider across our patch
- Ageing Well programme
- 24/7 collaborative care navigation hub
- Level 2 paediatric critical care
- Level 3 Neonatal Intensive Care Unit Improvement
- SDEC development – all specialties
- Maternity transformation programme
- Ockenden response actions
- Paediatric emergency flow development
- Emergency gynaecology and EPAU service development
- Maximising advantages of ACP/PA/ANP roles in PWE practices

Population Health

- Integrated pathways with GPs, community and social care services and a key role in prevention
- Driving health equity and access
- Personal case management/anticipatory care model

Safe Personal Effective

Population Health

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As an anchor institution, we will support the health of people living in our local area and the wider Lancashire and South Cumbria catchment. We will improve population health across the whole system of health and social care by working in partnership with other providers and services, working from early years through to older people's care to end of life care, and also expand our role as a partner in the wider pathway beyond our traditional hospital boundaries. This encompasses providing high quality healthcare but also working in a collaborative way with other services so that we can:

- support prevention of ill health and injury
- drive health equity and access
- provide whole system integrated pathways for patients, with no boundaries or duplication
- support personal case management, an anticipatory care model and a collaborative approach within the system to provide high quality, safe, personal and effective care.

To continue to advance services through Place based integrated care

- Continue with our commitment to all the work ongoing across Pennine Lancashire on whole system services, working with our partners in primary, community, social and voluntary care
- Primary Care Services provision via PWE development – GP services through to community to hospital care – whole system pathway redesign
- Community diagnostics – improvement of community diagnostic provision with a specific focus at BGTH
- Home first default - Discharge pathways further embedded and built upon so that the requirement to stay in a hospital bed is minimised to the clinically appropriate time and patients are supported to return to their usual home wherever possible
- Intermediate care and Community Hospital site development – further development and planning to improve the intermediate care tier of our emergency response with a focus on 'step-up' and admission avoidance
- 'Place' based planning and community service development – so that patients are seen at place, local to their home and community
- Partnership working fully embedded across primary care, mental health, care sector, LAs

Develop the 'NHS@Home' model

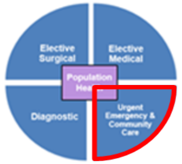
- A single point of access for patients so there is no wrong door to our service
- Providing a consistent Pennine offer to all our patients
- Develop an integrated collaborative care community hub
- Integrated IHSS Service
- Enhanced support to Care Homes (telehealth, joint working)

Healthy Start / Ageing Well

- Integrated Neighbourhood teams and a Population Health Management approach
- Support and empowerment for self-management
- Case management / Anticipatory care model approach - Anticipatory care helps people to live well and independently for longer through proactive care for those at high risk of unwarranted health outcomes
- Family health care – to improve holistic care management that supports families with all needs in a 'wrap around' model of care
- The Ageing Well programme focuses on key elements of supporting older people
- Development of interface medicine and interface joint workforce roles

To drive health equity in care and access to our services

- Delivery of the White Paper and L&SC Health Equity Commission outputs
- Be an active 'Marmot Trust' and aim to improve health equity in line with plans initially started by the Marmot review
- To develop our role as an anchor institution, supporting the wider population health of our community by working in partnership with other agencies to improve health from early years right through to ageing well
- Our Calico/Burnley development will support a collaborative care hub and our ability to respond to local health needs



Urgent Emergency and Community Care

Demand for emergency care continues to rise at a faster rate than resources allow and puts pressure on all parts of our health and social care system. In **striving for excellence in emergency healthcare**, we will continue to improve and transform all parts of our emergency offer to patients, both within our hospital-based services but as a partner and provider in the wider community response to patients in need of emergency care.

Our goal is simple - that patients receive high quality care at a time when they feel most vulnerable and in need of our help. 'Getting the basics right' may not be considered transformational or ambitious as a strategy – but this is fundamental to everything we value and everything we do, and is crucial to every patient that accesses our service in need of our help.

The emergency care system is complex and multi-faceted and thus our plans must also be multi-layered and tackle all parts of the process and pathway.

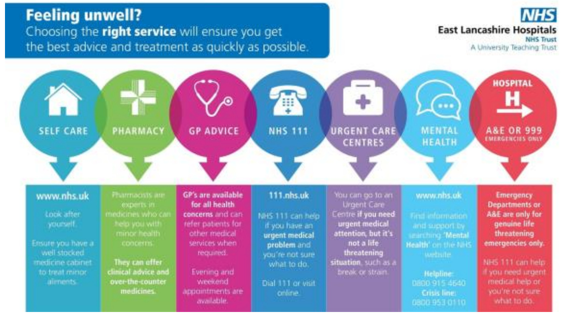
One of our fundamental aims is to continue to **develop our Hospital@home model**, including **anticipatory/preventative care**, an agile care model and being **a sole and single provider for the 2-hour community response service**. We will strive to achieve all aspects of the **Ageing Well Programme** and work closely with our partners to ensure that patients experience an integrated high-quality service consistently throughout the system – no matter where they enter or leave the pathway.

As a provider of **GP services through our PWE development**, we will continue to expand and develop all opportunities to provide patients with end-to-end seamless care. Joint workforce models, shared pathways, and joined up service provision will lead to streamlined, efficient care where patients feel that all parts of the service fit together for them.

Our in-hospital plans focus on hospital flow of emergency patients, starting **with a review of our bed base and detailed bed modelling/flow analysis.** This will feed into our planning so that we take full advantage of **new developments in virtual care**, as well as ensuring our bed base/workforce matches new/changing needs post pandemic.

We will support this work by further improvements in how patients access and use healthcare with **expansion of same day emergency care (SDEC) models**, as well as **development of the SAECU** for surgical emergencies and improvements to **paediatric, gynaecology and maternity emergency services. We will improve our level 3 Neonatal Intensive Care Unit.**

We will expand our acute stroke care by developing **an integrated Acute Stroke Centre and Recovery Unit and work with partners to support a single stroke rehabilitation 'offer' across residents in Lancashire and South Cumbria. We will develop Frailty and Medicine for Older People Services**. We will continue to build and expand our **paediatric critical care function** to ensure safe and effective care for children with critical illness and injury.



Elective Medical Care

Within elective medical care, we will continue to build on strengths and develop in some areas/gaps in provision. Specifically:

The development of a Heart Care Centre incorporates a combined unit for cardiology services including our current Coronary Care Unit, cardiology ward and Ambulatory Assessment Area. We will also provide a new electrophysiology list in partnership with colleagues at Blackpool, with one of their consultants completing a visiting list locally within our ELHT Cardiac Catheter Laboratory. This will support safe, personal and effective care, by improving patient experience and health outcomes by combined pathways into more streamlined efficient services. Productivity will be improved as well as ambulatory care services.

Improving Hepatology services within the clinical specialty of gastroenterology will ensure that patients have local access to services in a timely way. A growth in workforce will support management of waiting lists and allow us to further embed our multi-disciplinary approach to care.

We will work within the ICS and with other providers/our Tertiary colleagues to **support TB and neurology services** within the area. As a partner in the wider network, we can offer increased capacity and specialist care for local patients as a joint collaboration with partners within the system.

Therapy and ACP team development – levelling up to 24/7 care. As services have grown in recent years, it is important that underpinning therapies and advanced care practitioners (ACP) match the pace of growth – to offer alternative workforce to specialities with recruitment challenges, and also ensure that patients are cared for holistically by a multi-disciplinary team. Gaps in therapy support can impact significantly on patient outcomes and are thus are a crucial part of our clinical strategy.

The demand for mental health services for children and young people continues to grow, and has become an acute challenge for systems nationally in the wake of the Covid pandemic. Through our ELCAS service, we will work with partners to **ensure that in-reach into schools for specialist mental health support** and fast tracking into specialist care so that young people and their families/carers have a robust and integrated system of support.

We will work with partners in health, social care and education **to improve provision for young people with special education needs and disability (SEND).** Our key priorities are to improve transition into adulthood, reduce health inequalities and improve targeted treatment management.

We will make a small **expansion to our paediatric oncology shared care unit (POSCU) service** so that children and young people can have their chemotherapy within East Lancashire, rather than travelling to Tertiary centres at Manchester or Alder Hey. Enabling young people to have treatment locally will have a significant impact on patient experience allowing children to stay in school/at home on treatment days– rather than spending lots of time and cost travelling.

Improvements to our Haematology/Chemotherapy Unit is a crucial priority in the next five years as the current unit has outgrown its estate. The limits on this unit impact all clinical specialty functioning and creates a bottleneck in both elective and emergency care. A new and expanded unit would be co-located to achieve maximum impact on productivity and patient experience and would ensure that growth in demand could be matched by capacity.

We **will improve outpatient maternity care** by reviewing and improving consultations, so that our service is aligned with the national requirements of CNST, Ockenden and the Personalised Care Long Term Plan.

Elective Surgical Care

Our elective surgical plans build upon the foundations of our first clinical strategy and our key strengths within specialist elective surgery.

First and foremost, we will clear elective care backlogs resulting from the covid pandemic, with an ambition to achieve recovery targets well ahead of nationally mandated timelines. We will firmly embed GIRFT methods (*Getting it right first time*) within elective care to achieve this goal and also focus on outpatient care improvement and productivity. This will allow us to enact our second phase of our strategy– to 'build back better' post covid and further develop and expand our key specialist services:

- Build **a centre for excellence for robotic surgery**, to improve clinical outcomes for our patients and those within the wider ICS catchment as required.

- We will **create our Hybrid theatre** as part of the ICS Vascular network plans, working as a clear partner across Lancashire and South Cumbria. We will also offer partners increased vascular arterial surgery capacity as part of this development.

