East Lancashire Hospitals
NHS Trust
A University Teaching Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

Personal

Effective

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD MEETING (OPEN SESSION)

08 SEPTEMBER 2021, 13.00

VIA MS TEAMS

AGENDA

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

OPENING MATTERS				
TB/2021/098	**Chairman's Welcome**	Chairman	v	
TB/2021/099	**Apologies** To note apologies.	Chairman	v	
TB/2021/100	**Declaration of Interest Report** To note the directors register of interests and note any new declarations from Directors.	Chairman	v	
TB/2021/101	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 14 July 2021.	Chairman	d✓	Approval
TB/2021/102	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2021/103	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2021/104	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2021/105	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Interim Chief Executive	d✓	Information
QUALITY AND SAFETY				
TB/2021/106	**Patient/Staff Story** To receive and consider the learning from a patient story.	Executive Director of Nursing	p	Information/ Assurance
TB/2021/107	**Corporate Risk Register** To receive an update on the Corporate Risk Register and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Executive Medical Director	d✓	Assurance/ Approval
TB/2021/108	**Board Assurance Framework Review** To receive an update on the Board Assurance Framework and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Executive Medical Director	d✓	Assurance/ Approval
TB/2021/109	**Serious Incidents Assurance Report** To receive information in relation to incidents in month or that may come to public attention in month and be assured about the associated learning.	Executive Medical Director	d✓	Information/ Assurance

Agenda

ACCOUNTABILITY AND PERFORMANCE				
TB/2021/110	**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: • Introduction (Chief Executive) • Safe (Executive Medical Director and Executive Director of Nursing) • Caring (Executive Director of Nursing) • Effective (Executive Medical Director) • Responsive (Chief Operating Officer) • Well-Led and Director of (Executive Director of HR OD and Executive Finance)	Executive Directors	d✓	Information/ Assurance
STRATEGIC ISSUES				
TB/2021/111	**New Hospitals Programme Update and Case for Change**	Rebecca Malin, Programme Director, New Hospitals Programme	d✓	Information
TB/2021/112	**Pennine Lancashire ICP Update and Partnership Agreement for 2021-22**	Phillippa Cross, Head of ICP Development (Interim), Healthier Pennine Lancashire	d✓	Information
GOVERNANCE				
TB/2021/113	**Emergency Preparedness Resilience Response (Summary)**	Executive Director of Integrated Care, Partnerships and Resilience	v	Information
TB/2021/114	**Finance and Performance Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2021/115	**Quality Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2021/116	**Audit Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information
TB/2021/117	**Trust Charitable Funds Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information

TB/2021/118	**Trust Board Part Two Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
TB/2021/119	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties.	Chairman	d✓	Information
FOR INFORMATION				
TB/2021/120	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2021/121	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2021/122	**Board Performance and Reflection** To consider the performance of the Trust Board, including asking: 1. Have we, as the Board, via the agenda and our discussions fulfilled our objective of supporting our: a. Communities b. Staff c. Stakeholders 2. Have we, as the Board fulfilled our statutory obligations	Chairman	v	
TB/2021/123	**Date and Time of Next Meeting** Wednesday 10 November 2021, 1.00pm, via MS Teams	Chairman	v	

East Lancashire Hospitals NHS Trust
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TRUST BOARD REPORT

Item 101

8 September 2021

Purpose Approval

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

Summary: The minutes of the previous Trust Board meeting held on 14 July 2021 are presented for approval or amendment as appropriate.

Report linkages

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

Impact

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

Previously considered by: NA

(101) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST
TRUST BOARD MEETING, 1.00PM, 14 JULY 2021
MINUTES

PRESENT

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

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Director of Corporate Governance/ Company Secretary	
Mr D Byrne	Corporate Governance Officer	Minutes
Mrs G Currie	Matron	Agenda Item: TB/2021/083

Mrs E Davies	Deputy Director of HR&OD	
Dr C Gardner	Deputy Medical Director	
Mrs S Germaine-Cox	Associate Director of Workforce and Organisational Capacity, Birmingham and Solihull Mental Health NHS Foundation Trust	Observer
Miss K Ingham	Corporate Governance Manager/ Assistant Company Secretary	
Mr S McGirr	Director of Clinical System Analytics	
Mrs Lynne Peters	Head of Community Occupational Therapy and Physiotherapy	Agenda Item: TB/2021/083
Mr M Pugh	Corporate Governance Officer	Minutes
Mrs N Robinson	Assistant Director of Nursing, Community and Intermediate Care (CIC) Division	Agenda Item: TB/2021/083
Mrs K Quinn	Operational Director of HR and OD	
Mrs L Whalley	Independent Management Consultant	Observer

APOLOGIES

Mrs P Anderson	Non-Executive Director

TB/2021/075 CHAIRMAN'S WELCOME

Professor Fairhurst welcomed Directors and members of the public to the meeting. Directors were advised that Mr McGee would be joining later due to having to attend another event taking place in the wider system.

TB/2021/076 APOLOGIES

Apologies were received as recorded above.

TB/2021/077 DECLARATIONS OF INTEREST REPORT

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

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

TB/2021/078 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 12 May 2021 were approved as a true and accurate record.

TB/2021/079 MATTERS ARISING

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

TB/2021/080 ACTION MATRIX

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

TB/2021/063: Integrated Performance Report (Safe) – Mrs Pearson informed Directors that the Government had now lifted the pause to all incoming travel from India for nurses taking up employment in the NHS. She confirmed that any nurses arriving in the UK from India were still required to undertake a period of isolation in a Government approved hotel and reported that the majority had already arrived, with the remaining number due to be in place before October 2021.

TB/2021/064: Workforce Update - People Strategy Update and Implementation Plan – Mrs Quinn reported that 126 staff were currently employed in the mass vaccination programme and that confirmed that the Trust was encouraging them to either remain in employment or sign-up to be placed on the staff bank.

TB/2021/072: Open Forum – Professor Fairhurst requested that a copy of the written response provided in relation to the query raised by a member of the public at the previous meeting was circulated with the minutes of the current meeting.

RESOLVED: Directors noted the position of the action matrix.

The response provided to the question raised by a member of the public at the previous meeting is to be circulated with the minutes.

TB/2021/081 CHAIRMAN'S REPORT

Professor Fairhurst updated Directors on the work she had been involved in since the previous meeting. She advised that she had recently spent time with colleagues in the Trust's Spiritual

Care Centre and had thanked them on behalf of the Board for their commitment and the comfort they had provided, particularly during the pandemic.

Professor Fairhurst informed Directors that she had also been involved in a range of other external matters, including leading a roundtable which had been organised by the Good Governance Institute (GGI) on the building blocks of place-based integrated care. She had also taken part in a North West network event for NHS Chairs and had been involved in an event for Non-Executive Directors (NEDs) across Lancashire and South Cumbria (LSC) on system development.

Professor Fairhurst advised that the rest of her time had been spent at a system level, either at meetings with David Flory CBE and the other chairs involved in the Provider Collaboration Board (PCB) work or with the Chairs of Clinical Commissioning Groups (CCGs) to consider system reform.

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

TB/2021/082 CHIEF EXECUTIVE'S REPORT

In Mr McGee's absence, Mr Hodgson referred Directors to the previously circulated report and highlighted several matters for information across national, regional and Trust specific areas. He pointed out that there was a common thread across all areas around the management of the ongoing COVID-19 pandemic and the work taking place to restore other services, particularly for cancer and elective referrals, as well as high levels of emergency pressures.

Mr Hodgson reported that the vaccination programme continued to be a success, with high levels of vaccines being administered across the country. He informed Directors that the numbers of referrals continued to rise, and that work continued with the Trust's partner organisations on the design framework of the wider Integrated Care System (ICS), intended to deliver more integrated and joined-up healthcare. Mr Hodgson stated that the Trust had made significantly more progress in this area than many others and that much of the proposed framework was already in place across LSC. Directors noted that the Chief Nursing Officer for England, Ruth May, had recently expressed her thanks to the hundreds and thousands of volunteers who had played a key role in the fight against COVID-19.

Mr Hodgson reported that Pennine Lancashire (PL) continued to be a hotspot in terms of COVID-19 numbers, both in community and acute settings and was very much at the forefront of having to manage this, as it had been in previous waves. He confirmed that the restoration of elective care remained a key priority both regionally and nationally. Mr Hodgson advised

that the New Hospitals Programme (NHP) continued at pace and explained that it was a significant investment opportunity for LSC as a whole.

Directors noted that the programme's Case for Change was due to be presented to the Strategic Commissioning Group soon and would be brought back to a future meeting for further discussion. Mr Hodgson informed Directors that the outline business case for the LSC Pathology Collaboration had recently been submitted to NHS England/Improvement (NHSE/I) and that the full business case was currently being finalised. He added that the Pathology Collaboration Board had also recently endorsed the Enterprise Zone in Salmesbury as the location for a new Pathology Hub at the suggestion of NHS Improvement (NHSI).

Mr Hodgson went on to summarise a number of developments that had taken place within the Trust, advising that one of its consultant colleagues, Dr Iain Crossingham, had been selected to lead a recently published Cochrane Review paper with a number of his colleagues. He also drew Director's attention to the range of activities taking place over the coming month to celebrate Pride Month. Mr Hodgson concluded his update by informing Directors that the Diabetic Retinal Screening Service had recently been reviewed by the NHS England (NHSE) and that a new Artificial Intelligence (AI) system had been developed and introduced for the Trust's stroke services, adding that it was the first network across LSC to do so.

Professor Fairhurst thanked Mr Hodgson for his update and extended her congratulations on behalf of the Board to all colleagues involved in the important work currently being done.

RESOLVED: **The Case for Change for the New Hospital Programme will be presented and discussed at a future meeting.**

TB/2021/083 PATIENT/STAFF STORY

Mrs Pearson explained that the story being presented concerned a patient, referred to as 'Patient K' who had been treated at various locations within the Trust between 15 January 2021 and 9 April 2021. She informed Directors that Mrs Robinson, Mrs Currie and Mrs Peters would be providing updates on the actions implemented following the patient's discharge.

The patient was initially admitted to the emergency department (ED) at Royal Blackburn Teaching Hospital (RBTH) and was not moved to another area for 24 hours due to delays in securing a bariatric bed. She was later transferred to Clitheroe Community Hospital (CCH) to receive physiotherapy and her mobility slowly started to improve. During her stay at CCH, the patient tested positive for COVID-19 and was then transferred back to RBTH when her condition suddenly deteriorated. After some time on one of the hospital's COVID wards the patient was assessed by physiotherapists and was then transferred to Burnley General

Teaching Hospital (BGTH) where rehabilitation continued. Sometime later, arrangements were made for the patient to be discharged and a suitable bed was installed at home but, due to an error resulting in footrests being left of a wheelchair, this was delayed by a number of days.

The patient later fed back that she had encountered a number of issues during her stay at the Trust, including delays with the provision of appropriate bariatric equipment, transport issues, lack of knowledge amongst staff regarding treatment of bariatric patients and not feeling involved in some of the decisions made regarding her treatment. The patient had provided a number of suggestions to improve the treatment of future bariatric patients and hoped her experiences would help in future to change staff attitudes.

Mrs Currie (staff member) explained that she had first encountered the patient just prior to her discharge from the Community and Integrated Care (CIC) division and upon hearing of her experiences, had been keen to work with her to improve the care and treatment of bariatric patients.

Mrs Peters (staff member) confirmed that the patient had been closely involved in the development of the story presented as well as a number of actions already implemented. She advised that several other proposed actions were being considered and that Patient K was eager to be involved in the training of staff and the development of a formal Trust policy for the care of bariatric patients.

Mrs Robinson (staff member) informed Directors that ward 16 at Burnley General Teaching Hospital (BGTH) was now being used to develop additional expertise around bariatric care and that a future meeting had been arranged to identify sourcing of more appropriate equipment. She also reported that the Trust's Moving and Handling Cell was due to meet soon and would be considering the needs of bariatric patients prior to being cared for by the Trust.

Mrs Pearson thanked Mrs Robinson, Mrs Currie and Mrs Peters for their updates and stated that the story presented had clearly highlighted the importance of engaging with patients in improving the Trust's services.

Professor Fairhurst also extended her thanks to Mrs Robinson, Mrs Currie and Mrs Peters and the assurance they had provided to the Board and the public that patients remained at the heart of everything the Trust did.

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

TB/2021/084 CORPORATE RISK REGISTER (CRR)

Mr Husain referred Directors to the previously circulated report and requested it be taken as read. He informed Directors that the Trust had now successfully procured the BadgerNet system for its maternity services and confirmed that it had been configured to staff members' needs. He also confirmed that relevant training for staff had been rolled out and advised that the system was planned to go live in October 2021, after which the associated risk (ID 8243: absence of an end to end IT maternity system) could be removed from the CRR.

Mr Husain reported that there had been little movement in relation to Risk ID 7762 (risks associated with providing High-dependency unit (HDU) care in a district general hospital (DGH) with no funding for HDU provision and that there was unlikely to be a solution until the wider ICS had developed further. He informed Directors that there was likely to be an increased demand for HDU beds over the coming months due to the combination of COVID-19 cases and an expected surge in paediatric Respiratory Syncytial Virus (RSV) infections and confirmed that work was taking place with ICS colleagues and the Critical Care Cell to put necessary provisions, such as mutual aid, in place.

Mr Husain drew Directors' attention to the impacts from COVID-19 on many of the risks included on the CRR and reported that the Trust was still seeing significant transmission rates in the local community, particularly of the Delta variant. He explained that a number of actions had been put in place to mitigate the significant number of patients currently on holding lists.

Directors noted that COVID-19 had had a significant impact on Risk ID 8221 in particular (lack of recurrent investment and review of CNP (Community Neuro developmental Paediatrics) services resulting in service at risk), this is the only risk showing as having poor effectiveness of controls in place.

Mr Smyth observed that the majority of cases currently on the holding lists were for ophthalmology patients and enquired if there was any scope for this number to be reduced through wider system working. He also requested assurance that the proposal to upgrade the Trust's vacuum insulated evaporator (VIE) storage system in relation to Risk ID 8914 (potential interruption of high-flow oxygen therapy to critically ill patients across RBTH) had been approved and was now underway due to the potential adverse impacts if not done before winter.

Mr Husain responded by confirming that a systems-based approach was being taken to the management of ophthalmology patients and that there was good engagement with clinical and operational colleagues. He explained that every potential option was being considered but stressed that care was being taken as many of the patients were quite elderly and frail and

could therefore be put at risk by any unnecessary travel. Mr Husain also confirmed that the proposal to upgrade the Trust's VIE system had been approved by the Executive team and that a considerable amount of work was taking place to ensure the new system was built in in the run up to winter, adding that the risk would likely be removed from the CRR once complete.

Mr Wedgeworth noted that the issues with the Trust's CNP and HDU areas seemed to indicate a wider issue with paediatric admission that warranted greater consideration. He added that the matter had also been raised at the most recent meeting of the ICS Board.

Mr Husain stated that the expected surge of RSV cases would be a national issue and explained that the estimates for the increase in attendances and admissions currently ranged from 15% to 100%. He stated that this element, along with rising numbers of children displaying symptoms of COVID-19, was causing concern but confirmed that it was being addressed via the Hospital Cell.

Mr McDonald provided assurances that in addition to the Trust's internal planning, an update had also been provided to colleagues in the wider Integrated Care Provider (ICP) system at the most recent meeting of the Accident and Emergency (A&E) Delivery Board. He advised that a winter planning workshop had also been arranged for the following day and confirmed that the issues regarding paediatric admissions would feature heavily in the discussions there.

RESOLVED: **Directors approved the register.**

An update on the expected completion date for the upgrade to the Trust's Vacuum Insulated Evaporator (VIE) storage system in relation to Risk ID 8914 will be provided at the next meeting.

An update on the actions put in place to manage the patients on the Trust's holding lists will be provided at the next meeting.

An update on the preparations being made for the expected surge in paediatric admissions will be provided at the next meeting.

TB/2021/085 BOARD ASSURANCE FRAMEWORK (BAF)

Mr Husain summarised the main changes to the BAF and explained that a number of new controls had been added to each risk since it was previously presented to the Board.

Professor Fairhurst stated that the risks in relation to the Trust's strategic objectives were a work in progress and requested confirmation from Directors that they were content to accept the assurance provided by the report. Directors confirmed that they were content.

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

TB/2021/086 SERIOUS INCIDENTS ASSURANCE REPORT

Mr Husain referred Directors to the previously circulated report and requested it be taken as read. He advised that three Never Events had come to light during June 2021 and provided a brief update as to the circumstances behind them.

Mr Husain reported that the first Never Event related to a patient who had had a scope inserted incorrectly during a colonoscopy procedure. He explained that a biopsy had been taken due to suspected cancer and that the patient had been admitted for further assessment, at which point it was realised what had occurred. Mr Husain stated that this was clearly a Never Event and that a two-person confirmation would be required for when a scope was introduced for any future bowel inspections. He confirmed that a meeting had taken place with the clinician involved to reflect upon the incident.

Mr Husain reported that the second Never Event related to a patient who had been given a colonoscopy by mistake when one was not required. He confirmed that the patient had been taken through the appropriate consent process and had agreed to go ahead with the procedure. Directors noted that a roundtable had taken place following the incident and that there was recognition that in future the wording of the questions asked on the consent check may need to be changed to be more open-ended.

Mr Husain advised that the third Never Event related to an ophthalmology patient who had had an incorrectly sized lens inserted.

Mr Husain explained that two of the three incidents would likely be stepped down from never event status at a later date and confirmed that at a recent roundtable with NHSE, the Care Quality Commission (CQC) and CCGs, they had been assured by the steps taken by the Trust to prevent any similar occurrences. He added that as they were serious incidents, they would still go through the serious incidents requiring investigation (SIRI) process.

Miss Malik pointed out that two of the never events had emanated from the endoscopy team. She acknowledged that steps were being taken to learn lessons but enquired if any support was being provided to the staff members involved. Mr Husain confirmed that the staff members involved had met with senior nursing and medical team leaders and he advised that a small CQC type review was going to be carried out in the gastroenterology department to determine if any extra support was required.

Professor Fairhurst enquired if there were any specific areas of learning form the report to note. Mr Husain drew Directors attention to the learning from falls and advised that although the numbers of reported incidents have increased, there had been a decrease in moderate or

serious harms. He explained that the learning from these types of incidents had been widely disseminated throughout the Trust both through an increase in online training for healthcare workers and a review of the Enhanced Care Policy at the Trust's Policy Council.

Professor Fairhurst observed that the discussions that had taken place had made it clear that some areas in the Trust required further improvement and enquired if members were content to receive the report provided. Directors confirmed that they were content.

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

An update on the three never events raised will be provided at the next meeting.

TB/2021/087 INTEGRATED PERFORMANCE REPORT (IPR)

a) Introduction

Mr Hodgson introduced the item and confirmed that it covered the period to the end of May 2021. He explained that through May and June 2021 the Trust had been managing both a surge in COVID-19 cases due to the Delta variant, an increased volume of patients coming through emergency care pathways and the ongoing restoration of services. He added that another element to consider was the general pressure on the Trust's workforce and the impacts of staff having to self-isolate.

b) Safe

Mrs Pearson reported that nurse staffing had continued to be challenging throughout May 2021 but advised that the number of wards with a lower than average fill rate was at its lowest since October 2020. She requested that Directors noted the actions taken to mitigate any risks as well as the appointment of a new Lead Recruitment Nurse and confirmed that staffing continued to be monitored on a regular basis. Mrs Pearson reported that there had been an increase in bank fill rates in the family care division to cover a number of vacancies, as well as staff having to shield or self-isolate, and advised that a number of new midwives were to commence in post in September 2021.

Mr Husain reported that there had been no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia, Klebsiella pneumoniae or Pseudomonas bloodstream infections during May 2021. He advised that there had been an outbreak of Escherichia coli (E. coli) on the Trust's Neonatal Intensive Care Unit (NICU) at the start of the year and confirmed that the Infection Prevention and Control (IPC) team had done a substantial amount of work to manage this. He added that the NICU was now once again open to admissions after being closed

earlier in the year. Directors noted that the IPC measures taken by the Trust had enabled it to achieve the lowest number of reported nosocomial outbreaks in the North West. Mr Husain reported that there had been a total of four nosocomial infections in June 2021 and informed Directors that Duty of Candour letters had been issued both to patients who had acquired COVID-19 whilst in hospital and the relatives of those who had died after doing so. He explained that these letters had advised families that they would be kept informed regarding any lessons learned and had also extended an invitation to them to contribute to the Structured Judgement Review (SJR) into nosocomial deaths if they so desired.

Professor Fairhurst stated that the efforts and successes of the IPC team in keeping the numbers of infections as low as they had should be recognised, particularly in light of the challenging circumstances facing the Trust. She also noted that assurance could be taken from Mrs Pearson's update that safer staffing had not fallen by the wayside despite these challenges. Professor Fairhurst enquired if Directors were content to accept the paper as well as the assurance provided. Directors confirmed that they were content to do so.

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

c) Caring

Mrs Pearson referred Directors to the previously circulated report and explained that due to the pandemic, the collection of Friends and Family Test (FFT) had been suspended between April and September 2020. She confirmed that activity in this area was starting to increase and that there was a normal level of variation in the figures presented.

Mrs Pearson reported that the Trust had opened 23 new formal complaints in May 2021 and confirmed this remained below threshold. She informed Directors that in relation to patient experience, the Trust was achieving 90% for all competencies.

Professor Fairhurst commented that these results should also be considered a significant achievement and enquired if Directors were content with the assurance provided under the caring domain of the report. Directors confirmed that they were content.

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

d) Effective

Mr Husain drew Directors' attention to the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Indicator (SHMI) figures and explained that the figures provided

were from the period up to March 2021. He advised that, at the time, the Trust was seeing an increased number of deaths both from COVID-19 and non-COVID related matters and reported that its HSMR had been showing at 112.7. Mr Husain confirmed that, after discussions with colleagues at Dr Foster, the Trust's HSMR measure had been rebased and had come back at 103, well within expected tolerances. Directors noted that work was taking place to address the coding issues raised at previous meetings.

Directors confirmed that they had received sufficient levels of assurance through the information provided.

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

e) Responsive

Mrs Gilligan stated that there had been a number of areas of challenge during the period covered by the report, particularly in the Trust's ED. She reported that the Trust had seen 60 more attendances per day on average than it had during the same period in 2019 and confirmed this increase was being seen at all other Trusts across the country. Mrs Gilligan advised that, in addition to the greater numbers coming in to the Trust, there had been an increase in overall levels of patient acuity and explained that this, when combined with the additional complexities associated with the red and green COVID pathways, had placed an immense amount of pressure on the teams involved. Directors noted that a significant amount of work was taking place with system partners and within the Trust itself to ensure that standards were maintained despite these pressures. Mrs Gilligan reported that there had been nine breaches of the 12-hour trolley standard, all of which had been due to the unavailability of mental health beds.

Mrs Gilligan went on to report that there were currently 54 COVID-19 positive patients being cared for by the Trust, 15 of whom were in critical care, and advised that good work was taking place with the Critical Care Network across LSC to provide mutual aid where appropriate. Directors noted that there had also been significant improvements in the Trust's 52-week position and six-week diagnostic targets. Mrs Gilligan highlighted that the Trust had achieved 117.3% for its restoration activity in its outpatient department, against a target of 80%, and explained that this would help to bring down the significant backlog of patients that had built up during the pandemic.

Miss Malik noted that a significant number of mental health breaches had taken place in May 2021, the longest of which had been over 33 hours, and requested clarification on the work

taking place with system partners to mitigate this. Mrs Gilligan confirmed that the Trust was working closely with mental health colleagues but stressed that the shortage of beds causing these breaches was a national issue. She advised that funding had now been made available to increase available beds and stated that she was satisfied that Lancashire and South Cumbria NHS Foundation Trust (LSCFT) were responding to the situation to the best of their abilities given the current constraints in place. In response to a further query from Miss Malik regarding the link between the increase in ED attendances and patients not being able to access primary care, Mrs Gilligan confirmed that an audit was currently being developed to assess this. She explained that there was significant pressure on primary care colleagues but acknowledged that less face to face appointments were being made available to patients. Mrs Gilligan advised that work was taking place to ensure that system partners were doing everything they could to manage the situation but stressed that the pressures caused by the significant increase in ED attendances and COVID-19 cases could only be mitigated to a certain extent.

Mr McGirr explained that multiple factors were contributing to the difficulties being seen in Accident and Emergency (A&E) departments, adding that around 400 extra hours of work were currently being done at the seven main departments across LSC than prior to the pandemic.

Directors confirmed they were content that appropriate actions were being taken to manage the unprecedented pressures being seen by the Trust.

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

f) Well-Led

Mrs Quinn reported that the Trust was seeing an increase in general sickness and absence levels in addition to the increases caused by the pandemic. She confirmed that Occupational Health (OH) colleagues were doing as much as possible to get colleagues back into work and stated that she was hopeful that the newly published guidance around self-isolation would help to facilitate this. Mrs Quinn informed Directors that a recent bid for additional funding towards staff health and wellbeing had been successful and that £1,600,000 had been awarded. She clarified that whilst this funding was for use across the whole of the LSC ICS, the Trust would be leading on it.

Mrs Quinn reported that there had been a slight increase in staff turnover and explained that there were a number of reasons for this, including the impacts of the pandemic potentially

causing some colleagues to retire sooner than they otherwise would have done. She confirmed that a number of initiatives, such as more flexible contracts, were being considered to address this. Mrs Quinn informed Directors that there was also some concern around the impact of the latest pension consultation and that the Trust was trying to proactively identify staff concerns. She reported that the numbers of vacancies in the Trust had continued to decrease and that it had made significant progress on its inclusion agenda, adding that the Executive team would be putting out additional communications later in the week to combat the recent surge in racist activity on social media platforms and give confidence to colleagues that they were working for an organisation that doesn't tolerate racism in any form.

Miss Malik observed that the combination of increased sickness and staff turnover could lead to a 'perfect storm' scenario. She enquired if there were any other trends contributing to staff leaving the Trust and, if so, what was being done to encourage them to remain. Mrs Quinn reiterated that the pandemic had had a significant impact on people and that it had pushed a high proportion of staff in the Trust to leave sooner. She acknowledged that further engagement work was needed to understand what more the Trust could do to retain them and explained that the inclusion work currently being done would provide an opportunity to better understand what colleagues thought about working in it.

Mr Catherall commented that the news around the successful health and wellbeing bid was very positive and stated that he was sure it would be invested well. He enquired if any consideration had been given to a mentoring system for those retiring from the Trust and those who were just joining it, as it could be very rewarding for both parties if done correctly. Mrs Quinn agreed that it would be good to have such a system in place and that it was an area the Trust would be exploring.

Mrs Brown advised that the Trust would remain in the position of having a financial envelope for the first six months of the year and that it would likely not receive more information about its envelope for the second half of the year until October 2021. She informed Directors that the Trust had been forecasting a breakeven position but explained that this had needed to be reviewed recently due to a late change in funding flows. She added that this could potentially put the breakeven position at risk. Directors note that the Trust's capital programme was on plan and that its biggest investment would be the implementation of its new electronic patient record (EPR) system. Mrs Brown reported that there was a significant national focus on organisations to ensure they were achieving Better Payment Practice Tariffs (BPPT) and were paying 95% of suppliers within 30 days. She confirmed that the Trust was among the top

performing organisations in this area and was currently working with others to improve their performance.

Directors confirmed that they were content with assurance provided by the well-led section of the IPR with the understanding that some areas, such as the financial situation, were beyond the Trust's control.

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

TB/2021/088 NHS IMPROVEMENT ANNUAL BOARD SELF-CERTIFICATION

Mrs Bosnjak-Szekeres explained that all providers were required to self-certify at the end of each financial year that effective systems were in place to comply with NHS legislation, as well as the governance arrangements laid out in the relevant documentation.

Professor Fairhurst enquired if Directors were content for delegated authority to be granted to both her and Mr McGee for the self-certification forms to be signed off and submitted. Directors confirmed that they were content for this to be done.

RESOLVED: **Directors approved the request for delegated authority to be granted for the submission of the NHSI Self-Certification documents.**

TB/2021/089 FINANCE AND PERFORMANCE COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

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

TB/2021/090 QUALITY COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

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

TB/2021/091 AUDIT COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

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

TB/2021/092 TRUST CHARITABLE FUNDS COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

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

TB/2021/093 TRUST BOARD (CLOSED SESSION) INFORMATION REPORT

The report was presented to the Board for information.

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

TB/2021/094 ANY OTHER BUSINESS

Professor Fairhurst noted that this would be Mr McGee's last Board meeting and took the opportunity to recognise and acknowledge the contributions that he had made during his time at the Trust. She stated that the journey that the Trust had taken from a rating of 'requiring improvement' to 'good with areas of outstanding' as of its most recent inspection by the CQC was clear evidence of the stability and success of the team that Mr McGee had built up around him. Professor Fairhurst also stated this had also been made clear by the immense achievements made by colleagues during the COVID-19 pandemic, adding that this was a direct result of the strong leadership shown by Mr McGee and the Executive team. She noted that Mr McGee would have a crucial role to play in his new role as Chief Executive Officer (CEO) of the PCB and that the Trust's connection to this would be invaluable going forward.

Mr McGee thanked Professor Fairhurst for her comments and stated that it had been a privilege to be CEO of the Trust over the previous seven-year period. He added that he was proud of the Executive team that had developed under him and praised the strong leadership shown by Professor Fairhurst in her role as Chairman. Mr McGee stated that he hoped to be able to continue supporting the Trust in his new role in the PCB and that he looked forwarded to working with colleagues in a different way in the future. He extended his thanks to Directors for their support during his time at the Trust.

TB/2021/095 OPEN FORUM

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

TB/2021/096 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 that there had been a clear focus on organisational performance and how the Trust provided healthcare to the local population but also system working and how these were now becoming one and the same.

Mrs Brown agreed with Mr Hodgson's comments and enquired if there was anything more that could be done to engage members of the public more and improve attendance at future meetings.

Professor Fairhurst concurred and suggested that the Executive team could give some thought to this for future meetings.

Directors stated that they were content that the Board had fulfilled its statutory and regulatory duties.

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

TB/2021/097 **DATE AND TIME OF NEXT MEETING**

The next Trust Board meeting will take place on Wednesday, 8 September 2021 at 13:00, via MS Teams.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 103

8 September 2021

Purpose Information

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

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2021/063: Integrated Performance Report – Well-led	Mrs Quinn to provide an update on the appraisal process at a future Trust Board meeting.	Operational Director of HR&OD	November 2021	Agenda Item: November 2021
TB/2021/080: Action Matrix	The response provided to the question raised by a member of the public at the previous meeting is to be circulated with the minutes.	Corporate Governance Team	September 2021	Complete
TB/2021/082: Chief Executive's Report	The Case for Change for the New Hospitals Programme will be presented and discussed at a future meeting.	Interim Chief Executive	September 2021	Agenda Item: September 2021
TB/2021/084: Corporate Risk Register	An update on the expected completion date for the upgrade to the Trust's Vacuum Insulated Evaporator (VIE) storage system in relation to Risk ID 8914 will be provided at the next meeting.	Executive Medical Director	September 2021	Update: The project to upgrade the VIE storage system is expected to take place during October 2021. A Design Engineer visited site on 19th August to appraise and agree the site logistics plans. The oxygen supply capacity at RBTH will be double what is currently available once this work has been carried out.

Item Number	Action	Assigned To	Deadline	Status
	An update on the actions put in place to manage the patients on the Trust's holding lists will be provided at the next meeting.	Executive Medical Director/Chief Operating Officer	September 2021	Update: A process is in place for all patients on holding lists to be regularly Red, Amber and Green (RAG) rated and these ratings are regularly discussed and reviewed by operational and clinical colleagues. The wider pressures caused by workforce shortages and COVID-19 are causing difficulties but any areas falling short are being asked to provide their reduction trajectories.
	An update on the preparations being made for the expected surge in paediatric admissions will be provided at the next meeting.	Executive Director of Integrated Care, Partnerships and Resilience	September 2021	Update: A workforce model based on skills and competencies is being developed to support a predicted 20, 50 and 100% surge which will be presented to the Executive Team in September 2021. Equipment required to facilitate such a surge is being identified and procured. Pathways for the safe management of a Level 3 critical care patient requiring transfer for ongoing tertiary centre care in theatres at RBTH is being developed. This is for both a

Item Number	Action	Assigned To	Deadline	Status
				timely transfer when a bed is available and for the scenario where a bed is not available and the patient requires 'holding' locally whilst a bed becomes available. The area identified for the latter is the post-operative care unit (POCU) and the Standard Operating Procedure (SOP), equipment, additional training and staffing model is being planned to support this. A SOP has been agreed and is due to be presented at the ICC for approval for the management of young people over the age of 12 who can be safely managed in the Trust's critical care unit in order to support the prioritisation of younger children for the limited tertiary critical care beds. Plans are also underway with primary care for the development of pathways into secondary care, and wherever possible keeping children at home with the support of the Childrens Community Nursing Service and a GP led

Item Number	Action	Assigned To	Deadline	Status
				'hub' model.
TB/2021/086: Serious Incidents Assurance Report	An update on the three never events raised will be provided at the next meeting.	Executive Medical Director	September 2021	Three Never Events incident reports were discussed at August 2021 SIRI Panel, members agreed to request CCG and NHSE step down as Never Events as no issues were identified with National Patient Safety criteria guidance for these types of incidents. A number of lessons learnt were identified for internal systems and processes and detailed actions plans provided. **Never Event 1:** The WHO Surgical Safety Checklist is generally effective at checking the procedure that is being performed but may not always pick up errors where the wrong patient identifiers or the wrong procedure is documented on the Theatreman Endoscopy List (if the original listing letter is not cross checked from the case notes or from the

Item Number	Action	Assigned To	Deadline	Status
				Clinical Portal) **Never Event 2:** The team brief/debrief could be strengthened in this case. A number of recommendations have been made regarding appropriate identification of the area to be scoped. Further information on these recommendations can be provided if required. **Never Event 3:** An intense focus on the Endoscopy imaginary screens was identified, the procedure room lighting was dimed to reduce glare on media screens. Situational awareness was not considered at the time an abnormality had been identified and the expertise of the endoscopy nurses was not utilised. It is recognised that national procedures were followed but local procedures need to be embedded and a Standard Operating

Item Number	Action	Assigned To	Deadline	Status
				Procedure (SOP) for insertion of lens implants in theatres to be considered.
TB/2021/088: NHS Improvement annual Board Self-Certification	Directors approved the request for delegated authority to be granted for the submission of the NHSI Self-Certification documents.	Corporate Governance Team	September 2021	Complete: The Self-Certification forms have been completed and published on the Trust's website.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 105

8 September 2021

Purpose Information

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

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

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

Report linkages

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

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

CEO Report

September 2021

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

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

One - National Headlines

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

UK COVID-19 vaccine programme update

Latest data shows more than 47 million people have had a first vaccine dose - 87% of over-16s - and nearly 41 million - 75% of over-16s - have had both doses.

The number of first doses administered each day is now averaging about 41,000 with an average of more than 160,000 second doses being given each day. The delivery of second doses was accelerated in response to the emergence of the Delta variant.

The aim of the vaccination programme is to protect as many people as possible from serious illness through developing the UK population's immunity against Covid-19. Data from the Office for National Statistics (ONS) suggests more than nine in 10 adults in the UK now have coronavirus antibodies - which is evidence of a past Covid infection or having received at least one dose of a vaccine.

Roughly 93% of adults tested by the ONS during the week ending 18 July had Covid antibodies, up slightly from 92% a fortnight before. However, this figure does not tell us how many people are protected from infection or how close we are to reaching herd immunity - the point at which everyone is protected, directly or indirectly, as a result of high immunity levels in the population.

Details from Public Health England's latest COVID-19 vaccine surveillance report estimates the UK vaccination programme has prevented 84,000 deaths and more than 23 million infections.

The latest stage of the vaccination programme urges young people to get protected against the virus ahead of going to college and university in September. Findings from the ONS showed that willingness to

get jabbed has increased among 18 to 21 year olds and more than 1.4 million people between 18 and 24 have already been jabbed.

Pregnant women are also being encouraged to take up the offer of the vaccine. The latest PHE data shows that 62,311 women, who reported they were pregnant or could be pregnant at the time of receiving the vaccine, have come forward and received their first dose of COVID-19 vaccination, up to 31 July. This is an increase of 10,587 from 51,724 as of 18 July. Of the latest total, 43,737 have received their second dose.

Integrated Care Systems Update

Following several years of locally led development and based on the recommendations of NHS England and NHS Improvement, the Government has set out plans to put integrated care systems (ICSs) on a statutory footing. NHS England and NHS Improvement have published guidance and resources to support this transition.

In addition, NHS Providers have also produced a briefing which provides a summary of the guidance and sets out NHS Providers' initial analysis.

The Interim guidance on the functions and governance of the ICB sets out the headlines for how NHS England will ask NHS leaders and organisations to operate with their partners in ICSs from April 2022, and guidance in respect of what the employment commitment is, its application in practice, and how it affects people.

Key highlights from the new guidance include:

- ICBs will be statutory organisations that bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnerships across the ICS
- each ICB must be set out its governance and leadership arrangements in a constitution formally approved by NHS England and NHS Improvement
- while preparations for these new arrangements are being made, all NHS organisations must continue to operate within the current legislative framework retaining any governance mechanisms necessary to maintain operational delivery (including patient safety, quality, and financial performance).

The Building strong integrated care systems everywhere: Guidance on the ICS people function document builds on the themes and priorities set out in the NHS people plan and provides a framework for systems to consider workforce activity at system level.

It sets out the priorities for the remainder of this financial year, points towards requirements for greater collaboration over resource decisions at system level from April 2022 and provides a steer on the type of responsibilities Trusts and other partners may consider at ICS level.

The guidance provides a helpful framework for realising the benefits of workforce activity at scale, but also highlights the barriers that stop the realisation of these benefits, including significant workforce gaps.

The much-awaited HR framework for developing ICBs has also been published, outlining the national policy ambition and practical support for dealing with the change processes required to affect the transfer and the transition.

This guidance builds upon the four core HR transition principles (people centred approach, compassionate and inclusive, minimum disruption, and subsidiarity) agreed with national trade unions to support an effective and safe transfer. A comprehensive transition plan has been developed by the People Team which will now be reviewed to ensure it is reflective of this new guidance.

Amanda Pritchard appointed as NHS Chief Executive

Amanda Pritchard commenced as the new Chief Executive Officer of NHS England on Sunday 1 August, and is first woman in the health service's history to hold the post. Amanda takes up the role after serving as the NHS' Chief Operating Officer (COO) for two years.

As NHS chief executive, she will be responsible for an annual budget of more than £130 billion while ensuring that everyone in the country receives high quality care.

The George Cross awarded to the National Health Services of the United Kingdom

The National Health Services of the United Kingdom have been awarded the George Cross by Her Majesty The Queen. The award comes in recognition of 73 years of dedicated service, including for the courageous efforts of healthcare workers across the country battling the COVID-19 pandemic.

The George Cross - the highest civilian gallantry award, equivalent to the Victoria Cross - has only been bestowed collectively twice before, and 5 July 2021 marks the second time it has been awarded collectively by Queen Elizabeth II.

This unprecedented award rightly recognises the skill and compassion and the fortitude of staff right across the National Health Service – the nurses, the paramedics, the doctors, the cleaners, the therapists, the entire team– who under the most demanding of circumstances have responded to the worst pandemic in a century and the greatest challenge this country has faced since the Second World War.

NHS mental health crisis helplines receive three million calls

Mental health phonelines run by the NHS have answered around three million calls during the pandemic. The dedicated 24/7 NHS crisis helplines were fast-tracked to open a year ago so everyone could get rapid care they need without having to go to A&E.

Most of the callers are able to receive treatment over the phone or can be referred to a face to face assessment and fewer than 2% of the calls have resulted in an A&E attendance or a blue light response from ambulance or police.

The crisis lines have been rolled out four years earlier than planned, with nationwide coverage reached in May 2020, having originally been scheduled to go live by 2023/24 under the NHS Long Term Plan, but were fast-tracked to ensure support could be provided during the pandemic.

Waiting times drop despite busy summer

The NHS is continuing to make progress on non-urgent care despite experiencing one of its busiest summers ever. The number of patients waiting longer than 18 weeks for care has dropped by almost 25,000 while those waiting more than year fell by almost 32,000.

Average waiting times for elective care is down for the fourth month in a row to 10.4 weeks – more than seven weeks lower than this time last year. More diagnostic tests were carried out in August than at any point over the last year with almost two million tests carried out in July – up by more than 747,000 on the same period last year.

Around a quarter of a million people were checked for cancer in June, the second highest number on record, and more than 27,000 people started treatment for cancer in the same period, a 42% increase on June last year. Over eight million elective patients have been seen since the start of the pandemic in March 2020, while caring for over 420,000 COVID patients, meaning for every COVID patient the NHS has seen five non-COVID elective patients.

Meanwhile, hardworking NHS staff also have had to experiencing one of its busiest summers ever with 70,000 A&E attendances a day in July, almost 20,000 more each day than this time last year.

Long term action plan launched to reduce tuberculosis in England

The UK Health Security Agency (UKHSA), working with NHS England (NHSE), has launched a 5-year action plan to drive down tuberculosis (TB) cases in England.

The TB action plan for England, 2021 to 2026 will improve prevention, detection and control of TB, enabling the UK to meet its commitment to the World Health Organization (WHO) End TB Strategy and eliminate TB in England by 2035. Earlier detection and treatment of TB increases likelihood of recovery and reduces chances of onward spread of disease.