- We will **continue to expand our Head and Neck Cancer service**, in line with the wider ICS network plans. We have the capacity and capability to become a regional centre for Head and Neck Cancer and make this offer clearly to our partners in the ICS.

- We will continue to **expand paediatric surgery** provision locally in collaboration with our Tertiary Centres, including in orthopaedic, general surgery and urology specialities. We will work as partners with Tertiary Centres and other providers within the ICS so that a wider population catchment can benefit from local specialist expertise.

- We will **develop our General Surgery workforce, thus creating an increased offer for HPB** (hepato-biliary surgery) for our patients.

- **Outpatient Improvement and Transformation** are fundamental to our plans across all specialities. With pandemic recovery alongside increasing demand for elective, diagnostic and cancer care we must transform and change how we provide outpatient care in the future to enable us to meet these challenges. A whole system/whole pathway redesign is planned, to support clinicians to provide the highest quality in more productive and efficient ways.

Our Surgical Robot at work

Diagnostics

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Our diagnostic services are the underpinning infrastructure to a productive and safe elective, community and emergency service and are thus fundamental to providing continued high quality services and ‘getting the fundamentals of care right’.

To this end, our strategy for diagnostics is ambitious and focused.

Our key priority is to **update/expand our Radiology Unit at the Burnley Teaching Hospital site.** This is our main elective/diagnostic hub, situated away from the main emergency services at Blackburn and thus ‘protected’ as an elective centre. Whilst significant improvements have been made to clinical services on the Burnley site in recent years, our radiology unit falls short of the high quality estate we aspire to.

The **development of our Aseptic Unit** is also critical to our ongoing clinical strategy, as a key supporting function to all clinical specialities. The demand for aseptic services has far outstripped the capacity available and this key development will ensure management of elective waiting lists, better clinical outcomes and improved patient experience. Aseptic provision is particularly crucial to all cancer care within the Trust.

We are committed to collaboration across the Integrated Care System and will **continue to work with partners to develop a service model for Pathology, including opportunities for sub-specialisation of specialist service in hub models/networks.**

We will also **expand our ERCP / Endoscopy provision** within the Trust. There are significant backlogs as a result of the covid pandemic, but demand for endoscopy continues to rise exponentially and current capacity cannot keep pace with the requirement for endoscopy care to support chronic illness as well as cancer diagnosis. We will **develop a diagnostic hub** for endoscopy and cardio-respiratory testing therefore streamlining care.

How our Strategy fits into wider ELHT planning

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ELHT's Strategic Framework

How
we deliver
our plans

What
we plan to do

Our Strategic Framework summarises our overall Trust Strategy and structure of delivering all that we aspire to achieve. Our clinical strategy is just one arm of our ELHT framework. It aligns with all supporting strategies; which are delivered through our system working which are in turn firmly rooted in our goals, behaviours, values and ultimate vision to provide safe, personal and effective care.

Our supporting strategies define the 'what' of our plans, and our system working- including a strong focus on our SPE+ improvement practice and performance monitoring and delivery is the 'how'.

There are key interdependencies and enablers that underpin our strategy – our existing and future estate, our workforce plans, how our digital infrastructure will support us and how we will fund our schemes.

Our clinical strategy is therefore closely aligned to other key strategies in the Trust – it is one of several plans that all dovetail together to help us achieve our aims.

Through the development of the clinical strategy we have engaged with staff across all our clinical services as well as colleagues in finance, estates, workforce, education, quality governance and information/IT. There is close alignment and triangulation between all plans to ensure we can deliver our ambitions.

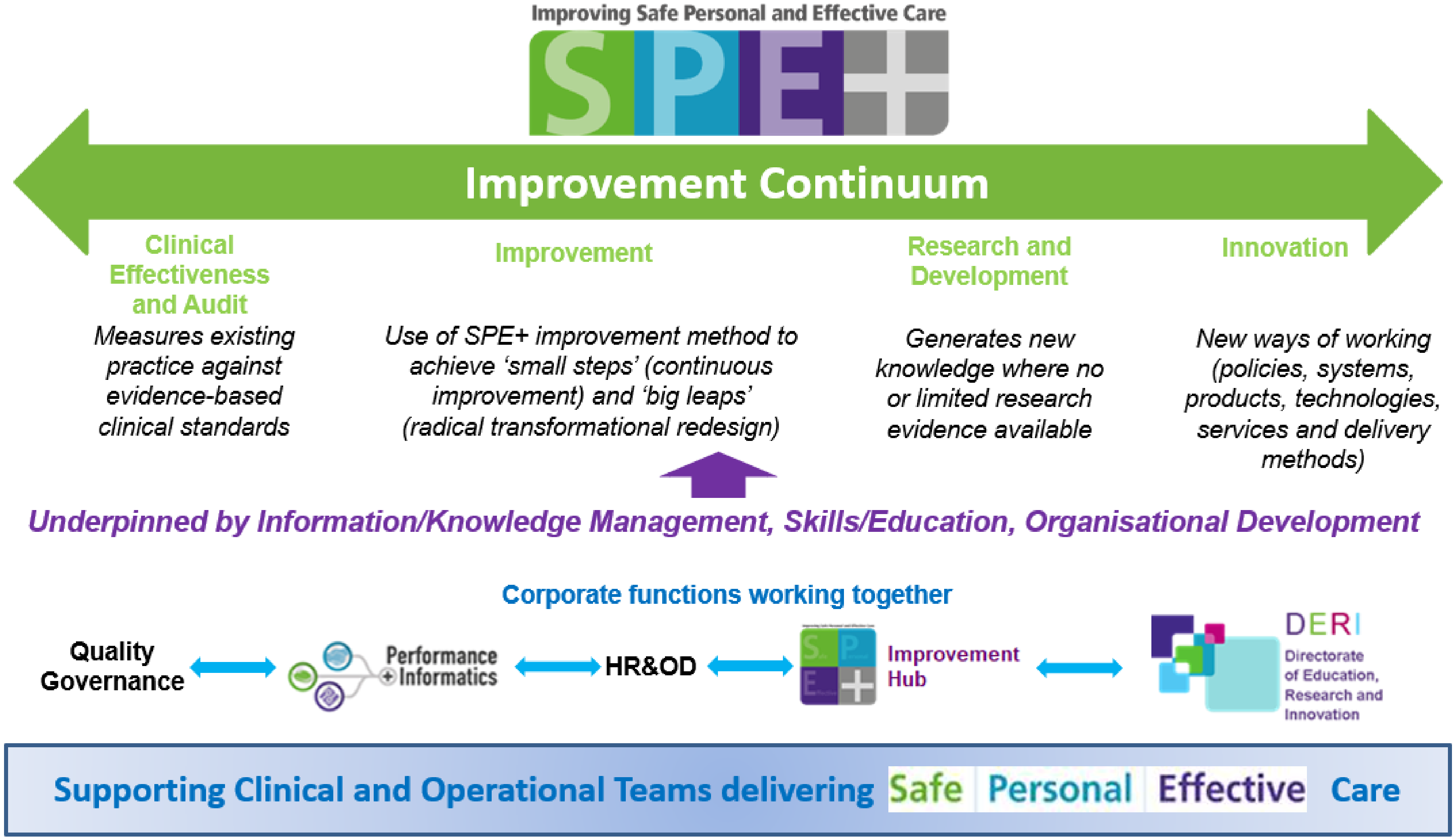
Our plans are phased into years over the next five years, and these are aligned with our business planning in the Trust – which feeds into wider system planning processes.

Delivery of our Clinical Strategy will be driven through our existing business structure within Clinical Divisions and monitored through our Divisional Boards. Cross-organisational Key Delivery Programmes, which dovetail to place-based and wider system programmes, will ensure a co-ordinated approach where required. Our strategy will be regularly reviewed and annually refreshed at our Senior Leadership Group as well as key Delivery and Transformation Boards and annually at Trust Board.

We recognise that we work within a quickly changing landscape as NHS structures change and clinical demand and our ability to respond continually evolves. The Clinical Strategy will thus be updated regularly, with our partners, within the next five years so that we can be ever responsive to the demands placed upon us and thus provide safe, personal and effective care.

ELHT Improvement Continuum

East Lancashire Hospitals NHS Trust
A University Teaching Trust



Improving Safe, Personal and Effective Care underpins all we do and developing a culture of learning and improvement is at the core of how we will ensure we can deliver the best outcomes for our patients.

Our Improvement Continuum describes our overall approach, ensuring we have the right combination of methods and approaches, supported by skills and organisational development to continuously improve and innovate.

Our Quality Strategy, SPE+ Improvement Practice Development Plan and Education, Research and Innovation Strategy and Plans will support delivery of our ambitions.

How our Strategy fits into the wider system: *ICS Clinical Strategy Alignment*

ICS 10-year Clinical Strategy / ICB/PCB Priorities	Alignment to ELHT 5-year Clinical Strategy
Integrated Care Board Overarching Vision / Goals: • Improve outcomes in population health and healthcare • Tackle inequalities in outcomes, experience and access • Enhance productivity and value for money • Help the NHS support broader social and economic development	• Our Clinical strategy has population at the heart of our aims, with a clear ambition to support the wider ICS achieve outcomes in population health, driving health equity and supporting people in the wider social and economic landscape that they live within. • A key thread of our delivery is to ensure productivity and value for money, working with partners to maximise our collective offer to patients.
10-year Clinical Strategy *Improving the health and wellbeing of local communities ▪ Delivering better, joined-up care, closer to home ▪ Delivering safe and sustainable, high -quality services* Short term goals – to restore and recover from the pandemic Medium to Long term goals – • Health and Wellbeing of Communities: Prevention/Health Education, population health management, anticipatory care • Living Well: support people to have the best possible start in life. We want to ensure that people are healthy and independent for as long as possible, and we want people to have happy, productive and fulfilling lives. • Managing illness through collaborative networked clinical services • Urgent and Emergency Care – Consistent offer of care, streaming and triage – right place first time, digital technology to enhance care • End of Life Care, Frailty and Dementia – supporting people as they enter the final period of their life • Workforce - develop systems and services that maintain a healthy and happy productive workforce, that makes L&SC a number one place to work for clinicians and other staff.	• The key short-term goal in the ICS Clinical Strategy is to fully recover from the pandemic. This aligns to our 1-to-2-year plans within our Strategy which focus primarily on elective care recovery, diagnostic improvement and improvements to emergency services to manage demand for emergency care • The medium to long term goals are all included within our local Clinical Strategy and we have made clear how we 'fit' into the wider system and what our offer and support of the wider system will be. • None of our local strategy contradicts the overarching aims of the ICS Clinical Strategy and as partners within that system we will ensure that delivery of our plans remain aligned to the wider system view. • Our strategy includes all aspects of the health and wellbeing of communities and the living well aims in the ICS strategy. • We have committed to working as part of collaborative networked clinical services in the future. • All aims for Urgent and Emergency Care are included in our priorities locally. • Our workforce plans continue to support the overarching aim to support a healthy, happy and productive workforce.

Alignment to L&SC PCB Clinical Strategy

East Lancashire Hospitals NHS Trust
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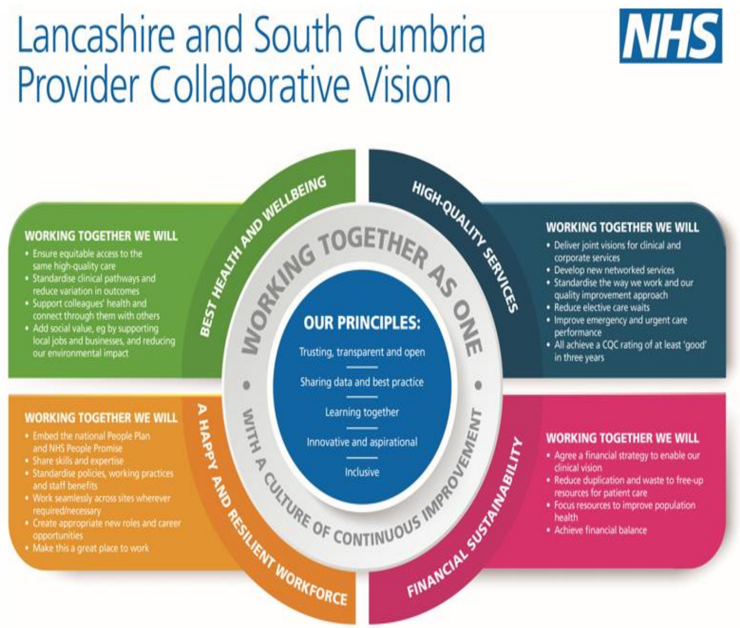
Our Clinical Strategy is aligned to the L&SC PCB Clinical Strategy, with clear links between clinical vision and priorities of the PCB work programme and our strategy.
We will continue to work within the wider PCB framework as plans develop.



Priority Services of PCB Clinical Business Plan /Work programme:	ELHT Clinical Strategy:
System Wide Opportunities / Priority Services – Cardiovascular /Cardiac Services / T&O / MSK/ Respiratory/ Frailty	Our Clinical Strategy notes our 'offer' to the system of local provision and our commitment to work within networks and the wider system. Specifically, our MFOP strategy supports Frailty pathway redesign, our development in cardiovascular diagnostics will support local provision and the wider network. Our expanded HASU and Cardiac Unit supports wider networked services. We have committed to supporting all priority areas of the PCB business plan.
Priority Services-Surgical Specialities – ENT/ General Surgery/Urology	Our Strategy notes our intention to expand general surgery/HPB provision locally. Our UIU will support Urology provision.
Transformation Programmes : Stroke / Vascular/ IR/ Ophthalmology/ Clinical Haematology/ Head & Neck / Robotic Surgery	As part of networked provision, we have identified our ability to provide an acute stroke and recovery unit (formally HASU), vascular arterial surgery through our Hybrid Theatre which is part of the Vascular Network plan. We aspire to become a Head and Neck Centre and a Centre of excellence for Robotic surgery.
Mental Health Integration	We have worked productively with our local Mental Health Trust in support of managing patients in crisis within our ED. Our children's mental health plans are part of the wider Children's & Young People's L&SC plans.
Development of Elective Hubs	Our Burnley elective and diagnostic hub is now well developed and we will continue with diagnostic expansion to support elective care recovery and separate elective from emergency flow.
Elective Care Recovery	This is a key priority of our Clinical Strategy, with clear plans to meet planning priorities guidance.
Urgent & Emergency Care Improvement	Our strategy is aligned to key PCB/Place based plans including SDEC, virtual ward development, anticipatory care, and collaborative models for out of hospital care. Our plans for Ageing Well programme are well defined in support of PCB /ICB aims.
Diagnostics Programme	We have identified key developments to improve diagnostics within Pennine Lancashire – specifically our Radiology unit at BGH, aseptic provision, specialist endoscopy/ERCP, cardio-respiratory diagnostic hub. These developments will provide key diagnostic capability within the ICS going forward.
Critical Care Improvement	We have identified our capability and aspiration to provide L2 Paediatric HDU, as part of the wider paediatric critical care network.
Health Inequalities	Population health and health equity and access is a key component to our strategy. Our strategy is supported with detailed delivery plans to support tackling health inequalities locally and supporting the PCB in addressing wider system disparities.

How our Strategy fits into the wider system: *Place Based Partnership Alignment*

Healthier Pennine Lancashire Partnership	Alignment in ELHT 5-year Clinical Strategy
The vision of the partnership is **Better health and wellbeing** People will: • have longer, healthier lives; • be more active in managing their own health and wellbeing, maintaining their independence for longer; • be supported to keep well both physically and mentally, with mental health and physical health being equally important; • be central to decision making **Better care for all** People will have: • consistent, high quality services across Pennine Lancashire • joined up services and support which are easier to navigate and access; • services and support responsive to local need; • equal access to the most effective support, with reduced waiting times. This vision will be achieved through - Integrated services - Population Health management - moving towards a preventative, proactive and holistic approach to the health and wellbeing of our residents - Improving the quality of services - Maximising the use of collective resources - Valuing and developing the workforce	• As an anchor institution with a focus on population health we will support the wider partnership in delivering their overarching goals to achieve better health and wellbeing and better care for all. • With a focus on integration of services and pathways, looking 'end to end' and how we can support that process – both in providing high quality healthcare and in how we can work with partners to develop seamless services – we will support the overall vision of the Partnership but also support the key objectives of integrated services, maximising quality of care and maximising the use of collective resources. • Our work to date has already supplemented the Partnership working, with development of shared workforce roles, shared pathways, virtual wards, 2 hour response, and supporting healthy starts and Ageing Well initiatives. We will continue to further embed such developments that have fallen out of a robust relationship with all agencies through the partnership. • Specific examples of alignment of our strategy to the Partnership include the development and further expansion of interface medicine, co-produced emergency pathways and improvements to emergency care in paediatrics, adult medical and surgical care. Developing a single point of access for intermediate services and a 'no wrong door' approach. Developing an integrated collaborative care community hub, integrated IHSS Service and enhanced support in Care Homes (telehealth, joint working).

Engagement and Consultation

This strategy has been developed in an open and inclusive way, by clinical teams across all the Divisions within the Trust, as well as all our enabling support services. It has also been reviewed and further developed by our Executive and Trust Board members.

Engagement has taken place through key meetings (including Senior Leadership Group, Trust Board, Divisional Management Boards and Transformation Boards), workshops and Directorate team meetings and via other communication methods - so that all our staff have had the opportunity to feed into our vision and plans for the next five years.

The strategy has also been shared and reviewed at key delivery boards with partners and our public and patient participation panel, to ‘check and challenge’ ourselves that our strategy delivers real improvement for our patients and that our offer and our ‘part’ of the joint Pennine partnership strategy is agreed.

Our plans are aligned to those of the wider Lancashire and South Cumbria Integrated Care System, as well as local plans within our local Place based partnerships within Pennine Lancashire. We recognise however that as structures at Place and system level change, so must our response. This document is therefore a ‘live’ document that we will continually adapt as our partners across the system update their plans, so that we remain aligned and integrated in our planning and delivery of clinical services going forward. Our aspiration is that at an appropriate time our aligned strategies become one strategy across Place and system level.