The significant impacts of the pandemic require renewed effort and focus to ensure that England gets back on track to eliminate TB. The joint UKHSA and NHSE TB action plan will build on the improvements in the prevention, detection and control of TB in England over the past 10 years. It will also focus on 5 key priority areas – Recovery from COVID-19, Prevent TB, Detect TB, Control TB disease and Workforce - to provide partners with the tools to reduce TB incidence in all our communities.

More than 10 million people now using the NHS App

As many as 10.4 million people have now signed up to the NHS App. Over 6 million new users have been added since the COVID-19 vaccination status service was included on 17 May.

The app's COVID-19 vaccine status service allows users to easily show their proof of vaccine, which has proved helpful for people when travelling abroad, returning to workplaces and attending largescale events.

The increase in app downloads also has potentially life-saving benefits as over 90,500 people have registered their organ donation preference via the app during May and June. And users are also benefiting from easier access to NHS services. During May and June over 1,248,800 repeat prescriptions were ordered and over 103,900 GP appointments booked via the app, saving patients and clinicians valuable time.

Warning issued as childhood respiratory infections rise ahead of winter

Health chiefs in England are encouraging parents to be aware of the signs of respiratory illnesses in young children, as data from Public Health England (PHE) shows cases are on the rise in parts of the country.

Respiratory illnesses, including colds and respiratory syncytial virus (RSV) are very common in young children and are seen every year.

Last winter, due to the various restrictions in place to reduce the spread of coronavirus (COVID-19), there were far fewer infections in younger people. This means many will not have developed immunity and so there may be more cases this year than in a typical season. For the majority of children, these illnesses will not be serious and they will soon recover following rest and plenty of fluids.

RSV is a very common virus and almost all children are infected with it by the time they are 2 years old. In older children and adults, RSV may cause a cough or cold.

New landmark strategy to improve the lives of autistic people

The government has launched a new multi-million pound strategy to speed up diagnosis and improve support and care for autistic people.

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

The 5-year strategy was developed following engagement with autistic people, their family and carers. It will support autistic children and adults through better access to education, more help to get into work,

preventing avoidable admissions to healthcare settings, and training for prison staff to better support prisoners with complex needs.

Report investigates diverse NHS workforce

A first of its kind report looking into race equality among England's doctors has found that the number from black and ethnic minority backgrounds working for the NHS is the highest on record.

New data published as part of the inaugural Medical Workforce Race Equality Standard (MWRES) commissioned by NHS Chief Executive shows that last year more than 53,000 doctors working in the NHS were from a black and minority ethnic (BME) background, up by more than 9,000, a rise of around one-fifth, since 2017.

The change confirms the ever-increasing diversity of NHS staff – with 42% of medical staff working in the NHS now from a BME background. However, despite this rise in ethnic minority medical staff, BME doctors currently remain underrepresented in senior positions, including at consultant grade roles and in academic positions.

Fund to fast-tract new drugs

NHS patients are set to benefit from early access to potentially life-saving new medicines, including cutting-edge gene therapies, thanks to a new Innovative Medicines Fund and £680 million of ringfenced funding, the NHS chief executive has announced today.

The Innovative Medicines Fund will build upon the success of the reformed Cancer Drugs Fund, by supporting patients with any condition, including those with rare and genetic diseases, to get early access to the most clinically promising treatments where further data is needed to support NICE in making final recommendations around their routine use in the NHS.

An estimated one in 17 people will be affected by a rare disease in their lifetime, and this fund will now support the NHS to fast-track patient access to treatments which can demonstrate substantial clinical promise.

Two - Lancashire and South Cumbria Headlines

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

COVID-19 update

In the North West community COVID-19 infection rates have started to plateau, with pockets of fluctuation, across the region. These fluctuations are likely to continue as more people return to normal levels of socialising and as education establishments re-open.

At this time, we also continue to see relatively lower numbers of patients requiring treatment in our hospitals and intensive care units. Our hospital acquired infection cases also remain very low.

Covid is going to become more of an endemic illness where persistent infection will be present through the winter months. Thankfully, due to the success of the vaccination programme, they should not be at the levels previously experienced.

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

Vaccination programme update

Almost 75 million vaccines have been delivered across England; 34.9 million have received a second dose. Across Lancashire and South Cumbria, more than 1.2 million people are now vaccinated - which is over 87% of the adult population. Over 1.06 million (77%) people have also had their second vaccination and we have now administered over 2.2 million doses.

More than a million children and young people across England can now receive their COVID vaccination. The vaccination programme has been extended to 16 and 17-year-olds, the country's most vulnerable children and those who live with vulnerable adults following changes to guidance from the Joint Committee on Vaccination and Immunisation (JCVI).

Providing convenient opportunities for our population to get vaccinated continues to be a priority. Working in partnership with Football Clubs, colleges, and universities, pop-up vaccination opportunities are being planned at matches, as well as keep college and university events, for example, Freshers Week.

COVID-19 infection in pregnancy carries a significant risk of hospital admission and a higher risk of severe illness than for the non-pregnant population and a higher risk of preterm birth. The Royal College

of Obstetrics and Gynaecology (RCOG) and the Royal College of Midwives (RCM) now recommend vaccination as one of the best defences against severe infection. Since 16 April, the JCVI has recommended that Pfizer or Moderna COVID-19 vaccines are the preferred vaccines for pregnant women coming for their first dose. The vaccination programme is working with Lancashire and South Cumbria Maternity and Newborn Alliance to promote vaccination before and during pregnancy, as well as ensuring midwives, obstetricians and all wider clinicians in contact with the pregnant population has the most up-to-date information available.

From September, the focus of the vaccination programme will shift towards COVID-19 booster doses to run alongside the seasonal flu programme. Challenges are expected this flu season because the very low number of infections last winter has had an impact on population immunity. Mathematical modelling referenced in the national flu letter indicates flu levels this winter could be up to 50 per cent higher than usual, and could start earlier. Interim JCVI advice suggests that "early evidence…supports the delivery of both vaccines at the same time where appropriate".

A letter sent to NHS Trusts, Foundation Trusts and others set out further information about how frontline health and care workers will be vaccinated in Phase 3. This includes greater alignment of the definitions of frontline healthcare workers for flu and COVID-19 vaccines in 2021/22, to maximise the number of staff covered, and to increase the opportunity for co-administration of the two vaccines if recommended by JCVI.

The evergreen offer for COVID-19 vaccination will still be in place for anyone yet to receive a first dose for any reason, and to provide a second dose for all those who received first doses over the summer.

The vaccination programme has already substantially reduced the risk from severe COVID-19 in the UK population. The latest national COVID-19 vaccine surveillance report updated on 12 August, estimates the programme has averted approximately 23 million infections and 84,000 deaths to date in England.

Elective Care Recovery

Recovery remains a primary focus. The latest figures show day case activity has dipped below the England average, however all other figures, for elective ordinary admissions, and both first and follow-up outpatient appointments, remain high and above the England average.

It is vital we progress our elective care programme as quickly as possible, while at the same time working to ensure those who have already waited for a considerable time are treated as soon as possible. Mutual aid is proving an invaluable tool to ensure the sickest patients are treated as quickly as possible in the most appropriate place, including cancer patients who, where necessary are being treated through our surgical hubs.

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

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

With additional funding we have been able to enhance and increase services to improve the care of our patients. These include extending the patient transport service, expanding and improving the Advice and Guidance service for GPs and non-face-to-face appointments and consultations for patients and maximising our theatre usage. However, balancing the reduction of our waiting lists alongside restoring our exhausted workforce continues to be extremely challenging.

Amanda Doyle as new Regional Director for North West

Dr Amanda Doyle has been appointed by NHS England and NHS Improvement as the new Regional Director for the North West. Amanda replaces Bill McCarthy, who retired as Regional Director at the end of July. She will leave her roles as Chief Officer for Blackpool CCG, Fylde and Wyre CCG, West Lancashire CCG and as the lead for the integrated care system in Lancashire and South Cumbria.

Andrew Bennett to become Interim Chief Officer for Lancashire and South Cumbria ICS

Andrew Bennett, the Executive Director for Commissioning for the Lancashire and South Cumbria Integrated Care System, is the new Chief Officer, following Dr Amanda Doyle OBE's appointment as North West Regional Director for NHS England and Improvement. The interim arrangement commenced in August and ensures continuity of leadership during the upcoming commissioning system reform and national programme of recruitment for ICS chief executives.

Lancashire and South Cumbria Integrated Care Board update

The Health and Care Bill progressing through Parliament means that measures relating to Integrated Care Systems (ICSs) will become law and will come into effect in April 2022.

The Bill contains a series of measures which would formally establish ICSs and give their governing bodies a broader range of responsibilities, including an NHS Integrated Care Board (ICB), which will act as the statutory NHS body for the system. A key element of the necessary preparation is confirming who is expected to take up senior roles for each NHS ICB, starting with the Chair-designates.

Following a robust process, NHS England and NHS Improvement have recommended, and the Secretary of State has agreed, that David Flory should be the NHS ICB Chair-designate for Lancashire and South Cumbria, ready to take up the post from April 2022 should Parliament confirm the current plans.
This will provide stability for Lancashire and South Cumbria as David will continue to work closely with a wide range of local partners, including Local Authorities and the Voluntary Sector, in order to better join

up health and care and develop the wider health and care partnership to improve outcomes and tackle health inequalities for local people.

David will also continue to provide interim support to Cheshire and Merseyside ICS while the national recruitment process for its ICS Board Chair takes place. The next stage of the national recruitment process will be the confirmation of ICB chief executive designates, which is expected to conclude by the middle of October.

Lancashire and South Cumbria Provider Collaborative

As part of the national move towards more integrated care across England, NHS providers within Lancashire and South Cumbria are working more closely together to address local challenges.

Throughout the COVID-19 pandemic, there have been many benefits of our NHS providers and wider system partners working together, providing vital mutual aid along with essential pieces of work such as the elective care recovery programme.

A Provider Collaborative Board (PCB) has been established to enable partnership working of the acute, mental health and community providers across Lancashire and South Cumbria. The organisations that are involved as part of the collaborative are:

- Blackpool Teaching Hospital NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Lancashire and South Cumbria NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust

Kevin McGee has been appointed as the lead Chief Executive of the PCB and this will be a key part of his role as he moves to his new position of Chief Executive at Lancashire Teaching Hospitals on 1 September. A Strategic Coordination Group (SCG) has also been developed to support the function of the PCB, which will help provide strategic direction for the PCB.

The approach of the PCB is to work together as one structured system, building a culture that is based on a data-driven and best practice approach, continuous improvement and an inclusive partnership, ensuring joint working between all NHS services, local authorities, VCSFE and private providers.

Working collaboratively, our five NHS providers will develop and deliver two visions; a single clinical vision that aligns with the Lancashire and South Cumbria Clinical Strategy and a shared corporate, clinical support and estates services vision. The PCB will also be responsible for developing a clear financial strategy, as well as continuing to oversee the recovery and restoration of elective care, clinical networks and transformation programmes, and continuing to make improvements in the emergency and urgent care performance of the system.

Our providers will be collaborating in a number of ways in Lancashire and South Cumbria:

- The five Provider Trusts will work on shared key issues.
- Lancashire and South Cumbria Foundation Trust will take on a 'lead provider' role across the system for mental health, learning disabilities and autism.
- All five Trusts will work together to review the way in which corporate services are provided.

A vision, values and purpose are currently being developed by the group, to describe how the organisations involved will work together to improve services across Lancashire and South Cumbria. We will share this as soon as it is ready. This is being done in close collaboration with the National Provider Collaborative Programme leads, as the Lancashire and South Cumbria Provider Collaborative Board is a member of the national Provider Collaborative pilot programme.

National guidance, Working together at scale: Guidance on Provider Collaboratives, was published in August 2021 and our Provider Collaborative leads will be working through the guidance as they continue to develop and begin to work through their initial priorities.

New Hospitals Programme update

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

The Case for Change is the first in a series of official documents that the local NHS must produce as part of the Lancashire and South Cumbria New Hospitals Programme. It explains the problems that the local NHS hopes to address through funding for new hospital facilities, and how this supports ambitions to improve health and wellbeing and deliver better care for local people. The report provides detailed evidence about the need to address significant issues with the ageing Royal Lancaster Infirmary and Royal Preston Hospital buildings, and to improve facilities at Furness General Hospital, due to its strategic importance and geographically remote location. Developed in collaboration with clinicians, staff, patients, key stakeholders and representatives of local communities in the region, it covers six important themes:

- Lancashire and South Cumbria: how ageing hospital buildings impact the local NHS's ability to provide for local people's current and future health needs
- Our hospitals: the pivotal role of hospitals in the local community and the poor condition of some of the buildings
- Our clinical strategy: the problems ageing hospital buildings present in the context of the region's

ambitions for hospital care and the wider health and care system

- Our workforce: the impact of poor hospital estate on existing NHS staff, and the ability to attract new staff
- Our digital ambitions: how ageing hospital buildings prevent them from fulfilling the NHS's digital technology and sustainability goals
- Our use of resources: how hospital infrastructure impacts local NHS productivity and efficiency.

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

Parents and carers advised to be aware of the signs of respiratory illnesses

Health experts across Lancashire and South Cumbria are urging parents and carers to be aware of the signs of respiratory illnesses in children. Respiratory illnesses, including colds and Respiratory Syncytial Virus (RSV) are very common in young children and we see them every year. RSV in particular are common viruses that cause coughs and colds in winter and is the most common cause of bronchiolitis in children under two. In the UK, the RSV season typically begins in the autumn – earlier than the adult flu season – and runs throughout the winter. However, this year we are now seeing this presenting in children much sooner.

New website helps survivors of sexual violence

A new NHS-backed website has launched that will provide a digital directory of services in North West England for survivors of sexual violence. The website features a postcode search which allows users to seek out the nearest services.

Also on the website are downloadable Survivor Support Packs, which have been designed in collaboration with survivors, and provide all the information you need to know around the definitions of sexual violence crimes, information for parents/carers on supporting children or how to have open conversations at home, and a simplified 15-step summary for the 'report to court' process. It also serves as a useful toolkit for people such as GPs.

Every Mind Matters campaign encourages prioritising mental health

The easing of lockdown restrictions across the country has left many people feeling anxious about a long-awaited return to normality. To help navigate these changes, Public Health England has launched the nationwide Better Health – Every Mind Matters campaign, which now offers practical tips, expert advice and an NHS-approved personalised mental health action plan.

Recent research has revealed that the Covid-19 pandemic has had a negative impact on the mental health of many and as circumstances continue to change, it is normal to feel nervous about what the future holds.

The Every Mind Matters website provides personalised action plans with practical tips to help deal with stress and anxiety, boost mood, sleep better and feel more in control. This is complemented by the Covid-19 content hub, which includes tips and support on coping with money worries, job uncertainty and how to ease back into socialising.

Three - ELHT Headlines

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

Use of the Trust Seal

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

- On **5 August 2021** the seal was applied in relation to a lease of Great Harwood Health Centre. The documents were signed by Mr Martin Hodgson, Deputy Chief Executive and Mr Jawad Husain, Executive Medical Director.
- On **5 August 2021** the seal was applied in relation to a Standstill Agreement for the development of Phase V at Burnley General Teaching Hospital. The documents were signed by Mr Martin Hodgson, Deputy Chief Executive and Mr Jawad Husain, Executive Medical Director.

NHS Improvement Reappoints Chairman

NHS Improvement has confirmed the reappointment of Professor Eileen Fairhurst as the Chairman of East Lancashire Hospitals NHS Trust for a further two year period from
1 February 2022.

Eileen has been in the post since February 2014 and during that time has overseen the improvement of the Trust to be taken out of ‘special measures’ and receive a recent Care Quality Commission (CQC) rating of ‘GOOD’ with areas of ‘OUTSTANDING’. Most recently, she has been the steady hand guiding the Trust through the Covid-19 pandemic.

The extension to the Chairman’s tenure will provide stability and continuity for the leadership of the Trust. Eileen will continue to work with Martin Hodgson, in his Interim Chief Executive role, following Kevin McGee’s move to Lancashire Teaching Hospitals NHS FT at the end of August.

Chairman pays tribute to Chief Executive Kevin McGee

The Chairman of East Lancashire Hospitals NHS Trust, Professor Eileen Fairhurst has paid tribute to Kevin McGee as he leaves his post as Chief Executive of the Trust.

In a message sent to all employees of the Trust, Eileen said: “Kevin has been a significant source of support to myself, the Board and indeed all of us all over the last seven years.

“His legacy of compassionate leadership will stay with us. Kevin’s dedication and commitment to providing Safe, Personal and Effective care has been immeasurable, as has his passion to ensure a happy and healthy workforce. I know you will join me in wishing Kevin the best of luck for the future.”

Kevin McGee leaves ELHT today to take up his new role as Chief Executive of Lancashire Teaching Hospitals NHS Trust.

Alongside his Chief Executive role, Kevin will also lead the Provider Collaborative Board which comes at an incredibly important time for the Lancashire and South Cumbria Integrated Care System.

Harry Catherall steps down as Associate Non-Executive Director

Harry Catherall, Associate Non-Executive Director, will be taking a sabbatical from his role at the Trust to join Oldham Council in a 12 month post as Interim Chief Executive.

Harry joined the Trust at ELHT in July 2019 and has been an integral part of the Board during that time. During his tenure he has brought a wealth of knowledge and leadership experience with a great passion for health and social care. He also had a pivotal involvement within our finance and performance committee.

We would like to thank Harry for his work and support at ELHT and wish him well in his new role.

Surgical face masks wearing to continue in healthcare settings

Covid restrictions in many settings in England ended from Monday19 July, 2021.

However, Public Health England’s infection prevention control guidelines and hospital visiting guidance remain in place for all staff and visitors.

That means NHS visitor guidance will stay in place across all health services including hospitals, GP practices, dental practices, optometrists and pharmacies to ensure patients and staff are protected.

Staff, patients and visitors will also be expected to continue to follow social distancing rules when visiting any care setting as well as using a surgical face mask and other personal protection equipment.

Chris Pearson, Chief Nurse for ELHT reminded people that the Trusts current guidance and procedures in place at ELHT will not change and colleagues, volunteers, patients and visitors inside our hospital buildings or community services will still be required to do the following:

HANDS: Wash hands regularly with soap and water or hand gel if hand washing facilities are not available.

FACE: Wear surgical face masks (not coverings) in all clinical and non-clinical environments, including corridors and public areas. (These are provided at each entrance to our buildings).

SPACE: Keep your 2m distance on corridors, and keep to the left.

There will be no changes to these requirements until there is clear instruction that they are no longer needed.

Putting East Lancashire mothers in control of their labour pain relief

ELHT has been offering Remifentanil Patient-Controlled Analgesia (PCA) for people in labour for over four years. Remifentanil PCA is an ultra-short-acting pain killer that goes into a designated drip, controlled by the person in labour as and when they need the pain relief.

More than 100 people, over half of them first time mothers, have benefitted from using Remifentanil PCA since it came into use in the Trust.

Remifentanil works within 30 seconds, disappears from the body within three to five minutes, and is completely safe for the baby in the womb. It provides a good alternative to epidural pain relief, and over half of those who used it chose it instead of an epidural.

A staggering 96.3% of those who used Remifentanil PCA said they would recommend it to others, 97.5% said they were very satisfied or satisfied with their experience with it, and 95.1% would use it again in labour in the future.

Closer colleagues than ever – how donating a kidney saved ELHT Surgeon's life

A Consultant Trauma and Orthopaedic Surgeon at East Lancashire Hospitals NHS Trust was given a second chance at life this year, after his colleague and Waiting List Clerk donated her kidney to him following his two-year wait on the national transplant list.

Andrew Sloan, who has worked at the Trust since 2010, received the devastating diagnosis of end stage renal failure in 2018 and was told he either required a transplant or faced having to receive dialysis for the rest of his life. By March 2020 Andrew was required to undergo dialysis at the Trust for 4-5 hours at a time, 3 times a week. This meant he had to do this after work on a Tuesday and Thursday as well as on a Saturday night.

After years of family members and friends coming forward to donate, but not being a match, his colleague and friend Rebecca Brazendale, a Session Utilisation Coordinator at the Trust, offered to donate. Amazingly, following weeks of testing and support, Rebecca was found to be a match and the transplant

surgery was able to go ahead in March this year, with both colleagues being admitted to the transplant ward at Manchester Royal Infirmary to undergo the surgery.

The pair now have a closer connection than ever before and are in contact every day since Andrew returned to work last week following his absence. After the surgery they also introduced their families to each other and were able to spend time enjoying Andrew's new lease of life.

Pancreatic Cancer Rapid Diagnostic Service shortlisted for top Macmillan award

The Pancreatic Cancer Rapid Diagnostic Service (RDS) at ELHT has been shortlisted for a Macmillan Professionals Excellence Award as recognition of their outstanding contribution to cancer services.

The service is part of a Lancashire and South Cumbria wide initiative designed to support earlier diagnosis in pancreatic cancer and has been shortlisted in the 'Integration Excellence' category. The award recognises teams who have improved the coordination of services and enabled integration across settings such as acute, primary, social and voluntary services to provide a seamless experience for people living with cancer.

The ELHT Cancer Services Team was nominated for their collaborative working with colleagues including diagnostic specialists, biomedical scientists and clinicians. They also work closely with representatives from the Lancashire and South Cumbria Cancer Alliance, Primary Care Networks and 3rd sector organisations, Pancreatic Cancer Action and Pancreatic Cancer UK.

The successful collaborative work has meant that an average wait time for a patient to be diagnosed with pancreatic cancer has reduced considerably following GP referral.

Bon Appetite! ELHT Chefs cook up a storm at new NHS competition

Two Chef's at East Lancashire Hospitals NHS Trust have fought off competition to be crowned Regional NHS Chef of the Year at the first ever NHS Chef competition which was launched in August with the first heats in Newcastle.

Sinto Jose and Sanish Thomas, both Chefs working at Royal Blackburn Teaching Hospital, were selected from their department to take part in the first set of heats in a competition to be crowned NHS Chef of the Year, 2021.

The pair travelled to Newcastle to take part and cooked up a storm with their healthy allergen-free dishes. Their starter of quinoa and roasted vegetables with an olive oil and orange dressing also picked up an award for the best plant-based meal of the day.

During the event, each team had 90 minutes to prepare, cook and present a three-course meal in line with hospital food budgets that would be suitable for delivery to a patient via a trolley. The meal also had

to reflect Government Buying Standards for Food and Catering Services, the Department of Health and Social Care's Obesity Strategy and must be nutritionally balanced in accordance with the British Dietetic Association (BDA) guidance.

Take a virtual tour around our Muslim Prayer Room

The Muslim Prayer Room in our Spiritual Care Centre, based at Royal Blackburn Teaching Hospital, has had the full 'Google Maps' treatment, with a new 360 degree virtual tour now available to view online.

The tour was facilitated by the Muslim Council of Britain as part of the 'Visit My Mosque' initiative, which supported more than 250 mosques across the UK to hold open days. This year, despite the lockdown, #VisitMyMosque went virtual with a series of live virtual tours in June.

The aim of 'Visit My Mosque' is to facilitate mosques to welcome in their neighbours from all faiths and none and build bridges across communities. You can watch the virtual tour here.

Our Maternity Services are gold standard, again

ELHT's Maternity Services have maintained their UNICEF UK Baby Friendly Initiative (BFI) accreditation, which they first achieved in 1998. The team were the first to receive the 'Achieving Sustainability' BFI GOLD award in 2017 and the first to revalidate in both 2018 and 2021.

The GOLD standards are designed to help services to embed Baby Friendly care long-term over four GOLD themes.

To achieve BFI GOLD accreditation and revalidation, the Trust has made a range of developments and innovations within the service, including:

- Appointing a BFI Guardian and establishing a BFI Gold Leadership Team, with representatives from all areas of maternity services.
- Monitoring the culture of kindness is strong and monitored via staff surveys, staff 'listening roadshows', parent audits and parent feedback. When carrying out audits, parents are also asked 'Is there anything else you would like to feed back?', 'How kind and considerate were the staff?' and 'How can we do better'.
- Designing a 'BFI data dashboard' to allow ongoing monitoring, examining all the data in one place and 'rag' rating it each month. This allows the team to develop interventions to support improvements.

ELHT secures funding for New Alcohol Care Team

The Trust has secured funding on behalf of the Pennine Lancashire Integrated Care Partnership to establish an Alcohol Care Team in Pennine Lancashire. The funding awarded by the NHS National Prevention Programme has been committed over a three year period to reduce alcohol related harm and the impact of this within the local area.

Pennine Lancashire has been identified as an area of significant risk around alcohol use with over 2700 alcohol related hospital admissions each year. From 2018-2019 approximately 6,852 alcohol dependant adults were identified across the area and it is expected that this figure will have increased during the coronavirus (COVID-19) pandemic.

ELHT have recently appointed Laura Walker as Lead Nurse for Alcohol who will be responsible for the recruitment and management of the new Alcohol Care Team (ACT). Laura is a qualified Mental Health Nurse and is looking forward to making a real difference.

Public Health England reported that alcoholic liver deaths increased by 21% across England since the onset of COVID-19, which is likely due to an increased alcohol consumption, particularly amongst heavy drinkers.

Stress, loneliness and the lack of access to alcohol support services have resulted in many people drinking more alcohol and putting their livers at risk. Alarmingly, these statistics show that those who come from the most deprived areas of the country are also disproportionately affected.

Whilst restrictions may have eased, the long-term effects of the pandemic, including the effect of excess alcohol consumption are still to be seen.

ELHT shortlisted twice for national awards

We are delighted to announce that the Trust has been shortlisted for this year's National Health Service Journal Awards (HSJ) in two categories:

- Patient Safety Award
- NHS Race Equality Award

Patient Safety Award

This nomination centres around the Trust's Critical Care Unit and its response to the Covid-19 pandemic. East Lancashire was one of the busiest critical care units in the UK, with the area as a whole registering some of the highest community infections rates, hospital admissions and sadly, deaths throughout the pandemic.

NHS Race Equality Award

This accolade recognises the important work being carried out by our Black Asian Minority Ethnic Staff Network that supports our wider workforce.

Kevin Moynes, Executive Director of HR at ELHT said, “The Trust is extremely proud of its diversity which is evident in our ELHT Family, both in hospital and in the community.

“We want everyone to feel involved, included and equally valued. We are so pleased that our commitment to this has been recognised via these awards.”

The HSJ Awards continue to be the most esteemed accolade of healthcare service excellence in the UK. The Awards do not only adhere values of sharing best practice, improving patient outcomes and innovating drivers of better service, but most importantly provide a well-deserved thanks to the sector.

Following one of the most demanding years on record for the NHS, the awards aim to shine a light on the outstanding efforts and achievements that individuals and teams across the sector have delivered. Whether or not our teams take home the trophy, we are immensely proud their achievements!

The judging panel was once again made up of a diverse range of highly influential and respected figures within the healthcare community.

Following the intense and in-depth judging process, ELHT was shortlisted in two categories, ahead of the official awards ceremony to be held later this year on Thursday 18 November. Standing out amongst tough competition from hundreds of other exemplary applicants, ELHT was selected based on ambition, visionary spirit and the demonstrable positive impact that it has had on both patient and colleague experience.

The full shortlist of nominees for the 2021 HSJ Awards can be found on the HSJ website.

Four – Communications and Engagement

A summary of the external communications and engagement activity.

July 2021

Communications and Engagement

Monthly Media Update

Top Stories...

- Closer colleagues than ever – how donating a kidney saved ELHT Surgeon's life
- East Lancashire Hospitals NHS Trust Appoints Interim Chief Executive
- Trust puts East Lancashire mothers in control of their labour pain relief
- Parents and carers in Lancashire and South Cumbria advised to be aware of the signs of respiratory illnesses and when to get help

Press and Media Relations...

17 mentions in all media

11 Media enquiries handled

6 media releases issued this month

99% of stories were positive or neutral

Projects the Communications Department has supported...

- Inclusion
- Restoration
- ELHT&Me
- Health and wellbeing

Website...

Our website got **133,201** page views by **48,653** people.

The most viewed webpage was – Waiting times

NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Social media and digital...

Followers on social media:

18,422 ↑

8,917 ↑

3,059 ↑

92,924 ↑
Avg Weekly Facebook Reach

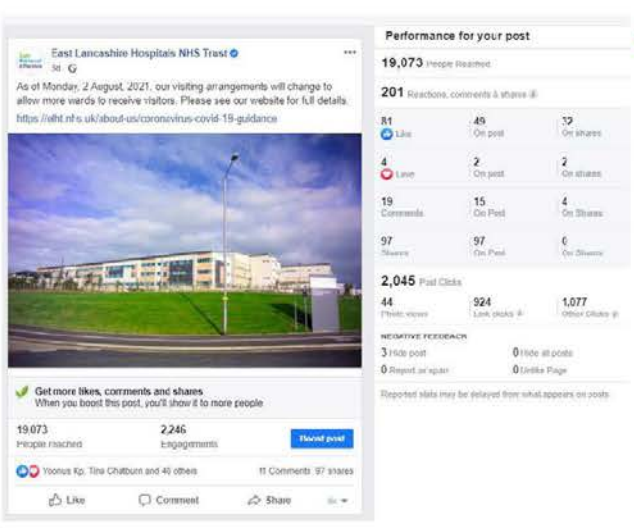
198,000 ↓
Twitter Impressions

239 ↓
Twitter mentions

The most talked about issues on our social networks..

- Changes to visitor restrictions (19.1k)
- A&E under extreme pressure (12.2k)
- Emergency Department extremely busy (10.8k)
- Burnley Birth Centre stats (9.5k

Posts of the month...



Top Tweet earned 18.2K impressions

⚠ Our A&E is extremely busy right now...

Dr Alabood Ahmad, Consultant in our Emergency Department, wants to remind you to contact NHS 111 in the first instance, so that they can direct you to the correct services for your care.

Only call 999 in an emergency.
#HelpUsHelpYou
pic.twitter.com/S4npNv6HVo

Routine activity:

Weekly staff bulletin
COVID briefing
Stakeholder Briefing
Other News
Website updates
Sharepoint/OLI updates

August 2021

Communications and Engagement

Monthly Media Update

Top Stories...

- Pancreatic Cancer Rapid Diagnostic Service shortlisted for top Macmillan award
- Bon Appetite! ELHT Chefs cook up a storm at new NHS competition
- Our Maternity Services are gold standard, again!
- East Lancashire Hospitals secures funding for New Alcohol Care Team
- Chairman pays tribute to Chief Executive Kevin McGee

NHS Improvement Reappoints Chairman

Press and Media Relations...

28 mentions in all media ↑

10 Media enquiries handled ↓

7 media releases issued this month ↑

71% of stories were positive or neutral ↑

Projects the Communications Department has supported...

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

Website...

Our website got **138,919** page views by **50,450** people.

The most viewed webpage was – Waiting times ↑

East Lancashire Hospitals
NHS Trust
A University Teaching Trust

Social media and digital...

Followers on social media:

18,490 ↑

8,981 ↑

3,080 ↑

96,935 ↑
Avg Weekly Facebook Reach

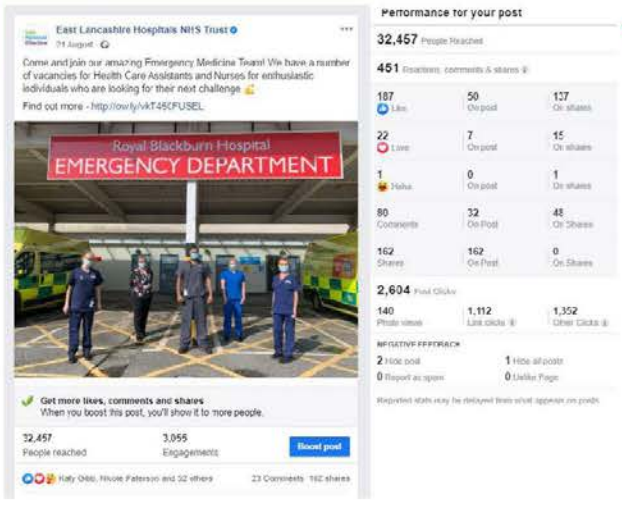
167,000 ↓
Twitter Impressions

269 ↑
Twitter mentions

The most talked about issues on our social networks..

- Pancreatic Cancer Rapid Diagnostic Service (RDS) shortlisted for a Macmillan Professionals Excellence Award (9.1k)
- A&E is under extreme pressure (5.3k)
- The new Critical Care Unit side C (Ward B20) at RBTH welcomed it's first patients (5.2k)
- Our vaccination hubs at Blackburn Cathedral and Burnley Mall administered their 200,000th vaccine (3.7k)

Posts of the month...



Top Tweet earned 9,169 impressions

Amazing news! Our Pancreatic Cancer Rapid Diagnostic Service (RDS) has been shortlisted for a Macmillan Professionals Excellence Award!

Read more here - elht.nhs.uk/news-and-media...

@HealthierLSC @EastLancsCCG @BwDCCG @PancreaticCanUK
pic.twitter.com/RwZXFDobGG

Routine activity:

Weekly staff bulletin
COVID briefing
Stakeholder Briefing
Other News

Website updates
Sharepoint/OLI updates
Facebook Group

Five - Chief Executive's Meetings

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

August 2021 Meetings

Date/Frequency	Meeting
Weekly – Monday	Lancashire and South Cumbria (LSC) Out of Hospital and Hospital Cell Touchpoint
Weekly – Monday	North West Hospital Cell Gold Command Escalation
Weekly – Tuesday	Executive Team
Weekly – Tuesday	David Flory, Independent Chair, (LSC) Integrated Care System
Weekly – Wednesday	LSC Chief Executives Briefing
Weekly – Wednesday	North West Regional Leadership Group
Weekly – Tuesday	Chairman/Chief Executive Briefing
Bi-Weekly – Friday	North West Capacity Oversight Group
Weekly – Monday and Wednesday	LSC Hospital Cell Team
Bi-weekly - Tuesday	COVID-19 STP Hospital Cell
Monthly – Tuesday	ICS Development Oversight Group
10 August	CQC visit
10 August	PL Chairs and Chief Officers Advisory Group
10 August	Cardiac Network Meeting
12 August	CEO Advisory Group
18 August	LSC System Leaders Executive
26 August	NHP Strategic Oversight Group
27 August	Provider Collaboration Board

September 2021 Meetings

Date/Frequency	Meeting
Weekly – Tuesday	Executive Team
Weekly – Tuesday	Senior Leadership Group
Weekly – Tuesday	Chairman/Chief Executive Briefing
1 September	LSC ICS Board
1 September	Employee Sponsor Group
2 September	Blackburn College
3 September	Step into ELHT Celebration Event
7 September	NW System Leaders
8 September	Trust Board
8 September	LSC Chief Executive Briefing
9 September	Annual General Meeting
14 September	PL Chairs and Chief Officers Advisory Group
15 September	LSC System Leaders Executive
21 September	NW System Leaders
23 September	STAR Awards
24 September	LSC Pathology Collaboration Board
24 September	Provider Collaboration Board
27 September	Festival of Inclusion
28-27 September	Cerner Alignment Event

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 107

8 September 2021

Purpose Monitoring

Title	Corporate Risk Register
Author	Mr M Stephen, Head of Safety & Risk
Executive sponsor	Mr J Husain, Executive Medical Director

Summary: This report presents an overview of the Corporate Risk Register (CRR) as of the 21/072021 these risks have been reviewed at RAM on the 25/06/2021 and will be reviewed in the next meeting on the 30/07/2021. This is the last update that went to the Quality Committee. An update will be sent to the next meeting on 22/09/21.

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do 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:

Changes to the report since last updated;

1. A controls review has taken place across all Corporate Register risks and there is now only one risk which is listed as having 'Poor' controls in place
2. All other risks have controls in place and these are regularly reviewed, those that are 'Limited' in controls may have active controls that are working but may have some GAPS within those controls which are stopping them from being fully effective. Further work to review these is underway. A lack of 'Adequate' controls may stop the risk from bringing the likelihood of the risk occurring, down.
3. A piece of work looking at **DCS risks** has been undertaken which has improved the quality of open risks and reduced the number of some older, unmanaged risks.

Risk Performance information;

1. **1699** risks are currently open. **(Decrease of 3% compared to last month)**
2. **135** of these risks are currently **OVERDUE**. **(53% reduction in overdue risks compared to last month, only 8% of LIVE risks are overdue)**
3. Training has been made available across the whole orginisation with regular face to face sessions and e-learning sessions being taken, this has improved the compliance of managing risks and some quality improvements have been seen.
4. **197 staff members** have taken the risk e-learning or training this year. **(This is up by 87% compared to last month)**
5. Risks with **'Health & Safety'** have increased over the last 12 months. Under-review, this has been down to increased risk assessments for clinical/non-clinical spaces in relation to Social Distancing/PPE and good compliance with the Trust's Social Distancing Policy and COVID Guidelines. There has also been a Trust increase in Fire Safety awareness and risk management which will have an impact on H&S risks for a short period whilst these are reviewed.

Table 1: List of Corporate Risks

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

Table 2: Detailed risk information

No	ID	Title				
1	8441	**Coronavirus (COVID-19) Outbreak**				
Lead		Tony McDonald	**Current score**	**20**	**Score Movement**	⟷
Description		This risk is to capture the risk to our patients and staff in the event of further infection rates across the UK from the coronavirus (COVID-19) outbreak.		**Actions**	1. Continuous actions managed and monitored through the ICC meetings and regular OCC meetings throughout the trust. 2. Mass Vaccination rollout	**All actions managed by Tony McDonald (Continued actions under development as pandemic progresses through the appropriate meetings)**
Top Controls		1. Co-ordination centre set up Trust HQ to enable the management and implementation of plans, processes and procedures, with daily update meetings taking place. 2. ICC meetings currently once a week with a Senior Leadership meeting once a week for key decision making and escalation. 3. Increased staffing during core hours to alleviate pressures - including current winter pressures measures. 4. Regular communications about next steps/working group outcomes to keep staff and patients informed 5. Social Distancing Group in place within the EPRR meeting (Monthly) to review key issues and escalations. 6. Established executive oversight group which will support A) Asymptomatic staff testing B) Mass staff vaccination C) Mass Vaccination. 7. Mass vaccination programme underway and launched 18/01/2021 8. Enhanced monitoring of Oxygen flow and capacity. Regularly reported on and discussed in Patient Flow meetings/ICC. 9. Increased activity within mass vaccinations to roll out vaccinations to younger age groups due to the variants of concern.				
Update since the last report		**23/06/2021 –**The Delta Variant has become the most dominant in East Lancs and inpatient numbers have risen over the past few weeks. Locality surge vaccination programme has been undertaken with army support and work is ongoing to support all cohorts (over 18+) getting their vaccine. No adverse impact on restoration of services at this time. Community transmission high but appears to be levelling off.		**Date Last reviewed**	**23/06/2021**	
				Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
					20	**20**	**X**	**X**
				8 week score projection	**20**			
				Current issues	**Impacted by COVID-19. Indian variant causing higher numbers of infections locally.**			

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

		Current issues	The risk is currently moving into a Project so further discussions will take place about the future management of this.

No	**ID**	**Title**						
3	7762	**Risks associated with providing HDU (High Dependency Unit) care in DGH with no funding for HDU provision (Family Care)**						
Lead		Neil Berry	**Current score**	**20**	**Score Movement**			
Description		ELHT provides HDU (High Dependency Unit) care as does most District General Hospitals with the tertiary centres providing formal HDU In recent years with increasing demand and limited tertiary capacity the provision for HDU care is increasing. We have received no funding to manage this provision and yet provide an estimated 1404 HDU days per year (70 % being Level 2 HDU).		**Actions**	1. STP leading review of DGH HDU care	1. Vanessa Holme	1. 26/06/2021 **(Was 09/03/2021 and 28/03/2021)**
Top Controls		1. Safer staffing is reviewed for nursing on a daily basis at Matron and Trust Director of nursing level. Staffing is managed according to acuity and therefore managed in a safe manner. 2. Medical staffing actions have been taken to mitigate risk of medical cover to HDU activity in winter months -specific winter planning takes place. 3. HDU competencies and training completed and co-ordinated in the Directorate to ensure suitable skills. 4. Safer staffing for nursing completed on a daily basis and acuity of patients managed at Matron/Trust level. 5. Medical staffing support monitored and winter planning actions put in place to support increased HDU activity.					
Update since the last report		**23/06/2021-** Demand is higher than the current amount of commissioned beds in the unit. There is a review underway with the ICS to look at funding the additional surge demand which is expected to take through past winter 2021. The original part of this risk is not resolved by this additional funding.		**Date last reviewed**	**17/06/2021**		
				Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
					20	**X**	**X**	**X**
				8 week score projection	**20**			
				Current Issues	CCG currently not funding L2 Critical care activity. Awaiting decision from the ICS. Surge in HDU use expected past winter 2021.			

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

Update since the last report	**23/06/2021-** We currently have 9012 patients on the surgical holding list. 4965 of these patients sit within the Ophthalmology specialty. All the current controls are still in place, but we are obviously very concerned as a team to be having this number of patients sat without review dates. We have had approval today to offer an increased rate of pay to the consultants to try and incentivize them coming forward to do extra clinics. We are hopeful this will deal with some of the red and over 6 months patients first.	**Date last reviewed**	**23/06/2021**
		Risk by Quarter 2021	**Q1** 16 / **Q2** X / **Q3** X / **Q4** X
		8 week score projection	**16**
		Current issues	**Impacted by COVID-19**

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

Update since the last report	**05/07/2021** Seconded General Paeds speciality doctor into vacant post for 12 months and will advertise role nearer the end of the secondment. Contacted Royal College of Paediatrics re review but no response as staffs are still furloughed. Funding non-recurrent from CCG given for 12 months to commence ASD pilot. However unable to recruit to posts leaving the matron delivering the role 3 days per week. **NO CHANGE**	**Date last reviewed**	**05/07/2021**
		Risk by Quarter 2021	**Q1** 16 / **Q2** X / **Q3** X / **Q4** X
		8 week score projection	**15**
		Current Issues	Funding has been extended because of COVID but that does not mitigate the risk as we still provide the service with no additional funding and uncertainty post COVID.

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

		(Ophthalmology)					
Lead	Victoria Bateman	**Current score**	**16**	**Score Movement**	⟷		
Description	Insufficient clinic capacity for patients to be seen in outpatient clinics resulting in unbooked new patients and a very large holding list of overdue patients. In some cases there is significant delay and therefore risk to patients The demand far outweighs capacity, and this has been exacerbated since the covid pandemic, with the requirement for social distancing meaning less patients can be accommodated in waiting areas. All patients are risk stratified (red, amber, green), however still cannot be seen within timescales and additional risk that amber patients could become red over time etc.	**Actions**	1. Community stable Glaucoma 2. Outsourcing of OCT & Visual Fields	1. Vikas Shankar 2. Vikas Shankar	1. 01/09/2021 (was 16/04/2021) 2. 31/101/2021 (was 02/08/2021)
Top Controls	1. Failsafe Officer in place - focuses on appointing the red patients and the longest waiters. Validates the holding list. 2. Capacity sessions where doctors willing and available. 3. Used locums previously - however not currently in place due to (i) lack of available space, (ii) calibre of personnel is questionable, (iii) specialised areas of expertise, and (iv) in practice they do not tend to discharge and it therefore adds to holding list concerns at a later date. 4. Flexibility of staff 5. Integrated Eye Care Service in place for specific pathways, keeping relevant patients out of hospital eye services where possible.						
Update since the last report	**21/06/2021-** We have now moved over to four sites and currently working through the IT issues that have arisen due to the move. Main arrear of concerns moving forward is band 2/3 staffs which are required to run clinic. (support workers).**NO CHANGE**	**Date last reviewed**	**21/06/2021**				
		Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**	
			15	**X**	**X**	**15X**	
		8 week score projection	**15**				
		Current Issues	**Impacted by COVID-19**				

No	**ID**	**Title**					
7	7067	**Aggregated Risk** - **Failure to obtain timely mental health (MH) treatment impacts adversely on patient care, safety and quality**					
Lead	David Simpson	**Current score**	**15**	**Score Movement**	⟷		
Description	ELHT is not a specialist provider or equipped to provide inpatient mental health services. Patients with mental health need do present to the Trust and they may require both physical and mental health assessments, treatment and referral to specialist services. Due to lack of specialist knowledge, this may cause deterioration of the patient.	**Actions**	1. ELHT to audit the number of patients admitted to the MHUAC from 1st of april on a monthly basis 2. Review impact of MH service provision with opening of MHUAC 3. To establish and embed clinical model of review times from MHLT 4. RCEM 2019-2020 Audit action plan completetion	1. Rafia Naser 2. David Simpson 3. David Simpson 4. David Simpson	1. 30/07/2021 **(was 30/04/2021, 30/06/2021)** 2. 30/07/2021 **(was 03/06/2021)** 3. 06/08/2021 4. 03/09/2021		
Top Controls	1. Daily system mental health teleconference, attended by ELHT Clinical Site Managers. 2. Discussion and review at four times daily clinical flow meeting 3. Expanded mental health liaison team service based in emergency department. 4. Treat as one group established to oversee the response to physical and mental health needs of patients. This group is chaired by the director of nursing and includes representatives from ELHT and LSCFT, LCC, BWDBC,CCG, Police. TAO group currently stood down but multiple meetings across the trust still cover core essentials. Multi agency oversight group also in place. 5. Mental Health Shared Care Policy including out of hours escalation process for MH patients.						
Update since the last	**14/07/2021-** Risk remains the same. There is current powerBI issues with capturing how many mental	**Date last reviewed**	**14/07/2021**				

report	health patients present to the department. This has now been escalated to informatics and discussed at DMB for June 2021, the ED business team are trying to rectifying this. There were 5, 12 hour mental health breaches Between June and 14th July 2021, with multiple delays for patients with mental health need. The number of patients going to the MHUAC remains low, the MHLT is now bringing weekly breakdown figures to the ED MH clinical working group so these can be reviewed with the aim of improving patient pathways in to the MHUAC.	Risk by Quarter 2021	Q1	Q2	Q3	Q4
			15	X	X	X
		8 week score projection	15			
		Current issues	Clinical model to be embedded, this has been added as a new action this month.			

No	ID	Title				
8	1810	Aggregated Risk - **Failure to adequately manage the Emergency Capacity and Flow system**				
Lead	David Simpson	Current score	15	Score Movement		
Description	Lack of capacity across the Trust can lead to extreme pressure resulting in a delayed delivery of the optimal standard of care across departments. At times of extreme pressure this increase in the numbers of patients within the emergency pathway makes medical/nursing care difficult and impacts on clinical flow	Actions	1. Nursing Assurances to be provided regarding care delivery to patient in ED 2. Review impact of NWAs direct streaming to AECU 3. To have an automated DTA validation list via Powerbi	1. Zoe Lewis 2. David Simpson 3. Shane Platt	1. 02/08/2021 (was 31/03/2021) 2. 27/08/2021 3. 03/09/2021	
Top Controls	1. Further in-reach to department to help to decrease admission 2. Workforce redesign aligned to demands in ED 3. Review of processes across Acute / Emergency medicine in line with Coronial process and incidents. 4. Work with CCG on attendance avoidance 5. Phase 6 build commenced - completion Nov 2020 6. Business plan in place to review the footprint of ED and urgent care.					
Update since the last report	**14/07/2021**-Risk reviewed and remains the same at present, which is supported by our current monthly performance of 71.30%. Noted increased demand, numbers remain similar picture as 2019, but the surges in presentation is the issue. Noted worse performance on one day this month on record at around 56%. Meeting with Divisional management team and ED SMT took place with simple but efficient ideas being worked through. Meeting planned 16th July 2021 with ED Head of Nursing and Head of clinical flow to simplify pathways and reporting structures, which will enable focus support to areas/team.	Date Last reviewed	14/07/2021			
		Risk by Quarter 2021	Q1	Q2	Q3	Q4
			15	X	X	X
		8 week score projection	15			
		Current issues	Impacted by COVID-19			

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

Lead	Julie Molyneux/Chris Pearson	**Current score**	**15**	**Score Movement**	⟷
Description	Use of agency staff is costly in terms of finance and levels of care provided to patients				
Top Controls	1. Daily staffing teleconference, chaired by Divisional Director of Nursing, who balances and mitigates risks based on professional judgment, debate and acuity and dependency. 2. The use of the Safe Care Tool within Allocate to support decisions regarding acuity an dependency 3. E rostering - Planned and actual nurse staffing numbers recorded daily and formally reported monthly following quality assurance processes; 4. Dashboard review of good rostering compliance 5. Monitor red flags, IR1s, complaints and other patient experience data	**Actions**	1. Twice yearly professional judgment review of nurse and midwifery staffing requirements 2. Ongoing recruitment ,, locally, nationally, and internationally	1. All actions owned and managed by Julie Molyneux	1. 31/01/2022 **(was 01/03/2021)** 2. On-going
Update since the last report	**21/06/2021**- No change in risk score - we have engaged with an agency called Jane Lewis on international recruits however due to pandemic the Indian nurses we usually recruit has been temporarily suspended.	**Date Last reviewed**	**14/07/2021**		
		Risk by Quarter 2021	**Q1**: **15**	**Q2**: X	**Q3**: X	**Q4**: X
		8 week score projection	**15**		
		Current issues	Some impact from COVID but risk has been in place for a while and recruitment nationally is still an issue.		

No	**ID**	**Title**				
10	7008	**Failure to comply with the 62 day cancer waiting time.**				
Lead	William Wood	**Current score**	**15**	**Score Movement**	⟷	
Description	Cancer treatment delayed. Potential to cause clinical harm to a patient if the treatment is delayed.					
Top Controls	1. CNS engagement with virtual PTL 2. Cancer escalation process modified and re-issued 3. Cancer Hot List issued twice weekly 4. Additional theatre capacity with additional capacity being attained throughout other hospital services. 5. Lancashire Cancer Tactical Group, Trust and CCG colleagues discuss performance, progress, and ideas for improvement. 6. Cancer Performance Improvement group has been established and is chaired by the Lancashire/South Cumbria Alliance.	**Actions**	1. Creation of comprehensive Cancer PT and automated Hot list 2. Implementation of Rapid cancer diagnostic and assessment pathways 3. Capacity & Demand Review 4. Investment of Alliance Funding in pathway to improve processes.	**All actions managed by William Wood**	1. 30/06/2021 **(was 31/03/2021)** 2. 31/09/2021 **(Was 31/12/2020 and 30/03/2021)** 3. 31/03/2022 **(was 30/03/2021)** 4. 31/03/2022**(was 30/03/2021)**
Update since the last report	**16/07/2021-** Particular attention being paid to the increasing 62 day backlog mostly being caused by the patients in the faster diagnosis backlog, ie. Those patients we know do not have cancer but we do not yet have evidence the patient has been informed. Meetings held with all Divisions and Deputy COO to discuss risks and issue and future plans for improvement that will be added to the wider action plan. LSC Cancer Alliance	**Date Last reviewed**	**16/07/2021**			
		Risk By Quarter 2021	**Q1**: **15**	**Q2**: X	**Q3**: X	**Q4**: X

	asking for ideas for "high impact interventions" some transformation funding will become available in the near future and they want schemes to invest into, currently discussing with relevant stakeholders to identify the best areas to put forward.	8 week score projection	15
		Current issues	Impacted by COVID-19

No	ID	Title				
11	8257	**Loss of Transfusion Service**				
Lead		Lee Carter	Current score	15	Score Movement	⟺
Description		Denial of the laboratory premises at RBH, especially blood transfusion, due to: 1. Planned evacuation due to fire alarm test. 2. Unplanned evacuation, in response to local fire alarm activation 3. Evacuation due to actual fire within the laboratory.	Actions	**All actions have been completed. The risk is being reviewed and should reduce in score and move to the 'Trust Wide' Risk register. Awaiting further updates.**		
Top Controls		**1.** Emergency bloods can be stored in temporary insulted boxes for a period of time **2.** The BMS (Bio Medical Scientist) would either station themselves outside the entrance to the laboratory, where they could issue emergency units out **3.** If level 0 was out of bounds, clinical flow room would be point of contact skilled staff. **4.** Hospital Transfusion Committee in place and review of meeting still underway.				
Update since the last report		**22/06/2021 –**The electronic blood banks have arrived on site and are awaiting installation. Installation on the RBTH site requires building works to alter a room, to specifically serve as the blood bank room. BGTH site involves a co-ordinate effort with Obs & Gyn to remove and re-site existing blood bank in theatres (also to be retrofitted with an electronic kiosk, to seamlessly link with the new electronic system). Once agreement has been reached to fund the change, this can go ahead. The new blood bank is to be placed in the existing area, but alteration works (data points) are required. Liaising with estates for work to be progressed, but also to see if there are temporary areas, across the Trust where we can start the validation work.	Date Last reviewed	22/06/2021		
			Risk by Quarter 2021	Q1: 15	Q2: X	Q3: X	Q4: X
			8 week score projection	10		
			Current issues	The siting of the fridges is being discussed and when in place they will need to go through change control.		

No	ID	Title				
12	8243	**Absence of an end to end IT maternity system (Family Care)**				
Lead		Neil Berry/Tracy Thompson	Current score	15	Score Movement	⟺
Description		Inability to have an end to end IT record of a woman's care throughout her antenatal, intrapartum and postnatal care. Impact on midwives work load as data capture will be manual, time consuming with an inconsistent approach to collect, no additional resources are available to collate this data manually which would equal at a minimum a full time post. Potential gaps and risks of inaccurate data capture	Actions	**All actions completed, awaiting further actions as risk is close to mitigation.**		

Top Controls	**1.** The ICS procurement process is nearing its conclusion and the supplier for the new maternity system should be decided by the 30st September 2020. A divisional, multidisciplinary maternity system steering group has been formed and will meet every fortnight from the 14th October. The group will begin by discussing and developing the business case for the new system, discuss and look at setting up the project team once the chosen supplier is known and then discussing the choice and purchase of new IT infrastructure, again once the chosen supplier known. **2.** Review of equipment used by midwives in the community for accessing systems is underway		
Update since the last report	**12/07/2021-** Current process mapping complete and future process mapping underway. Super user training starting in a week followed by user training throughout August and September. Interfaces being tested and changes requested from Clevermed.	**Date Last reviewed**	**12/07/2021**
		Risk by Quarter 2021	**Q1** 15 / **Q2** X / **Q3** X / **Q4** X
		8 week score projection	**12**
		Current issues	Roll out has been delayed which has paused some of the training.

No	**ID**	**Title**				
13	8652	**Failure to meet internal & external financial targets for 2021-22**				
Lead	Michelle Brown	**Current score**	**15**	**Score Movement**		
Description	Failure to meet financial targets is likely to lead to the imposition of special measures and limit the ability of the Trust to invest in the services it provides. Continued failure to meet financial targets may lead to the Trust being taken over by another provider.		Actions	1. Submit monthly financial monitoring returns to NHSEI 2. To ensure we have a financial training programme in place to support the wider organisation and network 3. To work across the Trust with non-financial colleagues	All actions managed by Charlotte Henson	**1.** Ongoing
Top Controls	**1.** Robust financial planning arrangements, to ensure financial targets are achievable and agreed based on accurate financial forecasts; **2.** Financial performance reports distributed across the organisation to allow service managers and senior managers to monitor financial performance against financial plans, supported by the Finance Department; **3.** Enforcement of Standing Financial Instructions through financial controls to ensure expenditure commitments to incur expenditure are made in accordance with delegated limits; **5.** Arrangements to monitor and improve delivery of the Waste Reduction Programme **6.** Enforcement of Standing Financial Instructions through financial controls to ensure expenditure commitments to incur expenditure are made in accordance with delegated limits					
Update since the last report	**13/07/2021-** The Trust has received an allocation of £6.9m from the ERF Fund and hence is now reporting a break-even financial position and forecast outturn for H1. The risk attached to this is the system achieving the ERF targets and financial compensation for the increased cost base. In addition Q2 targets have moved to the ERF being awarded on 95% of 19-20 activity from the 85% that was agreed as part of the H1 planning round.	**Date Last reviewed**	**13/07/2021**			
		Risk by Quarter 2021	**Q1** 15 / **Q2** X / **Q3** X / **Q4** X			
		8 week score projection	**15**			
		Current issues	Deficit under review with NHSI			

No	**ID**	**Title**

No	ID	Title
14	8543	**Fracture Clinic, Capacity & Demand**

Lead	Michelle Turton/Victoria Hampson	**Current score**	**15**	**Score Movement**	⟷

Description	Accommodation is currently being shared with UCC to support COVID green pathway for E/D. Inability to social distance in Fracture clinic due to it being used by 2 different departments. To support social distancing the main waiting room can only safely accommodate 17 patients. The numbers of patients attending both UCC and fracture clinic are increasing month on month. UCC use the waiting room to return patients to while they are waiting for investigations/results. Fracture clinic patients are having to wait on chairs on the corridor Medical students and trainee ACP's are unable to be accommodated due to lack of space so will impact on learning. ACP's are being moved to the BGH site so will not have the direct supervision they may require. Fracture clinic would be used for training but due to lack of space but is no longer an option.	**Actions**	**1.** Regular management meetings with Medicine	**1.** Victoria Hampson	**1.** On-going
Top Controls	**1.** Fracture clinic staff have worked on flow through the department so that patients are seen as promptly as possible and are moved from the main wait. **2.** A member of staff are placed at the front door to advise patients about infection control measures, advised where to wait and to support waiting patients. **3.** Spacing of Fracture clinic appointments to try to prevent over capacity. **4.** Fracture clinic making non face to face appointments as much as possible. **5.** Patient seating made available of hospital corridor. Move what can be moved to BGH fracture clinic.			
Update since the last report	**15/07/2021-** UCC (Urgent care) relocation in AM not yet assessed and will update risk once this change is embedded.	**Date Last reviewed**	**15/07/2021**	

Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
	15	**X**	**X**	**X**
8 week score projection	**15**			
Current issues	**Impacted by COVID-19**			

No	ID	Title
15	8839	**Failure to meet performance targets (SAS)**

Lead	Victoria Bateman	**Current score**	**15**	**Score Movement**	⟷

Description	The concern is the Division's ability to meet the national performance targets set for referral to treatment times. Non achievement on the standards ultimately impacts and causes delays in patient treatment. Due to covid 19 all surgical specialities are currently significantly challenged for meeting RTT. Failure of the standard means that individual patient care is impacted upon as patients have to wait an extended length of time for treatment. Impact on patient experience and patient treatment plan. Patients may deteriorate waiting for treatment for extended lengths of time. As this standard is monitored externally, failure to meet this standard has reputational issues for the Trust and patients may choose to not be treated at ELHT.	**Actions**	**1.** Utilise independent sector	**1.** Victoria Bateman	**1.** 01/07/2021

Top Controls	1. Strong monitoring at Trust, Divisional and Directorate Level. 2. Weekly PTL meeting within division to ensure awareness of current position and to ensure controls are continuously put in place to focus on achievement of the standard. 3. Bi-weekly performance meeting with Directorate Managers led by the Director of Operations. 4. Planning & information produced for trajectories. 5. Monitoring at directorate and divisional level at Directorate meetings and DMB. 6. Recovery plans being updated weekly by Directorate Managers. 7. Attendance of divisional information manager at directorate meetings to provide information regarding current position. 8. Strong management of standard at DMB and performance meeting with exec team. 9. Exception reports provided by divisional information manager for all specialities where the 28DR standard is not met. 10. Monthly performance meeting with exec team and DMB where divisional position is reported discussed and challenged. 11. Regular meetings with CCG colleagues to work together on demand management					
Update since the last report	**23/06/2021 –** Recovery plan is being updated weekly by directorate managers and this is to be fed back to to division giving current position. Discussion at monthly DMB, with each Clinical Director giving feedback. Issues: the outpatient capacity due to social distancing and volume of backlogs causing significant gaps to fill. Theatre staff have returned to theatre and the majority of lists have been reinstated but the increased backlog will take significant recovery	**Date Last reviewed**	**23/06/2021**			
		Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
			15	**X**	**X**	**X**
		8 week score projection	**15**			
		Current issues	**Impacted by COVID-19**			

No	**ID**	**Title**					
16	8914	**Potential interruption of high-flow oxygen therapy to critically ill patients across RBTH**					
Lead		Susan Chapman/Andrew Appiah	**Current score**	**15**	**Score Movement**	⟷	
Description		Risks to continuity of medical oxygen supply from the VIE due to inadequate resilience in current infrastructure. The designed maximum oxygen flow limits of the current VIE tank and vaporisers has been near enough exceeded during this pandemic. This could have potentially led to an interruption of essential treatment of critically ill patients, such as invasive ventilation and low- and high-flow oxygen therapies. When the total oxygen draw from the patients and devices exceed the designed limit of the vaporisers, the system would not be able to turn liquid oxygen into gas quickly enough; hence it could start drawing liquid oxygen into the system potentially damaging it.	**Actions**	1. Review outcome of funding	1. Andrew Appiah	1. 30/04/2021
Top Controls		**1.** Protocols for the Management of Oxygen during periods of High Demand have been developed. **2.** Elevated clinical demand for oxygen is monitored throughout the day and escalated. **3.** Appropriate escalation measures have been allocated to various departments to avoid interruption of supply for patient's clinical care					
Update since the last report		**23/06/2021-** During the 16th June Capital planning board meeting the Exec Finance Director shared the Finance proposal to grant Estates a budget for high risk items which will allow an upgrade of the current VIE system to deliver an increased maximum flow capacity from 2400L/min to 5000L/min to address any surges/potential breaches in winter. The breaches during the last	**Date Last reviewed**	**12/07/2021**			
			Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
				15	**X**	**X**	**X**

	winter occurred at 3600L/min. Air Products will need at least 14 weeks lead time to order the upgrade equipment, hence the funds to procure this needs to be approved by the end of June.	8 week score projection	15
		Current issues	Impacted by COVID-19

No	ID	Title				
17	8808	**Burnley Hospital (BGTH) - Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke.**				
Lead		Tony McDonald/Michelle Brown	Current score	15	Score Movement	⟺
Description		Deficiencies in provision of fire barriers in external cavity walls in Area 7 Phase 5, BGTH. This is a PFI building, not owned by the Trust. Excess gaps around fire doors have been identified, with inadequate fire stopping. Additionally issues have been identified within the Fascial Cavity Barrier & External Wall survey. Kingspan render/insulation is present but no test evidence to show fire resistance properties have been provided by Project Co or Kingspan. This has been requested by the Trust. The Trust has currently suspended fire stopping work internally due to COVID.		Actions	**There are a list of actions actively monitored in the Fire Stopping cell group which is led by the Executive Director of Finance and the Executive Director of Integrated Care, Partnerships and Resilience. These actions are regularly monitored whilst the Trust starts restoration on previous Fire Stopping works.**	
Top Controls		**1.** Fire alarm system throughout the building to provide early warning in case of fire. Tested, serviced and maintained. **2.** External monitoring of fire alarm and connected to RBTH switchboard. **3.** Staff completes fire safety training. **4.** Fire Policy in place. **5.** Engie Fire Risk Assessments for non-Trust locations, these include Plant Room areas which are not occupied by the Trust. **6.** Contractual arrangements in place between PFI and the Trust for maintenance of systems and PPM's. **7.** Monthly meeting between lead execs and support team to review this risk and outstanding fire stopping issues. Meeting will review the trust position on fire stopping each month and all parties aware of contractual agreements.				
Update since the last report		**17/07/2021-** Plant Room Construction Report added 04/11/20.See 8901. SGC Fire Marshals being reviewed. These are additional resources provided by the Trust over and above those provided by Project Co. Work ongoing to review all Fire Risk Assessments within the PFI and non-PFI estate. Training across the organisation being rolled out to bring back compliance with standards into a better position.		Date Last reviewed	17/07/2021	
				Risk by Quarter 2021	Q1	Q2 / Q3 / Q4
					15	X / X / X
				8 week score projection	15	
				Current issues	Impacted by COVID-19	

No	ID	Title				
18	7764	**Royal Blackburn Hospital (RBTH) Breaches to fire stopping in compartment walls and fire door surrounds allowing spread of fire and smoke**				
Lead		Tony McDonald/Michelle Brown	Current score	15	Score Movement	⟺
Description		There has been a Covid suspension of planned fire stopping works on site from March 20 but this will be reviewed in a regular monthly meeting with the Exec Director of Finance, PFI Partners, H&S (Fire) and Estates. The exception is for capital and restore and restoration work only. Additional issues have been identified in a recent 3rd party sample survey -Fascial Cavity Barrier & External Wall Internal lining Investigations. The decision to stop such works transfers the		Actions	**There are a list of actions actively monitored in the Fire Stopping cell group which is led by the Executive Director of Finance and the Executive Director of Integrated Care, Partnerships and Resilience. These actions are regularly monitored whilst the Trust starts**	

	risk of fire on the main site at Blackburn to the Trust. Project Co (PFI) cannot be held responsible until the Trust decides to reinstate such works which is being reviewed monthly.		**restoration on previous Fire Stopping works.**
Top Controls	**1.** Fire alarm system throughout building providing early warning of fire **2.** Evacuation procedures in place **3.** Fire Wardens in most areas **4.** All staff trained in awareness of alarm and evacuation methods **5.** Fire policy in place **6.** On site fire team response **7.** Total Fire Safety Ltd have also started the programme of works on phases 1-4 **8.** Balfour Beatty carrying out work in Phase 5. **9.** Monthly meeting in place with executives and senior management to review the trust position on the works being stopped and deal with escalations. First meeting 23/11/2020. The trust will review the position of this each month. **10.** Contractual arrangements in place between PFI and the Trust for maintenance of systems and PPM's.		
Update since the last report	**12/07/2021-** Capita COAU Compartmentation and Passive Fire Protection Analysis Report being reviewed with the risk. SGC Fire Marshals being reviewed as they are additional resources working alongside Project co provided staff.	**Date Last reviewed**	**12/07/2021**

Risk by Quarter 2021	**Q1**	**Q2**	**Q3**	**Q4**
	15	**X**	**X**	**X**
8 week score projection	**15**			
Current issues	**Impacted by COVID-19**			

No	**ID**	**Title**				
19	8960	Risk of undetected foetal growth restriction and possible preventable stillbirth given non-compliance with national Ultrasound guidelines				
Lead		Helen Collier	**Current score**	**15**	**Score Movement**	

Description	Diagnosis of intrauterine growth restriction could be missed some due to inability to report/action Pulsatility Index on uterine artery doppler measurement. The introduction of national/international recommendations will require investment of resources including the introduction of Viewpoint as the obstetric reporting package, an increase in sonography hours and midwife sonography hours currently allocated and updated ultrasound machines within maternity services.	**Actions**			
Top Controls	1. We have an additional ultrasound machine funded and due to arrive in the department in the next couple of weeks. 2. We have staff within the department trained in measuring and interpreting pulsatility index. 3. We have Viewpoint reporting software which allows us to interpret and report pulsatility index. 4. At present we are reporting umbilical artery end diastolic flow as present, absent or reversed with no measurement of the pulatility index. This will identify some babies with foetal growth restriction but is less sensitive than the recommended pulsatility index. Those babies that we feel demonstrate foetal growth restriction is referred to placenta clinic for further management. 5. Currently only women at very high risk of early-onset growth restriction are seen within Placenta clinic.		**1.** To complete a business case for additional staffing	**1.** Charlotte Aspden	**1.** 25/06/2021 **(was 30/04/2021) awaiting new date**
Update since the last report	**15/07/2021**- Business Case is drafted and on hold. The additional midwifery sonography element has been flagged as part of the funding request through the B0532 Maternity investment which is intended to	**Date Last reviewed**	**15/07/2021**		

Risk by	**Q1**	**Q2**	**Q3**	**Q4**

	support the delivery of the recommendations of Ockenden.	Quarter	15	X	X	X
		8 week score projection	15			
		Current issues	Business case for sonographer hours is being reviewed, awaiting update on approval of this.			

No	ID	Title				
20	4932	Patients who lack capacity to consent to their placements in hospital may be being unlawfully detained.				
Lead		Howard Stanley	Current score	15	Score Movement	⟷
Description		Patients referred to Lancashire County Council and Blackburn with Darwen Council (Supervisory Body) for a Deprivation of Liberty Safeguards (DOLS) authorisation are not being assessed by these agencies within the statutory timescales or at all, which means the DOL is in effect unauthorised. The Local Authority (Supervisory Body) is aware but has not been able to process the assessments within the statutory timescales.		Actions	New risk added – action plan being developed.	
Top Controls		1. The Mental Capacity Act Policy (C82v5) and DOLS procedure is being adhered to by wards and applications are being made in a timely manner. They are being supported by the Adult Safeguarding Team. 2. The policy was updated and agreed at Policy Council and includes up to date information regarding the 2014 Supreme Court Judgement. 3. Non mandatory MCA/DOLS Training Programme is available to all Trust employees. 4. Additional support and training to ward based staff has been provided by the Mental Capacity Act Lead and other members of the Adult Safeguarding Team. 5. Applications are tracked by the Adult Safeguarding Team and changes in patient status are relayed to the local authority (Supervisory Body). 6. Ability to extend the Urgent Authorisation for all patients up to 14 days in total, which provides some defence to ELHT. 7. Legal advice and support available to the Trust 8. Despite the legal framework issues, it is anticipated that the patients will not suffer any adverse consequences or delays in treatment etc, and Principles of the Mental Capacity Act will still apply.				
Update since the last report		**25/06/2021-** This risk remains in place, as no changes can be made by ELHT to expedite matters. Local Authorities are aware of backlog of assessment and Safeguarding adult boards are aware that patients are being detained (appropriately) but without formal authorisation. Longer term national plans to replace DoLS with Liberty protection safeguards are ongoing, but still awaiting code of practice before implementation and assurance model can be developed internally.		Date Last reviewed	23/06/2021	
				Risk by Quarter 2021	Q1	Q2	Q3	Q4
					15	X	X	X
				8 week score projection	15			
				Current issues				

East Lancashire Hospitals NHS Trust
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TRUST BOARD REPORT

8 September 2021

Item 108

Purpose Assurance
Approval

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

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

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

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

(108) Board Assurance Framework Review

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

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

6. It is proposed that the **risk score remains at 16 (**likelihood **4** x consequence **4)**.
7. Following review of this risk by the Associate Director of Improvement there have been no changes made to this risk.

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

8. It is proposed that the **risk score remains at 20 (**likelihood **4** x consequence **5).**
9. The key controls section has been updated with one new control added as follows:
   a) Work is ongoing to appoint clinical staff via targeted recruitment activity.

10. Internal and external assurances have been updated to add further information and clarification to existing items. In addition, three new sources of assurance have been included, as follows:
    a) The Trust's behaviour framework has been developed and will be launched in September 2021 in addition to the Trust's flexible working manifesto and a number of other flexible working pilots to support recruitment and retention.
    b) There is ongoing development of a national performance dashboard to support delivery of the people plan.
    c) £1,500,000 has been secured across the ICS to develop an enhanced health and wellbeing offer.
11. Mitigating actions has been updated to include the completion of the first phase of the HCA recruitment programme with a second cohort of recruits due to commence in post shortly.

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

12. The **risk score remains at 16** (likelihood **4** x consequence **4**).
13. Key controls have been updated with minor revisions for clarification and readability purposes. In addition, there has been one new control added:
    a) National Provider Collaboration Board guidance has been released.
14. The sources of assurance section have been updated to reflect minor changes for clarification. In addition, there has been one new source of assurance added:
    a) There are a number of service areas being assessed in terms of clinical priorities across the ICS area. This work is being undertaken by Medical Directors and Chief Operating Officers across the Trusts within the ICS region.

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

15. The **risk score remains at 20** (likelihood **5** x consequence **4**).
16. The key controls section has been updated to include four new controls:

a) Elective Recovery Fund (ERF) costs are covered for months 1-4 currently.
b) Additional funding has been secured for further costs associated with the Accelerator Programme.
c) The Director of Finance is the lead for the Elective Care Recovery Fund.
d) Mersey Internal Audit Agency (MIAA) have been commissioned to carry out a review of acute provider accelerator costs to allow peer to peer reviews.

17. The internal and external sources of assurance have been updated with the following new item:
    a) The Trust has senior finance representation on the ICS Financial Sustainability Group.

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

18. The **risk score remains at 16** (likelihood **4** x consequences **4**).
19. Key controls have been updated with four new additions which are shown in the BAF in green text.
20. The sources of assurance section has been updated with a small number of minor updates. There have also been two new additions as follows:
    a) The Chief Operating Officer is the lead for restoration across the ICS region.
    b) A report is being prepared for submission to the Trust Board regarding lessons learned from the pandemic, particularly nosocomial infections and duty of candour. All Duty of Candour requirements have been completed.
21. The gaps in control section has been updated to add further information and clarification to existing items. In addition, two new items have been added, as follows:
    a) New guidance on self-isolation for NHS staff is affecting the availability of staff and is open to interpretation.
    b) Similar to the above point, there is an unavailability of staff within care homes which has a negative effect on the discharging of patients, and therefore affecting patient flow across the Trust.

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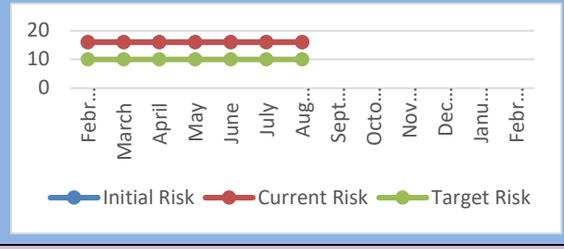
Appendix – Board Assurance Framework (Full)

BAF Risk 1

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

Controls:
• The programme is monitored through the Improvement Practice Office reporting to the Senior Leadership Group (SLG), Finance and Performance Committee, Quality Committee, and the Executives through the Executive Leadership Wall (virtual wall in development).
• The 4 elements of Quality, Delivery, Morale and Finance are monitored through internal governance groups.
• Divisional improvement is monitored through the Divisional Governance structures.
• Improvement Practice Priorities and development strategy – three-year plan. 12-month plan in development.
• Patient Participation Panel involvement in transformation projects delayed due to ongoing pandemic response.
• Trust involvement in ICS restoration and recovery programmes including Adapt and Adopt Improvement Programmes.
• Work to review and revise the Trust's Quality Strategy and Quality Priorities for the next 12 months, through engagement with Senior Leadership Group, Quality Committee, all staff representatives, patients and other partners.
• Review and revision of the Trust's Strategic Framework underway to agree revised strategic goals and work programmes aligned to key organisational strategies underpinned with partnership working.
	Assurances:
	Internal Assurances
	• The Trust planning process has identified a single set of key work programmes and improvement priorities for the Trust in conjunction with ICP Partners. The priorities identified are aligned to the Trust's Clinical Strategy, the ICP priorities as outlined in the Pennine Plan, key ICS and national restoration priorities and to the NHS Long-Term Plan.
	• Ownership and embedding of the improvement plans across the Pennine Lancashire ICP.
	• The Trust has adopted and is implementing a consistent improvement approach (improving Safe Personal and Effective Care Plus (SPE+) based on Lean and is a founder Trust of the Vital Signs programme.
	• The Trust has invested in dedicated improvement capacity through the development of the Improvement Hub Office and seeks, through the planning round, to align capacity across the organisation to the delivery of a single plan. The improvement hub is developing a revised training and capability programme for improvement to be launched in summer 2021.
	• Operational and Executive oversight is provided via:
	  • Executive Visibility Wall (virtual in development)
	  • Executive Team meeting- weekly
	  • Senior Leadership Group
	  • Monthly Clinical Leaders Forum and bi-monthly Joint Clinical Leaders Forum
	  • Weekly Medical Director meetings

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BAF Risk 1

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- Monthly Board assurance is provided via reporting to:
  - Finance and Performance
  - Quality Committee
  - Trust Board (bi-monthly reporting)

<u>External Assurances</u>

- Work is on-going to align improvement approaches and deliver associated training to upskill across the ICP.
- Reporting of improvement activities to the Trust Quality Review meetings with the CCG.
- There has been good participation by system partners in several system-agreed improvement events.
- There is ongoing alignment of improvement resources across the ICP including commissioning portfolios.
- System-wide Programme Boards have been developed to focus on delivery of system priorities and dovetail to Trust's information and transformation plans. These Boards cover Urgent and Emergency Care, Scheduled Care, Integrated Community Care and Mental Health. A Programme Co-ordination Group, consisting of senior responsible officers and delivery leads, established to oversee delivery.
- New Hospitals programme
- The Trust is part of the ICS level Elective Cell Recovery Group

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Gaps in controls and assurance:

- Capacity and resilience building in relation to improvement is in early phase but being addressed through development of capability and training programme.
- Dependency on stakeholders to deliver key pieces of transformation
- Financial constraints
- Transformation priorities not yet fully aligned to appraisal and objective setting
- Capacity and time to release staff to attend training related to improvement in order to build improvement capability across the organisation.

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Mitigating actions:

Action	Target Date
There will be a re-focus on delivery and impact via the Executive Visibility Virtual Board which will improve assurance to Trust Board subcommittees.	Q1/2 2021/22
Continued alignment of improvement approach for the Trust and launch of revised capability package in Q2.	Q1/2 2021/22
Refresh of the Trust's Quality Strategy and Quality Priorities	Q2 2021/22

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Appendix – Board Assurance Framework (Full)

BAF Risk 1

• Adequate assurance mechanism that the service integration plans are on track together with the rigour of governance arrangements/lack of delegation from the sovereign bodies to the system. • Impact of ICP/ICS governance changes on improvement plans. • Ongoing effect of COVID-19 on restoration, staff wellbeing and morale.	Trust Wide Electronic Patient System approval and implementation	August 2022

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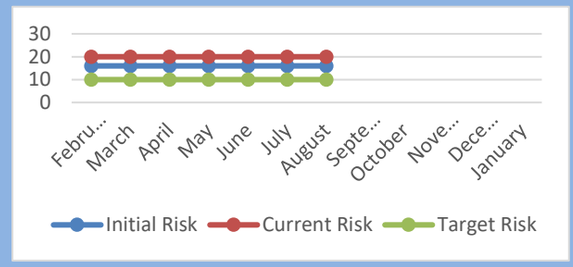
Appendix – Board Assurance Framework (Full)

BAF Risk 2

Objective theme: Workforce	**Executive Director Lead**: Director of HR and OD
Risk Description: Recruitment and workforce planning fail to deliver the Trust objectives	**Date of last review**: August 2021
Risk Rating (Consequence x likelihood): Initial Risk Score: 4 x 4 = 16 Current Risk Score: 4 x 5 = 20 Target Risk Score: 2 x 5 = 10 	**Effectiveness of controls and assurances**: [ ] Effective [X] Partially Effective [ ] Insufficient **Risk Appetite:** The Trust has **NO** risk appetite for any risk surrounding NICE guidance which has the potential to cause harm to patients and staff. The Trust has a **Low** risk appetite to any risk that could affect patients, staff, contractors, public and Trust assets.
Controls: • Workforce transformation is being worked into the Trust's improvement methodology. • Divisional Workforce Plans aligned to Business & Financial Plans through the planning process. • SLG monitor on-going performance, actions and risks. • Regular reports to Finance & Performance Committee and Board on delivering the People Strategy. • Trust is in the process of reviewing and revising the Workforce Controls process to review all vacancies and support the Workforce Transformation strategy. • Pennine Lancashire ICP Workforce Strategy agreed, and ICP People Board established. • ICS People Board established, and complementary workforce strategy developed to enable collaboration. • People Strategy aligned to deliver National ICS, ICP and Trust workforce objectives and is cognisant of the NHS People Plan. • Increased staffing during core hours to alleviate pressures.	**Assurances:** Internal Assurances • On-going monitoring of vacancies and bank/agency usage via Trust IPR, performance measures, time limited focus groups with action plans, Board and Committee reports, regulatory and inspection agencies, stakeholders, internal audit. • WRES and WDES action plans with timelines in place. Regular reporting to the Board on progress. Ongoing monitoring of workforce diversity through the re-establishment of the Diversity and Inclusion Steering Group and Trust staff networks. Establishment of a strategic BAME oversight group (including Board members and BAME Network Chairs to provide oversight). • Joint Medical and Non-Medical Agency Group in place. Dashboard giving overview of bank/agency usage presented monthly. Additional scrutiny from a nursing perspective. • Integrated Performance Report, Performance Assurance Framework, Workforce Dashboard reporting key performance indicators within Divisions on a monthly basis, Details of these reported on a quarterly basis to the Finance & Performance Committee. • Lean Programme (Vital Signs) overall linking into workforce transformation. Improvement priorities are now being identified as part of the delivery of the People Strategy, working to embed in culture.

Appendix – Board Assurance Framework (Full)

BAF Risk 2

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

Appendix – Board Assurance Framework (Full)

BAF Risk 2

- Development and launch of the Trust's Behaviour Framework due in September 2021 and the launch of the flexible working manifesto and a number of flexible working pilots to support recruitment and retention.

External Assurances

- Staff Friends and family test (further detail in BAF risk 5).
- Benchmarking of agency spend is available through the Model Hospital data.
- Collaboration across the ICS on agency usage. Participation in ICS Bank and Agency Collaborative to manage agency rates across the region. ICS collaboration on Careers, International Recruitment and Workforce mobility. ICS wide People Board - looking at nurse recruitment across the whole system.
- Joint work taking place across the ICS to consider implications and options to mitigate the impact on pensions. The Trust has agreed a range of measures with ICS colleagues to help address the pensions challenges along with implementation of NHSE's interim solution for financial year 2019/20.
- Establishment of a Pennine Lancashire and a Lancashire and South Cumbria People Board.
- Improving staff survey completion rate.
- WRES/WDES results.
- Ongoing development of national performance dashboard to support delivery of the people plan.
- £1.5m secured for the ICS to develop an enhanced health and wellbeing offer.

Gaps in controls and assurance:

- National recruitment shortages, capacity for delivery of transformation programmes, financial restrictions. Reduction of CPD monies from HEE (could be offset by the apprenticeship levy). Varying incentive schemes/packages across provider sector.
- Additional gap in relation to the unknown impact of COVID on long term travel plans, which may affect international recruitment.