As we move to implementation we will build on our existing programmes of work through joint delivery groups to create plans that fully support the ambitions of this strategy. We will reach out colleagues and partners across the whole system as we develop our delivery plans. We will continue to improve and adapt, and thus continually ***improve safe, personal and effective care together.***

Glossary of Terms

East Lancashire Hospitals
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ACP -Advanced Clinical Practitioner
AMU - Acute Medical Unit
CAST – Care Home Allocation Service Team
CT - computerized tomography scan
CCU – Coronary Care Unit
CNST – Clinical Negligence Scheme for Trusts
CVW – Covid Virtual Ward
ED - Emergency Department
EPR – Electronic Patient Record
ERCP - Endoscopic Retrograde Cholangio-Pancreatography
ELCAS - East Lancashire Child & Adolescent Service (Child mental health)
EPMA – electronic Prescribing & Medicines Administration
HDU – High Dependency Unit
ICAT – Intermediate Care Allocation Team
ICS – Integrated Care System
IHSS – Intensive Home Support Service
LA – Local Authority
L&SC – Lancashire & South Cumbria (the current integrated care system footprint
MRI - Magnetic resonance imaging (MRI) detailed scan of the organs and tissues in your body.
PLACE /Place-based partnerships are collaborative arrangements that have been formed across the country by the organisations responsible for arranging and delivering health and care services in a locality or community.
SAECU – Surgical Ambulatory and Emergency Care Unit
SDEC – same day emergency care
SEND – Special educational needs and disability
SPOA – Single point of Access to a service

APPENDIX 2 Development of the Clinical Strategy

PHASE 1 – Development

- Clinical Strategy 2015 – 2021
- October 2019 – 10 Big Ticket Items to complete the strategy
- Draft Clinical Strategy 2021 - 2025
- Review at Jan 21 at Trust Board
- Achievement of Year 1 Developments
- Strategic Framework Review/ Goal Setting/ Strategy Review and Updated (Oct/Nov/Dec 2021)
- Jan/Feb/March Trust Board Strategy Sessions
- February 22 – 'Kick off session' with clinical specialities
- Feb /March 22 Series of local clinical meetings to build up the strategy - held in all Divisions and at key transformational /cross service Boards
- Feb/March Lots of discussion/meetings between clinical specialities as well as local Directorate speciality sessions to define 5 year plans
- 23 March 22 Cross Divisional Session to share ideas, correlate and combine plans
- 29th March 22 Sharing of Clinical Strategy Templates across teams/ Execs/SLG members
- 5th April 22 Divisional Feedback Session *Check & Challenge*
- Trust Board Strategy Session Clinical Strategy 2022 - 2027

PHASE 2 – Drafting the Strategy

- Clinical Strategy 1st Draft
- Document shared with CEO/Chairman/ Execs/key leads for feedback and changes
- Clinical Strategy 2nd Draft
- Document shared with
  - Divisional triumvirates – Divisional Directors of Nursing, Medical Directors/Director of Operations
  - Support Enabling services
  - Communications Team
  - Other key service leads
- Clinical Strategy 3rd Draft
- Supporting Presentations – one internal / one external developed at approved at executive level to share with teams

PHASE 3 – Feedback /Engagement

- Stakeholder Analysis completed at Trust Board Strategy Session – identification of all key stakeholders
- Development of Engagement & Communication Plan
- Implement Engagement Plan
- Share draft with all teams and staff through key existing Board / Departmental Meetings
- Share with all external partners at PLACE and Integrated Care System level
- Share plans with patient and public reps, unions, key leads
- Support presentations with podcasts, team brief summaries, spotlight on CEO blog, drop-in sessions, Directorate/Divisional planning sessions / website
- Raise awareness / seek feedback and comments
- Strategy updated following feedback

Appendix 3

Clinical Strategy : Engagement and Consultation Plan

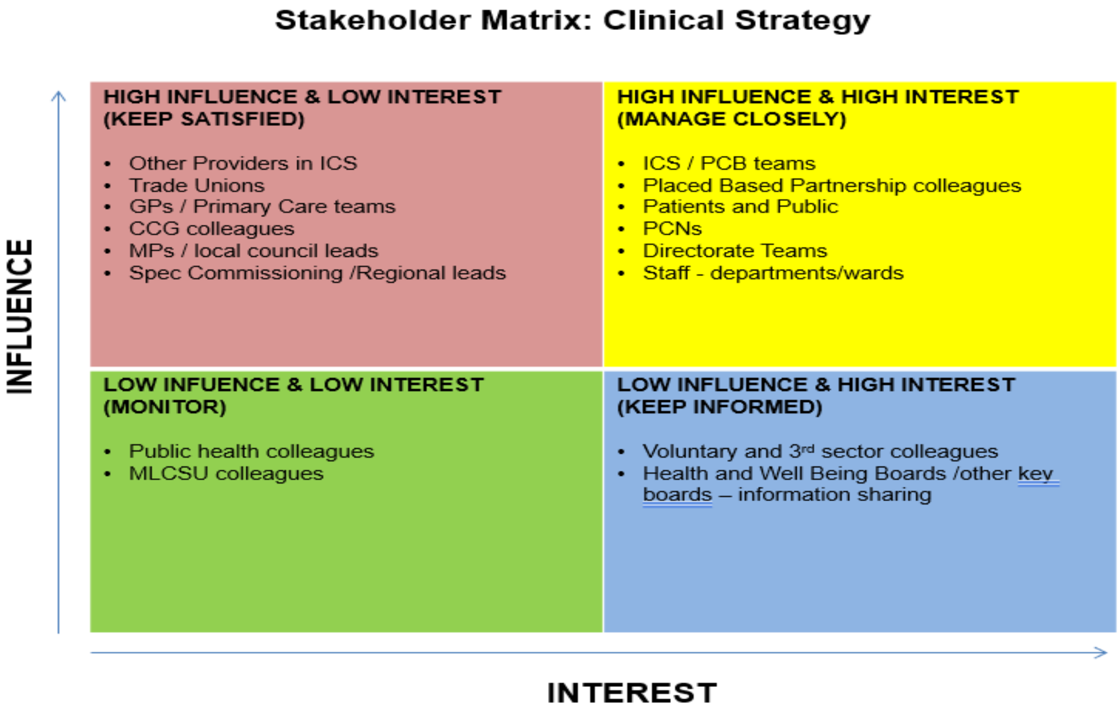
Aims of the Plan

1. The Clinical Strategy has been developed by the Clinical Divisions of the Trust and with support of the Trust Board team - a first draft for engagement and further development has been produced.
2. Engagement will take place in May and June, with a final draft to be finalised and presented at Trust Board early in July 2022.
3. The aims of the engagement plan are
    - To raise awareness and sharing of the Clinical Strategy and to develop shared understanding of our five-year plans within the Trust– to enable clear consistent messages across the Trust / one 'True North' to build plans upon
    - To raise awareness and support of our clinical 'offer' within the wider system, by sharing our plans with key partners and external stakeholders
    - To engage with stakeholders and consult – this is more than information sharing – it's an iterative process of seeking feedback & revising the Strategy
    - What we are *not doing* as part of engagement – Making significant changes/whole re-writes to strategy (*if so, this needs full sign off again*)
    - Endpoint is to achieve a 'signed off by all' Clinical Strategy…. with agreed and recognised plans for the next five years.

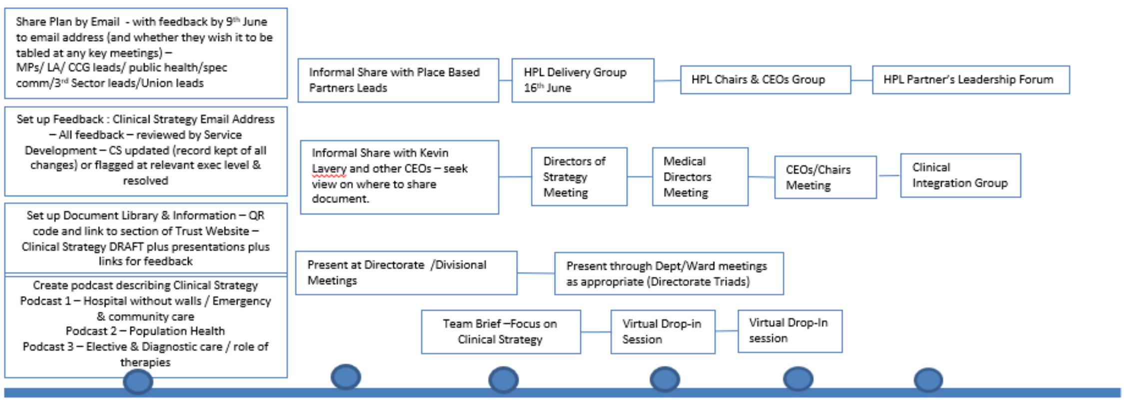
Key Considerations

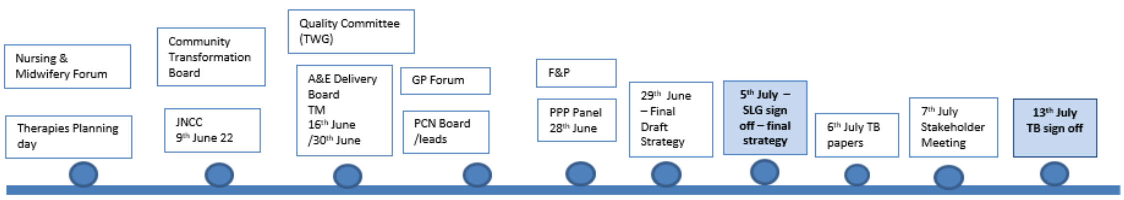
4. We have separated out engagement into those that we 'inform' / 'involve' / 'consult' – our plan covers our staff internally and a range of external stakeholders (ICS/ICP/Providers/Patients & Public etc.)
5. We are keen to consult and widely engage all our staff - actively engage and seek input into the strategy (Floor to Board)
6. We will have a standard internal presentation and a standard external presentation for leads to use – to ensure consistent messages and ensure that the strategy lands at all key groups/meetings.
7. A DRAFT clinical strategy to tweak/change to share with people as a start to the process.
8. Alongside the presentation there will be a focus / tailoring of approach depending on audience – as different groups of stakeholders/staff may be interested in specific aspects of the strategy.

Stakeholder Matrix



Engagement Plan Timeline /Summary of Detailed Plan





Key Communications:

- Share at all key existing Board and departmental meetings including key meetings across Trust.
- Managers to cascade information to local teams through email, meetings, presentations
- Share at all key transformation and improvement meetings – across whole system to involve wider stakeholders
- Share with key leads in ICB/PCB and at PLACE
- Team Brief slot on Clinical Strategy
- CEO Blog on Clinical Strategy
- Podcasts – 3 x – focusing on different aspects of strategy
- Website established and central point for feedback - email address
- Share with unions and at JNCC
- Check & Challenge – with Patient and Public Participation Panel
- Advertise on twitter, Facebook throughout engagement period
- Drop-in virtual sessions to answer queries or discuss the strategy
- Seek feedback through emails to key leads, and through 121 meetings where applicable.