Mitigating actions:

Action	Target Date
Annual Festival of Inclusion planned for September/October 2021.	September/ October 2021

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BAF Risk 2

• The impact of the changes to the pension rules and taxation has resulted in a significant reduction in capacity and additional work being undertaken by senior medical staff. This has resulted in a reduction in clinical capacity. • Inability to control external factors (COVID-19, Brexit, visas etc). • Regulators stance on safe staffing and substitution of roles in place of registered workforce. • Lack of data/intelligence regarding the number of nurses and clinical staff in the 55+ age category and the related risk of 'brain drain' in the coming years. Work has been done by ICS across the system but it does not contain the level of detail needed for each Trust. Efforts need to be made to understand and refine the workforce data in order to address the issues in the Trust. • Risk of staff leaving the NHS due to post COVID burnout • Potential ongoing staff sickness from COVID-19 • COVID-19 impact on appraisals • COVID-19 impact on Black and Minority Ethnic (BAME) population	HCA recruitment continues, contributing to the reduction in HCA bank shift requests adding further stability and flexibility to our support workforce. 100 HCA applicants being processed following recent campaign and are currently in pre-employment stages with envisaged start dates in Q1 2021/22 First phase complete, with a second cohort to commence shortly.	Ongoing
	AHP job planning project underway across the ICS.	Due for completion September 2021

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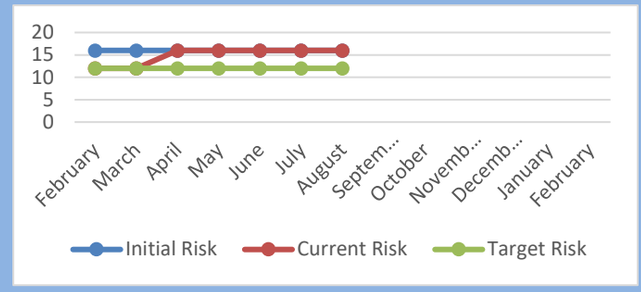
Appendix – Board Assurance Framework (Full)

BAF Risk 3

Objective theme: Quality, Delivery, Workforce and Finance	**Executive Director Lead:** Deputy Chief Executive, Director of Finance, Director of Service Development and Medical Director
Risk Description: Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities.	**Date of last review:** August 2021
Risk Rating (Consequence x likelihood): Initial Risk Rating: 4 x 4 = 16 Current Risk Rating: 4 x 4 = 16 Target Risk Rating: 3 x 4 = 12 	**Effectiveness of controls and assurances:** Effective X Partially Effective Insufficient **Risk Appetite:** The Trust has a **Moderate** risk appetite for opportunities which enable achievement of the Trust's strategic objectives, and collaboration with system partners in the Integrated Care System (ICS) and Integrated Care Partnership (ICP) within the available resources. The Trust has a **Low** risk appetite for risk, which may affect the reputation of the organisation.
Controls: • CEO and Deputy CEO are members of the ICS Board and System Leaders Executive. The Chairman, CEO and Deputy CEO are members of the ICS PCB. • PCB guidance released • Number of senior clinicians involved with ICS work groups. Professional Leadership Committee (PLC) has ELHT representation. • The ELHT Accountable Officer is the senior responsible officer (SRO) for the Pennine Lancashire Transformation Programme, sits on the System Leaders Forum and on the Integrated Care System for Lancashire and South Cumbria (ICS) Programme Board. • Working relationships with stakeholders in relation to mental health services including shared policies. • Multiple COVID-19 initiatives at ICP level. • Strategic planning – planning guidance received (regional and ICS planning groups established, Deputy CEO on both and COO on ICS level group).	**Assurances:** Internal Assurances • Standing agenda item at Trust Board where approvals will be established, and permissions are provided by the Board to let Executives progress the generation of ideas and options with external stakeholders. Standing agenda item at Executive meetings. • Potential gains in strengthened reputation with regulators and across the ICS and region. • Early stage discussions being undertaken for creating single teams across the system, e.g., 'one workforce' with timelines for implementation. Progress covered under BAF risk 2. • Board CEO report including updates on system developments and engagement. • Refreshed Clinical Strategy – presented at Board Strategy Session. Internal/External Assurances • The Pennine Lancashire and ICS Cases for Change have been published.

Appendix – Board Assurance Framework (Full)

BAF Risk 3

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

Appendix – Board Assurance Framework (Full)

BAF Risk 3

	• Vital Signs is a system wide transformation programme across the Pennine Lancashire ICP. Patient experience strategy envisages good patient and public involvement to support the collaborative transformation. Progress with work covered under BAF risk 1. A system financial and investment group for the ICP looking into the priorities and aligning them with the financial envelope for the local system. • Underpinning governance of the ICS Provider Collaboration Board (PCB) recently reviewed with a view to expedite decision making for improved provider collaboration. Strategic Co-ordination Group established, comprising Executives from across the 5 NHS Trusts. Role of the group is to be the engine room of the PCB. The group is under the chairmanship of the PCB Director. • Regular communication with NHS England, NHS subsidiaries, Commissioners and Senior/Exec Management between teams. (BAF 5) • New Hospitals Programme (NHP) • Emergency Care Recovery Group (ECRG) leading on recovery and restoration planning. • Financial Assurance Committee • There are a number of service areas being assessed in terms of clinical priorities across the ICS area. This work is undertaken by the Medical Directors and Chief Operating Officers within the ICS area.
Gaps in controls and assurance: • The capacity of the Trust Directors and others to continue to work at Trust level and also at ICP and ICS level to the degree that is required. • There is a need for consistent leadership across the system. in order to ensure that we continue prioritising in line with system affordability. • Building trust and confidence and agreeing collaborative approaches to service provision. • Point being reached relating to ICS workstreams (e.g. Head and Neck services) where dependent on scoring implications there may be an impact on priorities and risks to the Trust. • Lack of clarity regarding the investment priorities across the ICP have the potential to destabilise acute services. • Lack of unified approach in relation to procurement by Commissioners.	**Mitigating actions:** **Action** — **Target Date** Developing relationships with the ICP and ICS — Ongoing work Refresh of the Trust's strategic framework, particularly the strategic goals of the Trust. This work is being done in conjunction with David Fillingham, Executive Sensei for the Vital Signs Programme in the context of the White paper and system working and the ICS system design framework. — End July 2021

Appendix – Board Assurance Framework (Full)

BAF Risk 3

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

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

BAF Risk 4

Objective theme: Finance	**Executive Director Lead**: Director of Finance
Risk Description: The Trust fails to achieve a recurrent sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to achieve H1 financial balance, with a further risk associated with lack of clear guidance for H2 planning.	**Date of last review:** August 2021
Risk Rating (Consequence x likelihood): Initial Risk Rating: 4 x 4 = 16 Current Risk Rating: 5 x 4 = 20 Target Risk Rating: 3 x 4 = 12 	**Effectiveness of controls and assurances:** Effective X Partially Effective Insufficient **Risk Appetite:** The Trust has a **Low** risk appetite to financial risk which could threaten the financial stability of the Trust. The Trust has **NO** risk appetite for any risk which has the potential to compromise data security. The Trust has **Low** risk appetite for any risk which has the potential to compromise our reduction of cost base and the Waste Reduction Programme.
Controls: • Budgetary controls (income & expenditure) in place including virement authorisation, workforce control and variance analysis. • Measures to mitigate financial risk overseen by the Finance Assurance Board reporting to the Finance and Performance Committee. • Financial Assurance Board in operation, which reviews the financial position, making recommendations for improvement. • Financial investment/recovery strategy is in development. • Robust financial planning arrangements supported by financial reporting • Standing Financial Instructions enforcement • Waste Reduction Programme • National block contract in place to continue for H1 and likely H2 • Robust costing systems to support block contract monitoring	**Assurances:** Internal Assurances • Regular reporting to Finance and Performance Committee and the Board to reflect financial position. • Financial objective included in individual appraisals. • Robust financial forecasting • Use of data sources (e.g. model hospital and PLICS data) to drive improvement and mitigate deterioration. Evidencing the routine use of benchmarking data to drive positive change. • Alignment and involvement in all ICS collaborative working opportunities including agency group, pathology etc. • Full alignment to the ICS Finance Assurance Committee

Appendix – Board Assurance Framework (Full)

BAF Risk 4

- Capital programme overseen by Capital Planning Board
- Agreed financial plan for H1.
- ERF costs are covered for months 1-4 currently.
- Additional funding secured for additional accelerator programme costs.
- Director of Finance is the lead for the Elective Care Recovery fund.
- MIAA commissioned to carry out a review of acute provider accelerator cost to allow peer to peer review.

- Counter fraud updates, including new Counter Fraud Champion (Deputy Director of Finance)
- Representation on ICS Financial Sustainability Group.

External Assurances

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

Gaps in controls and assurance:

- Uncertainty of Financial envelope for H2 2021-22
- Uncertainty of ERF funding and costs for H1
- Deterioration in the underlying financial position outside of NHSE/I request requiring additional improvement schemes in 2021/22.
- Workforce policies and procedures may require amendments.
- Controls around improvement schemes and WRP to be monitored by the FAB.
- Lack of standardisation in applying rostering controls.
- Weaknesses in discretionary non-pay spend.
- Officers operating outside the scheme of delegation.
- Inadequate funding assumptions applied by external bodies (pay awards).
- Hidden costs of additional regulatory requirements - highlighted with NHSE/I.
- Cost shunting of public sector partners increasingly managed through ICS and ICP.
- Significant external pressures which may intensify internal financial pressure.
- Ensuring consistent capacity to work externally as well as internally by building system collaboration into the leadership roles and having good joined leadership programmes.

Mitigating actions:

Action	Target Date
Review funding with CCG on level 2 critical care and CNP	End of March 2022
Greener NHS Campaign Trust Strategy	Q2 2021/22
2021/22 financial forecasting being reviewed for robustness	Q1 2021/22
ELHT DOF is the lead for ERF/accelerator Finances in the ICS	Q1/2 2021/22
Non-pay control review underway	Q2 2021/22
Pay control review underway	Q2 2021/22

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BAF Risk 4

• Lack of funding to meet provision of HDU capacity and Community Neuro Developmental Paediatric services (CNP). • Impact of COVID-19 wave three and restoration could impact the forecast position.	Senior Finance Team restructure to support capacity requirements, currently being implemented	Q2 2021/22

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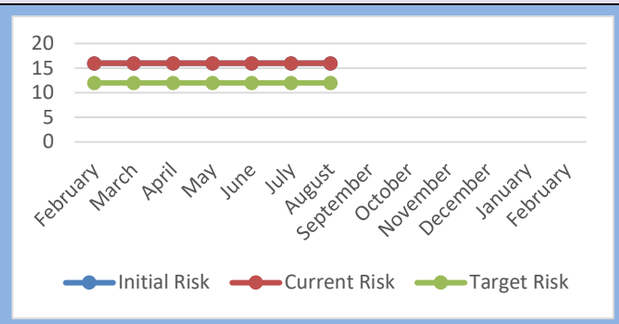
Appendix – Board Assurance Framework (Full)

BAF Risk 5

Objective theme: Quality, Delivery and Finance	**Executive Director Lead:** Chief Operating Officer, Director of Nursing and Medical Director
Risk Description: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil the regulatory requirements defined in the NHS Constitution and relevant legislation.	**Date of last review:** August 2021
Risk Rating (Consequence x likelihood): Initial Risk Rating: 4 x 4 = 16 Current Risk Rating: 4 x 4 = 16 Target Risk Rating: 3 x 4 = 12 	**Effectiveness of controls and assurances:** [ ] Effective [X] Partially Effective [ ] Insufficient **Risk Appetite:** The Trust has **Low** risk appetite for risks which are non-clinical but affecting the day-to-day services the Trust provides. The Trust has a **Low** risk appetite for risk, which may potentially slightly affect the delivery of services without compromising the quality of those services.
Controls: • Weekly operational performance meeting covering RTT, holding lists and key operational indicators. Separate dedicated weekly cancer performance meetings. Weekly performance is reviewed at SLG and operational update provided to the Executive Team. • Engagement meetings with CQC in place monitoring performance against the CQC standards. Work is being undertaken to prepare for the transitional monitoring approach (virtual visit) – 7 core services to be reviewed between July 2021 and Feb 2022. • Quality and safety compliance assessed by each division and assurance through the Divisional Quality and Safety Boards (DQSB) reporting into the TWQG. Pre-Covid meeting structure to be re-introduced in April 2021. A revised version is being implemented. Eg patient safety, patient experience and clinical effectiveness committees have been realigned into two committees. • Divisional Assurance Boards feeding into the operational sub-committees and the Quality Committee. • Nursing Assessment Performance Framework reporting through to the Quality Committee and involvement of NEDs on the SPEC Panels. Board approval for the award of SPEC awards.	**Assurances:** <u>Internal Assurances</u> • IPR reporting to the SLG and at Board/Committee level, also presented to JNCC for information. • Regular deep dive into the IPR through Quality and Finance and Performance Committees including RTT, all cancer standards and the emergency care standards. • Performance monitoring provided through the weekly operational meeting, Scheduled Care Board (joint Board with CCG). • Regular reporting from the divisions into the operational sub-committees and the Quality Committee. Alignment with national priorities through the quality and safety governance mechanisms. • Silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments continues. • Rolling programme of assessments under the framework planned for all inpatient wards and departments including Community Services.

Appendix – Board Assurance Framework (Full)

BAF Risk 5

• A&E Delivery Board (co-chaired by the Executive Director of Integrated Care, Partnerships and Resilience and the Medical Director for East Lancashire CCG) with Emergency Care Pathway assurance feeding into it. • Elective, Diagnostic and Cancer Board with elective pathway assurance feeding into it. • Elective Care Recovery Group set up across the ICS (Chief Operating Officer, Executive Medical Director and Director of Finance attend). • Daily nurse staffing review using safe care/allocate Nursing and Midwifery. • Medical Staffing Group held weekly to review rotas and address gaps. • Weekly Medical Staffing Review - Nursing and Midwifery staffing review feeding into the annual professional judgement review for all wards. Professional Judgement Review deferred until October 2021 due to COVID-19 response. • Daily operational flow meetings at 08.30, 12.30, 15.30 and 19.30. Site walkaround carried out by COO/Deputy COO at around 18.00 instead of the meeting. • Everyday matters meeting held daily to assist patient flow, discharge and long Length of Stay improvement. • Incident Management Team (for COVID-19) has been re-established currently on a weekly basis to manage the increasing numbers of patients. • Re-established the Critical Care daily meetings with Executive Directors and the Management Team of the division and department to ensure management of COVID-19 and non-COVID patients. • Process implemented to ensure elective smoothing for patients requiring critical care post-op to ensure cancellations are reduced/removed. • Weekly ED / urgent care performance and improvement meeting. • Appointed Clinical Scheduled Care Lead (Deputy Medical Director) who will work with Clinical Leads to create and monitor improvement plans for the RTT and holding list positions. • NHS 111 referral measures - including home testing and support to alleviate UCC/ED (Urgent Care and Emergency Department) pressures. • Cancer performance improvement group chaired by the ICS Cancer Alliance	• Independent Complaints Review Panel being established with Non-Executive Director representation. • Quality Committee will oversee the CQC action plan. A full plan is in place for the TMA, core services are beginning to collect evidence – urgent and emergency services were the first to be inspected (27 July 2021). On 10 August Maternity Services were also subject to review. • Reduction in use of nursing agency staff continues. The Trust is also part of the ICS-wide agency staffing collaborative. • Staffing escalation process for nursing including forecast gaps in staffing and senior decision making. Standard Operating Procedure (SOP) developed and monitoring through Nursing and Midwifery Leaders' Forum reported to Quality Committee. • Maternity Floor to Board report presented to the Quality Committee at each meeting. The Trust also has named Maternity Champions, one Executive Director and one Non-Executive Board member. • Infection Prevention and Control (IPC) feeds into the Quality Committee. • CEC is recommencing and feeds into TWGC. • Director of Nursing and the Executive Medical Director are working on enhanced SIRI processes. • Virtual Quality Walk rounds in all clinical areas. • Weekly monitoring of complaints at the Executive Team and reporting to the Patient Safety and Experience Committee and End of Life Care Group, focusing on reducing any 50+ day complaints (non-currently in the system). Complaint reviews are being undertaken with both Exec and NED leads following conclusion of a complaint. • NAPF - operational monitoring through the Nursing and Midwifery Leaders' Forum monthly, receiving assurance from the Assistant Director of Nursing and NAPF team and monitoring by matrons at ward level where they carry out mini-NAPFs on a weekly basis to keep up the improvement work and report to Quality Committee (every other meeting). • Trust response to Ockenden Review of Maternity Services covering the seven immediate and 12 urgent clinical priorities and monitored through the Trust's Quality Committee. • Assessment against GIRFT, NICE and national audits. • Single points of contact being set up across all divisions/directorates to ensure smoother communication and delivery (operational co-ordination centres).

Appendix – Board Assurance Framework (Full)

BAF Risk 5

• Extended ED and plans for restoration. Performance and restoration update provided weekly to Executive team and SLG as well as monthly to Finance and Performance Committee and each Trust Board. • Insourcing supporting endoscopy, pain management and oral surgery. • Weekly Medical and Clinical Directors meetings. • Joint Leadership Clinical Forum. • ICS been selected as an accelerator system aiming to deliver 120% of the activity based on 2019/20 figures from July 2021. • Job Planning Scrutiny Panel for delivery of service. • RSV (paediatric respiratory) Contingency plan in place overseen by RSV Cell which feeds into ICP and ICS groups. • Via the ICC there is work taking place on paediatric RSV because of the pandemic. This work includes primary care, secondary care and community and tertiary services. There are also additional paediatric ambulance transfers available as part of this work • Vascular Board has been stood up to establish the delivery of services across the ICS. • COVID-19 related harms are being reviewed across the ICS by Medical Directors and Chief Operating Officers.	<u>External Assurances</u> • Trust rated 'Good' by CQC in 2018 with improvements in various areas and some outstanding services. • Nurse staffing review as part of the IPR. Staff Care Allocate and daily monitoring of allocation for staff and three times daily matrons' meetings to monitor. Audit carried out by MIAA for nurse staffing received significant assurance. • MIAA have carried out an emergency care risk assessment audit which gained an assurance rating of 'Significant Assurance'. • Cancer Alliance commissioned a review of internal processes for cancer performance management and patient tracking. Highly commended with strong processes in place. • Guardian of Safe Working Hours reporting to Quality Committee. • COO is the lead for restoration across the ICS region. <u>Internal / External Assurances</u> • System wide approach to Emergency Care Pathway, as part of monthly A&E Delivery Board. • PLACE assessments - percentage improved in all areas and monitoring continues. Annual PLACE report presented to the Quality Committee for assurance. Nursing and Midwifery Leaders' Forum also monitor. Patient Experience Committee receives minutes of the PLACE Steering Group. NAPF Team also monitors environmental issues linking to PLACE Assessments. No dates for when the PLACE assessments will recommence. • Positive responses to Friends and Family Test and patient surveys with improvement areas identified. Monitoring at ward level, local divisions prepare monthly patient experience action plans that feed into the Patient Experience Committee that reports to the Quality Committee. Monthly monitoring is provided by the Nursing and Midwifery Leaders' Forum. • Positive response and results from the 2020 National Staff Survey. • Inpatient survey 2019/20 results were presented to the Executive team by Quality Health. Inpatient survey for current year deferred due to COVID-19. There is an inpatient survey due in 2020/21.

Appendix – Board Assurance Framework (Full)

BAF Risk 5

	• Daily Incident reporting from the central governance team - daily updates and analysis sent through to the ICC (Incident Co-ordination centre) who collate and share this information. • Nosocomial Infections Report highlighting patients who have died following COVID-19 and requiring a structured judgement review. • A report is being prepared for submission to the Board regarding lessons learned from the pandemic, particularly nosocomial infections, and duty of candour. All duty of candour requirements has been carried out with all the affected patients/families. • Mental Health Urgent Assessment Unit opened.
Gaps in controls and assurance: • Restrictions in the supply of medical, nursing, midwifery and other staff groups to meet demand. Reference in BAF risk 2. • Risk of mental health providers not being able to ensure sufficient assessment and treatment capacity although work is taking place to address this. • Restrictions in the primary care system to ensure sufficient capacity. • Insufficient capacity to deliver comprehensive seven-day services across all areas. • Insufficient capacity in the ED and Urgent Care workforce to manage the demands and surges in attendance (unpredictable pressure on A&E with increased attendances on previous years). • Pathology industrial action extended from one month to two, therefore potential impact on service provision. Mitigation is in place to minimise impact. Exploring conciliation with ACAS to help bring resolution to the dispute. • Insufficient bed capacity to ensure there are no delays from decision to point of admission. • Histopathology pressures affecting cancer performance. Outsourcing in place but external firms are unable to deliver within the required timeframes. • Lack of unified approach in relation to procurement by Commissioners. • Priorities of CCGs starting to be aligned with priorities for pathway redesign (e.g. stroke) but this work is still in the early phases. • Future role of NHSE/NHSI merged teams to be determined. • Ensuring consistent capacity to work externally as well as internally by building system collaboration into the leadership roles and having good joined leadership programmes.	**Mitigating actions:** **Action** / **Target Date** Systems are in place to monitor audits to provide ongoing assurance in relation to the CQC action plan. The Action Plan is monitored by the CQC and through the Quality Committee. — Ongoing Elective Recovery Cell Group work in progress to ensure equity of access across the ICS and address long waiters — Ongoing Utilisation of independent sector for planned surgical capacity — In place and ongoing Mini mock-CQC visits regularly carried out and focussing on all areas with regular reporting back to the Quality Committee. The next round will be scheduled to take place in Q2 of 2021/22 — Q2 2021/22 PLACE assessments oversight of the reports will be provided by the Quality Committee and summary updates as part of the committee updates to the committee to the Board. Training for key members of the inspection teams was completed by the Trust's Estates and Facilities team prior. Results will be included in the PLACE Annual Report to the Quality Committee. — TBC – Deferred as a result of COVID-19

Appendix – Board Assurance Framework (Full)

BAF Risk 5

• Adequate assurance mechanism that the service integration plans are on track together with the rigour of governance arrangements/lack of delegation from the sovereign bodies to the system. • Understanding what is happening to providers with regard to financial milestones in the ICS. • Costs associated with the ICP and ICS 5-year plan may have an effect on Trust finances. • Capacity to manage COVID patients. • Capacity in critical care beds/staffing. • Staff exhaustion, resilience and availability as a result of the pandemic response. • New guidance on self-isolation for NHS staff is affecting the availability of staff and is open to interpretation • Similar to the above point, there is an unavailability of staff within care home which has a negative effect on the discharge of patients, therefore affecting patient flow in the Trust.	

East Lancashire Hospitals NHS Trust
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TRUST BOARD REPORT

8 September 2021

Item 109

Purpose Information
Decision

Title	Serious Incident Assurance Report
Author	Mrs A Brown, Associate Director Quality and Safety
Executive sponsor	Mr J Husain, Executive Medical Director

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

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: No formal Committee

1. Serious Incidents Reported from 1st July to 31st August 2021

1.1 From 1st July 2021 to 31st Aug 2021 the Trust reported 14 Serious Incidents to our commissioners. The top 2 categories:

- 5 Pressures Ulcers (PUs) (reduction of 7 on the previous two months)
- 3 Diagnosis failure / problem

1.2 Serious incident investigations have now been completed for the 3 incidents reported under the Never Event criteria and reports were presented to the August SIRI panel. Investigations confirmed that the required safety processes had been completed and documented in line with national expectations. All were agreed therefore as no longer meeting the national criteria for Never Events and suitable for de-escalation. This will be discussed with the CCG in order to remove them from this category of reporting on the National Reporting and Learning System (NRLS).

1.3 One further incident has been considered under Never Event criteria however the round table agreed this did not appear to have been met. This will be considered following outcome of investigation. The report is due to be presented to SIRI Panel in September 2021.

1.4 There have been no breaches of duty of candour reported in July and August 2021.

2. CCG Assurance Dashboard (Appendix A)

2.1 The East Lancashire Care Commissioning Group (CCG) provides a serious incident dashboard each month to the Trust (see appendix A). At the time of the Dashboard being produced the Trust had 133 Serious Incidents open for investigation and learning with the local CCG.

- 78 are under investigation
- 5 investigations have been completed and awaiting closure or de-escalation by the CCG
- 45 investigation reports further information has been requested from divisions before closure agreed
- 5 are HSIB investigations

2.2 The CCG dashboard highlights that 62 reported StEIS incidents have been de-escalated on completion of the investigations to date for 2020.

2.3 The three top externally reported incident categories:

- Pressure Ulcers
- Slips/trips/falls
- Diagnostic

3 SIRI Panel Overview (July and August)

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

- 15 reports were approved with learning
- 13 reports approved and de-escalation requested (8 were PUs)
- 1 not approved as further work required

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

- There are continuing issues with the external provider around delivery and retrieval of equipment to homes which can be distressing for families. These issues are being monitored and reviewed on the risk register for consideration for escalation to Senior Leaders Group if no improvement.
- There have been several recent incidents relating to security issues. The Trust has given notice to the security provider to terminate the contract and there is a new contract in place. The new contract is to include assurances around the knowledge and skills of the new security provider's employees, and that a multi-disciplinary approach is to be taken when dealing with vulnerable patients
- The revised Restraint policy is being monitored and reviewed on the risk register by the Trust's Security Manager. The provision of training for Trust staff is currently being agreed.
- Translation/Language services access difficulties during Covid. A new service was now in use and the initial difficulties experienced were being

addressed as part of a relaunch of the service. The new service information has now been circulated across the trust.

- Learning difficulties and mental capacity. Discussions with Safeguarding and learning disability team to devise an action plan to strengthen the recognition of learning disability and the consideration to assess capacity with nursing and therapy team. The Trust has agreed to expand mandatory MCA eLearning to all clinical staff in the Trust, especially to be undertaken by staff involved in the care of long term complex patients.

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

4.1. In November 2019 the Trust was chosen to represent the North West as an early adopter of the proposed PSIRF approach to investigating serious incidents. This model links patient safety investigations with improvement approaches, increases the engagement of patients and their families throughout investigations, recognises the impact investigations have on staff involved and strengthens the focus on organisational learning whilst retaining a focus on addressing immediate safety issues.

4.2. The Trust is participating in this programme in partnership with East Lancashire CCG. Following attendance at a launch event in January 2020, the Board formalised its agreement to participate in this programme in Feb 2020 and the Care Quality Commission (CQC) were informed.

4.3 This was necessary as PSIRF has been designed to replace the current Serious Incident Framework (SIF) as the national guidance for all NHS organisations regarding the required reporting and investigation of patient safety incidents. Participation as an early adopter will therefore require the Trust to respond to and report patient safety incidents in line with guidance that will not become a national requirement until April 2022.

4.4. During the initial waves of the Covid-19 pandemic the national PSIRF implementation programme was paused, restarting in March 2021. Throughout this pause the Assistant Director Safety and Risk has represented the Trust at monthly online update events with NHS England and the national PSIRF implementation team.

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

- A survey of the 300+ staff trained as investigators has confirmed that staff are often expected to lead investigations in addition to their existing role, rather than provided with focussed time. This often delays completion and affects the extent to which staff and families can be engaged in the process. This is in line with national feedback.

- An options appraisal in line with the PSIRF recommendations was presented to the Executive and wider senior leadership group in June 2021. This has resulted in the agreement to fund a team of 4 senior patient safety incident investigators, with allocated administration support.

- A refocus of the SIRI panel, to enable Executive sign off of investigations, and a move to introduce a portfolio of investigation methods is ongoing.

- The introduction of a weekly complex case meeting has already resulted in improved coordination of complaints, inquest and patient safety investigation processes, early engagement with families and improved responsiveness to coronial processes.

4.5. The Trust is on track for full adoption of PSIRF processes from October 2021.

- The Board is asked to consider receiving a full presentation on PSIRF at the next meeting.

Alison Brown – Associate Director of Quality and Safety
30th August 2021

Appendix A: Serious Incident Dashboard produced by East Lancashire CCG on 13th August 2021

Provider: ELHT | 13/08/2021

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

Total number of incidents: 655

2021/22	2020/21	2019/20
52	120	68

2018/19	2017/18	2016/17	2015/16
54	64	66	76

Total number of incidents closed: 522

2021/22	2020/21	2019/20
0	39	68

2018/19	2017/18	2016/17	2015/16
54	64	66	76

Total number of incidents open: 133

2021/22	2020/21	2019/20
52	81	0

2018/19	2017/18	2016/17	2015/16
0	0	0	0

ELHT extension requests: July 2021: 1

Difference from rolling 12 month mean	Rank
-9.0	5

Month	Count	Difference from rolling 12 month mean	Rank
Jun-21	1	-9.0	5
May-21	1	-9.0	5
Apr-21	0	-10.0	11
Mar-21	1	-9.0	5
Feb-21	1	-9.0	5
Jan-21	59	49.0	1
Dec-20	1	-9.0	5
Nov-20	0	-10.0	11
Oct-20	37	27.0	2
Sep-20	9	-1.0	3
Aug-20	9	-1.0	3

Overdue from initial date

0-10	5
11-20	8
21-30	2
31-40	4
41-50	7
51-60	5
61-70	6
71-80	3
81-90	4
91-100	1
>100	8

Top 5 Incident Types (12 month rolling): 13 August 2020 - 13 August 2021

Pressure ulcer (grade unknown)	58
Slips/Trips/Falls	15
Diagnostic incident including delay (including failure to act on test results)	12
Maternity/Obstetric incident meeting SI criteria: baby only (this includes foetus, neonate and infant)	12
Surgical/invasive procedure incident	9

Reported in 2 working days of SI identified: 2020/21

Yes	154	No	22

Status of all open StEIS incidents

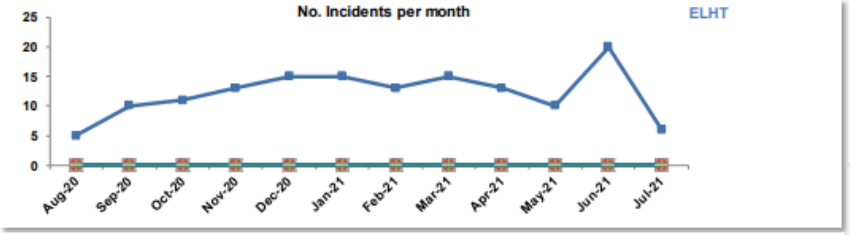
Awaiting additional information	45
Awaiting closure	5
Under HSIB investigation	5
Awaiting RCA	78
LAT Managed	0
Total	133

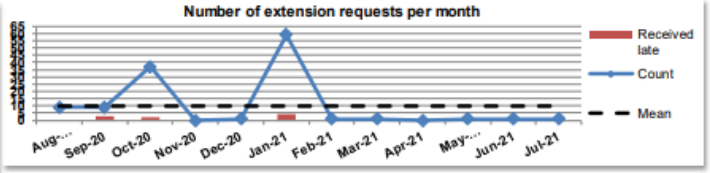
RCAs due (all years)

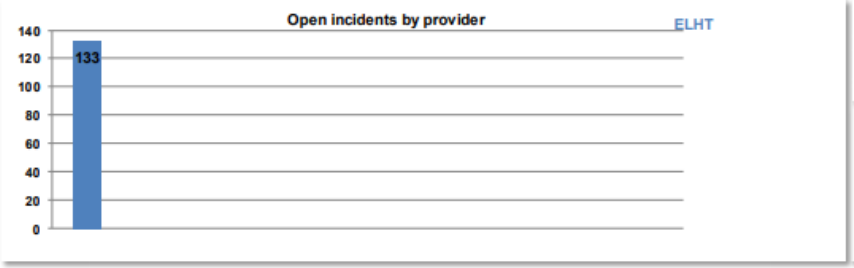
More than 14 days till due	27
Due within 14 days	10
Stop the clock in place	0
Overdue	47
Total	84

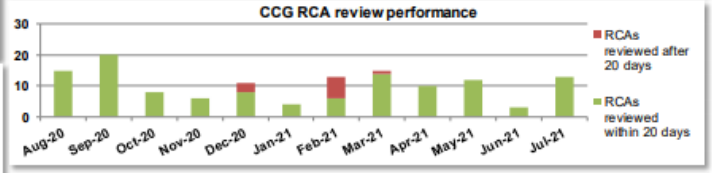
Never Events

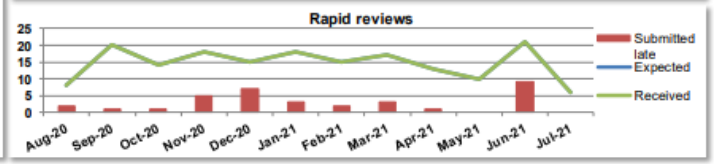
2020/21	2019/20	2018/19	2017/18	2016/17
3	5	1	7	1











East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 110

8 September 2021

Purpose Information
Action
Monitoring

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

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

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

Report linkages

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

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

Board of Directors, Update

Corporate Report

Executive Overview Summary

Positive News

- There were no confirmed post 2 day MRSA bacteraemia in month.
- There were no medication errors causing serious harm.
- Average fill rates for registered nurses/ midwives and care staff remain above threshold, although continue to be extremely challenging.
- The complaints rate remains below threshold.
- The Trust is reporting an adjusted deficit of £0.4 million in month 4 and a £0.1m adjusted surplus for year to date, in line with the H1 plan.

Areas of Challenge

- There was 1 never events reported in month.
- There were 3 healthcare associated clostridium difficile infections detected in month ('Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)'.
- There were 6 steis reportable incidents in month.
- The HSMR is 'above expected'.
- 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 July at 75.4%
- There were 8 breaches of the 12 hour trolley wait standard (7 mental health and 1 physical health)
- There were 448 ambulance handovers > 30 minutes and 13 > 60 minutes. Following validation, 2 of the 13 were ELHT breaches. The trend is showing significant improvement.
- The cancer 62 day standard was not met in June at 73%.
- There were 12 breaches of the 104 day cancer wait standard.
- The 6wk diagnostic target was not met at 19.5% in July.
- The Referral to Treatment (RTT) number of total ongoing pathways has increased on last month to 33,575, however the number over 40 weeks has reduced to 1574.
- There were 768 breaches of the RTT >52 weeks standard due to COVID-19, which is below the monthly trajectory.
- There were 4 breaches of the 28 day standard for operations cancelled on the day.
- Sickness rates are above threshold at 6.1%
- The Trust vacancy rate is above threshold at 5.1%

- 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.
- Compliance against the Information Governance Toolkit has fallen below the 95% target at 94%
- Temporary costs as % of total pay bill remains above threshold at 11%.

No Change

- The SHMI has remained as expected at 1.09.
- VTE risk assessment performance remains above threshold.
- All areas of core skills training are above threshold, with the exception of information governance and basic life support.
- The emergency readmission rate is showing no change
- Length of stay is within normal levels.
- There were 77 operations cancelled on the day (non clinical). This has returned to pre covid levels.
- CQUIN schemes are on hold until September.

Introduction

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

Key to Scorecard Symbols

Variation

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

Assurance

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

Safe

	Indicator	Target	Actual	Variation	Assurance
M64	Clostriduim difficile (C.diff) - 'Hospital onset healthcare associated (HOHA)'	not set for 2020	2		No target set to provide assurance against
M64.3	Clostriduim difficile (C.diff) - 'Community onset healthcare associated (COHA)'	not set for 2020	1		
M64.4	Clostriduim difficile (C.diff) Cumulative from April (HOHA& COHA)	not set for 2020	20		
M65	MRSA	not set for 2020	0		
M124	E-Coli (post 2 days)	not set for 2020	2		
M155	P. aeruginosa bacteraemia (total post 2 days)	not set for 2020	0		
M157	Klebsiella species bacteraemia (total post 2 days)	not set for 2020	1		
M66	Never Event Incidence	0	1		
M67	Medication errors causing serious harm (Steis reported date)	0	0		
M68	Maternal deaths	0	0		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)	No Threshold Set	7.4		
M69	Serious Incidents (Steis)	No Threshold Set	6		
M70	Central Alerting System (CAS) Alerts - non compliance	0	0		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	98%		

Caring

	Indicator	Target	Actual	Variation	Assurance
C38	Inpatient Friends and Family - % who would recommend	90%	96%		
C31	NHS England Inpatients response rate from Friends and Family Test	No Threshold Set	42%		
C40	Maternity Friends and Family - % who would recommend	90%	89%		
C42	A&E Friends and Family - % who would recommend	90%	70%		
C32	NHS England A&E response rate from Friends and Family Test	No Threshold Set	8%		
C44	Community Friends and Family - % who would recommend	90%	92%		
C38.5	Outpatient Friends and Family - % who would recommend	90%	92%		
C15	Complaints – rate per 1000 contacts	0.40	0.22		
M52	Mixed Sex Breaches	0			

Effective

	Indicator	Target	Actual	Variation	Assurance
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Within Expected Levels	1.09		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at Mar-21)	Within Expected Levels	111.6		
M74	Hospital Standardised Mortality Ratio - Weekday (as at Mar-21)	Within Expected Levels	109.4		
M75	Hospital Standardised Mortality Ratio - Weekend (as at Mar-21)	Within Expected Levels	118.3		
M73	Deaths in Low Risk Conditions (as at Mar-21)	Within Expected Levels	3.4		
M159	Stillbirths	<5	0		
M160	Stillbirths - Improvements in care that impacted on the outcome	No Threshold Set	n/a		
M89	CQUIN schemes at risk	CQUIN Suspended for 2020/21			

Responsive

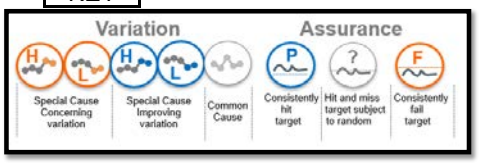
	Indicator	Target	Actual	Variation	Assurance
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95.0%	74.0%		
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95.0%	75.4%		
M62	12 hour trolley waits in A&E	0	8		
M82.1	Handovers > 30 mins ALL (Arrival to handover)	0	448		
M84	Handovers > 60 mins (Arrival to handover)	0	13		
C1	Referral to Treatment (RTT) admitted: percentage within 18 weeks	No Threshold Set	51.3%		
C3	Referral to Treatment (RTT) non admitted pathways: percentage within 18 weeks	No Threshold Set	86.5%		
C4.1	Referral to Treatment (RTT)waiting times Incomplete pathways Total	No Threshold Set	33,575		
C4.2	Referral to Treatment (RTT) waiting times Incomplete pathways -over 40 wks	No Threshold Set	1574		
C37.1	Referral to Treatment (RTT) 52 Weeks (Ongoing)	955	768		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1.0%	19.5%		
C18	Cancer - Treatment within 62 days of referral from GP	85.0%	73.0%		
C19	Cancer - Treatment within 62 days of referral from screening	90.0%	75.9%		
C20	Cancer - Treatment within 31 days of decision to treat	96.0%	96.9%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98.0%	98.1%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94.0%	95.3%		
C36	Cancer 62 Day Consultant Upgrade	85.0%	89.2%		
C25.1	Cancer - Patients treated > day 104	0	12		
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	4		
M138	No.Cancelled operations on day	No Threshold Set	77		
M55	Proportion of delayed discharges attributable to the NHS	New reporting in development			
C16	Emergency re admissions within 30 days	No Threshold Set	13.7%		
M90	Average length of stay elective (excl daycase)	No Threshold Set	3.7		
M91	Average length of stay non-elective	No Threshold Set	5.0		

Well Led

	Indicator	Target	Actual	Variation	Assurance
M77	Trust turnover rate	12.0%	10.4%		
M78	Trust level total sickness rate	4.5%	6.1%		
M79	Total Trust vacancy rate	5.0%	5.1%		
M80.3	Appraisal (Agenda for Change Staff)	90.0%	57.0%		
M80.35	Appraisal (Consultant)	90.0%	95.0%		
M80.4	Appraisal (Other Medical)	90.0%	98.0%		
M80.2	Safeguarding Children	90.0%	94.0%		
M80.21	Information Governance Toolkit Compliance	95.0%	94.0%		
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	£0.0		
F2	Variance to H1 Waste Reduction Programme (WRP) achieved (£m)	£0.0	£0.00		
F3	Liquidity days	>(7)	(7.4)		
F4	Capital spend v plan	85.0%	100.0%		
F18a	Capital service capacity	>1.25	1.8		
F19a	H1 Income & Expenditure margin	>(2.5%)	0.0%		
F12	Better Payment Practice Code (BPPC) Non NHS No of Invoices	95.0%	97.4%		
F13	Better Payment Practice Code (BPPC) Non NHS Value of Invoices	95.0%	98.4%		
F14	Better Payment Practice Code (BPPC) NHS No of Invoices	95.0%	94.6%		
F15	Better Payment Practice Code (BPPC) NHS Value of Invoices	95.0%	98.4%		

NB: Finance Metrics are reported year to date.

KEY

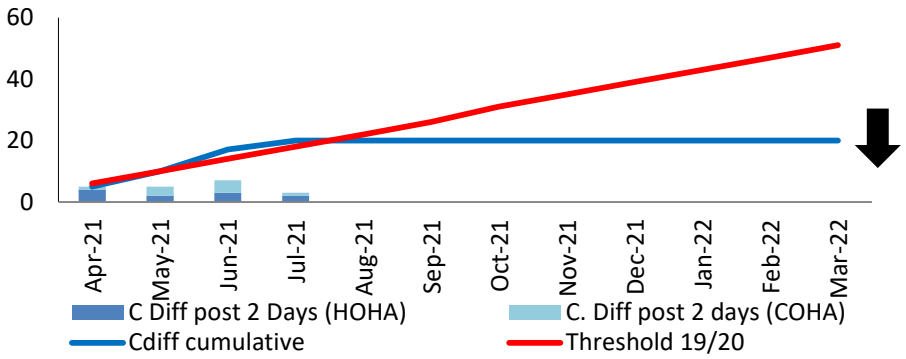


SPC Control Limits

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

SAFE

C Difficile

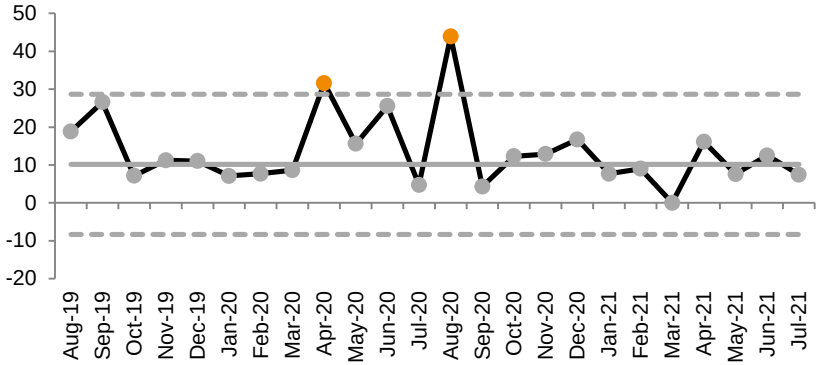


There were no post 2 day MRSA infection reported in July. So far this year there has been 1 case attributed to the Trust.

The objective for 2019/20 was no more than 51 cases of 'Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)' . The final figure for cases reported in 2020/21 was 69.

The 2021/22 objective has not yet been set. An indicative threshold based on 2019/20 is shown in the chart.

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

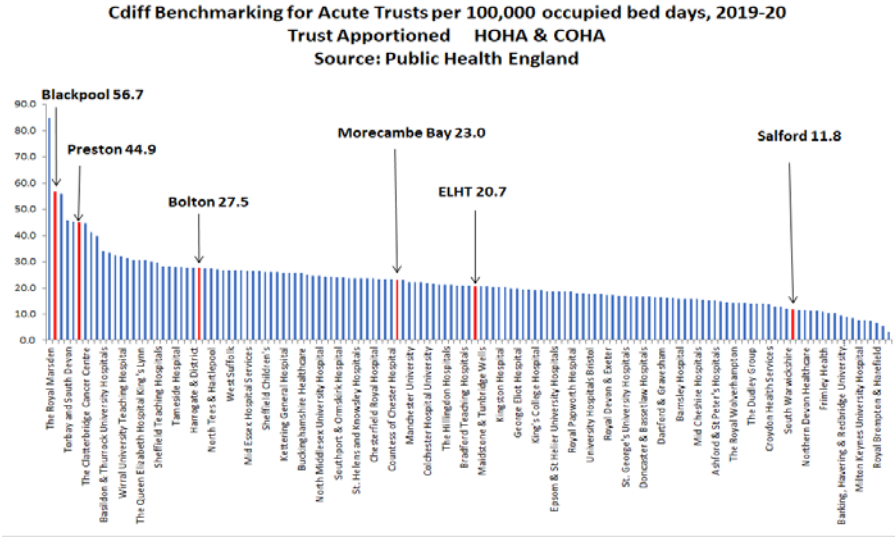


There were 3 healthcare associated Clostridium difficile toxin positive isolates identified in the laboratory in July, post 2 days of admission, of which there were 2 'Hospital onset healthcare associated (HOHA)' and 1 'Community onset healthcare associated (COHA)'

The year to date cumulative figure is 20 (HOHA & COHA). The detailed infection control report will be reviewed through the Quality Committee.

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

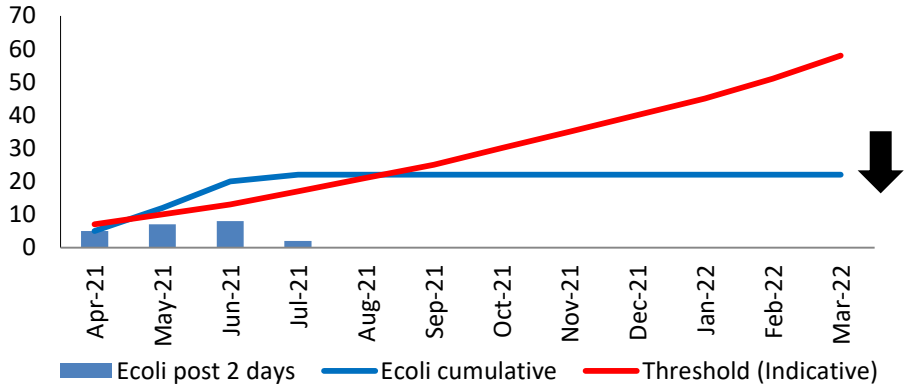
C Difficile benchmarking



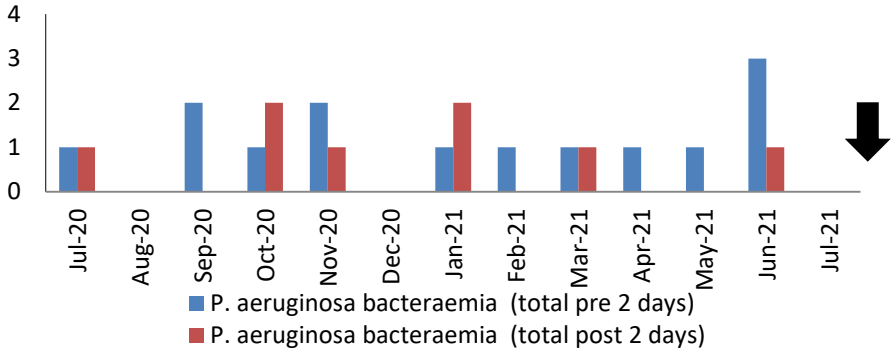
ELHT ranked 75th out of 146 trusts in 2019-20 with 20.7 HOHA & COHA clostridium infections per 100,000 bed days. The best performing trust had 0 and the worst performer had 85.0 infections per 100,000 bed days.

SAFE

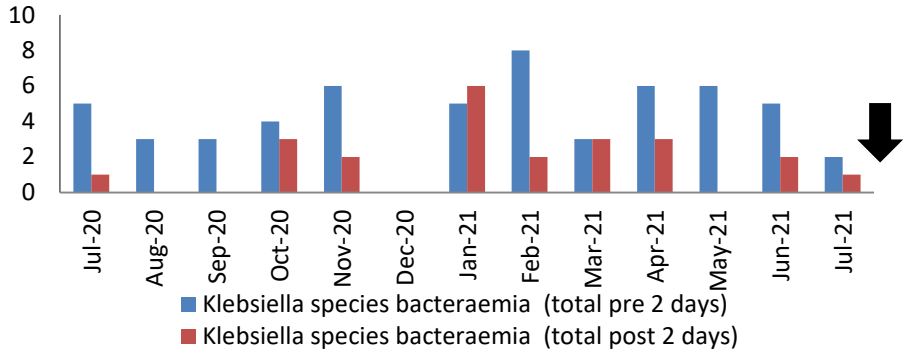
E. Coli



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.

The year end figure for 2019/20 was 70 cases and for 2020/21 was 54.

This year's trajectory for reduction of E.coli has not yet been published, so an indicative trajectory of 58 has been included for information.

There were 2 post 2 day E.coli bacteraemia detected in July, which is below the indicative monthly threshold.

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

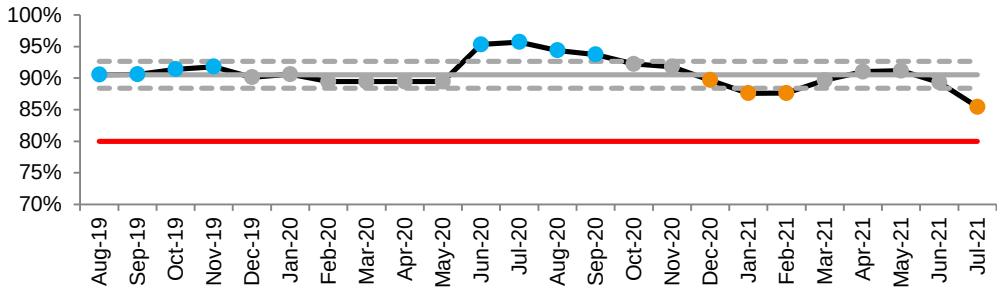
Surveillance will be undertaken in line with current requirements (e.g. E. coli bacteraemia). This surveillance will be carried out by the Infection Prevention and Control Team.

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

SAFE

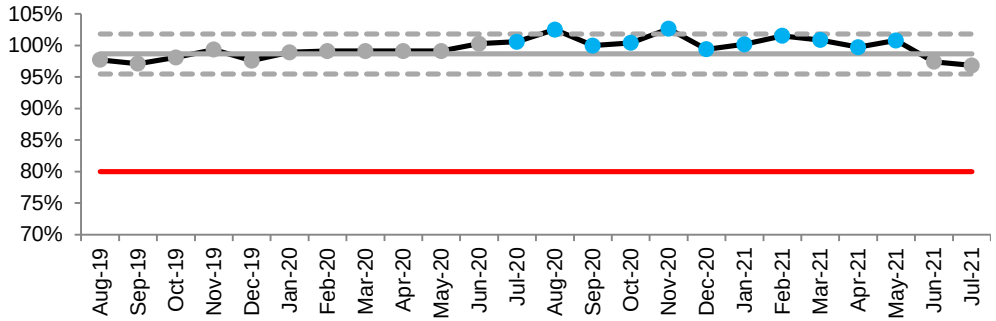
NB: Mar - May 20 figures were not collected due to COVID 19, so are estimated here for purposes of calculating the Statistical Process Control (SPC) limits

Registered Nurses/ Midwives - Day



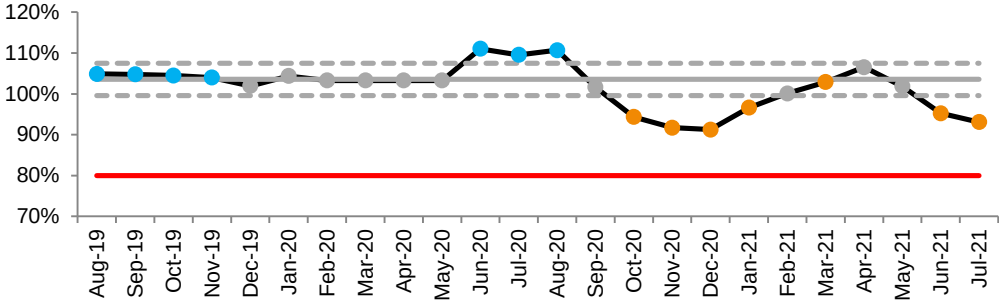
The average fill rate for registered nurses/ midwives during the day is showing a reduction in July, however based on current variation will consistently be above threshold.

Registered Nurses/ Midwives - Night



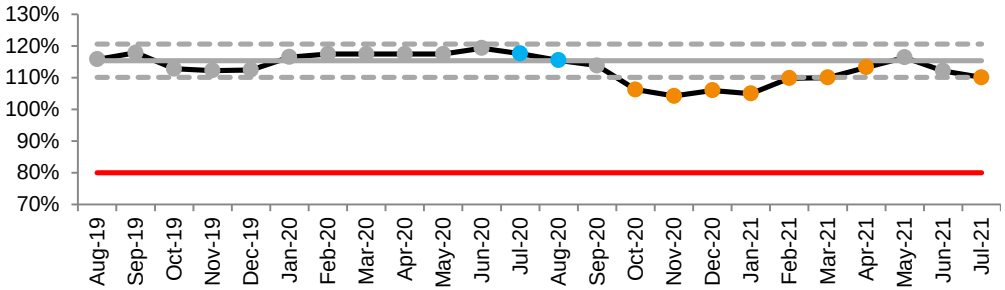
The average fill rate for registered nurses/ midwives at night is showing normal variation and based on current variation will consistently be above threshold.

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 a reduction, however based on current variation will consistently be above threshold.

SAFE

Staffing in July 2021 has continued to be extremely challenging. Restoration and recovery plans are underway but the already established vacancies, impact of acuity, shielding and staff sickness remains very challenging. Lots of cross cover between wards and the high use of bank and agency staffing continues.

8 wards fell below the 80% for registered nurses in July for the day shift. The filling of Health Care Support Worker shifts remains a challenge

Wards below 80% for Registered Nurses during day shifts:

Medicine & Emergency Care (MEC)

B4 - This was due to a lack of shift co-ordinators.
C5 - This was due to a lack of shift co-ordinators.
C7 - This was due to a lack of shift co-ordinators. Not all beds were full due to Ward C7 being a covid+ ward.
C9 - This was due to a lack of shift co-ordinators. Not all beds were full due to Ward C7 being a covid+ ward.

Community & Integrated Care (CIC)

Hartley- There were 3 shifts in July where registered nurse staffing ratios dropped below 1:8 ratio during the day. This was mitigated with student nurses and cross cover from neighbouring wards. No patient safety incidents.
Rakehead- This was due to a lack of shift co-ordinators.
Reedyford- There were 4 shifts in July where registered nurse staffing ratios dropped below 1:8 ratio during the day. This was mitigated with student nurses and cross cover from neighbouring wards. Staff shortage incidents were raised but no red flags and no harm to patients.

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.

Red Flags

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

In line with the NICE Safe Staffing guidance there were 3 red flags for the month of July.

Medicine & Emergency Care (MEC)

D1 – Over 30 minute delay in providing pain relief. Due to sickness there was a lack of staff to check the controlled drug painkiller. Simultaneously a patient complaining of feeling well who required blood pressure medication management. Pain scores reviewed, care prioritised. Patient requiring analgesia came to no harm. Escalated and reported appropriately.

C1 – Increased acuity on ward. Delays in undertaking pressure relief for patients that required 2 hourly positional changes. No harms identified

C1- Increased acuity on ward C1 due to patient needs/presentation. Delays in undertaking intentional rounding and staff missed their breaks. No patient or staff harms identified.

Whilst restoration is almost complete, anecdotally staff continue to feel tired and some very effected 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. Continued Covid admissions to Critical Care have put the team under immense pressure

Support is ongoing to all areas through the divisional and corporate teams and working groups with the recruitment lead nurse and divisions to work collaboratively to address recruitment are about to commence

Actions taken to mitigate risk

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

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

• Relaunch of recruitment strategy

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

• Impact of COVID 19 on nursing and midwifery staffing levels and care provision paper ratified through Information Control Centre (ICC) specifying expected staffing levels and minimum staffing levels in extremis with contingency for supporting ward staffing

SAFE

• Due to improvements to the COVID-19 situation in India, the UK Government has lifted the pause to all international travel from India for nurses taking up employment in the NHS. All nurses have to undergo a period of isolation on arrival into the UK. . 14 overseas nurses for ELHT have arrived at the Trust in June and July. There are 4 nurses expected in August and a further 10 planned for each month until December

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

SAFE

Family Care

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

There were no red flags reported for the month of July

Maternity (Midwife to Birth Ratio)

Month	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Staffed to full Establishment	01:24	01:26	01:26	01:25	01:26	01:27	01:26	01:27	01:27	01:28	01:27	01:26
Excluding mat leave	01:26	01:27	01:27	1:26.71	01:27	01:28	01:27	01:28	01:28	01:29	01:27	01:27
With gaps filled through ELHT Midwife staff bank	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage	Bank Usage
Per week	8.40wte	10.14wte	13.15wte	10.52wte	8.03wte	18.82wte	18.90wte	19.53wte	11.25wte	24.14wte	17.98wte	17.40wte

SAFE

Maternity- The bank filled rate hours covering vacancies/ pregnancy shielding and sickness is 17.40

The Enhanced hourly rate of pay in view of the significant increase with self-isolation continues in July, an additional specialist midwife rota has been completed for the month of July to cover staffing gaps Monday to Friday, Primarily Antenatal clinic (ANC).

Intrapartum births at Blackburn centre still redirected to Burnley Birth Centre to support midwifery gaps at the Lancashire Womens & Newborn Centre.

Please note within the month of July staffing planned and actuals hours for post-natal ward was reduced to 69.3 % this was further reviewed by the matron for accuracy. The planned hours had not been reflected in line with the actuals in that a number of days beds were closed due to reduced capacity. This was an oversight and will be accounted for and rectified moving forwards.

Safe Staffing levels are reviewed with appropriate risk assessments throughout the day at each safety huddle on the Central Birth Suite; midwives are redeployed to other areas to support acuity and activity as and when required.

Maternity staffing has been extremely challenged. ELHT have 24 midwives recruited to who commence in post following qualification in September 2021.

Neonatology - Bank and agency use required for staff related/ shielding absences. Agency shifts covered where acuity/ activity reflects a gap. Safe staffing calculated in line with the North West connect tool, reflected in the safety huddles to demonstrate, all duties are covered to achieve safe staffing levels where required. The unit has closed twice (15th and 24th) to external admissions due to staffing in the month of July.

Paediatrics- Activity/Acuity has increased however safe staffing levels have been maintained at all times, no nursing red flags reported within the month of July. Staffing plans in progress to review the nursing workforce with the pending Respiratory Syncytial Virus (RSV)surge.

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. Five substantive posts just recruited with stat dates pending. No nursing red flags reported.

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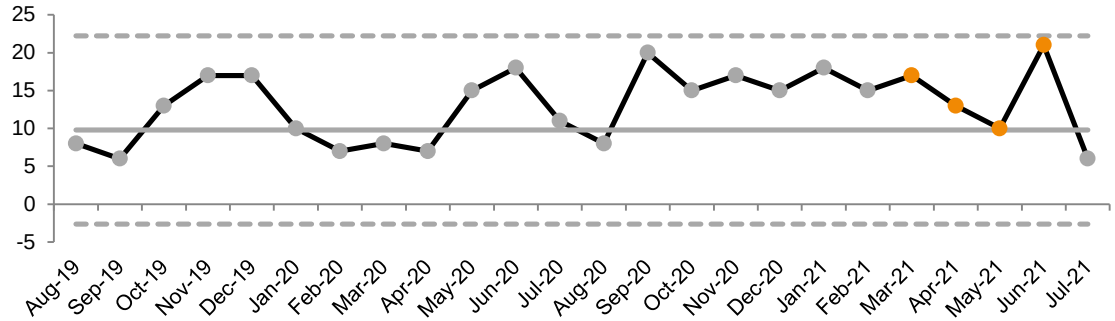
Please see appendix1 for UNIFY data and appendix 2 for nurse sensitive indicator report.

SAFE

Serious Incidents



There was one never event reported in July.

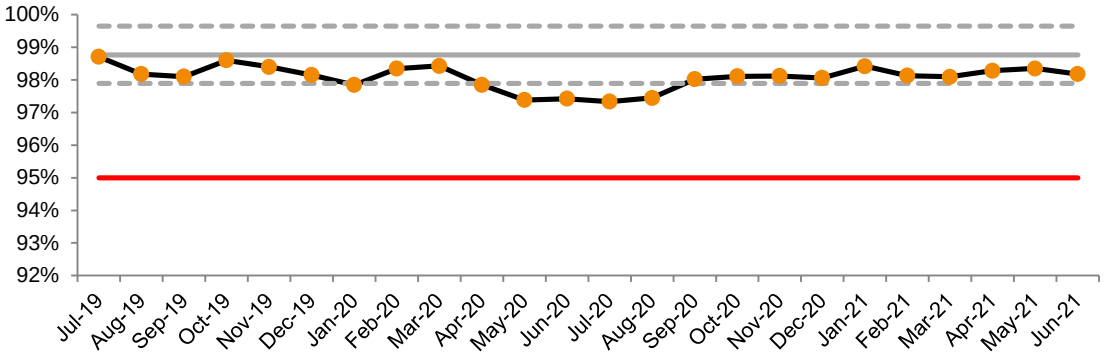
The Trust unverified position for incidents reported to the Strategic Executive Information System (StEIS) in July was 6 incidents.

The trend is showing a return to normal variation.

Strategic Executive Information System (StEIS) Category	No. Incidents
Pressure ulcer	3
Apparent/actual/suspected self-inflicted harm	1
Surgical/invasive procedure	1
Diagnostic	1

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

VTE assessment



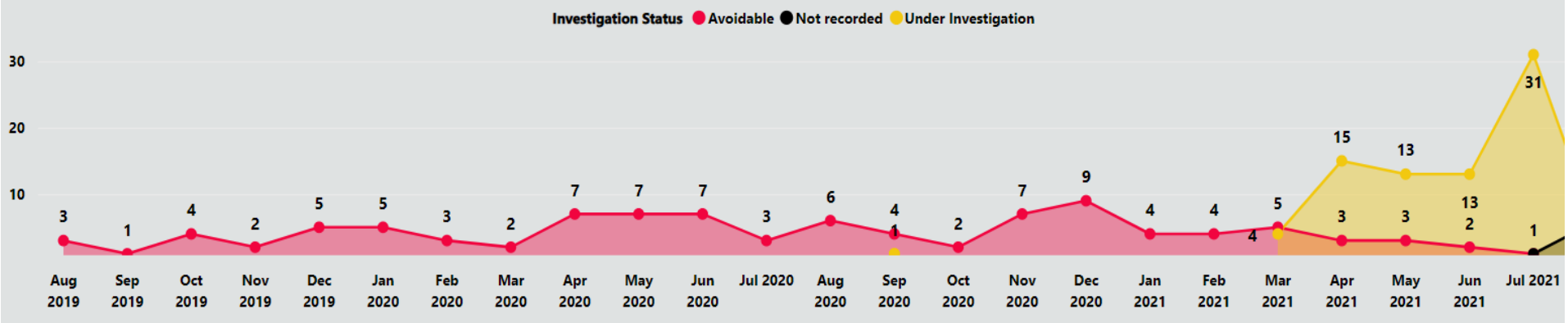
The Venous Thromboembolism (VTE) assessment trend continues to be below previous levels, however based on recent performance will consistently achieve the standard.

SAFE

Pressure Ulcers

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

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



A meeting was held with NHS England, North West and commissioners, to discuss our pressure ulcer data. A request was made to NHS England to standardise reporting across Lancashire & South Cumbria. Following the meeting with commissioners, it was decided that no changes will be made at this time due to capacity, but this will continue to be reviewed over the coming months.

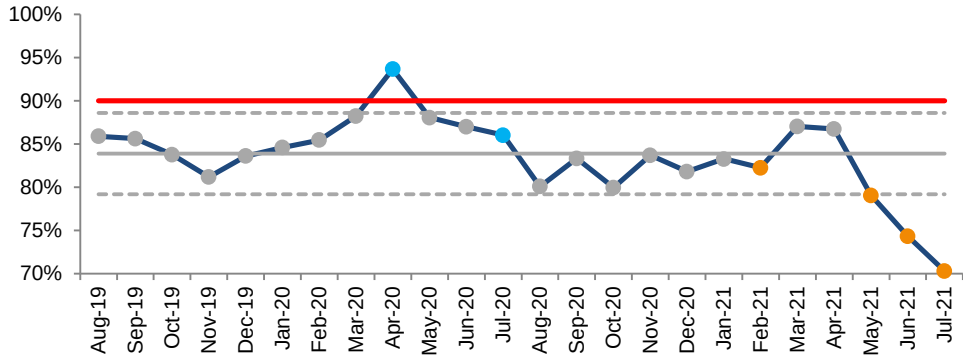
A review of the test of change (not to StEIS report unstageable pressure damage for the community setting) has taken place and our commissioner colleagues are happy to continue this.

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.

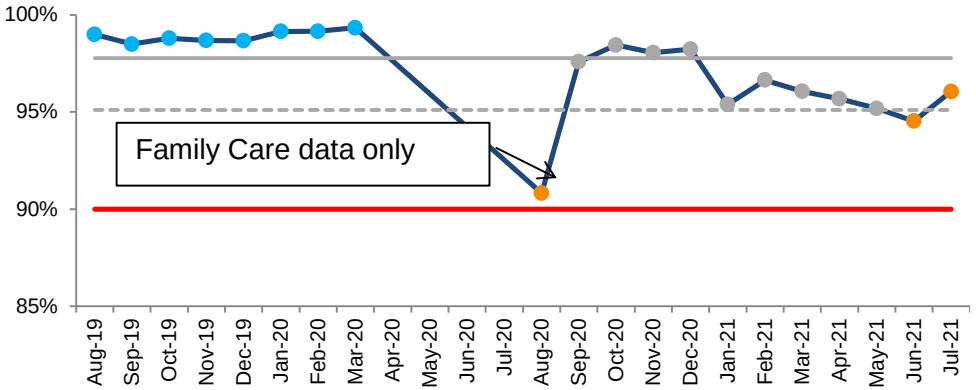
Inpatient data collection was suspended April 20 - Sep 20 due to COVID

Friends & Family A&E



A&E scores are showing a significant deterioration in the last 3 months. Based on current variation this indicator is not capable of hitting the target routinely.

Friends & Family Inpatient

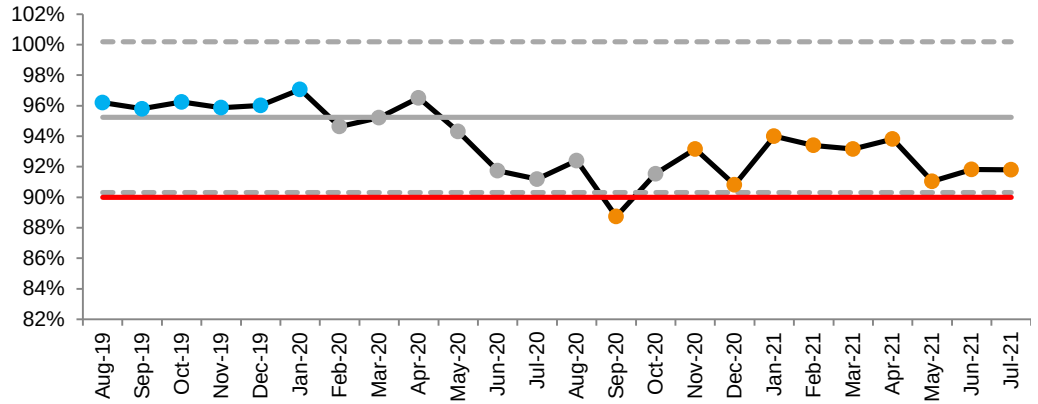


Inpatient data was suspended April - September 20 due to the COVID pandemic. Paper surverys were resumed in Family Care from 1st August 20 and across all areas from 1st September 20.

The trend is showing significant deterioration.

CARING

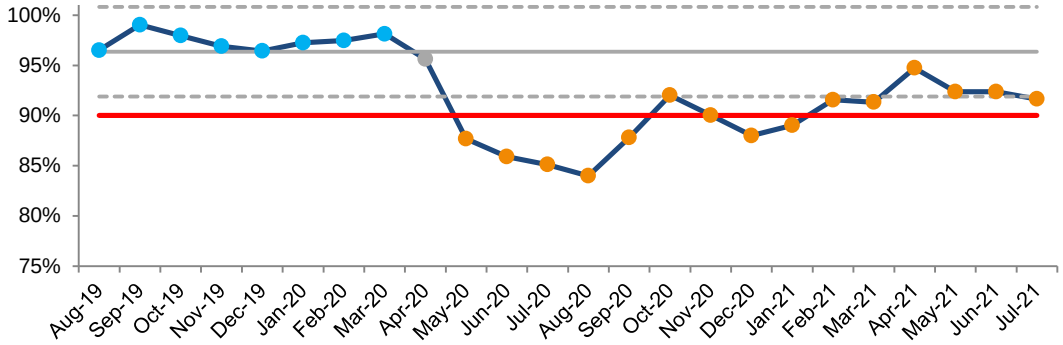
Friends & Family Outpatients



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

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

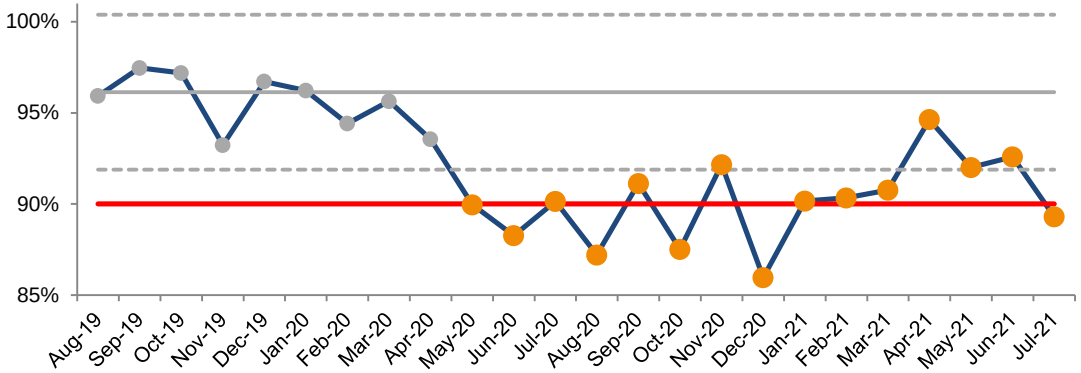
Friends & Family Community



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

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

Friends & Family Maternity

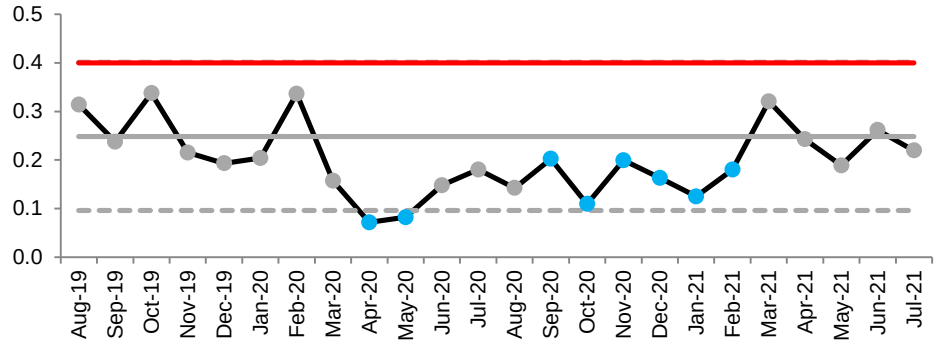


Maternity scores continue to show a reduction, which is significantly lower than usual variation and have fallen below threshold this month.

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

CARING

Complaints per 1000 contacts



The Trust opened 29 new formal complaints in July.

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 July the number of complaints received was 0.22 Per 1,000 patient contacts.

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

Patient Experience

		Dignity	Information	Involvement	Quality	Overall
Type	**Division**	Average Score	Average Score	Average Score	Average Score	Average Score
Community	Community and Intermediate Care Services	94.72	92.49	91.71	94.14	92.95
Community	Diagnostic and Clinical Support	100.00	90.18	95.24	100.00	95.08
Delivery	Family Care	100.00	86.21	100.00	96.43	95.90
ED_UC	Surgery	93.59	78.57	88.30	86.54	87.50
Inpatients	Community and Intermediate Care Services	75.00	100.00	91.67	100.00	95.00
Inpatients	Diagnostic and Clinical Support	100.00	84.24	91.05	93.00	90.26
Inpatients	Family Care	91.67	83.93	92.14	89.66	89.84
Inpatients	Medicine and Emergency Care	85.74	79.53	79.17	84.49	81.53
Inpatients	Surgery	95.11	86.22	89.52	87.50	89.73
OPD	Diagnostic and Clinical Support	100.00	100.00	97.73	93.88	96.11
OPD	Family Care	100.00	100.00	98.48	96.55	98.40
OPD	Medicine and Emergency Care	100.00	100.00	100.00	87.50	96.25
OPD	Surgery	97.87	98.60	100.00	100.00	99.08
Paediatric	Family Care	98.15	94.44	100.00	100.00	98.36
Postnatal	Family Care	100.00	100.00	100.00	99.29	99.69
SDCU	Family Care	89.66	93.48	93.92	93.06	92.52
	Total	**94.68**	**89.68**	**91.09**	**93.75**	**92.17**

From 1st May 2020 the Trust moved to a new system, CIVICA to manage the Friends 7 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 July 2021.

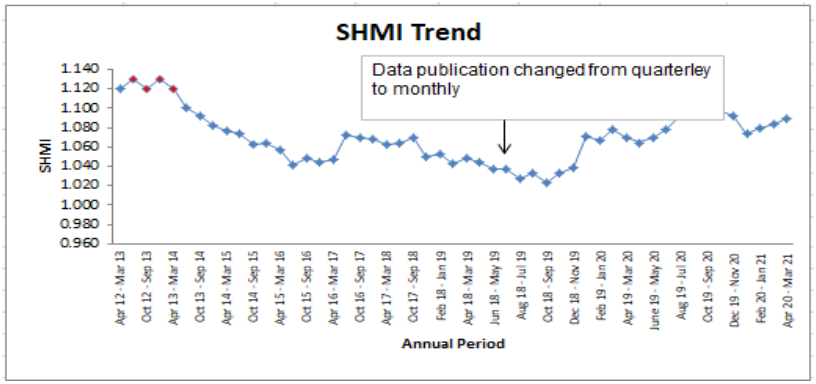
The threshold is a positive score of 90% or above for each of the 4 competencies.

The overall Trust performance from the range of patient experience surveys is above the threshold of 90% for all of the 4 competencies in July 2021.

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

EFFECTIVE

SHMI Published Trend



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

Dr Foster HSMR rolling 12 month

	HSMR Rebased on latest month April 20 – March 21	
	ALL	Excluding COVID
TOTAL	111.6	101.8
Weekday	109.4	98.6
Weekend	118.3	111.6
Deaths in Low Risk Diagnosis Groups	237.2	3.4

The latest indicative 12 month rolling Hospital Standardised Mortality Ratio (HSMR), (April 20 – March 21) has improved slightly from last month but is still 'above expected' at 111.6 against the monthly rebased risk model. Excluding COVID patients, the HSMR is 'as expected' at 101.8.

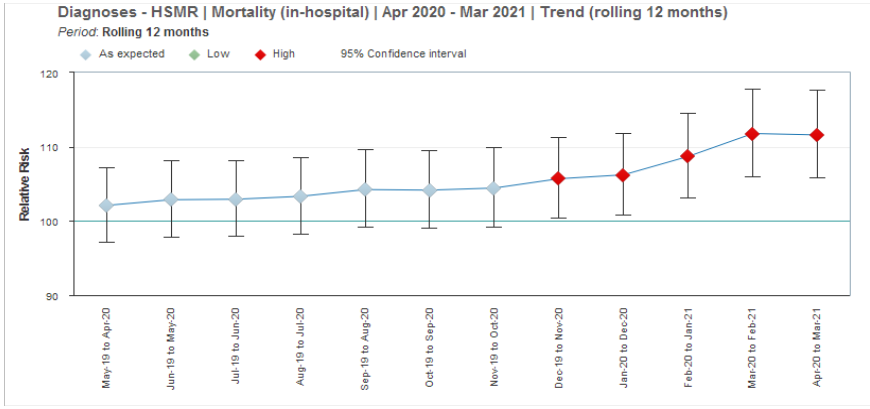
There are currently six HSMR diagnostic groups with significantly high relative risk scores;

Pneumonia, Urinary tract infection, Acute cerebrovascular disease, Peripheral and visceral atherosclerosis, Chronic obstructive pulmonary disease and bronchiectasis, and Liver disease, alcohol related.

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

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

Dr. Foster HSMR monthly



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 (LeDeR)

No update provided in July

EFFECTIVE

Structured Judgement Review Summary

The new structured judgement review process was launched at the beginning of December 2017 for deaths meeting specified criteria. A team of reviewers have been trained on how to complete SJR's and are now undertaking the monthly reviews.

The table below shows a breakdown of SJR's completed and the scores allocated. Any death allocated a SJR score of 1 or 2 will have a stage 2 SJR completed.

The stage 2 SJR reviewer will determine whether or not any lapses in care may have contributed to the death and if so a SIRI and RCA will be triggered.

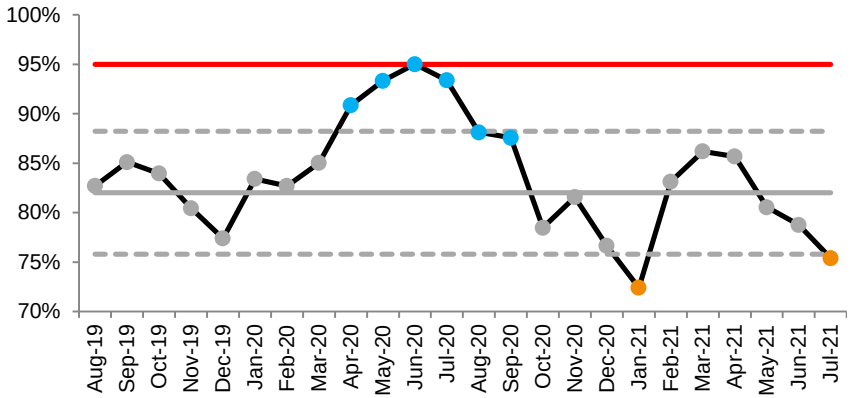
	Month of Death									
Stage 1	pre Oct 17	Oct 17 - Mar 18	Apr 18 - Mar 19	Apr 19 - Mar 20	Apr 20 - Mar 21	Apr-21	May-21	Jun-21	Jul-21	TOTAL
Deaths requiring SJR (Stage 1)	46	212	250	260	199	13	19	14	28	74
Allocated for review	46	212	250	260	188	10	14	9	15	48
SJR Complete	46	212	250	260	181	9	13	9	10	41
1 - Very Poor Care	1	1	0	0	0	0	0	0	0	0
2 - Poor Care	8	19	22	34	29	0	3	1	1	5
3 - Adequate Care	14	68	70	68	55	0	4	2	1	7
4 - Good Care	20	106	133	129	88	7	6	5	7	25
5 - Excellent Care	3	18	25	29	9	2	0	1	1	4
Stage 2										
Deaths requiring SJR (Stage 2)	9	20	22	34	29	0	3	1	1	5
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	1	4	1	0	0	0	0	0
Allocated for review	6	18	21	30	28	0	3	1	1	5
SJR-2 Complete	6	18	21	30	28	0	3	1	0	4
1 - Very Poor Care	1	1	1	2	0	0	0	0	0	0
2 - Poor Care	3	6	7	13	11	0	2	0	0	2
3 - Adequate Care	2	10	13	13	16	0	1	1	0	2
4 - Good Care	0	1	0	2	1	0	0	0	0	0
5 - Excellent Care	0	0	0	0	0	0	0	0	0	0

Commissioning for Quality and Innovation (CQUIN)

As per the guidance on finance and contracting arrangements for H1 2021/22, the block payments approach for arrangements between NHS commissioners and NHS providers in England will now remain in place for the first half of the 2021/22 financial year. Block payments to NHS providers are deemed to include CQUIN, and there will be no 2021/22 CQUIN scheme (either Clinical Commissioning Group or specialised) published at this stage.

RESPONSIVE

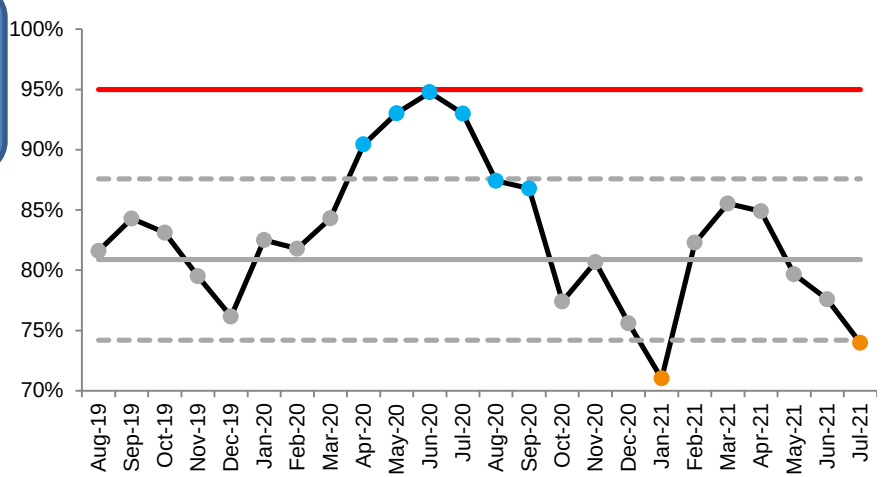
A&E 4 hour standard % performance - Pennine



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 75.4% in July, which is below the 95% threshold and the Trust trajectory (87%)

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

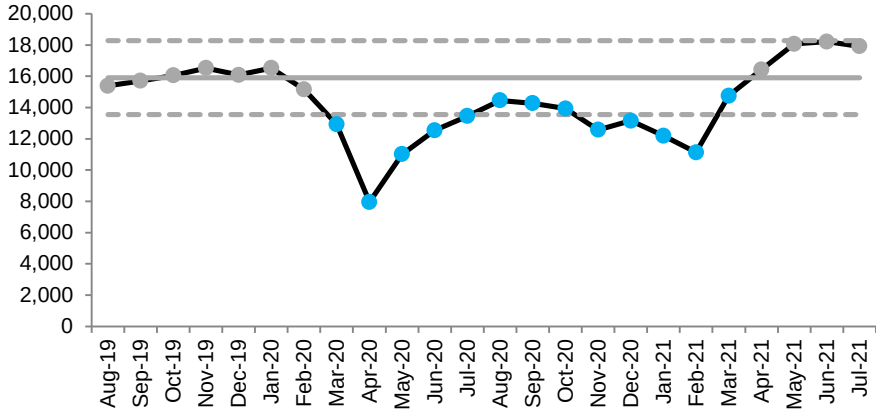
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 74.0% in July.

The national performance was 77.7% in July (All types) with 1 of the 112 reporting trusts with type 1 departments achieving the 95% standard.

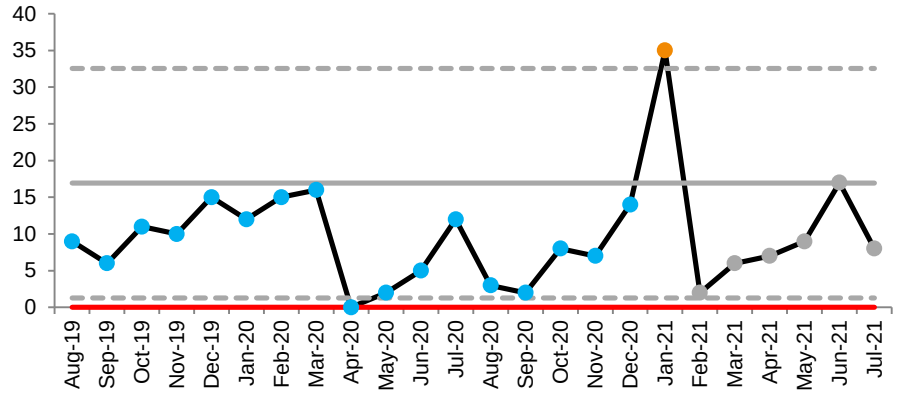
A&E Attendances - Trust



The number of attendances during July was 17,919, which is within the normal range, however continues to be above average and is the 3rd highest month in the last 24 months.