APPENDIX 4

Feedback from Engagement Exercise– Draft Clinical Strategy

Feedback has been largely positive, with no significant challenge or change to the Clinical Strategy content.

Those engaged felt that the Strategy picked up the key priorities and focus of the organisation at the present time, whilst recognising the environment that ELHT will work within in coming years (working in a more clinically integrated and networked way).

A summary of key themes of feedback, and the noted changes to final document/response, are provided:

a) More information in relation to phasing of developments, logistics/impact on enabling and support services, and detailed plans on key improvements.

   **More detailed plans have been included in the year 1 & 2 operational plan to support the strategy.*

b) Our commitment to providing and improving our level 3 Neonatal Intensive Care Unit (NICU) within ELHT should be noted in the strategy.

   **Our commitment to providing a level 3 NICU within ELHT has been added to the strategy document under Urgent & Emergency Care service priorities.*

c) Opportunity at some point in the future to develop one joint community/primary/acute Clinical Strategy at Place, rather than individual provider/agency strategies?

   **Our current strategy is firmly aligned and embedded in the concept of integrated services working in collaboration, and ultimately one Strategy could be the aim of partners. With the current structural changes within the NHS landscape at both Place level and Integrated Care System level, the timing to develop joint Strategy is perhaps premature, but ELHT would support a future joint strategy at Place or at ICS level.*

d) Emergency & Urgent services - our Strategy could perpetuate patient flow to the hospital rather than in different community services by continuing to expand and develop hospital emergency services. This is a difficult one to balance given the demands on ELHT services. There should also be consideration of Urgent Treatment Centres (UTCs) developing at scale and whether these should be primary care led. This is not mentioned and needs addressing as a singular plan.

**Our Strategy notes the joint pathway work to support wider emergency models and pathways than accessing the Emergency Departments/Urgent Care Centres, making specific reference to a focus on 'out of hospital care' throughout the Strategy document. No change has been made on this feedback, but it is noted and recognised.*

***The development of UTCs and a wider system plan has been developed through the A&E Delivery Board and this should be fed into that wider joint work.*

e) Culture change - the strategy certainly references a hospital without 4 walls. The system we have is at breaking point, and if we really are going to have a hospital without 4 walls, and I would say the same for other sectors which also need to work differently, then it needs culture change. We have to quickly recognise that collaboration not competition has to become our modus operandi. I say this on a macro and micro level.

   **This concept is noted in the Clinical Strategy and is a key cornerstone of the Strategy.*

f) Stroke rehabilitation should be a singular offer across Pennine Lancashire - similar to the work we are doing with IHSS. We need to get beyond the current inequities in health and access and put patients and staff first.

   **This is currently being developed across the Stroke Network in Lancashire and South Cumbria – we have added this to the Clinical Strategy under urgent care as "We will expand our acute stroke care by developing an integrated Acute Stroke Centre and Recovery Unit <u>and work with partners to support a single stroke rehabilitation 'offer' across residents in Lancs & South Cumbria."</u>*

g) Request to include Pathology Collaboration as part of the Clinical Strategy.

   Now included in Strategy : "Continue to work with partners to develop a service model for Pathology, including opportunities for sub-specialisation of specialist services in hub models/networks'.

h) Request to include a focus on surgical trauma services under the umbrella of achieving a first class emergency service. Management of surgical emergency care and trauma, is key to achieving this overall aim, and also supports a functioning elective care service as one is interdependent on the other.

Now included in Strategy : This has been included as a key priority in the quadrant table.

Appendix 5:

Clinical Strategy : Delivery & Monitoring

Context

Once ratified, delivery of our key aims and objectives will be broken down into key milestones by year, closely aligned to our enabling strategies and our financial planning. As a cornerstone of our strategic framework the Clinical Strategy is a key part of our annual planning cycle and key milestones must be realistic and pragmatic and fit with our financial planning and workforce changes required.

Our strategy is ambitious but much of the initial work in years 1 and 2 are about re-forming the foundations of clinical care post pandemic and getting the basics back to outstanding levels. Later years focus on key service developments.

The planning cycle for 2022/2023 has been significantly delayed due to the ongoing pandemic in the winter/spring months and overall planning submissions for workforce, finance and activity are still pending final ratification at end of June. Strategy and planning cycles have been 'kick started' in 2022 but are still out of sync with usual business as usual processes. Our delivery plan for the Clinical Strategy will therefore focus on both years 1 and 2 of the strategy and key milestones will be determined post finalisation of finance plans for ELHT/ICB.

Plan for Delivery and Monitoring of the Clinical Strategy

The strategy will be delivered through Clinical Divisions and key projects will be monitored at Divisional Management Boards and the relevant transformation boards.

As the strategy covers many areas of the Trust, as well as linking into all key delivery programmes and enabling strategies, it is proposed that this will be drawn together into a wider 'strategic dashboard' for the Trust that provides assurance on progress against our key strategic aims and plans. This will underpin and support our existing reporting/dashboards around performance within the Trust and links to the Board Assurance Framework.

The strategic dashboard will be reviewed bi-annually at Trust Board, and regularly reviewed through the Senior Leadership Group of the Trust. The Trust Service Development Team will co-ordinate production of the strategic dashboard on behalf of relevant services/leads.

The following framework summarises next actions in the delivery and monitoring of the Clinical Strategy, so that we ensure that key priorities of the Clinical Strategy are identified by year, aligned with our wider strategic framework and Business Assurance Framework and that the Board are assured of regular monitoring and delivery against our key aims.

Priority Setting – July

- Split key improvements into each of 5 years of the plan
- Identify key focus & list of priorities for years 1 & 2

Alignment to Key Strategies/Plans

- Alignment to financial plans
- Alignment to workforce plans
- Alignment to key enabling plans
- Alignment to key strategies
- Updated Y1&2 Plan
- Operational Delivery Plan to support Clinical Strategy

Key Metrics/Outcome Measures

- Identify measurable outcomes for each key priority with the delivery plan for years 1 & 2

Strategic Dashboard – August

- Strategic Dashboard to note key milestones, outcomes and metrics

Delivery – September

- Local project plans for key priorities that sit within the strategic dashboard
- Key leads, milestones and support agreed
- Develop business cases where required for key improvements
- Improvement Practice &workforce planning to enable some improvements

Monitoring

- Regular review of strategic dashboard to provide assurance of delivery against agreed plans for Y1 &2
- Delivery monitored through Clinical Divisions
- Quarterly updates on progress to SLG
- Bi-annual updates on progress to Trust Board

The process for developing the Clinical Strategy is linked to our business planning cycle, and clinical strategy priorities are included in Divisional business plans this year and will be for next year.

As part of our strategy deployment framework this strategy will be an ongoing process of development.

East Lancashire Hospitals
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TRUST BOARD REPORT		**Item**	**93**
13 July 2022		**Purpose**	Information Approval

Title	NHS Improvement Annual Board Self-Certification
Director Sponsor	Mrs A Bosnjak-Szekeres, Director of Corporate Governance/Company Secretary

Summary: NHS providers need to self-certify after the end of the financial year as to whether they have:

1. Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have a regard to the NHS Constitution (condition G6)
2. Complied with governance arrangements (condition FT4) and
3. (for Foundation Trusts only) The required resources available if providing Commissioner requested services (CRS) (condition CoS7).

Although NHS Trusts do not need to hold a provider licence, they are legally subject to the equivalent of certain provider licence conditions and are required to self-certify under these licence conditions.

The attached documents provide the draft self-certification by ELHT for the financial year 2021-22 against the conditions G6 and FT4.

It is recommended that the Trust self-certifies as confirming compliance with both conditions. The narrative setting out the factors for confirming compliance is provided in the attached templates issued by NHS Improvement.

The Board is asked to review the draft self-certification and agree for it to be signed by the Chairman and the Chief Executive before its publication on the Trust website.

Recommendation: The Board is asked to agree the annual self-certification for signing by the Chairman and the Chief Executive before its publication on the Trust website.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice

Impact: Directions from the Secretary of State for Health and Social Care require NHS Improvement to ensure that NHS Trusts comply with conditions equivalent to those in the NHS provider licence. The Trust is required to carry out an annual self-certification against the set criteria and publish it on its website.

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates | **2021-22** | Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed — **OK**

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Please Respond

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Please Respond

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

ELHT is not a Foundation Trust, so we have not responded to question 3a, 3b and 3c as they are not applicable.

The Trust reported a £0.02 million adjusted financial performance surplus for the 2021-22 financial year which was in line with the 2021-22 financial plan.

The Trust continues to work with partners within Lancashire and South Cumbria Integrated Care System (ICS) and has agreed an individual and system breakeven financial plan and elective recovery plan for 2022-23.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Professor Eileen Fairhurst	**Name**	Mr Martin Hodgson
Capacity	Chairman	**Capacity**	Interim Chief Executive/Accountable Officer
Date	13 July 2022	**Date**	13 July 2022

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates 2021-22 Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Embedded Board and Committee structures have been adjusted to release capacity during the COVID-19 pandemic, however this has reversed to the usual meeting schedule during the 2021-22 financial year. Board development programme is ongoing. The Trust was awarded 'good' rating by CQC overall and in the well-led domain following an inspection in September 2018 with some service areas rated 'outstanding'. The Trust has had a recent CQC inspection in April 2022 and received positive informal feedback. The formal report will be published by the CQC in quarter 2.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	As above; the Board Assurance Framework and risk appetite reviewed by the Board; annual review of risks as part of the Annual Governance Statement; regular review of the BAF and Corporate Risk Register by the Audit Committee, Finance and Performance Committee and Quality Committee and the Board. The Annual Head of Internal Audit Opinion was Significant Assurance.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Same as the response under statement 1 and effective operational structures; Divisional accountability framework is under review; Senior Leadership Group acts as a senior operational decision body with delegated authority, annual self-assessment of the effectiveness of the Committees and escalation of matters to the Trust Board as appropriate. With the onset of the Covid-19 pandemic the Corporate Governance structures were reviewed in order to continue receiving assurance whilst at the same time releasing capacity to fight the pandemic. This has reversed to the usual governance structures in the 2021-22 financial year.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Oversight of each of the matters under this statement is overseen by the Trust Board and where appropriate delegated to the relevant risk and assurance Committee. In instances where matters require escalation then the Board has the final oversight and decision making authority on further mitigation and residual risks.	#REF!