RESPONSIVE

12 Hr Trolley Waits

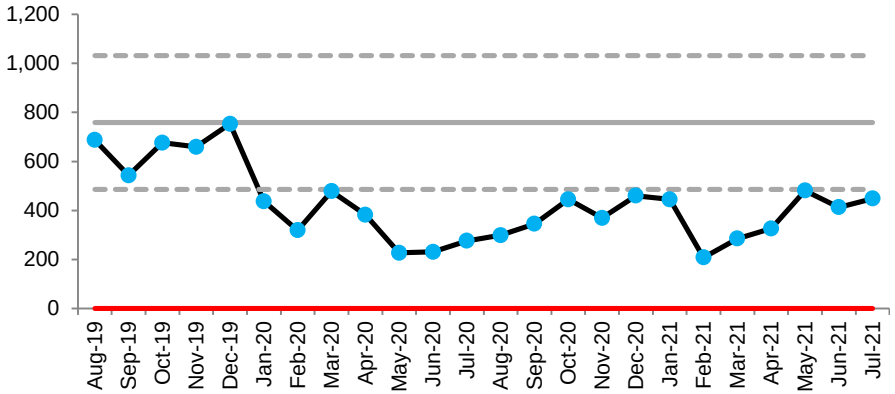


There were 8 reported breaches of the 12 hour trolley wait standard from decision to admit during July. 7 were mental health breaches and 1 was a physical health breach.

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	7	1
Average Wait from Decision to Admit	24hr 30 min	13hr 35 min
Longest Wait from Decision to Admit	66hr 40 min	13hr 35 min

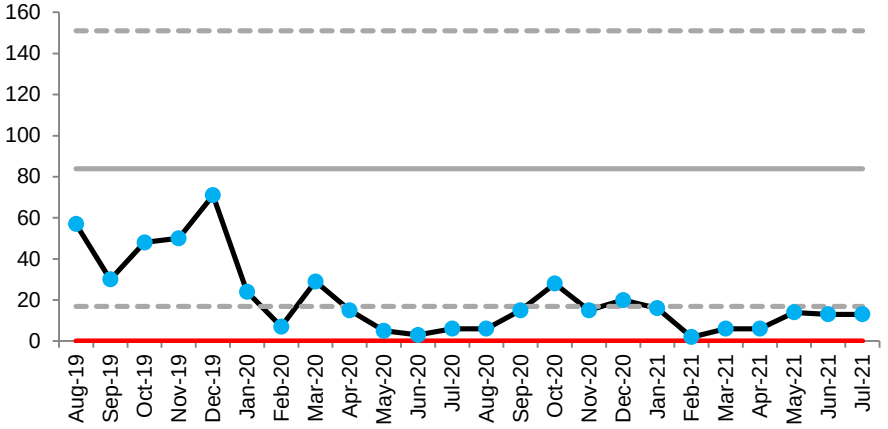
Ambulance Handovers - >30Minutes



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

There were 448 ambulance handovers > 30 minutes in July. The trend is still showing significant improvement from previous levels.

Ambulance Handovers - >60 Minutes

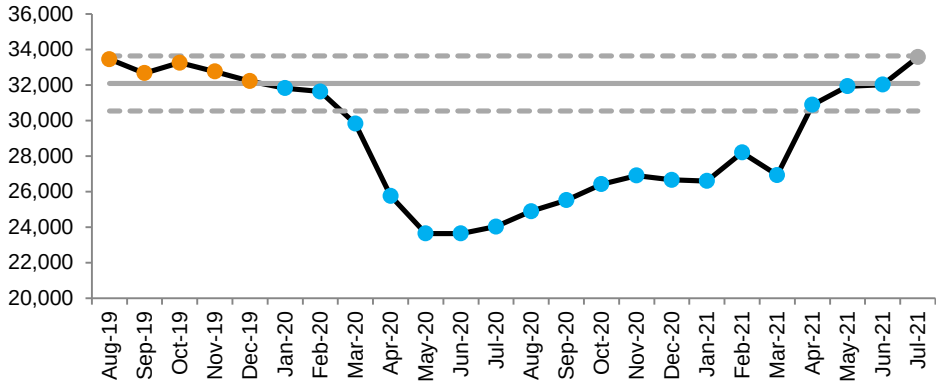


There were 13 ambulance handovers > 60 minutes in July, which continues to demonstrate a signifcant improvement. Following validation, 2 of the 13 were actual ELHT breaches and 11 were due to non-handover compliance.

The average handover time was 21 minutes in July and the longest handover was 1hr 30 minutes.

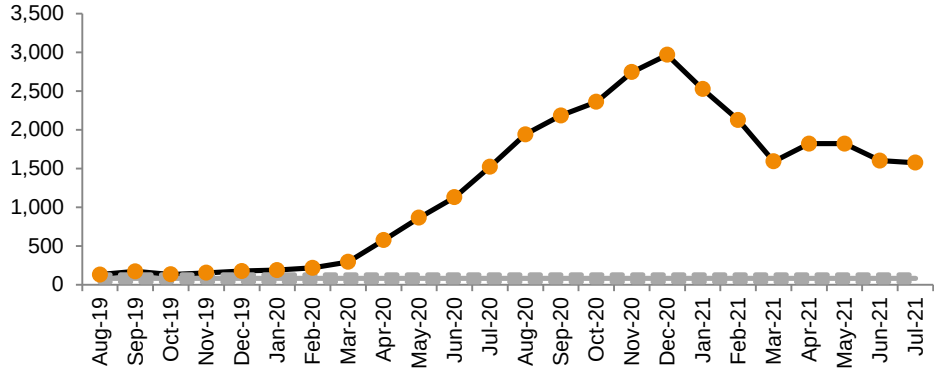
RESPONSIVE

Referral to Treatment (RTT) Total Ongoing



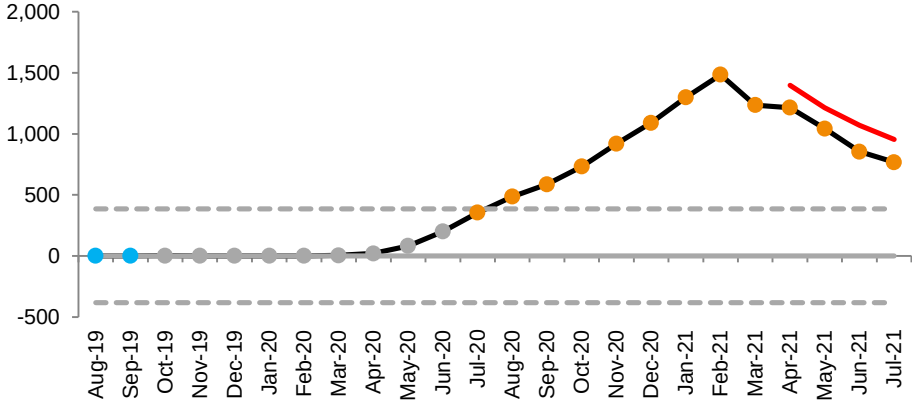
At the end of July, there were 33,575 ongoing pathways, which has increased on last month and is now similar to pre-COVID levels.

RTT Total Over 40 wks



The number of pathways over 40wks decreased in July with 1574 patients waiting over 40 wks at month end.

RTT Total Over 52 wks

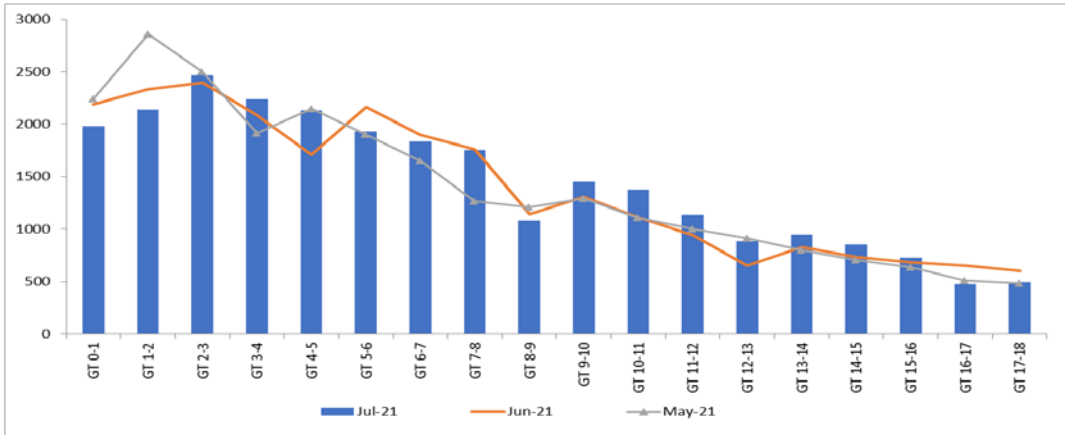


There were 768 patients waiting over 52 weeks at the end of July, due to the COVID-19 pandemic, which was below the month end trajectory (955).

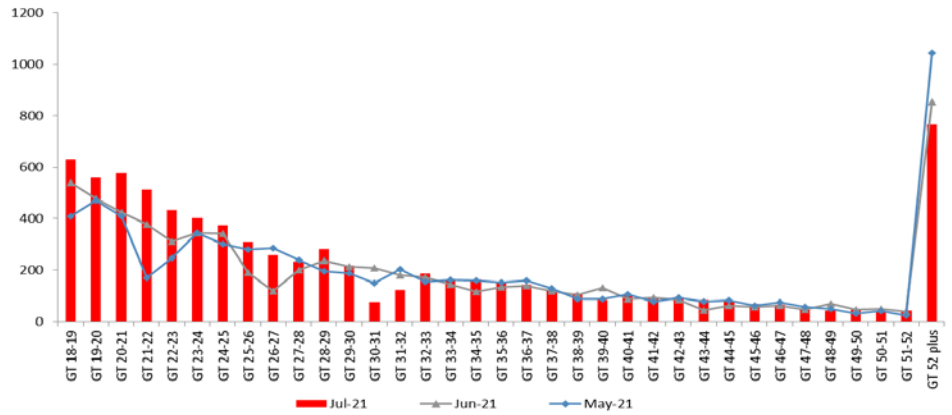
There were 5 patients waiting over 104 weeks.

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

RTT Ongoing 0-18 Weeks

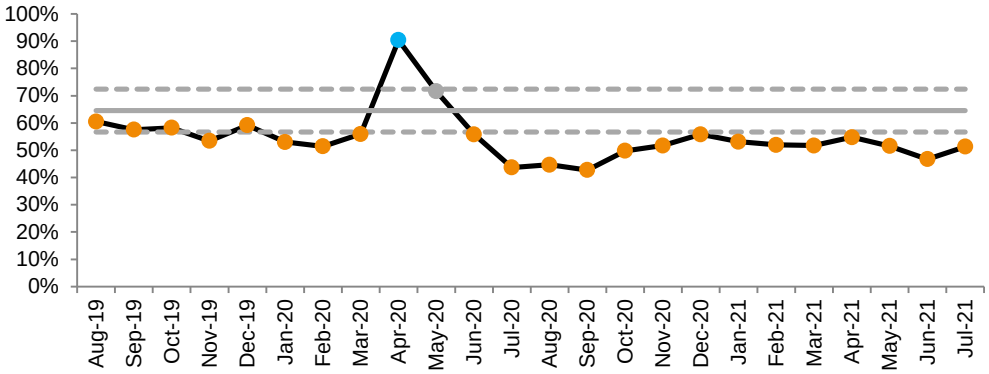


RTT Over 18 weeks

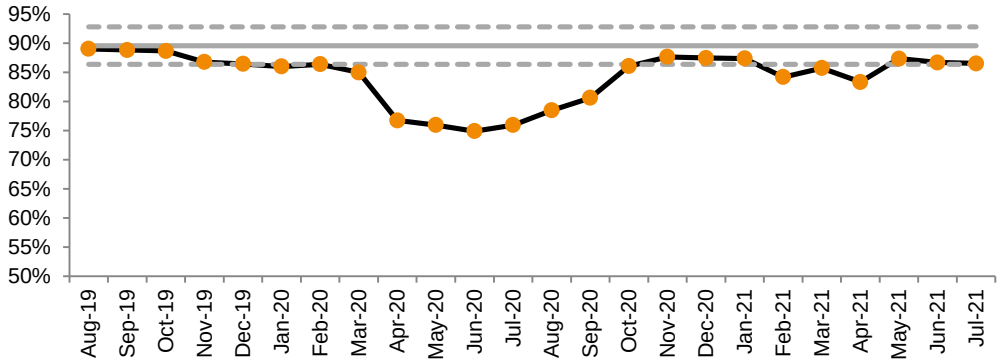


Although no longer a national target, the proportion of admitted and non-admitted patients, admitted within 18 weeks is included for information.
During April 20 and May 20, only priority and urgent patients were admitted.

RTT Admitted

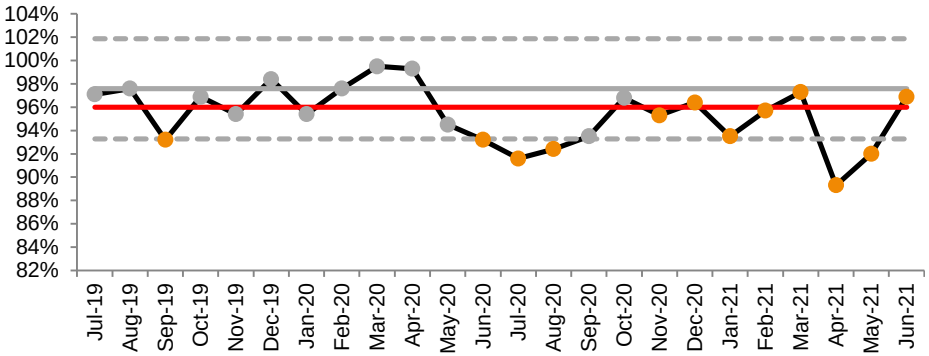


RTT Non-Admitted



RESPONSIVE

Cancer 31 day

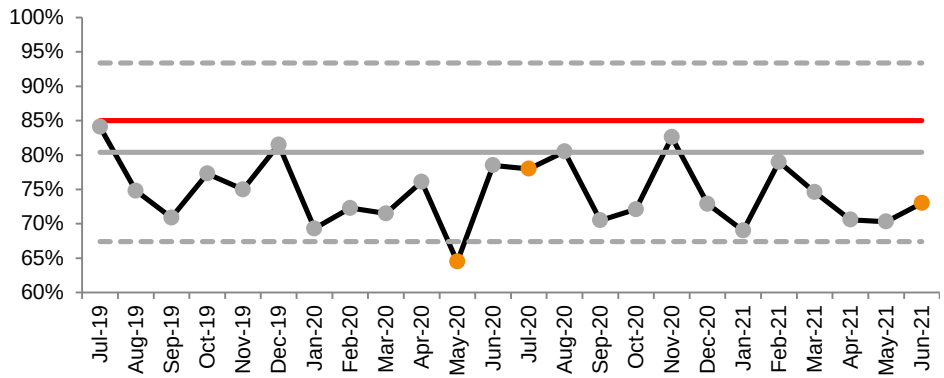


The 31 day standard was achieved in June at 96.9%, above the 96% threshold.

Q1 was not achieved at 93.1%

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

Cancer 62 Day

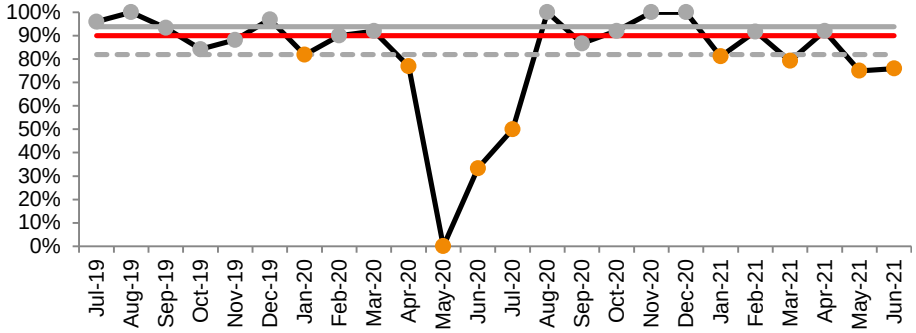


The 62 day cancer standard was not achieved in June at 73.0% below the 85% threshold.

Q1 was not achieved at 71.6%

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

Cancer 62 Day Screening



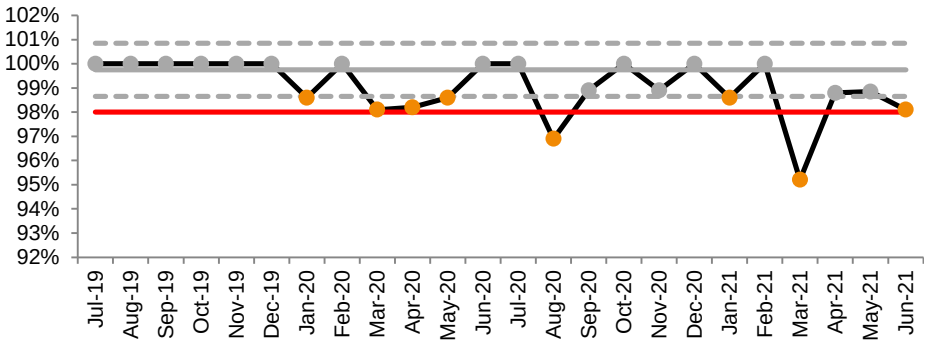
The 62 day screening standard was not achieved in June at 75.9%, below the 90% threshold.

Q1 was achieved at 82.2%

The trend is showing deterioration 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)



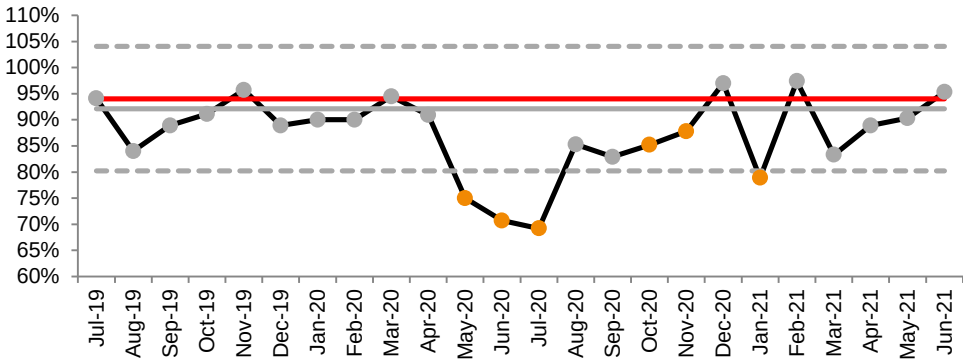
The subsequent treatment - drug standard was met in June at 98.1%*, above the 98% threshold.

Q1 was achieved at 98.5%*

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

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

Cancer - Subsequent treatment within 31 days (Surgery)

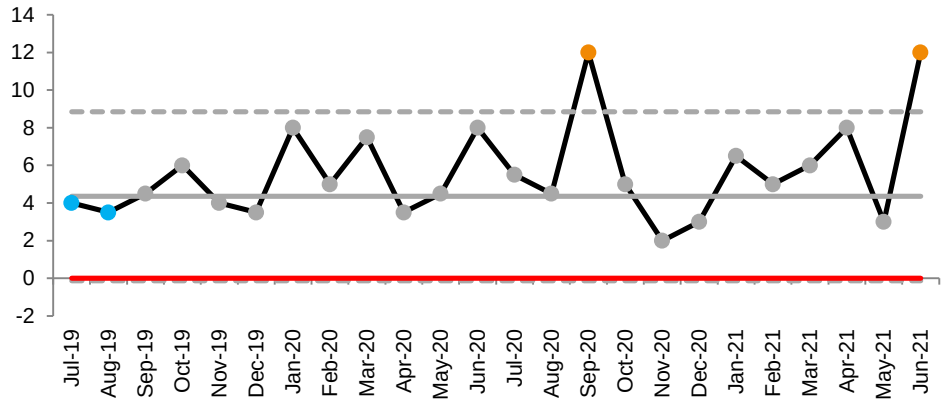


The subsequent treatment - surgery standard was met in June at 95.3%, above the 94% standard.

Q1 was not achieved at 91.6%

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

Cancer Patients Treated > Day 104

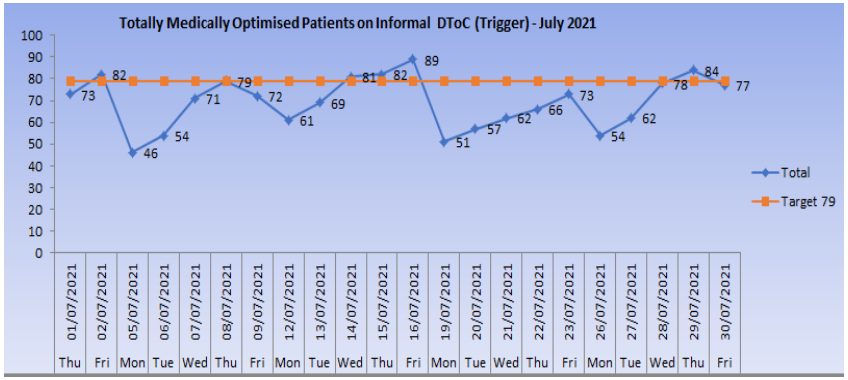


There were 12 breaches allocated to the Trust, treated after day 104 in June and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the consultants involved in the pathway as required.

The trend is showing a significant increase this month.

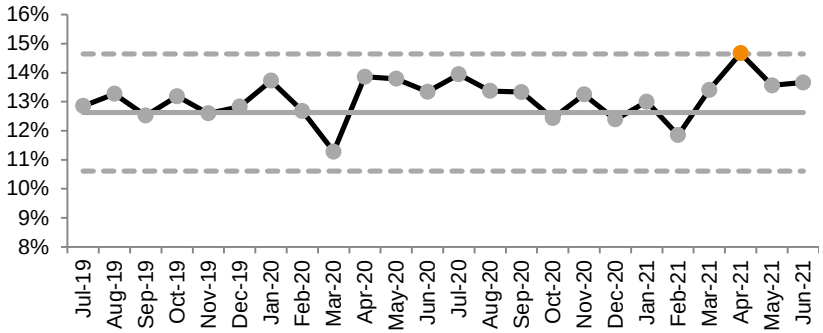
RESPONSIVE

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).

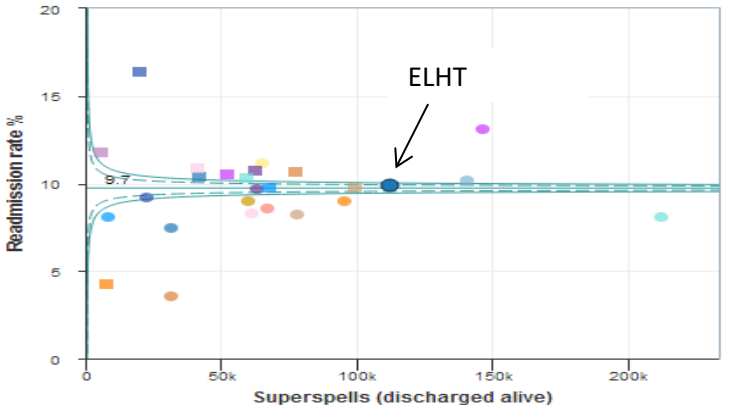
Emergency Readmissions



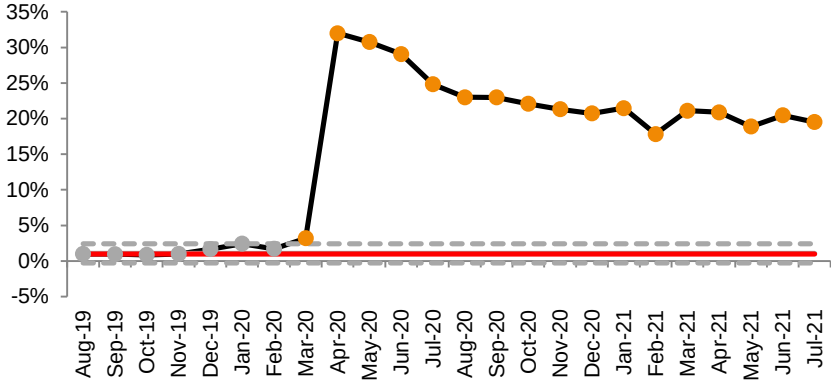
The emergency readmission rate trend is within the 'normal' range.

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

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



Diagnostic Waits



In July 19.5% 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 22.4% in June (reported 1 month behind).

RESPONSIVE

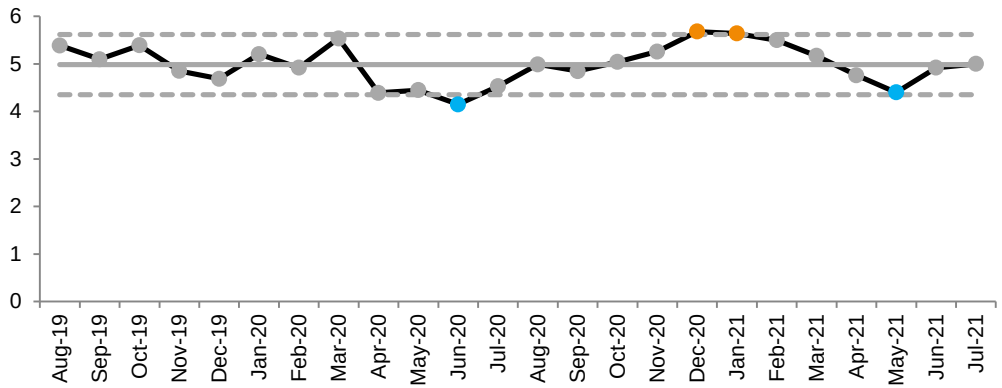
Average length of stay benchmarking

Dr Foster Benchmarking April 20 - March 21

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	43,795	6,998	36,797	3.2	2.3	-0.9
Emergency	51,668	51,668	0	4.3	4.2	-0.1
Maternity/ Birth	12,240	12,240	0	2.1	2.1	0.0
Transfer	160	160	0	9.4	24.3	14.8

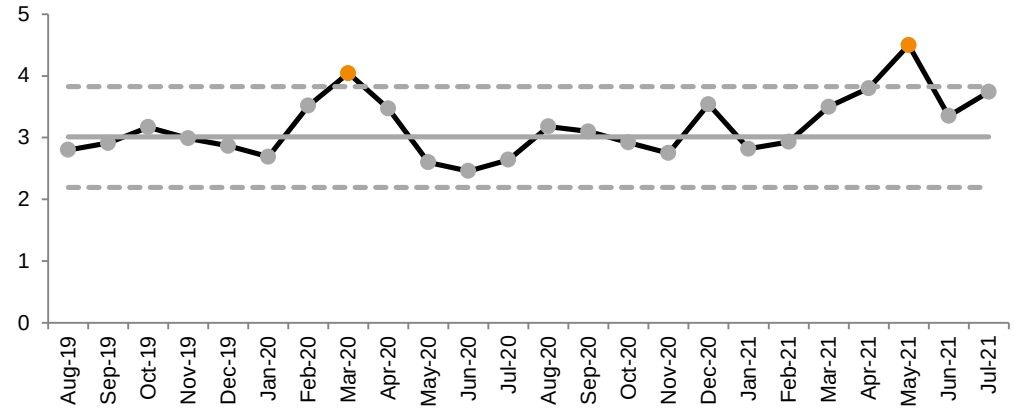
Dr Foster benchmarking shows the Trust length of stay to be below expected for non-elective and for elective when compared to national case mix adjusted, for the period April 20 - March 21.

Average length of stay - non elective



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

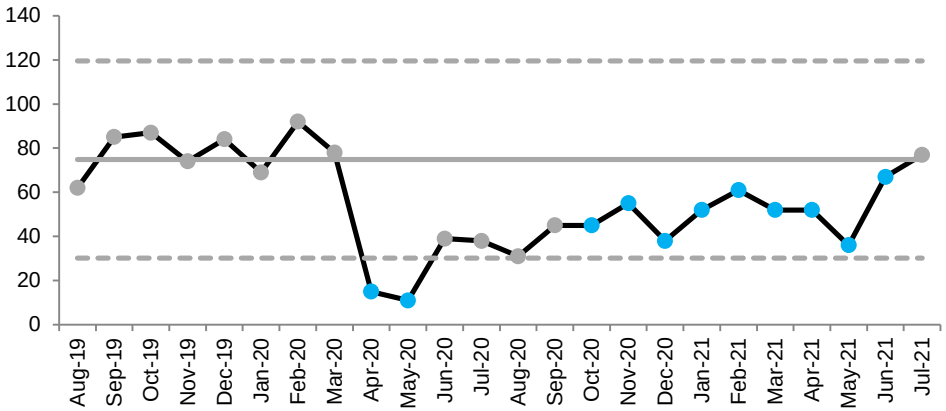
Average length of stay - elective



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

RESPONSIVE

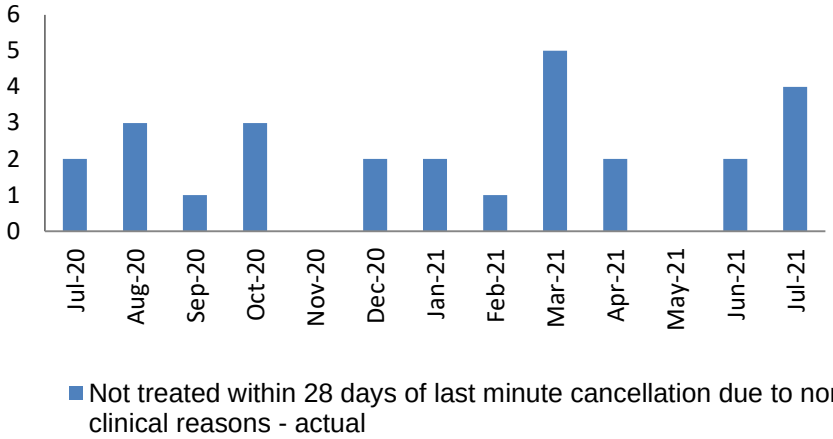
Operations cancelled on day



There were 77 operations cancelled on the day of operation - non clinical reasons, in July.

The trend is showing a return to normal variation.

Operations cancelled on day - breaches of 28 day standard

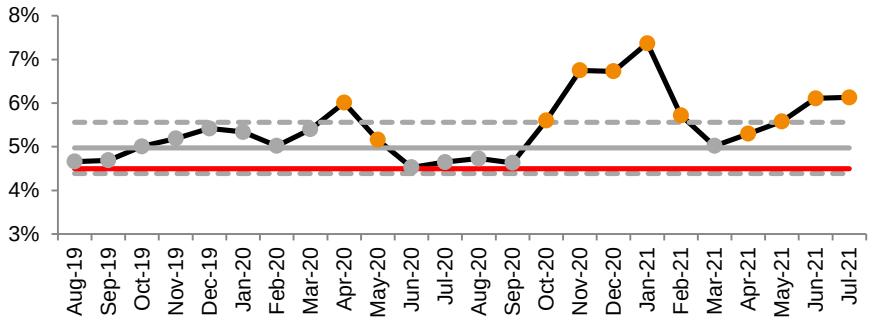


There were 4 'on the day' cancelled operations not rebooked within 28 days in July.

Patients that had procedures cancelled on the day are monitored regularly to ensure dates are offered within the 28 days. Risks are escalated to senior managers and escalated at the weekly operations meeting.

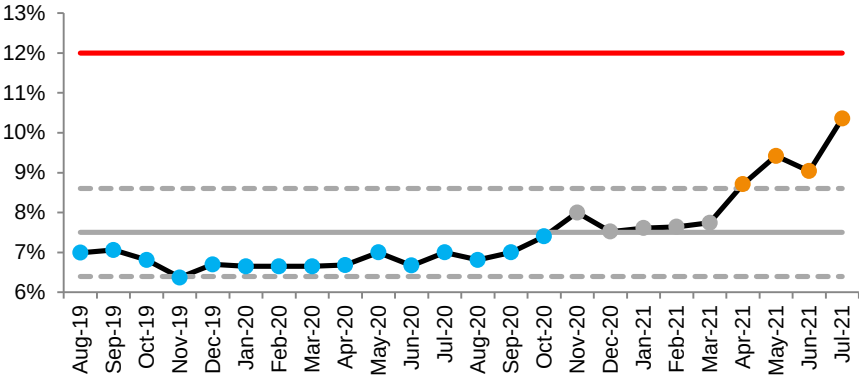
WELL LED

Sickness



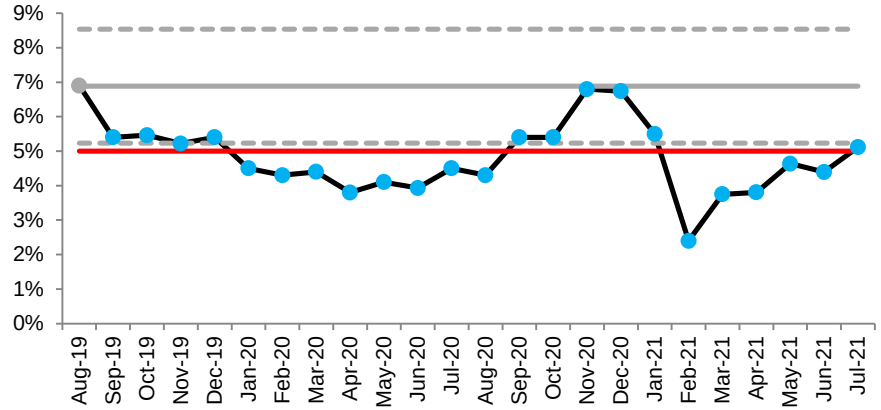
The sickness absence rate was 6.1% for July which is above the threshold of 4.5%. The trend is showing a significant increase and based on the current level of variaton, remains unlikely to acheive the target.

Turnover Rate



The trust turnover rate continues to be higher than normal at 10.4% in July, however remains below threshold. Based on current variation, the indicator will consistently be below the threshold.

Vacancy Rate



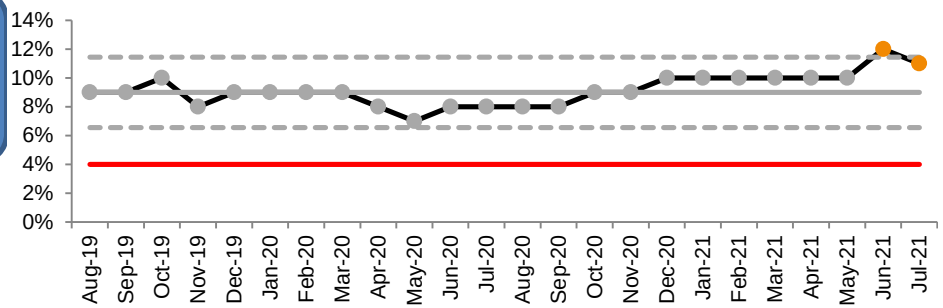
The vacancy rate is 5.1% for July which is above the 5% threshold.

This continues to be a significant reduction on previous levels.

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

WELL LED

Temporary costs and overtime as % total pay bill

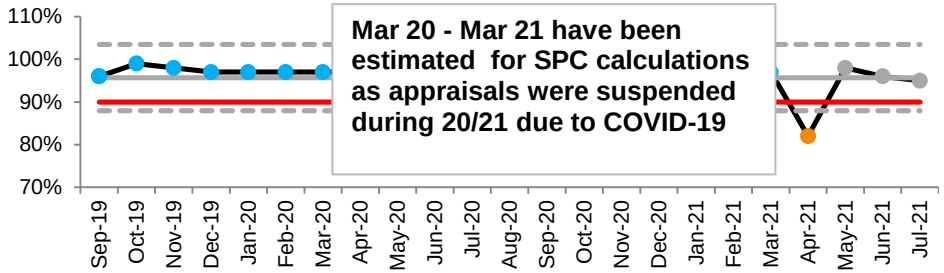


In July 2021, £4.4 million was spent on temporary staff, consisting of £1.6 million on agency staff and £2.8 million on bank staff

Whole Time Equivalent (WTE) staff worked (9,175 WTE) was 11 WTE less than is funded substantively (9,186 WTE).

Pay costs are £0.3 million less than budgeted establishment in July. Excludes Capacity Pay and Pay Reserve.

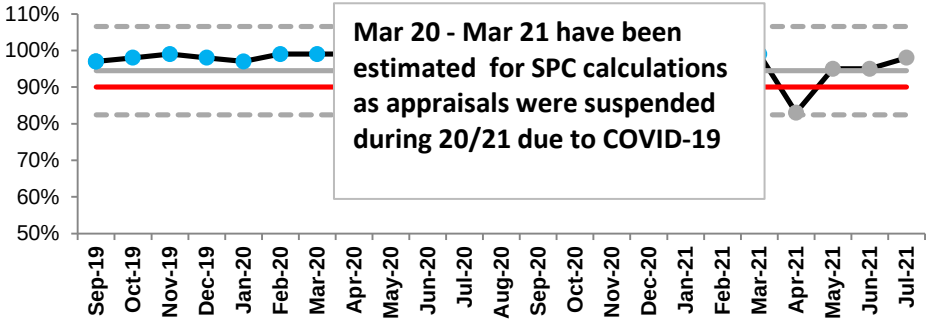
Appraisals, Consultant



At the end of July 21 there were 447 vacancies

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

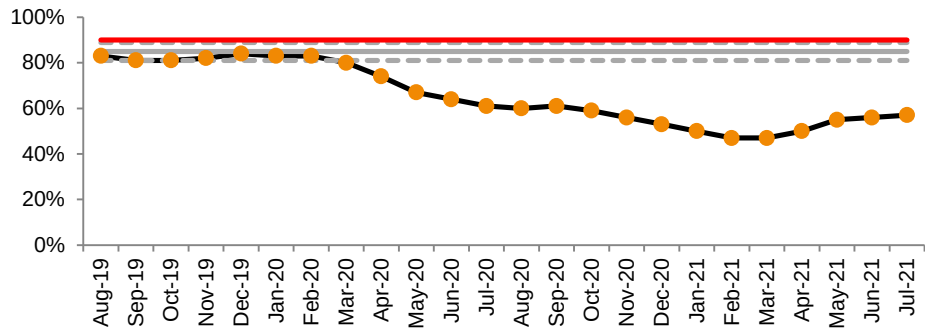
Appraisals, Other Medical



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 July 21 and reflect the number of reviews completed that were due in this period.

Appraisals Agenda for Change (AFC) Staff



The AFC appraisal rate continues to be reported as a rolling 12 month figure and remains below threshold. Appraisals were suspended until March 21, due to COVID pressures.

The trend is showing significant deterioration and based on current variation the indicator is not capable of achieving the target

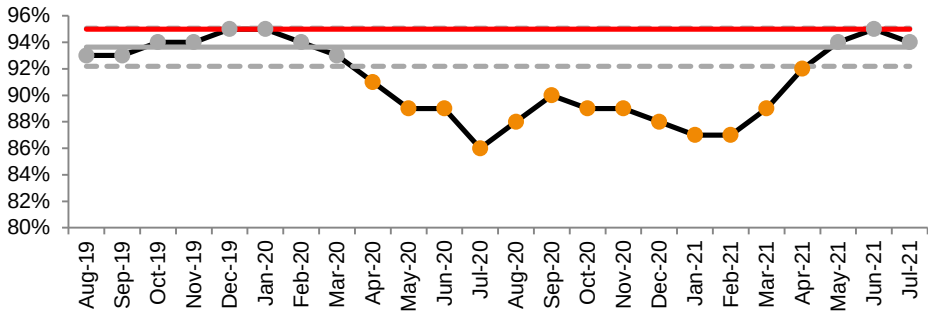
There has been a range of Trust wide actions to support compliance which are on-going. These actions are monitored through the Finance & Performance Committee.

Job Plans

Stage	Consultant	SAS Doctor
Not Published	1	4
Draft	4	0
In discussion with 1st stage manager	194	33
Mediation	0	0
Appeal	0	0
1st stage sign off by consultant	46	4
1st stage sign off by manager	33	1
2nd stage sign off	21	7
Signed off	42	2
Locked Down	0	0

As at July 2021, there were 341 Consultants and 51 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 94% in July which is below the 95% threshold. The trend is showing a return to normal variation, however based on current variation, the indicator is not capable of achieving the target routinely.