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Board composition reviewed as part of the Board development plan and concentrates on good governance and risk management. All Executive (voting Director) positions are held by full time employees of ELHT apart from the Chief Executive and the Director of Service Development and improvement. The substantive CEO recruitment will be carried out during August 2022, and following this, the recruitment for the substantive Director of Service Development and Improvement will commence. The Executive Director of Nursing is leaving the organisation is leaving the Trust on 15 July 2022 and the interim position will be filled in by the Director of Nursing and recruitment to the substantive post will be carried out in September 2022. The vacancies for NED positions are filled in a timely manner working with NHSI; the Quality Committee which is a sub-committee of the Board meets monthly and receives reports from various risk committees in relation to patient care and quality of services and sends summary reports to the Board. The Trust received overall rating of 'Good' by the CQC following an inspection in September 2018 with some services rated 'Outstanding'. The Trust has had a recent CQC inspection in April 2022 and received positive informal feedback. The formal report will be published by the CQC in quarter 2.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	See response for statement 5 in relation to the Board composition; the Board members undertake an annual Fit and Proper Persons Test (FPPT) check and the Director of Corporate Governance/Company Secretary reports to the Remuneration Committee on the outcome of the same. All Board Executive and Non-Executive Director positions are filled on a permanent basis, apart from the interim roles indicated in section 5 (above). There are a number of Associate Non-Executive Directors working with the Board. The HR department is supporting talent management and succession planning at all levels of the organisation.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature **Signature**

Name Professor Eileen Fairhurst **Name** Mr Martin Hodgson

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A The Trust continues to monitor its risks and review the action plans where performance of the national standards requires improvement. OK

TRUST BOARD REPORT

Item 94

13 July 2022

Purpose Information

Title	Ockenden Final Statement
Executive sponsor	Ms C Douglas, Executive Director of Nursing

Summary: The signed Ockenden Final Statement is presented to the Board for information. The statement confirmed that the immediate and essential actions from the first Ockenden Report have been carried out. It also confirms that the 15 actions from the second publication are in the process of being completed.

Recommendation: The Board is asked to note the statement.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No

Equality	No	Confidentiality	No

Previously considered by: NA

Delivering safe and effective Maternity care across Lancashire and South Cumbria

Every day the Lancashire and South Cumbria Local Maternity and Newborn Services work hard to deliver high quality care across our local communities.

We strive to ensure that all women, babies and their families experience safe, kind, compassionate and personalised care, and to make sure they can access support that is centred on their needs and circumstances.

We understand that since its publication on 30th March 2022, the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust (the final Ockenden Report) has rightly put Maternity Services across the country under the spotlight.

Since receiving the first Ockenden report in December 2020, our local providers have been focused on using the Immediate and Essential Actions of the report to improve services where required.

This includes listening to women and families, informed consent, monitoring fetal wellbeing and managing complex pregnancies.

The second publication now provides a further 15 Immediate and Essential Actions and our teams are already working hard to review, understand and implement these actions to help strengthen our services and to ensure that lessons are learned from the findings of the Ockenden report.

We would like to reassure communities across Lancashire and South Cumbria that any changes necessary will see timely implementation, and our teams in co-production with each of the four Maternity Voices Partnerships, will continue to provide the standard of care that our local communities both want and deserve.

Sarah Cullen
Nursing, Midwifery and AHP Director
Lancashire Teaching Hospitals

Christine Pearson
Chief Nurse/Executive Director of Nursing
East Lancashire Hospitals

Bridget Lees
Executive Chief Nurse
University Hospitals of Morecambe Bay

Peter Murphy
Executive Director of Nursing, AHPs and Quality
Blackpool Teaching Hospitals

Anne Goodwin
Chair, MVP Pennine Lancashire

Vanessa Wilson
Programme Director - Women's and Children's Services
SRO for L&SC LMS
L&SC ICS

Tracy Thompson
Head of Midwifery & Divisional Director of Nursing
East Lancashire Hospitals

Mr Martin Maher MRCOG
Consultant Obstetrician (High Risk Obstetrics & Fetal Medicine)
Clinical Director for Obstetrics & Gynaecology
East Lancashire Hospitals

Mike Chew
Divisional Director of Operations
Blackpool Teaching Hospitals

Eric Mutema
Head of Department – Women's Health
Blackpool Teaching Hospitals

Lancashire and South Cumbria Health and Care Partnership | Maternity and Newborn Alliance

NHS

Janet Cotton
Divisional Midwifery and Nursing Director
Lancashire Teaching Hospitals NHS Foundation Trust

Sanjay Sinha
Women's and Children's Clinical Director
University Hospitals of Morecambe Bay

Alison Mayor
Head of Midwifery
University Hospitals of Morecambe Bay

Cathy Atherton
Independent Chair Maternity and Newborn Alliance Board (MNAB)

TRUST BOARD REPORT

Item	**95**

13 July 2022

Purpose Discussion
Approval

Title	Ratification of Board Sub-Committee Terms of Reference a) Trust Charitable Funds Committee b) Remuneration Committee
Director Sponsor	Mrs A Bosnjak-Szekeres, Director of Corporate Governance/Company Secretary

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Charitable Funds Committee Terms of Reference

Constitution

The Trust Board has established this Committee to be known as the Charitable Funds Committee. The Committee will report its actions and decisions to the Trust Board.

The Committee has overarching responsibility for the monitoring and approval of activities relating to charitable fundraising and the uses to which charitable funds are applied, providing assurance to Trust Board members in their role of Trustees of the organisation's Charitable Funds.

The Committee has the authority to appoint short term, outcome focused subcommittees but does not routinely receive reports from other subcommittees.

Purpose and Delegated Responsibilities

The Trust receives funds for charitable purposes from a number of sources. The Trust, as a corporate body, is the Trustee of these funds. The Trust Board must therefore ensure that its duties as a Trustee are discharged correctly taking advice as necessary.

The Board, when acting as Trustees of the charitable funds, will act in accordance with guidance from the Charities Commission, and will discharge its function as Trustee as far as possible, separately from its duty as a Trust Board.

The Trust Board appoints this Committee to discharge this function. In addition, the Trust Board delegates to this Committee the authority to examine and approve the annual accounts of funds held on trust and recommend them for ratification to the Trust Board acting as the Trustee.

The Committee will oversee the management of funds held on trust and charitable funds. In particular the Committee will:

(a) Set a corporate strategy for the management of these funds

(b) Assure the Trust Board that the policies and procedures for the management and administration of these funds are adequate, effective and observed

(c) Review the investments held by the Trust at regular intervals

(d) Review the performance of funds on a regular basis

(e) Approve and review the application of funds

(f) Approve, accredit and support fundraising activities in accordance with the Trust's guidelines for fundraising activities

(g) Approve and review the appointment of those managing investments on behalf of the Trustees

(h) Make recommendations to the Trust Board regarding the management and performance of funds

(i) Provide regular reports to the Trust Board on the Committee's activities

Membership

Two Non-Executive Directors/Associate Non-Executive Directors (a Non-Executive Director will be the Chair of the Committee)

Executive Director of Finance

Executive Director of Nursing

Executive Director of Communications and Engagement

In attendance

Director of Corporate Governance/Company Secretary, the Charity Manager, and Deputy Head of Financial Control will also be in attendance at the Committee meetings.

Any other Executive or Non-Executive Director may be in attendance at meetings in their role as Trustee of the Charitable Funds.

Divisional Directors of Operations will attend meetings where requests for funds from their Division appear as an agenda item.

Frequency of Meetings

The committee will meet a minimum of four times per year in line with the reporting schedule from the Investment Managers.

Quorum

One Non-Executive Director/Associate Non-Executive Director and one Executive Director.

A quorum must be maintained at all meetings. Members are expected to attend all meetings but will attend at least 75% of meetings. Members who are unable to attend will arrange for their nominated deputy to attend, their attendance will be recorded in the minutes, making clear on whose behalf they are attending.

Regular Reports

Financial Performance Report

ELHT&me Report

Staff Lottery Update

Report of the Investment Manager (annual report)

Reporting

The Committee will provide a summary of its decisions and actions to the next meeting of the Trust Board.

The Committee does not regularly receive reports from other subcommittees.

Review

The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board Business Cycle. The Committee will provide regular reports on its activities to the Trust Board.

The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit Committee through the internal and external auditors and external regulatory bodies.

Committee Services

Lead Director	Executive Director of Finance
Secretariat Support	Corporate Governance Team

Authors: **Mrs A Bosnjak-Szekeres, Director of Corporate Governance/ Company Secretary**
Miss K Ingham, Corporate Governance Manager

TERMS OF REFERENCE: REMUNERATION COMMITTEE

Constitution

The Trust Board has established this Committee to be known as the Remuneration Committee. The Committee will report to the Trust Board. The Committee has overarching responsibility for the remuneration of, arrangements for the appointment of, and agreement of termination packages for Executive Directors. The Committee has the authority to appoint short term, outcome focused sub-committees but does not routinely receive reports from other sub-committees.