Core Skills Training %

	Target	Compliance at end July
Basic Life Support	90%	87%
Conflict Resolution Training Level 1	90%	97%
Equality, Diversity and Human Rights	90%	96%
Fire Safety	90%	95%
Health, Safety and Welfare Level 1	90%	97%
Infection Prevention L1	90%	97%
Infection Prevention L2	90%	88%
Information Governance	95%	94%
Prevent Healthwrap	90%	96%
Safeguarding Adults	90%	96%
Safeguarding Children	90%	94%
Safer Handling Theory	90%	96%

The core skills framework consists of eleven mandatory training subjects. Training is via a suite of e-learning modules and knowledge assessments on the learning hub. The threshold has been set at 90% for all areas except Information Governance which has a threshold of 95%

All training is above threshold except for information governance and basic life support

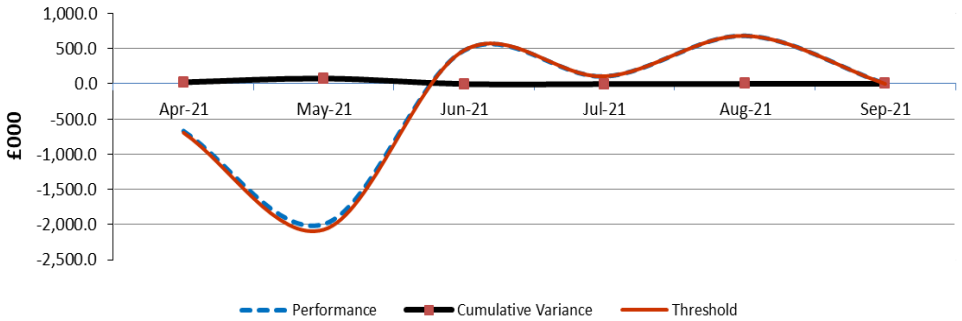
New starters are now being requested to complete as much of their Core Skills e-Learning requirements as possible prior to attending the Trust Induction training programme via the e-Learning for Healthcare platform. Additionally, there will be a limited amount of time for new starters to undertake any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

Finance & Use of Resource metrics

Adjusted financial performance suplus

WELL LED

Efficiency Savings



The Trust is reporting an adjusted deficit of £0.4 million in month 4 and a £0.1m adjusted surplus for the year to date, in line with the H1 plan.

As it currently stands, the Trust is forecasting that it will achieve the H1 plan of an adjusted breakeven position.

The cash balance as at 31st July 2021 was £46.4 million, an increase of £4.3 million on the position at the end of the previous month. This is principally due to the receipt of £5.5 million of ICS funding received in advance, which has been deferred.

The 2021-22 capital programme remains at £27.4 million, of which £4.1 million has been spent in Month 4, and £5.4 million year to date. The capital programme for the year has been approved through the Capital Planning Board.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

8 September 2021

Item 111

Purpose Information

Title	New Hospitals Programme Quarter 1 Board Report
Author	Mr J Hawker, Programme SRO Mrs R Malin, Programme Director
Executive sponsor	Mr M Hodgson, Director of Service Development

Summary: The purpose of this report is to provide an update on the New Hospitals Programme for the quarter 1 period, April – June 2021.
The report includes progress on the revised governance, progress against plan including the key products to support business case development along with the public, patient and workforce communications and engagement activities underway.

This quarterly report is presented to the following Boards;

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

And the Strategic Commissioning Committee.

Recommendation:

- Note the progress undertaken in Q1.
- Note the development of the products to support business case development (section 5).

Report linkages

Related strategic aim and corporate objective	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	Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe

and effective care through clinical pathways

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

NEW HOSPITALS PROGRAMME Q1 BOARD REPORT

1. Introduction

1.1 This report is the 2021/22 Quarter 1 update from the New Hospitals Programme (NHP).

2 Background

2.1 The New Hospitals Programme is a key strategic priority for the Lancashire and South Cumbria Health and Care Partnership. It sits within the integrated care system's wider strategic vision, with the central aim of delivering world-class hospital infrastructure from which high-quality services can be provided.

2.2 The New Hospitals Programme offers Lancashire and South Cumbria a once-in-a-generation opportunity to transform our ageing hospitals and develop new, cutting-edge hospital facilities that offer the absolute best in modern healthcare.

2.3 Investment in Lancashire and South Cumbria's NHS hospital infrastructure will enable us to provide state of the art facilities and technology, strengthening our position as a centre of excellence for research, education and specialised care. This will significantly boost the attractiveness of the area to potential recruits and the highest calibre of clinicians.

2.4 The programme is committed to ensuring new hospitals fully embrace the benefits of digital technologies to create an agile network of care, allowing us to optimise the size of our physical footprint and minimise environmental impact. This will, in turn, enable us to provide more specialised services in our hospitals and deliver more care closer to home as part of the wider ambitions of the Lancashire and South Cumbria Health and Care Partnership.

3 Programme governance and risk

3.1 During Q1 an internal review was undertaken of the current governance arrangements including feedback from a range of executive and non-executive directors. A set of recommendations were proposed to streamline decision making whilst strengthening non-executive involvement. The recommendations were approved by boards leading to a revised governance structure being implemented in August 2021. To support this

new way of working, a governance advisory group is now meeting monthly with attendance from the Trust Executive Director leads and nominated Non-Executive Directors from UHMB, LTHTR and the Strategic Commissioning Committee. In addition a monthly drop in for Non-Executive Directors to meet with the SRO and Programme Director is now established.

3.2 All working groups and oversight groups are now mobilised with representation from across the ICS including lay member representation on the Communications and Engagement Oversight Group.

3.3 During Q2, MIAA (Mersey Internal Audit Agency) will begin working with the NHP to undertake an independent review of the programme governance arrangements. This will include completion and agreement to a decision making matrices in line with programme and statutory body governance frameworks as well as that of the PCBC and SOC process.

3.4 The programme has a fully populated risk register and risk management processes in place with working groups taking ownership for allocated risks and associated mitigations. The full risk register is reported to the Programme Management Group on a monthly basis with risks scoring 15 and above reported to the SOG each month.

4 National New Hospital Programme – NHSEI, DHSC

4.1 In May 2021 the NHP presented the draft Case for Change and Communications and Engagement Plan to a NHSEI stage 1 assurance panel. This strategic sense check provided useful feedback and guidance for the NHP, particularly with regard to strengthening the Case for Change in the context of the ICS vision and strategy. The panel confirmed their support for the NHP to proceed to developing a PCBC.

4.2 In June 2021, the Programme received an update from the national team. The salient points are as follows:

a) Continued aim to create a national programme, consolidating learning and facilitate continual improvement in the support provided to schemes

b) Commitment to delivering the whole programme (40 new hospitals) by 2030 with the provisional assessment of timings for the L&SC scheme being construction starting in the period January 2025-September 2026 and completion between 2027-2030.

c) Specific timeline, including expected business case preparations and submission dates to be determined along with future funding aligned to the required pace of delivery.

5 Progress against plan (for the period April – June 2021)

5.1 Programme scope

System partners have been integral to refining the scope of the New Hospitals Programme. In particular, it is worth noting the programme is focused on hospital facilities/sites, with the integrated care system's clinical strategy determining the clinical model, including configuration of services. This work will continue in parallel to, and aligned with, the New Hospitals Programme. Significant progress is being made to ensure close alignment between the Provider Collaborative Board and the New Hospitals Programme.

5.2 **Key products to support business case development –** During Q1 a number of key products were developed and reviewed by the SOG prior to being presented to statutory bodies for approve/information as required. These products represent key building blocks in the development of the PCBC and SOC, including the process and methodology that supports progressing from a long list of proposals to the final short list of options to be included in the PCBC and SOC. Statutory Bodies are not required to approve all these products, but the programme has ensured that all statutory boards and committee members have been engaged, sighted and supportive of them recognising the final business cases will be constructed using them. Each product has been subject to significant engagement, input and challenge from all the NHP working and oversight groups and was presented to SOG with their support. The products are:

5.3 **Case for change** – members will be well sighted on the progress made on the Case for change over this period. Following approval by the SOG (29th April 2021) and the SCC (13th May 2021), the case for change was presented to NHSEI stage 1 assurance. Our case for change was subsequently updated responding to feedback

from NHSEI stage 1 assurance and key stakeholders. The final document was approved by SCC at its meeting held in public on 15th July 2021. Agreed communications and engagement activities are now underway.

5.4 **Communications and engagement strategy and plan** – members will be familiar with the communications and engagement strategy having received a presentation on the approach at the Board to Board held earlier in the year. Feedback from a wide variety of stakeholders resulted in a strengthened strategy which was approved by the SOG (29th April 2021) and SCC (13th May 2021) ahead of presenting to the NHSEI stage 1 assurance panel. This was well received by the panel with minor amendments required. NHSEI and colleagues from the Department of Health and Social Care remain linked in via established relationships, working and oversight groups. The plan is now well underway.

5.5 **Framework model of care** – clinical leads have worked alongside external partners to develop a framework model of care. This is the clinical vision and outlines the aspirations for what future care should look like within our hospitals. The document will be iterative throughout the course of the programme. The latest version of the framework model of care will be presented to the Clinical Oversight Group (COG) and SOG in August 2021. Given this is interdependent with the work of the Provider Collaborative Board (PCB), work is underway ensure alignment. Finally, the North West Senate will undertake an informal review of the framework. This is in the role of critical friend to help support the NHP to further develop the document ahead of a formal Senate review as part of NHSE stage 2 assurance.

5.6 **Key assumptions –** A robust set of assumptions have been developed combining local intelligence and National guidance and will be used to develop the long list of proposals and associated sizing and costing of hospital facilities. The assumptions include the key outputs from the demand and capacity modelling. These phase 1 working assumptions were approved by SOG on 9th July 2021. It is worth noting that:

a) These assumptions do not include planned or future service reconfiguration in line with the agreed scope of the programme – SOG agreed to the principle that these are included once any formal consultation is complete.

b) Some assumptions require wider system commitment to delivery e.g. Investment in Integrated Community services / Intermediate Care services etc.

5.7 **Long list of proposals –** A long list of proposals have been developed exploring different scenario's around new builds (new site), rebuilds (existing sites) and refurbishment. These have been used to support our understanding of the feasibility of different approaches and continued discussions with the National team on aligning potential options with affordability and deliverability. The long list of proposals have been shared with the SCC and used to support Board discussions with LTHTR.

5.8 **Critical Success Factors (CSFs) –**The CSF's help to provide a framework for assessing all proposed options against the Case for Change, National ambitions/requirements and our local ambitions and objectives. CSFs will be used to underpin the process to appraise the long list of options to determine a shortlist to be carried forward to the PCBC.

5.9 It is important the Board notes the strong interdependency between the Programme assumptions and critical success factors and the requirement to demonstrate that all options included in the business cases are affordable, clinically viable and deliverable.

6 Programme timeline

6.1 The programme remains on track to deliver the final business case by mid-2024 and to start building in 2025, with new hospital facilities opening by 2030.

6.2 The programme will be subject to a series of checks and balances, including scrutiny and agreement from decision makers within the NHS, the Government and local authorities. As our proposals develop, there will be greater clarity regarding the scope of any public consultation.

7 Public, patient and workforce communications and engagement

7.1 A number of key communications, involvement and engagement activities got underway this period namely:

a) Colleague summit – attended by c1000 attendees over 2 events. Colleagues from across L&SC received and update on the NHP and dedicated time for questions and answers with a panel made up of senior leaders from across L&SC.

b) The Big Chat – as at 25th June 2021 this online workshop had received contributions equivalent to 80+ workshops. The first phase of the Big Chat closed early July and has now launched with new themes for discussion focused around the case for change. Subsequent conversations will focus on proposals and appraisal criteria. The Big Chat is open to all NHS staff across L&SC along with the Trust membership and governors from UHMB and LTHTr.

c) Healthwatch workshops – to meet our ambition to involve a wider audience, Healthwatch has launched a series of small workshops and outreach focusing on those who are digitally excluded, marginalised, harder to reach groups and people representing protected characteristics groupings.

d) Finally, the launch of proactive promotions of the brand and social media channels went live this period:

- **New Hospitals Programme website**
- **like the New Hospitals Programme on Facebook**
- **follow the New Hospitals Programme on Twitter**

8 Board development

8.1 Following an initial joint Boards session (UHMB and LTHT) in Q4 2020/21, subsequent Board developing sessions (separate and joint) were held this quarter. Boards focused on the case for change and draft long list of proposals with a focus on the capital funding available and how best to maximise this in addressing the case for change. These were highly engaged sessions with broad alignment demonstrated.

9 Dependencies

9.1 Members will recognise that with any complex programme such as this there are many dependencies and interdependencies. This period, the NHP has focused on understanding these aligned to the demand and capacity assumptions and programme risks. As a reminder, at business case stage the NHP can only proceed with options that are affordable, clinically viable and deliverable. The NHP therefore has dependency relationships including but not limited to a-d below.

a) Successful and timely delivery of out of hospital services.

b) Successful and timely delivery of planned or future service reconfiguration and associated clinical models.

c) Agreement to the capital funding available.

d) Depending on c above and any resulting scenarios requiring new sites/land, there is a dependency on land availability.

9.2 A series of mitigation actions have been agreed to manage the dependencies and interdependencies including; alignment of the NHP work with the Provider Collaborative and discussions with the national programme team etc.

10 Stakeholder management

10.1 The Board will recognise there will be a breadth of stakeholders in such a programme. During Q1, there has been the launch of proactive internal and external communications including stakeholder updates with MPs and local authorities. A report was submitted and presented to the Cumbria Health Overview and Scrutiny Committees (HOSC) in July 2021 and an informal update with the Lancashire Scrutiny Officer was held. Formal engagement is underway with MPs across the region with a focus on the case for change and the process the NHP is following. In addition, the NHP has progressed discussions with the Lancashire Local Enterprise Partnership (LEP) Health Sector Board and the programme is looking forward to working with Board partners over the coming period.

11 Next period – Q2 2021/22

11.1 The next quarter will see significant progress in translating the key products developed in Q1 into the PCBC/SOC (subject to options). The next quarter will also be crucial in our negotiations with the National team regarding finalizing the capital envelop.

12 Conclusion

12.1 This paper is a summary of progress on the New Hospitals Programme throughout Quarter 1 2021/22.

13 Recommendations

13.1 The Board is requested to:

- Note the progress undertaken in Q1.

- Note the development of the products to support business case development (section 5).

Rebecca Malin
Programme Director
July 2021

Jerry Hawker
Programme SRO

Lancashire & South Cumbria
New Hospitals
Programme

NHS

Summary of our Case for Change

July 2021

Introduction

The New Hospitals Programme offers Lancashire and South Cumbria a once-in-a-generation opportunity to transform our ageing hospitals and develop new, cutting-edge hospital facilities that offer the absolute best in modern healthcare. Our ambition is to make our region a world-leading centre of excellence for hospital care.

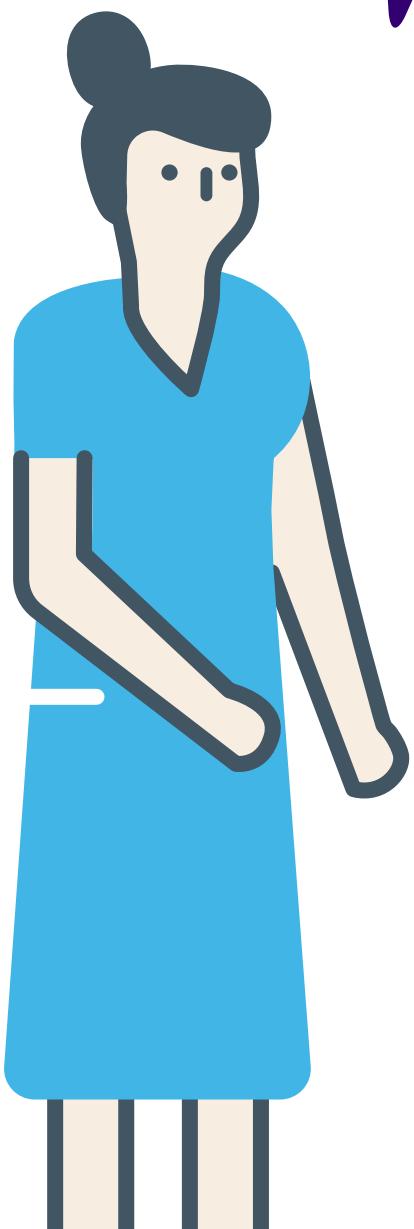
We have a clear process to follow in developing our proposals. Making our Case for Change is the first step on our region's journey to new hospital facilities. The purpose of this document is to explain why the people of Lancashire and South Cumbria need new hospital estate.

This Case for Change has been developed in collaboration with experts: our clinicians, staff, patients, key stakeholders and representatives of the local communities we serve.

This summary version is a shortened version of the full Case for Change document, which is available at **www.newhospitals.info/CaseForChange**

We want to hear your feedback

Throughout this process, we are seeking the views of those who may be most impacted by any possible change. This includes our NHS staff, patients and representatives of the public, all of whom will be given the opportunity to contribute through the Big Chat online discussion, telephone research and in person at events and meetings. We are also carrying out public opinion research and holding focus groups.



To develop this Case for Change, we have:

- Listened to views, ideas and suggestions in dedicated Case for Change workshops with more than 100 people, including clinicians, staff, patients and key stakeholders.
- Undertaken a series of workshops involving patients, clinicians, staff and key stakeholders to understand how our hospital infrastructure impacts on care.
- Held listening meetings with elected representatives, community leaders and interested parties.
- Engaged in desktop research, data analysis and examination of the problems we face and how modern infrastructure can support us to address these challenges.
- Begun an online conversation, the Big Chat, with staff, Foundation Trust members and community leaders about their hopes, fears and expectations. We have recorded and analysed more than 20,141 interactions from the 7,340 visits as of 1 July 2021.

Some of the comments shared on the Big Chat are included in this document.

We have listened carefully and reflected on the evidence to help us produce this document, which sets out the problems we hope to address and the ambitions we have for the future.

The Case for Change

We believe the need for new hospital facilities in the region is unequivocal. The age, condition and layout of some of our existing hospital buildings mean that we must address this critical need if we are to serve both the current and future needs of our local population.

However, our ambitions go much further than providing new hospital infrastructure to meet the basic health needs of local people. We want to be part of a regional health system that is regarded as one of the best in the world and plays its part in revitalising the regional economy.

This document marks the beginning of our journey. We will continue to develop and shape our Case for Change and subsequent proposals as further evidence becomes available and we gather more insight and feedback from our patients, clinicians, staff and key stakeholders.

You can find out more about how to have your say at **www.newhospitals.info**

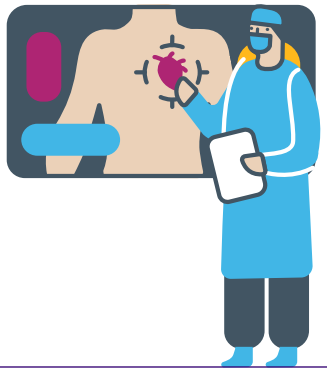
Contents

Helping local people live longer, healthier lives

We have set our ambition to achieve the absolute best, world-leading care. Investment in our hospitals will go much further, having a positive impact on life expectancy, health and wellbeing of our population and bring jobs and skills to the region.

To achieve this, we have set the following objectives for the Lancashire and South Cumbria New Hospitals Programme:

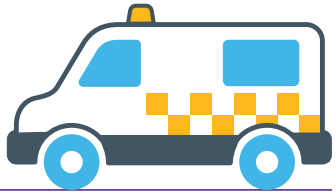
Provide patients with high-quality, next generation acute hospital facilities that will **improve health outcomes** across our population.



Improve service delivery and provide **access to cutting edge hospital technologies** and deliver the best possible quality of care.

Design new hospital buildings and facilities that can meet demand and are **flexible and sustainable**.

Increase resource capacity and effectiveness, working collaboratively to **increase integration in service delivery**.



Reduce health inequalities and be ready to meet the health needs of the people of Lancashire and South Cumbria – both now and in the future.

Have a **positive impact on our local area**, bringing jobs, skills and contracts to Lancashire and South Cumbria's businesses and residents.

Our ambition

The New Hospitals Programme offers a once-in-a-generation opportunity to transform our hospitals and the services we provide for local people by 2030. Our ambition is to make Lancashire and South Cumbria a world-leading centre of excellence for hospital care.

The Government has provided us with an opportunity for significant capital investment. This presents us with the potential to do something amazing. We want to build on what we are already great at, while developing new, cutting-edge hospital facilities that take advantage of emerging digital technologies, artificial intelligence and robotics to offer the absolute best in modern healthcare.

Government funding has been granted to address significant issues with our ageing hospitals in Preston and Lancaster. These buildings were designed for a different time and cannot accommodate today's more complex patient needs or new technologies. We also need to invest in Furness General Hospital's infrastructure in the context of its strategic importance and geographically remote location. As well as addressing these issues with existing buildings, our proposals will be more far-reaching.

We want to create a new digitally linked network of brand new and refurbished facilities covering our entire region and making Lancashire and South Cumbria a renowned centre of excellence for hospital care. Our hospitals will work together to deliver highly specialised services to local people, ensuring patients can access pioneering treatment either in person or using digital technology and providing joined up, truly excellent care.

Our region is large and complex with widespread health inequalities. We have 1.8 million people living in cities with diverse cultures and communities, rural areas and coastal towns.

Many people rely on our hospitals and other services to work as a team to overcome the health challenges they face on a day-to-day basis. We will give people of all ages and communities equal access to the best possible hospital facilities. We will bring mental and physical health closer together. We will help local people in our region live longer, healthier lives.

We want to expand the range of medical procedures and therapies available closer to home, bringing new highly specialised services, currently only available to patients who travel out of the area, into our region.

We will offer outstanding hospital services, including cancer and trauma care that patients and staff know are world leading. These will be delivered in purpose-built spaces that employ the latest ground-breaking technology and research, attracting the best clinical minds to work and study in our region.

We will also look at the experience that patients, families and carers have when they visit our hospitals. We want to offer privacy and dignity through more private rooms and create the space for our staff to care for patients in the way they would like.

The positive impact of this work will reach further than new hospitals. It will deliver sustained economic benefit to a region with significant socioeconomic challenges, attracting investment and jobs. It is also a key element of delivering our local NHS's vision of offering patients complex care closer to home, improving community health and wellbeing services and the overall experience for local people.

We do not yet know what our new hospital facilities will look like or where they will be located. Our proposals will be led by the needs of our patients, staff and local people. We will be guided by clinical opinion, experience, robust scientific evidence and data, along with the power of feedback, ideas and the imagination of our local communities.

Hospitals have the power to transform our region. We want to use this opportunity to achieve just that, working together to help local people live longer, healthier lives.

How hospitals of the future could look

Our five critical challenges

To play its part in improving healthcare and health outcomes, the New Hospitals Programme must address five critical challenges:

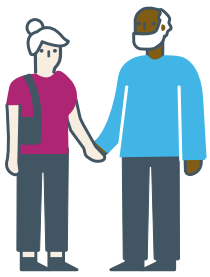
1. Demographic trends and access
2. Ageing acute estate
3. Specific hospital site-related problems
4. Keeping up with the best in the world
5. Playing a full part in rebuilding our regional economy

The five critical challenges
1. Demographic trends and access

- We provide health services to a population of 1.8m people across diverse communities and varied geographies.
- Access to services and travel pose a significant challenge: towns and cities are widely spread and our region's geography adds to expected travel times.
- Our population is ageing: the number of people over 65 is projected to increase by 22% by 2030.
- More people in our region experience mental and physical ill-health than in the rest of England.
- We also face deep socioeconomic challenges: 20% of our population lives in the 10% most deprived communities in the country.
- All of these factors will increase demand for health services both in and out of hospitals in the future.

A population of
1.8m

22%▲
increase in over 65s by 2030



20%
of our population lives in the
10%
most deprived communities

The five critical challenges
2. Ageing acute estate

- The age, design and condition of some our hospital buildings mean they do not comply with many basic standards, restricting our ambition to provide high-quality, safe, efficient and cost-effective services for our communities.

The condition of Royal Lancaster Infirmary (University Hospitals of Morecambe Bay NHS Foundation Trust) and Royal Preston Hospital (Lancashire Teaching Hospitals NHS Foundation Trust) has reached a critical stage. Without investment, buildings and services could fail, increasing our patients' deepening health inequalities and increasing the burden of ill-health on our population.

Royal Lancaster Infirmary

Royal Preston Hospital

Furness General Hospital

- Any adverse impact on services due to the quality of the estate at Furness General Hospital (University Hospitals of Morecambe Bay NHS Foundation Trust) would have a deeper impact due to its remote location.
- The poor condition of our hospitals also means we cannot recruit and retain the number of staff we need to deliver services.

The five critical challenges
3. Specific hospital site-related problems

Royal Preston Hospital (RPH)

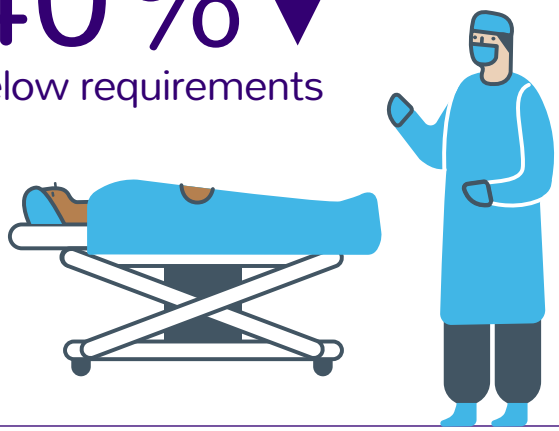
- Serious dilapidation of buildings due to decades of underinvestment, and backlog maintenance costs totalling £157m.
- Demand exceeds capacity across all clinical areas: outdated buildings lack flexible capacity, leading to congestion and overcrowding so that patients wait longer than is acceptable for all aspects of care.
- Non-compliance with Health Building Notes (HBN): only 19% of rooms are single-person (should be 50%) and operating theatre capacity is 40% below requirements. This makes it challenging to implement safe infection control measures and to meet the privacy and dignity standards we expect for our patients.
- The distance between clinical departments makes the hospital experience worse for patients and carers.
- Some tertiary (highly specialised) services have developed and expanded without being able to meet all the estate requirements, restricting our ability to offer some specialised services that should be available to our population.

Royal Preston Hospital

19%
of rooms are single-person

this should be
50%

Operating theatre capacity
40%▼
below requirements



Royal Lancaster Infirmary (RLI)

- Backlog maintenance costs totalling £88m, predominantly due to the condition of the estate. Running costs are double that of a new build at £442 per square metre due to the age of the site.

Most of the site is located on a slope, which in some areas is too steep for patients to be safely moved except by ambulance. Access to much of the site is challenging for people with a disability.

Royal Lancaster Infirmary

- The estate fails to meet many Health Building Notes (HBN) standards – single room provision is only 50% of the recommended standard capacity and less than a third of our ambition for 70% single rooms.
- Site made up of around 20 separate buildings, some linked by long passages, with some separated from the main complex by public highways. This means staff and patients must make longer journeys than is desirable, leading to poor experiences of care, patient discomfort and significant operational inefficiencies.

Furness General Hospital (FGH)

- Significant backlog maintenance, including an element of physical condition and lifecycle works. Estate running costs of £375 per square metre.
- Site fails to meet some Health Building Notes (HBN) standards and capacity requirements, in particular in the Critical Care Unit / High Dependency Unit and single room provision.
- Significant risk that this site may never meet carbon emission standards.

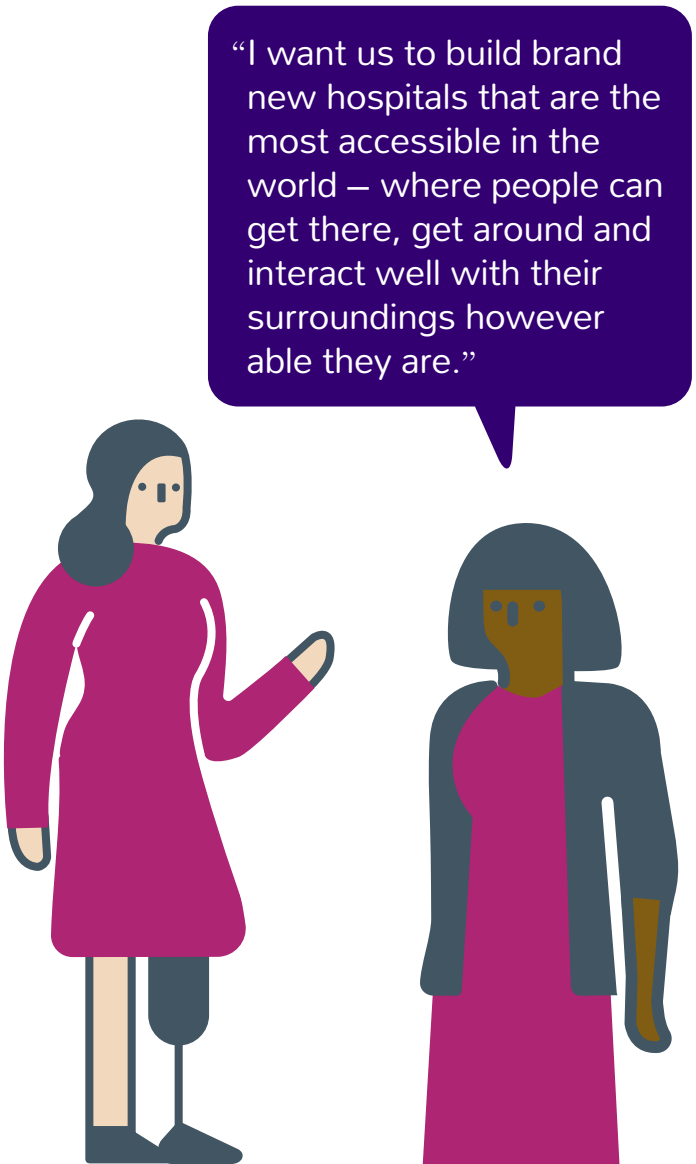
Difficulty in accommodating the latest digital technologies and robotics needed to create an agile network of care across the region: these are essential given the remote geographic location.

The five critical challenges
4. Keeping up with the best in the world

- Providing state of the art hospital facilities and technology will strengthen Lancashire and South Cumbria's position as a centre of excellence for research, education and specialised care, significantly boosting the region's attractiveness to potential recruits and the highest calibre of clinicians.
- We need to ensure new hospitals fully embrace the benefits of digital technologies to create an agile network of care, allowing us to optimise the size of our physical footprint and minimise environmental impact.
- This will also enable us to provide more specialised services in our hospitals and deliver more care closer to home.
- We want to play a leading role in tackling the key issues of our generation - cutting carbon emissions and environmental damage. Aged estate, which was built to service the needs of previous generations, is hampering our ability to achieve this.

The five critical challenges
5. Playing a full part in rebuilding our regional economy

- Our hospitals are some of Lancashire and South Cumbria's most significant community assets: they are anchor institutions providing healthcare to our population and employment to around 40,000 people.
- The New Hospitals Programme will create jobs and support the economic regeneration of our region, needed now more than ever as the global Covid-19 pandemic has disproportionately impacted those most in need.
- Investment in hospital infrastructure will support us to build back better and help the NHS deliver on its net zero carbon ambition.



Making the Case for Change

We have structured our Case for Change as follows:

1. **Lancashire and South Cumbria** – how our infrastructure impacts on our ability to provide care for local people and respond to current and future health needs

2. **Our hospitals** – the pivotal role of our hospitals in our community and the poor condition of some of our estate

3. **Our clinical strategy** – the fitness for purpose of our estate in the context of our ambitions for hospital care and the wider health and care system

4. **Our digital ambitions** – the role of our infrastructure in fulfilling our digital and sustainability goals

5. **Our workforce** – the impact of our estate on our workforce supply and experience

6. **Our use of resources** – how our infrastructure impacts on our productivity and efficiency

1

Lancashire and South Cumbria Health and Care Partnership

Directly supporting the Lancashire and South Cumbria Health and Care Partnership strategy

Lancashire and South Cumbria Health and Care Partnership (our region's integrated care system) is committed to improving health and wellbeing and delivering better care for all. To achieve this, the 'Healthier Lancashire and South Cumbria' strategy[1] outlines the ambition that local people will:

- Have longer, healthier lives
- Be more active in managing their own health and wellbeing to maintain their physical independence for longer
- Be supported to keep well both physically and mentally
- Be central to decision making
- Have consistent, high quality services across Lancashire and South Cumbria
- Have joined up services and support, which are easier to navigate and access
- Have services and support that are responsive to local need
- Have equal access to the most effective support with reduced waiting times.

New hospital facilities will support the delivery of these goals. Although it will take up to 2030 to plan and build new hospital facilities, we believe that the prospect of better, more agile hospital facilities, designed to accommodate the region's changing population demographics and health needs, will support the delivery of these goals in the short term by increasing staff morale, recruitment and retention.

1 Lancashire and South Cumbria's Healthier Lancashire and South Cumbria Strategy is available at **https://healthierlsc.co.uk/Strategy**

Demographic demands and trends

Lancashire and South Cumbria's hospitals serve a population of 1.8m across a diverse range of communities. Our region faces unprecedented challenges in caring for our population:

- **Ageing population:** the number of people over 65 is projected to increase by 22% by 2030. Looking after our older population is fundamental in terms of cost: rising numbers will create a significant proportional impact on operational and financial pressures.
- **Life expectancy:** people in Lancaster, Preston and Barrow-in-Furness all have lower average life expectancy than the England average. Access to top quality acute hospital facilities can have a dramatic impact on length and quality of life[2].
- **Our diverse communities:** our ethnic minority population is rising and is of significance in terms of health service provision. Ethnic minority groups are more likely to report ill-health and experience ill-health earlier and have more requirements for specialised care.
- **Deep socioeconomic challenges and associated health issues:** more people experience mental and physical ill-health in our region than in the rest of England, and more people than average face deep socioeconomic challenges.
- **Health outcomes:** health outcomes in Lancashire and South Cumbria are significantly worse than the national average, with unexplained variation in outcomes for people with conditions such as cancer, coronary heart disease and mental health.
- **Increasing demand:** demand for our hospital services is increasing and our region's hospitals are already constrained. Advances in medical technology and practice mean that more children are surviving with conditions that would not have been viable a few years ago.

2 Edwards, N. Covid-19: lessons for hospital building programmes (2020). Nuffield Trust. Available from: **https://www.nuffieldtrust.org.uk/news-item/covid-19-lessons-for-hospital-building-programmes**

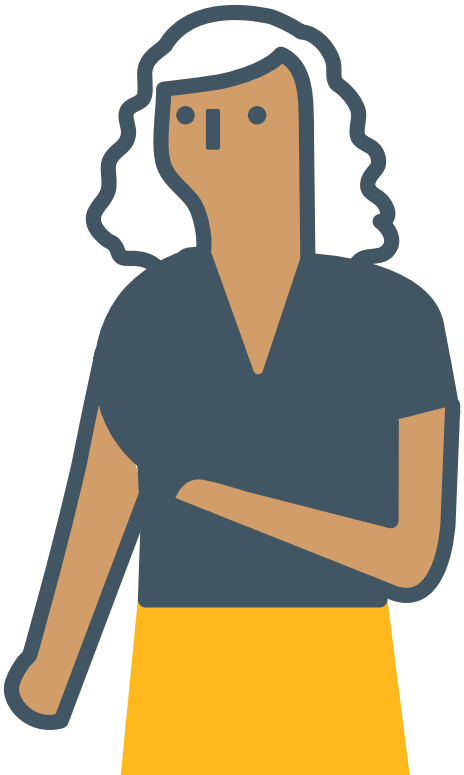
Implications for our hospitals

The Royal Lancaster Infirmary and Royal Preston Hospital buildings were not designed to care for patients with complex co-morbidities. The age, condition and poor functional content of these facilities mean that we cannot respond even to existing pressures on demand.

Investment in modern, flexible and adaptable infrastructure that will be able to accommodate future demand and enable the transformation of services is required urgently.

"The recent pandemic has taught us key things about our estate, including flexibility. Whatever the solution, we must build in the ability to be flexible at the point of care."

Royal Preston Hospital



2 Our hospitals

Our hospitals are some of our region's most significant assets. They are anchor institutions providing healthcare and employment to 40,000 people.

We have now reached a critical situation with the condition of some of the hospital estate within our region: the depth and extent of problems at Royal Lancaster Infirmary (University Hospitals of Morecambe Bay NHS Foundation Trust) and Royal Preston Hospital (Lancashire Teaching Hospitals NHS Foundation Trust) are unparalleled. They have some of the worst hospital estate in the North West, if not the country.

In addition, Furness General Hospital (University Hospitals of Morecambe Bay NHS Foundation Trust) also requires investment. Located in Barrow-in-Furness, a geographically isolated area with significant population health needs, it is a major local employer. This area also houses some of the UK's major strategic national assets. The sustainability of this site is a vital consideration for the New Hospitals Programme.

The poor condition of our hospital estate restricts our capacity to provide high-quality safe, efficient and cost-effective services for our patients and impacts our ability to attract and retain staff. Investment in our infrastructure is essential. Without it, services could fail, impacting on our population's health, economic prosperity and the sustainability of other providers, who cannot absorb the additional demand.

1. Royal Preston Hospital
2. Chorley and South Ribble Hospital
3. Royal Lancaster Infirmary
4. Furness General Hospital
5. Westmorland General Hospital
6. Royal Blackburn Teaching Hospital
7. Burnley General Teaching Hospital
8. Blackpool Victoria Hospital

Map of NHS hospitals across Lancashire and South Cumbria

Royal Preston Hospital

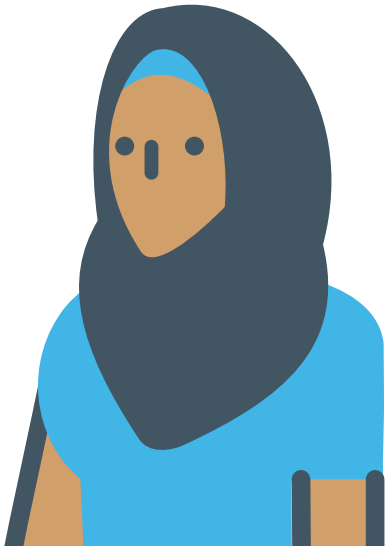
Services provided

Royal Preston Hospital (RPH) provides a full range of district general hospital services including: emergency department (ED); critical care; general medicine, including elderly care; general surgery; oral and maxillo-facial surgery; ear nose and throat surgery; anaesthetics; children's services; and women's health and maternity. It also provides several specialist regional services including: cancer; neurosurgery and neurology; renal; vascular; plastics and burns; rehabilitation. It is the major trauma centre for Lancashire and South Cumbria.

Site layout

Royal Preston Hospital has developed in a largely opportunistic manner, with the majority of the estate planned to 1950-60s specifications and built in the 1970s and early 80s. The site is landlocked with little space to extend.

"The Neurology ward is in a unit not physically connected to the main hospital site. This results in patients requiring an ambulance transfer within the grounds of the Royal Preston Hospital to move from the Neurology ward to the main hospital building. This provides a poor patient experience, and the reduced amount of ward space available has resulted in this location for the regional Neurology ward."



The Case for Change

Royal Preston Hospital has suffered from decades of under-investment. 70% of clinical facilities date from 1970s to 1990s and, as a result, experience serious dilapidation.

- Backlog maintenance costs total £157m.
- Demand exceeds capacity across all clinical areas and aged buildings lack flexible capacity leading to congestion and overcrowding.
- Non-compliance with Health Building Notes (HBN), with space and single room provision at only 19%. Compared to the HBN standard, a typical 28-bed ward at Royal Preston Hospital would need to increase capacity by 220% to comply.
- Poor clinical adjacencies and lengthy circulation spaces.
- Some tertiary (highly specialised) services have developed and expanded without fully being able to meet all the estate requirements.
- Almost all operating theatres and all day case theatres are well below the HBN recommended size of 55sqm. The rationale behind these space requirements is to enhance flexibility in accommodating new technology.
- Supporting scrub, anaesthetic and sterile preparation rooms are up to 75% lower than HBN capacity requirements.
- Clinical adjacencies are poor: the radiology department, medical assessment unit and surgical assessment unit are not co-located with the emergency department. Endoscopy and maternity theatres are also further from the Critical Care Unit than HBN standards would ordinarily mandate.
- Independent appraisal has confirmed 80% of the site requires redevelopment or demolition over the medium to long term, significantly limiting opportunity for refurbishment.
- Limited potential to redevelop the current site in a way that is practically achievable and compliant with the Government's New Hospital Programme.
- Car parking capacity is inadequate and consistently highlighted as a concern, with 1,000 staff required to park off-site and use Park and Ride.

19%
of rooms are single-person

220%
increase required to comply with HBN

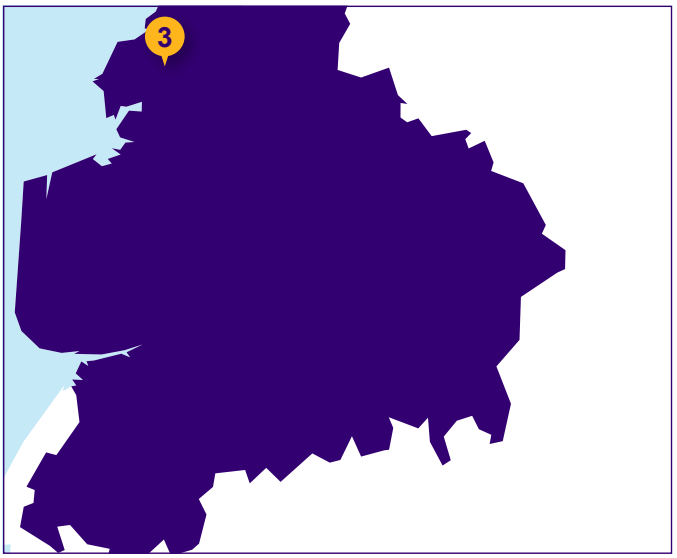
HBN recommended operating theatre size

55sqm ▼
almost all are well below this

"In Royal Preston Hospital we have episodes of flooding into clinical areas due to the age and condition of some parts of our hospital. This has resulted in operations being cancelled and damage to clinical equipment. Episodes of flooding are unpredictable, and result in some occasions of clinical care being delayed."

The need for investment at Royal Preston Hospital both to support the viability of services provided from this site and to provide the quality of care and experience our patients deserve is unequivocal.