Purpose

The Committee has authority to determine, in consultation with the Chairman and the Chief Executive of the Trust:

- the policy on the remuneration of Executive Directors
- the specific remuneration packages for each of the Executive Directors including pension rights and any compensation payments
- the arrangements for the appointment of individuals outlined above
- the termination packages of any individual outlined above.

Duties and Responsibilities In determining the remuneration and termination packages and the remuneration policy, the Committee has a duty to keep in mind:

- firstly, the desirability of the maintenance throughout the Trust of a competitive, fair remuneration structure which operates in the interests of, and to the benefit of, the financial and commercial health of the Trust
- secondly, ensuring the members of the executive management of the Trust are provided with appropriate incentives to encourage enhanced performance and are, in a fair and responsible manner, rewarded for their individual contributions to the success of the organisation.

The Committee will receive an annual report from the Chief Executive on the remuneration and pay packages of the very senior staff that are not Executive Directors and are not on the Agenda for Change pay grades. The Chief Executive is responsible for:

- the remuneration of other very senior employees who are considered by the Committee to hold key positions within the Trust and whose remuneration package is, or is considered appropriate to place, outside the provisions of the Agenda for Change framework

- the remuneration of other employees who are considered by the Committee to hold key positions within the Trust who are employed to perform specific short- term functions on a semi-consultancy basis.

Committee Authority/Delegated Authority

The Committee is authorised through/with the assistance of the Company Secretary to:

- seek any information it requires from any employee in order to perform its duties
- obtain any outside legal or other professional advice including the advice of independent remuneration consultants
- secure the attendance of external advisors at meetings and to obtain reliable up to date information about remuneration in other Trusts.

The Committee has authority to commission reports and surveys that it considers necessary to fulfil its obligations.

Membership

The Committee shall be constituted of the Trust's Chairman and at least four other Non-Executive Directors.

The Chairman of the Board shall be the Chairman of the Committee.

Associate Non-Executive Directors can also be members of the Committee, but will not have the right to a vote

No individual will be involved in any part of a meeting at which decisions as to their own remuneration will be taken.

In Attendance

The Chief Executive, Executive Director of Human Resources and Organisational Development and the Director of Corporate Governance/Company Secretary will normally be in attendance at the meetings.

Frequency

At least two meetings will be held annually. Additional meetings will be convened by the Director of Corporate Governance/Company Secretary at the request of any member of the Committee.

Quorum

The Chairman of the Trust Board and two Non-Executive Directors are required to ensure quoracy. A quorum must be maintained at all meetings.

Members are expected to attend at least 75% of the meetings throughout the year. In the unusual event that a member of the Committee cannot attend the following are the delegated deputies:

- Chair of the Committee – Vice Chairman of the Trust Board
- Chief Executive – Deputy Chief Executive
- Any other Executive Directors, who would normally be in attendance or in attendance because of the nature of the agenda items, may be deputised for by their deputy or another senior manager within their corporate structure if required.

Regular Reports

Chief Executive's Annual Appraisal

Annual Report on the Remuneration of Very Senior Staff (under SFI s.9.1.4)

Annual Fit and Proper Persons Test Report

NHS VSM Salary Benchmarking Report (when published)

Reporting

The Committee will report to the Trust Board.

Review

The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board Business Cycle. The Committee will provide an annual report on its activities within the Trust's Annual Report. 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: Chief Executive

Secretarial Support: Corporate Governance Team

Authors: **Mrs A Bosnjak-Szekeres, Director of Corporate Governance/ Company Secretary**

Miss K Ingham, Corporate Governance Manager

TRUST BOARD REPORT **Item** **96**

13 July 2022 **Purpose** Information

Title	Finance and Performance Committee Update Report
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 May and 27 June 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 Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Finance and Performance Committee Update

At the meeting of the Finance and Performance Committee held on 23 May 2022 members considered the following matters:

1. Members received the financial performance report for the month 1 financial position. Members noted that the Trust was reporting a £2,100,000 deficit, which was £900,000 behind plan. Members were also informed that the deficit for the wider Integrated Care System stood at £80,300,000 and that a 5% efficiency requirement had been applied to the Waste Reduction Programmes for all provider organisations. The Trust's cash balance was reported at £59,000,000.
2. The Committee received two presentations detailing the improvement work taking place on Urgent and Emergency Care Pathways and Elective Pathways. Members noted that a number of areas of good practice had already been shared with national colleagues.
3. Members received an update on the Trust's recent performance figures. It was noted that accident and emergency and cancer performance were both showing signs of improvement and that the Trust was showing as within expected levels for its Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) mortality indicators.
4. The Committee received a quarterly workforce update. Members noted that a number of pieces of work were underway to support the Trust's recruitment efforts and that its internal nursing recruitment programme was progressing well, with a total of 113 colleagues having joined since its inception. They were informed that a new health and wellbeing website had been launched across the Integrated Care System and that this formed part of the £1,500,000 investment that had been provided the previous year to fund health and wellbeing schemes.
5. The Committee considered a proposal to replace the Trust's pharmacy robot and infusion pump devices, requiring an investment of £1,000,000. Members were informed that both devices required replacement due to their age and that this would be done via a leasing opportunity in partnership with Becton Dickinson and CHG-Meridian. Members noted that the proposal had been through the relevant options appraisal process and agreed that it was appropriate for it to be presented to the Trust Board in July 2022.
6. Members received an update on the work taking place to address a number of ongoing fire safety concerns at the Royal Blackburn Teaching Hospital and Burnley

General Teaching Hospital sites. They were advised that Lancashire Fire and Rescue Service had recently served the Trust with an enforcement notice which would need to be addressed by April 2023 and that an action plan was currently being developed in response.

7. The Committee received an update on the Corporate Risk Register and members were informed that consideration was being given to establishing a new Executive Risk Committee to provide further strategic oversight.

At the meeting of the Finance and Performance Committee held on 27 June 2022 members considered the following matters:

1. Finance Reporting, including Financial Performance 2021/22, Financial Envelopes and Planning 2022/23
2. Improvement Update
3. Integrated Performance Report: Workforce and Operations Update
4. COVID-19 & Restoration Update
5. PFI Update
6. Corporate Risk Register
7. Board Assurance Framework

A more detailed report from this meeting will be provided at the next Board meeting.

Mr D Byrne, Corporate Governance Officer, 1 July 2022

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item	**97**

13 July 2022 **Purpose** Information

Title	Quality Committee Information Report
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 27 April 2022 and 25 May 2022. Also contained within he report is the list of agenda items discussed at the meeting on 29 June 2022, a full summary of the discussions that took place will be provided at the next meeting.

Recommendation: The Board is asked to note the report.

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Quality Committee Update

At the meeting of the Quality Committee held on 27 April 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 been a significant reduction in numbers since the previous meeting. They were informed that the Trust had now been able to reduce its number of dedicated COVID wards but would continue to maintain two at Royal Blackburn Teaching Hospital and one at Burnley General Teaching Hospital. Members also noted that the Trust was working to facilitate a change in its testing methodology from polymerase chain reaction (PCR) to lateral flow tests as per national guidance.
2. The Committee received an update on the newly implemented Patient Safety Incident Response Framework. It was noted that work was underway to close the 51 investigations that were still open under the previous Serious Incidents Framework. Members were also informed that the first meeting of the new Patient Safety Learning Event had taken place earlier in the month.
3. Members received a summary of the results from the most National Staff Survey for 2021-22. It was noted that 58% of Trust staff had responded to the survey, significantly above the national average and a significant increase from the previous year. Members were informed that the Trust had scored above average for seven of the nine themes identified in the survey and that a number of actions had already been taken to address any issues identified in the areas where it had fallen short.
4. The Committee was informed that there were currently 76 live complaints and that there had been a significant reduction in the numbers of complaints with a duration of 60 days or over from 100 down to 18 since December 2021.
5. The Draft Quality Account for 2021-22 was presented to members for their comments and feedback.
6. Members considered the Terms of Reference for the Committee and confirmed that they were content with the revisions made since the previous iteration.
7. 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 25 May 2022 members considered the following matters:

1. Members received a presentation about the Care at End of Life team. The presentation covered the priorities for the service in 2021-22, an overview of the revised plan of care for patients and work being undertaken on the actions that had not yet been completed from the previous survey. In addition, the presentation provided an overview of the findings from the National Audit of Care at the End of life (NACEL), particularly the areas where the findings had been positive and those where work was required to improve in the future, such as discussion concerning preferred place of death.
2. The Committee were provided with a presentation from the Trust's Cancer Services team regarding the work being carried out to establish a number of rapid diagnostic centres across a range of tumour groups to improve the patient pathway. In addition, the team reported on the Trust's compliance with the Quality Surveillance Information System (QSIS) themes and the actions being taken to address areas of non-compliance. Members noted that three of the five standards had improved since 2019 (the last time the information was collated) with performance against two areas remaining static.
3. In addition to the above items the Committee also received updates on a number of standing agenda items, including the Patient Safety Incident Response Framework, Maternity Services, Mortality, Getting it Right First Time (GIRFT) the Integrated Performance Report and the CQC Well-led Inspection Update.
4. There were no items raised for escalation to the Audit Committee at the meeting held on 25 May 2022.

At the meeting of the Quality Committee held on 29 June 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. Patient Safety Incident Response Framework Report
3. Floor to Board Report for Maternity Services
4. Nursing Assessment Performance Framework Update
5. Safeguarding Update: Deprivation of Liberty and Liberty Protection Safeguard Standards
6. Medical Examiners Update (deferred to July 2022)

7. People Plan Annual Report
8. Quarterly Report on Safe Working Hours: Doctors and Dentists in Training
9. Patient Participation Panel Report
10. Corporate Risk Register
11. Improvement Update (including Feedback from Report Outs)
12. Records Management Update
13. Quality Account
14. Board Assurance Framework
15. Infection Prevention and Control Report
16. Integrated Performance Report
17. Trust Wide Quality Group Update
18. There were no items raised for escalation to the Audit Committee at the meeting held on 29 June 2022.

Dan Byrne, Corporate Governance Officer, 1 July 2022.

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 98

13 July 2022

Purpose Information

Title	Audit Committee Information Report
Executive sponsor	Mr R Smyth, Non-Executive Director, Committee Chair

Summary: The report details the agenda items discussed in the Audit Committee meetings held on 27 April and 14 June 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 Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

(98) Audit Committee Information Report

Audit Committee Update

At the meeting of the Audit Committee held on 27 April 2022, members considered the following matters:

1. The Committee received an update on the Consultant Job Planning process. It was noted that good progress was being made and there was a target of 90% completion by year end. Members requested a further update on the progress to be provided in the Autumn.
2. Members received the Management Response to Internal Audit on Risk Management noted that following the review by Mersey Internal Audit Agency (MIAA) earlier in the year, an award of Moderate Assurance had been received. In addition, 6 management actions had been recorded with 1 being rated as high-risk. Members were informed that mitigations were now either in place or had commenced for all of the management actions.
3. Members received the Cyber Security Assurance report, noting how the Trust had avoided a cyber incident due to the systems and mitigations in place.
4. Members received the Internal Audit Progress report and the Internal Audit Charter. Members were informed that the report covered the period January to April 2022 with 4 reports being finalised and 6 reports being in the draft stage. Members provided approval for MIAA to undertake a review into the "Well Led Evidence Framework".
5. The Committee received an update on the work undertaken by the External Auditors, Mazars, who advised that all intended work had been completed. Furthermore, the draft accounts were being reviewed and good progress had been made on the Value For Money (VFM) work which would be reported at the end of June in line with the national submission.
6. Members received the Anti-Fraud Service Annual Report and noted the work undertaken over the previous 12 months. Members were informed that report contained details on investigations that had been undertaken.
7. The Committee received the Draft Annual Governance Statement and were asked for their comments and feedback prior to the Annual Governance Statement being presented to the Audit Committee for final sign off.
8. The Committee received the Draft Going Concern Statement, noting that the report sets out the management assessment of the going concern assumption. Members were asked for approval to adopt the going concern assumption that had been submitted to NHS England/Improvement (NHSE/I) and the auditors. Members provided approval to the going concern assumption.

9. Members received the Draft Response from those Charged with Governance. It was noted that there is a requirement for the external auditors to make enquiries of the Audit Committee members. Members provided approval for the Draft Response from those Charged with Governance.

10. Committee members noted the 2021/22 Annual Reports and Accounts Timetable. It was noted that although the deadline for submission of the Annual Report was to be confirmed, it was expected to still be in September.

11. Members were informed that there had been changes made to the accounting policies used when preparing the accounts for financial year 2021/22. Members were provided with a full list of changes, with the main ones being the new standard for leases, International Financial Reporting Standard 16, which had been deferred several times since it had been intended to come into effect in April 2020. Further changes related to national template and changes in revenue for NHS contracts. Members provided approval for the use of the policies.

12. Committee members were presented with the Corporate Risk Register (CRR) and advised that the report outlined the focus and next areas for risk management improvement. Members noted that work is taking place to create a financial risk relating to the 2022.23 financial plan and that this would be included on the paper when presented at the May Trust Board. Members noted the work that had taken place to improve the CRR, however, it was felt that further work was required in order to provide sufficient assurance.

13. Members were presented with the Whistleblowing Assurance Report and informed that this provides an update on any whistleblowing reports raised since October 2021. Members were advised that a summary of the reports, along with any actions taken and future actions was contained within. It was noted that with the exception of one incident, which had been raised via the Care Quality Commission, all reports have been raised to the Trust through internal procedures. Members provided comments and feedback on the report to ensure that proper oversight of the concerns and actions taken to address the issues could be provided to the Audit Committee.

14. Members were provided a copy of the Waivers Report. It was noted that there had been a slight increase in waivers in March 2022 due to year-end spend. In addition, the Lancashire Procurement Cluster will be releasing a series of videos to help raise awareness and compliance of procurement activities.

15. Committee members were presented with the updated Standing Financial Instructions (SFIs) for ratification following their presentation at the March Trust Board. Members were informed about changes to the SFIs, noting that references to the European Union had been updated to the World Trade Organisation and that where tenders are advertised had been changed. Members proved approval to the SFIs.
16. Members were advised that the Terms of Reference (TOR) were usually reviewed annually, however due to the COVID-19 pandemic the schedule had not been followed. Members were informed that the TOR had been brought for discussion prior to presentation at the May Trust Board. Comments on the TOR were provided with the agreement that an updated version would be shared with members prior to presentation at Trust Board.
17. Committee members were presented with copies of the Standards of Conduct Policy and the Anti-Fraud, Bribery and Corruption Policy for ratification. Members were informed that following the Internal Audit review of the Declarations of Interest policy a change had been made to Section 27.10 of the Standards of Conduct policy in accordance with best practice and learning. Members provided approval to the policies following the update to the Standards of Conduct policy.
18. Committee members also received copies of the minutes from the Quality Committee, the Finance and Performance Committee and the Information Governance Steering Group.

At the meeting of the Audit Committee held on 14 June April 2022, members considered the following matters:

1. Members received the Head of Internal Audit Opinion, noting that it has been a challenging year due to the continued effects of the Covid-19 pandemic, however all plans had been delivered successfully. Members noted that sufficient work had been completed to deliver an overall opinion that Substantial Assurance had been provided.
2. Members were presented with the draft Internal Audit Plan for financial year 2022/23 and asked for comments and approval for the fees and proposed plan. Members discussed the plan, offering suggestions for other areas that could be reviewed in the future and provided approval for the fees and plan.

3. Committee members were presented with the East Lancashire Financial Services (ELFS) independent auditors report for the 2021/22 financial year. Members noted this had been created by Grant Thornton and, following the Type 1 review undertaken in the previous year when the design of controls had been assessed, a Type 2 review had been undertaken which looked at the operational effectiveness of the controls. Members were informed that the Trust had assessed and considered the report and found no implications for the Trust accounts. Queries were raised regarding the qualification within the report and when assurance would be provided that matters are being delt with. It was agreed that this would be raised during the operational contract meeting with ELFS.
4. Members reviewed the Response from Those Charged with Governance, noting that this is an annual exercise and involves the external auditors looking at the processes and controls used. Members reviewed and approved the response.
5. Members were presented with the Audit Completion Report from Mazars, the External Auditors for the Trust. They were informed that there had been one change to the audit plan when a new risk had been identified during the audit of expenditure recognition. Members noted that there had been no change to materiality and that Mazars were working to meet the deadline for the final version of the report. Members provided approval for the Letter of Representation, noting that this requires signing by the Trust.
6. Members received the audited annual accounts and financial statements for review and approval. Following an explanation of a small number of changes that had been made following distribution of the papers, members approved the accounts.
7. Members received the Annual Report and the Annual Governance Statement. A summary was provided from the Interim Chief Executive. Members were informed that the remuneration section of the report was being reviewed by Mazars and could result in some minor changes to wording. Members provided approval to the Annual Report and Annual Governance Statement on the basis that nothing substantial would be changed following Mazar's review of the remuneration section of the report.
8. Members were advised that the Modern Slavery Statement is published as part of the Annual Report and had been developed with the Safeguarding team and the Lancashire Procurement Cluster (LPC) and was presented for approval and publication. Members approved the statement for publication.
9. Members were informed that the Quality Account was being finalised and would be shared with the Quality Committee before being shared with Audit Committee for

approval on behalf of the Trust Board. Members were advised that this would be shared with Committees in the coming week.

Martyn Pugh, Acting Corporate Governance Team Leader, 13 July 2022

TRUST BOARD REPORT

Item 99

13 July 2022

Purpose Information

Title	Trust Board (Closed Session) Information Report
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 11 May 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 Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Trust Board Part Two Information Report

1. At the meeting of the Trust Board on 11 May 2022, the following matters were discussed in private:
    a) Round Table Discussion: Current Operating Context
    b) Round Table Discussion: ICB / PCB Update
    c) Round Table Discussion: Elective Recovery Current Pressures Update
    d) ELHT 2022-23 Planning Submission Summary
    e) Professional Judgement Review of the Nursing & Midwifery Staffing Establishments 2021-22
    f) Ockenden Report Update
    g) Pathology Update
    h) Electronic Patient Record Progress Update
    i) Health and Safety Executive Report and Action Plan
    j) Regulation 28 Management and Assurance Report
    k) Nosocomial Infections Update
    l) Responsible Officer's Report to Trust Board Regarding Doctors with Restrictions
    m) Industrial Action Update
    n) Fire Safety Update
    o) Car Parking 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.

Mr D Byrne, Corporate Governance Officer

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT		**Item**	**100**
13 July 2022		**Purpose**	Information

Title	Remuneration Committee Information Report
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The list of matters discussed at the Remuneration Committee held on 11 May 2022 are presented for Board members' information.

Recommendation: This paper is brought to the Board for information.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

(100) Remuneration Committee Information Report

Remuneration Committee Information Report

1. At the meeting of the Remuneration Committee held on 11 May 2021 members considered the following matters:
   a) Deputy Chief Executive Appointment and Remuneration
   b) Review of Committee Terms of Reference

Mr D Byrne, Corporate Governance Officer