Royal Lancaster Infirmary



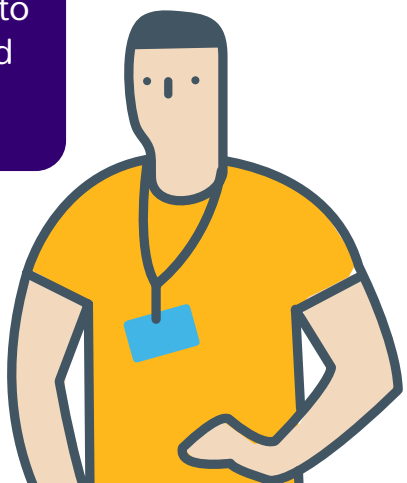
Services provided

Royal Lancaster Infirmary (RLI) is University Hospitals of Morecambe Bay NHS Foundation Trust's principal hospital, providing a range of general acute hospital services with an emergency department, critical coronary care units and various consultant-led services. Royal Lancaster Infirmary also provides a range of planned care, including: outpatients; diagnostics; therapies; maternity; and day case and inpatient surgery.

Site layout

The Royal Lancaster Infirmary site comprises of around 20 separate buildings of varying sizes and ages. Most, but not all of the buildings are linked by long passages, with some buildings separated from the main complex by public highways. As a result, staff and patients must make longer journeys than is desirable, leading to poor experiences of care and significant operational inefficiencies. Several services are provided in temporary buildings offering poor quality accommodation and others are past their useful life. Most of the site is on a slope, which in some areas is too steep for patients to be safely moved except by ambulances. The hospital lacks an obvious main entrance, which can be confusing for patients and visitors.

"Royal Lancaster Infirmary is bursting at the seams, there is no room to expand, parking is insufficient and emergency vehicles have to travel through a congested city centre."



The Case for Change

Royal Lancaster Infirmary has suffered from under-investment, with 65% of facilities constructed before 1985.

- Backlog maintenance costs total £88m – this is predominantly relating to the condition of the estate.
- Running costs double that of a new build at £442 per square metre due to the age of the site; running costs involve replacement i.e. lifecycle costs over maintenance.
- The site is configured over a challenging geography. Access is particularly challenging for people with a disability and transport to some parts of the hospital (separate ward blocks) is only possible by ambulance, at a cost of £500,000 a year to the Trust.

"The ward is not connected to the main hospital and requires the patient to be transferred within an NHS or private ambulance. Over a three-month period, we had 130 ambulance transfers out of hours, 28 of these patients either had diagnosed dementia, undiagnosed dementia, delirium or cognitive impairment and 11 of the total had a definite diagnosis of dementia."

Non-compliance with Health Building Notes (HBN) standards for space, including single room provision:

- 28% of beds are single rooms, with 11% en-suites, compared to an HBN requirement of 50%. Many of the patient toilet facilities are inadequate partition-style facilities, with two or three toilets in one room. These create a significant risk of infection, in addition to providing a poor patient experience and lack of privacy.

Transport to some parts of the hospital is only possible by ambulance, at a yearly cost of

£500,000

The Case for Change continued

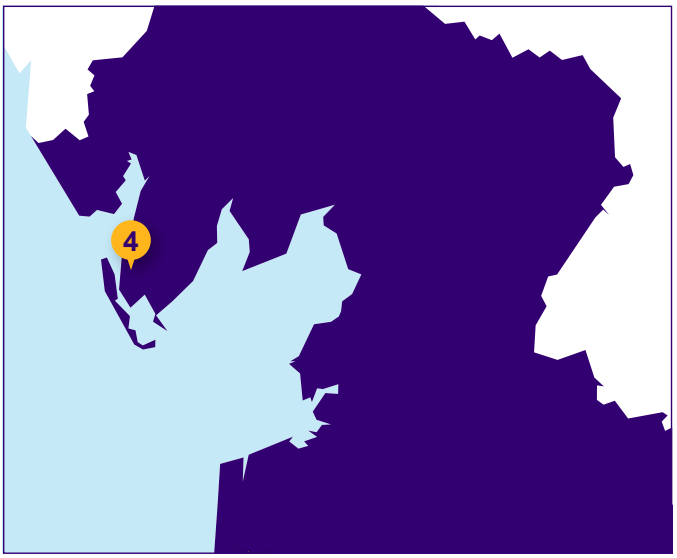
- Operating suite floors are non-HBN compliant for all areas, and are well below the HBN-recommended size of 55 sqm. Space requirements for an anaesthetic room, preparation room, scrub up and gown or dirty utility are not met.
- Multi-bedded bays predominate, which exceed the current HBN standard of four beds as a maximum. Some bays at Royal Lancaster Infirmary range from six to ten beds.
- Other compliance issues include the resus bay within the emergency department (Royal Lancaster Infirmary resus bay is 11 square metres versus minimum standard of 20 square metres) and sluice provision, which does not meet HBN standards of one sluice per 14 beds, often resulting in sewage leaks due to inadequate plumbing capacity.
- Electricity supply does not currently meet national standards.
- Car parking space provision is desperately insufficient across both sites.

Ability to manage demand is constrained by the inflexibility of the estate: during Covid-19, oxygen and electricity supply could not be increased to meet surges in demand, with oxygen supply identified as a critical area of investment need.

Over 50% of the Royal Lancaster Infirmary estate requires demolition and the majority of the remaining site will require refurbishment if it is retained in use. There is a powerful case for investment in new estate.

Royal Lancaster Infirmary

Furness General Hospital



Services provided

Furness General Hospital (FGH) provides a range of general acute hospital services, with an accident and emergency (A&E) department, critical / coronary care units and various consultant-led services. Furness General Hospital also provides a range of planned care, including: outpatients; diagnostics; therapies; maternity; and day-case and inpatient surgery.

Site layout

The Furness General Hospital site has a reasonable amount of strategic expansion space available. Some of the land is currently used inefficiently. There is an opportunity to reduce the percentage of the site currently set aside for non-patient facing activities to increase and improve the estate for patients

The Case for Change

Facilities at Furness General Hospital are generally more modern than at Royal Lancaster Infirmary and the site has good functional compliance. However, Furness General Hospital is faced with a significant challenge caused by backlog maintenance in estate that fails to meet some Health Building Notes (HBN) standards and capacity requirements. This inflates the issues the hospital has in recruiting and retaining staff.

Key challenges and specific investment needed to meet the future heath needs of the local population include:

- Significant backlog maintenance, including an element of physical condition and lifecycle works. Furness General Hospital has estate running costs of £375 per square metre.
- The estate fails to meet some HBN standards and capacity requirements, in particular, the Critical Care Unit / High Dependency Unit. There is a need to improve the environment for patients and staff, including increasing the single room provision.

There is a significant risk that this site may never meet crucial carbon emission standards.

The geographic location of Furness General Hospital is remote, meaning it is essential we accommodate the latest digital technologies and robotics to create an agile network of care across the region.

The overall quality of the Furness General Hospital estate is good. However, there is a strong case for investment to support its future sustainability in the context of its strategic importance in the provision of services to the population of Barrow-in-Furness and its proximity to major strategic national assets.

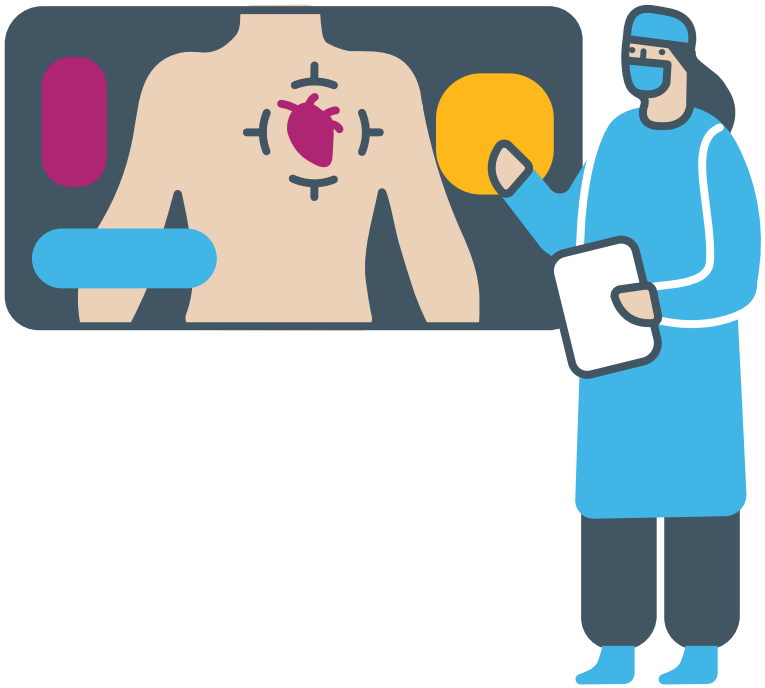
3

Delivering the Lancashire and South Cumbria Clinical Strategy

Our region has higher than expected levels of emergency admissions compared to the national average. Residents are 12% more likely to be admitted for all causes, 28% more likely for coronary heart disease and 27% more likely for Chronic Obstructive Pulmonary Disease (COPD). Mortality rates (for under 75s) are greater for 50% of counties in Lancashire and South Cumbria compared to the North West region average.

The Lancashire and South Cumbria Health and Care Partnership's Clinical Strategy[3] sets out three principle aims to help address this:

1. **Improving health and wellbeing**
2. **Delivering better joined up care closer to home**
3. **Safe, sustainable high-quality services.**



3 Lancashire and South Cumbria Health and Care Partnership (2020). Our Clinical Strategy: Creating a Healthy Population. Available from: **https://www.healthierlsc.co.uk/ClinicalStrategy**

To achieve these aims, help to deliver on the NHS Long Term Plan[4], and support the future health needs of our population, the Clinical Strategy outlines the following priorities:

(highest priority integrated pathways for improvement are indicated with **)

1 Health and wellbeing of our communities

- Prevention and health education
- Population health management
- Anticipatory care

2 Living well

- Self and personalised care
- Integrated place based care
- Intermediate care
- Mental health**
- Learning disability and autism**
- Maternity and children's services**

3 Managing illness

- Collaboration, shared services and networks
- Planned and elective care**
- Specialist and acute care

4 Urgent and emergency care

- Emergency care**
- Urgent care**
- Mental health urgent assessment centres

5 End of life care, including frailty and dementia

- Care of the elderly
- Ending life well
- Palliative care

6 Maintain a healthy and happy workforce

- Compassionate leadership and systems development
- Positive employment experience
- Opportunities for all
- Building a sustainable workforce

4 NHS Long Term Plan (2019). NHS. Available from: **https://www.longtermplan.nhs.uk/**

The New Hospitals Programme will support the long term future development of our clinical priorities, including single shared services or specialty networks, which will be based on:

A single service approach across Lancashire and Cumbria, delivered from a **specialised hub and with outreach across the network** to provide care locally where possible

Or

Services provided from one central site as part of a single service offer for Lancashire and South Cumbria, in order to meet the volumes and co-location required to meet national standards

Or

Single service offers achieving standards **across more than one site**.

The Lancashire and South Cumbria Provider Collaborative is already transforming services and exploring the benefits to patients and staff of networks and greater collaboration. Our Major Trauma Network has facilitated significant improvements to access and sustainability of these services.

Further work is taking place to inform our long-term clinical services strategy. Some of these plans may require engagement and / or consultation.

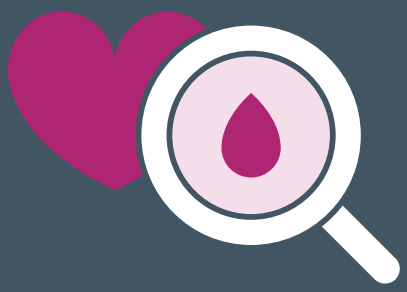
Specialised services

Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) is the main provider of specialised care, with a hub and spoke model underpinning delivery. However, one third of our total spend on specialised hospital care is taking place with providers outside of Lancashire and South Cumbria.

Specialised services in Lancashire and South Cumbria

- Vascular surgery
- Neurosciences, including neurology, neurosurgery and neurorehabilitation
- Major trauma
- Adult critical care
- Renal
- Cardiology and cardiothoracic services
- Hepatobiliary and pancreatic diseases (HPB)
- Haematology – autologous bone marrow transplant
- Specialised cancer surgery
- Chemotherapy, radiotherapy, SABR (Stereotactic Ablative Body Radiotherapy)
- PET-CT (Positron emission tomograph – computed tomography)
- Critical care
- Cystic Fibrosis
- Specialised respiratory including Interstitial Lung Disease
- Specialised HIV (human immunodeficiency virus), Hepatitis C
- Neonatal care
- Perinatal mental health
- Inpatient mental health
- Sexual Assault and Referral Centre (SARC)

While some specialised services can only be delivered at a national or cross-Lancashire and South Cumbria level, some of our patients are having to travel long distances to access care when:



(i) **We could expand choice for patients by providing services closer to home**, where there is the expertise, volumes and ability to deliver outcomes in line with national standards.

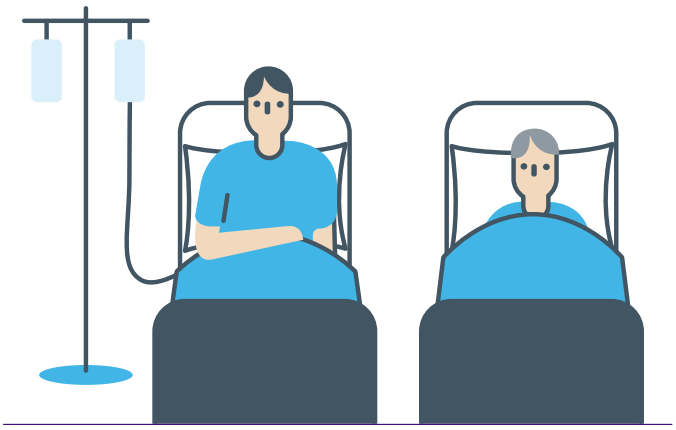
(ii) **There could be opportunities for further specialist services to be provided in Lancashire and South Cumbria**, where they have historically been provided elsewhere. Further work is required to understand this, but potentially some services in cardiac, neurosciences and haematology could be provided in Lancashire and South Cumbria.

How our estate impacts on the quality of clinical care and our patients' experience

Our poor hospital infrastructure is an important contributing factor to underperformance against key national access and quality standards. This means our patients wait longer for urgent treatment, routine surgery, diagnostics and cancer treatment than they should.

In their recent study of NHS hospital build programmes, the Nuffield Trust found significant evidence that better infrastructure and, in particular, access to a view led to quicker recovery time for the patient.[5]

The standards of our facilities and lack of single room provision do not give our patients the privacy and dignity they deserve and create risk of infection.



Patients wait longer for treatment than is acceptable because of the lack of capacity in and flexibility of our estate. We are below the national average position on several key performance standards.

- 70% of elective cancellations at Lancashire Teaching Hospitals NHS Foundation Trust were due to a lack of bed capacity / equipment.
- The built capacity of our emergency departments exceeds today's patient flows – patients wait longer for urgent emergency treatment at increased clinical risk.
- Bed occupancy rates are 95% and consistently above the National Institute for Health and Care Excellence (NICE) standards.
- Inability to separate planned and elective work, in line with recognised best practice in achieving good flow and maximising patient experience elective work is a consistent theme across women's services at Royal Lancaster Infirmary and Furness General Hospital.
- Co-location of mental health facilities, preventing an acceptable standard of care for patients with acute mental illness.
- Limited single room provision and toilet and shower facilities, negatively impacting patient experience and increasing risk of infection, as evidenced in our hospital-acquired infection rates compared to the national average.

5 Edwards, N. Covid-19: lessons for hospital building programmes (2020). Nuffield Trust. Available from: **https://www.nuffieldtrust.org.uk/news-item/covid-19-lessons-for-hospital-building-programmes**

Royal Lancaster Infirmary's emergency department

Predicted capacity
40,000

Attendances per year
60,000

Furness General Hospital's emergency department

Predicted capacity
25,000

Attendances per year
36,000

Royal Lancaster Infirmary's emergency department was built for a predicted capacity of 40,000 patient attendances per year, with actual attendances at around 60,000.

Furness General Hospital's emergency department has an annual capacity of 25,000, but actual attendances are around 36,000. This means patients remain on corridors or in crowded waiting areas, with significant delays to admission or treatment and an added infection risk.

Royal Preston Hospital has a cancellation rate of 4%, well over the national average of 1%. 20% of patients in LTHTr were not treated within 28 days of a cancellation, twice as high as the national average of 9%. Over 70% of these cancellations are attributable to capacity or equipment. Central Lancashire has been the most challenged area for Delayed Transfers of Care (DTOC) across the Lancashire footprint, with 7.28% for LTHTr.

Cancellation rate

Royal Preston Hospital
4%

National average
1%

How the New Hospitals Programme will help deliver our clinical strategy

We cannot deliver our clinical strategy with our current infrastructure because we do not have:

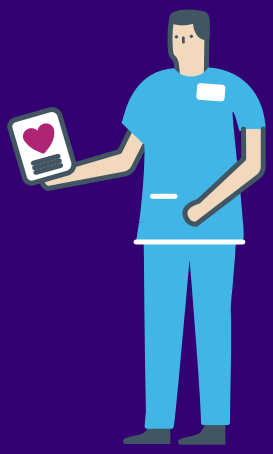
- Quality and adaptable infrastructure that supports delivery our principle aims and key priorities.
- The capacity for specialised and support services, including the associated workforce. We have previously outlined how specialised services have expanded at Royal Preston Hospital over time without the required physical space.
- The flexible capacity to transform and accommodate services that are changing with rapidly advancing technology.
- Single room capacity to ensure the highest standards of infection control, in particular for cancer patients.
- The required capability to accommodate advances in digital technology to support care closer to home and networked hospital solutions.

New models of acute care will be needed to deliver the clinical vision for 2030. The integrated care system clinical services strategy sets an expectation for closer working of providers across Lancashire and South Cumbria to achieve this.

Development of new hospital infrastructure will be a key enabler in delivering our long-term clinical strategy, improving outcomes and delivering care closer to home for our population.

4

Our infrastructure does not support our future digital technology ambitions



Digital technology will be an important enabler for realising the integrated care system ambitions and is vital for the delivery of sustainable, high quality, accessible acute care.

The NHS in Lancashire and South Cumbria has a well-established reputation as a leader in digital technology adoption. We have already made significant progress in implementing digital innovation and our Covid-19 response is accelerating this change.

More than 30% of outpatient appointments are now offered virtually and we have adopted innovations in robotic surgery. We have set out an ambitious digital strategy for change, which harnesses the benefits of technology for patients and staff, underpinned by a system wide approach.

The New Hospitals Programme presents us with an exciting opportunity to maximise the potential of digital technology in our region's hospitals:

- Patient experience will be enhanced through optimised digital front door, biometric identification systems, self-service check-in, digital signage and wayfinding, together with integrated bedside terminals.
- Virtual care will be embodied by remote monitoring in the form of telehealth, interfaced with immersive technologies, virtual assistants, digital therapeutics, access to personal health records and telemedicine.
- Staff will connect and share information with each other through a digital workplace, real-time location systems and digital whiteboards, supported by robotic process automation.
- Interoperability will support integrated, more joined up care with care record systems and coordinated care through digital transfer.
- New buildings and technology will enable staff to interact and interface with the wider care system and other care settings, including social care, while supporting home care through monitoring and observations, and assessment by healthcare workers.
- Automated facilities management will transform the performance of assets, facilities and infrastructure. This will need to be implemented into the building design process.
- Support and managerial staff can continue the flexible working patterns established during Covid, allowing them to work from home more often, delivering a significant cost saving and reducing the hospital floor space required for non-patient facing functions.

5

Our infrastructure impedes our ability to recruit and retain our workforce

The very poor condition of our buildings at Royal Preston Hospital and Royal Lancaster Infirmary is a structural barrier to attract and retain workforce. This is now a significant - and increasing - issue for both our ability to operate, and our sustainability as a health service within the region.

Staff recruitment and retention

Our NHS hospitals across Lancashire and South Cumbria employ 40,000 staff, with Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) employing 7,000 and 7,500 people, respectively.

Like many healthcare systems, we face significant issues with workforce supply and retention. Regionally, our vacancy gap is 9% - this is above the national average of 6.9%[6]. More than 20% of the workforce is over 55 years of age, which creates an added retirement risk[7].

It is hugely challenging to recruit and retain enough skilled staff to operate our hospitals. As a result, many UHMBT and LTHTr services are heavily reliant on the use of agency staff.

In 2019/20, £49m was spent on Band 5 agency usage alone, with £16m spent at LTHTr. UHMBT agency nursing spend is much lower, but the Trust spends £3m per year on medics, nursing / midwifery and allied health professionals (AHP) agency staff. **Poor working environments are a significant contributor to this issue**.

Forward-thinking commercial organisations are focusing their efforts on the design of workforce environments that offer healthier, more comfortable and more effective places to work – indeed this is a key consideration for most people seeking employment. Alongside wellbeing, staff feedback tells us that they want a working environment where they can care for patients and operate with the space and facilities they need to perform their roles to the standard that they and patients expect. This is often not the case in the ageing buildings we are asking them to work within.

6 NHS Digital. Available from: **https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey#latest-statistics**

7 Lancashire and South Cumbria Health and Care Partnership (2020). Our Clinical Strategy: Creating a Healthy Population. Available from: **https://www.healthierlsc.co.uk/ClinicalStrategy**

Research, education and specialist status

There are ground-breaking innovations taking place in research and education in Lancashire and South Cumbria. We want to stay at the forefront of this work for the benefit of our patients and to secure our position as a centre of excellence in specialist care.

Our strong reputation is evident from the NHS in Lancashire and South Cumbria's significant contributions to the National Institute of Health Research (NIHR). Lancashire Teaching Hospitals NHS Foundation Trust is also home to the NIHR Lancashire Clinical Research Facility and the Health Academy, which has won a number of prestigious awards. However, we cannot attract the best clinical leaders and leading medical researchers in their fields with our current infrastructure.

The outdated condition of our estate, and tired education and research facilities mean that University Hospitals of Morecambe Bay NHS Foundation Trust and Lancashire Teaching Hospitals NHS Foundation Trust are not an attractive proposition for trainees embarking on their career. There should be an opportunity to attract more medical students from Lancaster University, the University of Central Lancashire (UCLan), Edge Hill University and the University of Manchester. New infrastructure will be paramount to encourage recruitment and support the teaching of these students.

We work with a range of external academic and business partners at both a regional and national level. Our links with the university sector are going from strength to strength and there is a shared ambition to drive research, education and innovation across our region. There is a significant opportunity to increase our attractiveness as a partner of choice.

Opportunity for economic contribution

The New Hospitals Programme offers a significant opportunity to enable the people of Lancashire and South Cumbria to train and work in our healthcare system, both within our anchor institutions and through additional investment and economic growth opportunities brought to our region by this development.

6

Our infrastructure impacts our use of resources

NHS deficit

Around a £340m deficit exists across the NHS in Lancashire and South Cumbria, with more than 60% attributable to Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT).

Planned short to medium term productivity savings at Royal Lancaster Infirmary and Royal Preston Hospital will be substantial, but will be limited by important structural problems:

- Lancashire and South Cumbria is a net importer of workforce due to huge recruitment and retention challenges driven by the quality of our estate. These have impacted our use of resources through high levels of agency spend.
- Poor clinical adjacencies have led to diseconomies, higher costs of treating infection rates and duplication of services across multiple sites.
- Long transfer times within our hospitals, in particular Royal Preston Hospital, which is an inefficient use of staff time.
- The requirements for ambulance transfers across sites at significant cost to UHMBT and LTHTr.

- The poor condition of our estate means it lacks sufficient environmental controls and is expensive to run.
- Inadequate space for equipment and to provide separation for infection control.
- Antiquated IT systems, which increase manual processing times and duplication of tasks.

Not only will replacing old buildings with high quality, net zero carbon buildings be cost-effective to run, but clinical services can be organised in co-located settings to make the best use of staff time.

It is essential that we secure investment in new infrastructure to address these issues and improve the long-term financial position of the NHS in Lancashire and South Cumbria.

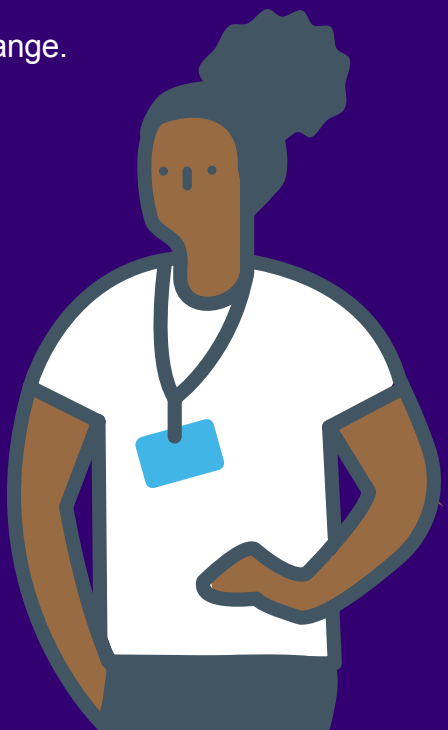
Conclusion

The evidence and data presented, along with feedback from patients, clinicians and the staff within our Trusts and wider NHS locally clearly underlines that the existing hospital buildings at Royal Lancaster Infirmary and Royal Preston Hospital cannot continue in their current form. Without investment, these buildings and services will continue to deteriorate, deepening health inequalities and increasing the burden of ill-health on our population as we seek to build-back after Covid-19. We must also invest in Furness General Hospital to ensure it can continue to serve its geographically isolated population.

The Government has made clear its commitment to addressing key areas of backlog, including cancer care and waiting lists. Lancashire and South Cumbria Health and Care Partnership shares this commitment. Our local NHS aspires not only to be able to keep pace with post-pandemic requirements, but to become a national exemplar for delivering on these as part of the fundamental levelling up that our regions - and in particular those within the North - must drive in order to attract investment, reduce inequalities and create a level playing field for communities across the UK. Investment in new hospital facilities will be a critical enabler for that.

The impact of new hospital funding will reach beyond healthcare alone. As anchor institutions within our region, our hospitals provide healthcare to 1.8m people and employment to 40,000. With the right levels of investment, we can become a catalyst for and driver of positive change.

We want to build the hospital facilities that our patients, staff, local communities and future generations deserve.



Next steps

We want to hear your views on the Case for Change that we have outlined. Do you agree or disagree with our Case for Change? What do you feel is strong, wrong or missing?

As we gather and reflect on your feedback, the New Hospitals Programme team will work with clinical and health system leaders to construct a longlist of possible solutions, which we will publish. We'll then ask the opinions of our NHS staff, patients and representatives of the public, working with Healthwatch and local voluntary, community, faith and social enterprise sector organisations (VCFSE), to help us narrow the longlist down to a shortlist of proposals, with only potentially viable option(s) taken forward. These proposals may require a public consultation.

Find out more about how to have your say and get involved at **www.newhospitals.info**

Lancashire & South Cumbria
New Hospitals
Programme

NHS

Find out more and get involved

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East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

8 September 2021

Item 112

Purpose Action

Title	Pennine Lancashire ICP Update and Partnership Agreement for 2021-22
Author	Mrs P Cross, Head of ICP Development (Interim), Healthier Pennine Lancashire
Executive sponsor	Mr M Hodgson, Interim Chief Executive, East Lancashire Hospitals Trust

Summary: This report and associated appendices, provide the Board with an update on key matters in relation to health and care system reform and provide an overview of how these relate to the Pennine Lancashire Integrated Care Partnership (ICP). The aims, ambitions and delivery priorities for the ICP in 2021-22 have been articulated, in the form of a Development and Delivery Proposition and the Board is asked to endorse this Proposition, along with a revised Partnership Agreement, to reaffirm its commitment to supporting the on-going development of partnership arrangements in Pennine Lancashire, throughout this period of Health and Care reform.

Recommendation: The Board is recommended to:

a) Note the update on health and care system reform as outlined in this paper and discussed in further detail in the course of their meeting
b) Note the Lancashire and South Cumbria ICP Narrative (Appendix A) which confirms the role and remit of ICPs in Lancashire and South Cumbria
c) Endorse and provide their support to the Pennine Lancashire Development and Delivery Proposition, as contained at Appendix B
d) Note that the Proposition is intended to be iterative, and it is likely that as our collaborative delivery arrangements evolve and national guidance is received, further amendments will be required
e) Endorse the Pennine Lancashire ICP Partnership Agreement 2021-22

Report linkages

Related strategic aim and corporate objective	Work with key stakeholders to develop effective partnerships
Related to key risks identified on assurance framework	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	No
Equality	No	Confidentiality	No

Previously considered by:

1. Introduction and Purpose

1.1 The purpose of this report is to provide the East Lancashire Hospitals NHS Trust Board with an update on key matters in relation to health and care system reform and provide an overview of how these relate to the Pennine Lancashire Integrated Care Partnership in 2021-2022.

1.2 The paper seeks reaffirmation of the Board to its commitment to supporting the on-going development of partnership arrangements in Pennine Lancashire, throughout this period of Health and Care reform, thus contributing to the organisations strategic aim to "*work with key stakeholders to develop effective partnerships".*

1.3 By continuing to be a key strategic partner in the Pennine Lancashire Integrated Care Partnership the Board will also be taking steps to mitigate one of the key risks identified within the Assurance Framework relating to "*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*."

2. Background

2.1 For the past few years, health and care organisations in Lancashire and South Cumbria have worked together as the Healthier Lancashire and South Cumbria Integrated Care System (ICS). The ICS is a partnership of organisations working together to improve services and help the 1.8 million people in Lancashire and South Cumbria live longer, healthier lives. The partnership is made up of Local Authority, Public Sector, NHS and voluntary and community organisations coming together to improve outcomes and care. The aims of the ICS partnership are to join up health and care services, to listen to the priorities of local communities, citizens and patients and to tackle some of the biggest challenges we are all facing.

2.2 Within Lancashire and South Cumbria ICS, there are five local areas, including Pennine Lancashire, that provide a way in which all organisations and groups involved in health and care can join up locally. These are called Integrated Care Partnerships (ICPs).

2.3 Pennine Lancashire Integrated Care Partnership has operated formally since 2016, it represents all of the health and care organisations in the Pennine Lancashire region as well as local councils and the voluntary, community and faith and social sector.

The Partnership serves to connect health and care services across Pennine Lancashire and create 13 neighbourhoods of 30,000 to 50,000 people registered to a GP. Integral to these neighbourhoods are services that support the health and wellbeing of the Pennine Lancashire residents, including those provided by our local government and Voluntary, Community, Faith and Social Enterprise (VCFSE) partners.

2.4 Health and care services are about to embark on a nationally driven, programme of reform, that aims to simplify how services are planned and delivered, encourage great collaboration between services (as opposed to historical competition driven approaches) and put people, population health and reducing inequalities, firmly at the heart of everything we do. This paper is intended to provide a brief overview of these reforms and offer an update on what this means for the Pennine Lancashire ICP and its partners during 2021-22.

3. Health and Care Reform Update

3.1 In February 2021 the Government published a White Paper outlining how the NHS in England needs to change to enable health and care to work more closely together. It has long been our aspiration to improve the way services work together and to be excellent partners to each other, but bureaucracy has sometimes got in the way. In summary, the White Paper and the subsequent Health and Care Bill (currently on second reading in the House of Commons) outlines how:

a. Change is needed to enable health and care systems to further build on innovation born from the pandemic.
b. The NHS, local authorities and other partners will come together legally as part of integrated care systems (ICSs) to plan health and care services and focus on prevention.
c. ICSs will become statutory and will be accountable for the health and wellbeing outcomes of the population.
d. The current functions of Clinical Commissioning Groups (CCGs) will move into the ICS.
e. Legislation that hinders collaboration and joint decision-making will be removed.

f. A 'duty to collaborate' will apply to NHS organisations and local authorities. This will promote joint working across healthcare, public health and social care.

g. A shared duty to have regard for the 'triple aim' of better health and wellbeing for everyone, better care for all people and sustainable use of NHS resources is proposed.

h. NHS England's main role will be to support improvements in health outcomes, the quality of care and the use of NHS resources.

3.2 The proposals and guidance that has followed, are designed to be flexible and will allow our health and care system to continue to evolve in a way which best suits us locally. It is recognised that the Health and Care Bill does not address adult social care or public health reforms, which will be critical to ensure ambitions for integrated care are achieved, proposals for these areas are expected later in the year.

4. Key points for Pennine Lancashire in 2021-2022

4.1 Whilst legislation and detailed guidance relating to health and care reform is slowly emerging, place-based partnerships are recognised as the arena where NHS organisations will continue to forge deep relationships with each other, alongside local government, VCFSE and communities to join up services, support PCN delivery and tackle the wider social and economic determinants of health.

4.2 Within Lancashire and South Cumbria, we have clarity that our place-based partnerships/ICPs of the future will be collaboratives of providers and planners, working together to simplify and modernise care and implement service models that are grounded in neighbourhoods and communities, which deliver improved outcomes for our residents through a whole population health approach.

4.3 Through September to December 2020, the ICP Directors from each of the Lancashire and South Cumbria ICPs, collaborated and engaged with stakeholders from across the breadth of the system, to produce a common Strategic Narrative for the ICPs in Lancashire and South Cumbria. This ICP Strategic Narrative was agreed with the ICS Board in December and sets out the blueprint for future working at place level, within our system. This is attached at Appendix A for the information of the Board.

4.4 Through January to March 2021, further whole system engagement in the scoping and production of an ICP development programme took place, this included the

development of an ICP Maturity Matrix, which was undertaken to baseline each ICP against the core aspects of the Strategic Narrative. The outcomes of the maturity baseline and engagement events resulted in recommendations being identified in relation to key activities ICPs could undertake, some collectively and some individually, to progress the maturity of their ICPs in 2021-22. The recommendations were tested with a wide range of system leaders via a workshop in April with c.70 attendees and were formally agreed by the Lancashire and South Cumbria ICP Development Advisory Group and ICS Board in May. The agreed actions now form the basis of a development plan for each ICP and have been supplemented by additional, locally relevant actions.

4.5 Through discussions with all partners, alongside a review of recent national publications (namely the ICS Design Framework and the System Development Progression Tool), a Pennine Lancashire ICP Development and Delivery Proposition which sets out the core purpose, aims and objectives for the Pennine Lancashire ICP in 2021/22. This document. It is intended to be used to guide the further development of our collaborative workstreams and for the purposes of stakeholder engagement. The ICP Development and Delivery Proposition 2021-22, attached at Appendix B, seeks to clarify what our ICP is and what it will work to collectively deliver, it clearly articulates our purpose, ambition and functions, drawn from the Lancashire and South Cumbria ICP Strategic Narrative, but localised to reflect our own arrangements, partners and priorities.

4.6 The Development and Delivery Proposition has been endorsed by the ICP Partnership Leaders' Forum and is recommended now for endorsement by the Board.

4.7 A key feature of our ICP development work in 2021-22 will be to develop closer working with our district councils, particularly through the district health partnership/action groups that have continue to evolve throughout the pandemic. The contribution of our district councils and their networks to vital issues such as population health and wellbeing and community asset development is widely acknowledged across our Partnership. We have now seized the opportunity within our Proposition document, to signal clear intent to support the evolution of these partnerships to be a key part of our infrastructure, working together to ensure that local needs and priorities are understood and inform the delivery of our integrated services moving forward.

4.8 In line with the national direction of travel, there is clear recognition now within our ICP, that addressing health inequalities, through a concerted focus on population health improvement and collective action on the wider determinants of health, must be at the heart of our collaboration moving forward. To this end, we are working to establish a Population Health Board for Pennine Lancashire, that will bring together all relevant partners to coordinate a whole system approach to improving population health. Whilst the full remit of the Board is still to be scoped with partners, it is envisaged that this will inform on priorities for health outcomes, inequalities and improvement and oversee delivery of key system actions to address inequalities.

4.9 The ICP Development and Delivery Proposition also outlines the key programme areas which will form the focus of our collaborative delivery. ELHT officers and clinicians will be actively engaged in these workstreams, as relevant to their portfolios. The workstreams are:

- Primary, Community and Social Care
- Intermediate Care
- the Care System
- Urgent and Emergency Care
- Children and Maternity
- Learning Disabilities and Autism
- Restoration and Recovery
- Mental Health

4.10 The governing group for the ICP, for the remainder of 2021-22, will be the Partnership Leaders' Forum and ELHT representation on the Forum is through the Chairman, Interim Chief Executive and Executive Medical Director.

5. Pennine Lancashire Partnership Agreement 2021-2022

5.1 The Pennine Lancashire ICP has operated under a Memorandum of Understanding since its formal inception in 2016. The Memorandum of Understanding was signed by all the key partners during that year, outlining their commitment to working together to integrate health and care services. The Memorandum was endorsed by the ELHT Board in July 2016.

5.2 Through collaborative working across all of the ICPs in Lancashire and South Cumbria, it has been agreed that revised partnership agreements would be put in

place for each ICP, which outline the role and responsibilities partners within the place during the 2021-22 transition phase. In support of this, a common draft Partnership Agreement developed by the ICP leads and was endorsed by the ICS Board in May 2021, with a view that ICPs would then build on the common draft with content relevant to their own partnership arrangements.

5.3 The draft Agreement has now been adapted to reflect arrangements within Pennine Lancashire and was endorsed by our Partnership Leaders' Forum on the 21 July. The Pennine Lancashire Partnership Agreement is not designed to be a legally binding document, but rather an agreement that sets out principles, behaviours and ways of working and a reaffirmation of commitment to work in partnership, to improve health and care. It is recognised that a formal Memorandum of Understanding or other such agreement, will be required as the ICPs and the Lancashire and South Cumbria Health and Care Partnership/NHS Body develop throughout 2021-22 and as national guidance/legislation is released.

5.4 The Pennine Lancashire ICP Partnership Agreement 2021-22 is attached at Appendix C for the endorsement of the Board.

6. Recommendations

6.1 East Lancashire Hospitals Trust Board is asked to:

a) Note the update on health and care system reform as outlined in this paper and discussed in further detail in the course of their meeting

b) Note the Lancashire and South Cumbria ICP Narrative (Appendix A) which confirms the role and remit of ICPs in Lancashire and South Cumbria

c) Endorse and provide their support to the Pennine Lancashire Development and Delivery Proposition, as contained at Appendix B

d) Note that the Proposition is intended to be iterative, and it is likely that as our collaborative delivery arrangements evolve and national guidance is received, further amendments will be required

e) Endorse the Pennine Lancashire ICP Partnership Agreement 2021-22.

Lancashire and South Cumbria
Health and Care Partnership

Developing Integrated Care Partnerships in Lancashire and South Cumbria

Bay Health & Care Partners delivering
bettercare together
Fylde Coast Integrated Care Partnership
OUR Central Lancashire
Healthier Pennine Lancashire
WEST LANCASHIRE PARTNERSHIP

What do we mean by an 'Integrated Care Partnership'?

An Integrated Care Partnership (ICP) is a collaboration of planners and providers across health, local authority and the wider community, who take collective responsibility for improving the health and wellbeing of residents within a place, with a population of up to 500,000. Most people's day to day care and support needs will be met within a place and delivered in neighbourhoods of 30,000 to 50,000 people.

Our partnership will create a feeling of belonging to a place, where all partners are valued and respected, and mutual support is offered to all partners. This will be particularly significant in challenging times. It is important to acknowledge that residents are co-partners in the continued evolution of ICPs, and that social movements in communities can increase people's ownership of their own health and wellbeing and mobilise communities to support each other.

The common purpose of an ICP is to enable collaboration that will address specific place-based challenges and deliver within each place the component parts of the Integrated Care System (ICS) strategy.

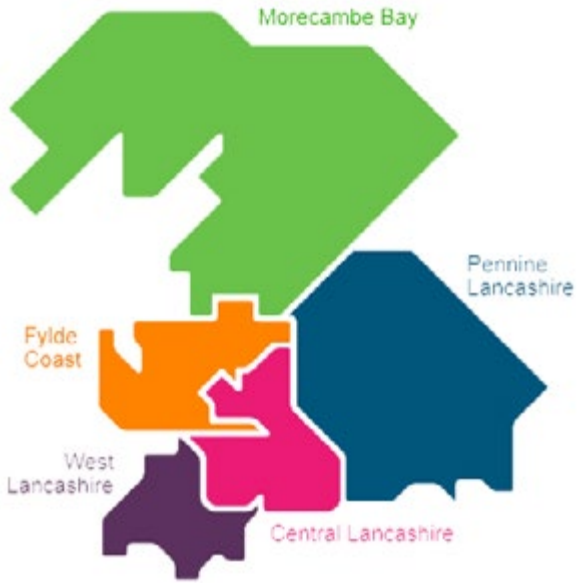
The document entitled "***Integrating care: Next steps to building strong and effective integrated care systems across England***", published by NHSEI in November 2020 states that:

> "Every area is different, but common characteristics of the most successful are the full involvement of all partners who contribute to the place's health and care; an important role for local councils (often through joint appointments or shared budgets); a leading role for clinical primary care leaders through primary care networks; and a clear, strategic relationship with health and wellbeing boards."

Take a look at our glossary for a list of terminology we are using in Lancashire and South Cumbria: www.healthierlsc.co.uk/glossary

The core aims of an ICP are to:

- Improve the health and wellbeing of the population and reduce inequalities.
- Provide consistent, high quality services that remove unwarranted variation in outcomes.
- Consistently achieve national standards / targets across the sectors within the partnership.
- Maximise the use of a place-based financial allocation and resources.



What will happen within ICPs?

As a minimum, each ICP will have the following all age service provision at place level, working together to simplify and modernise care and implement service models which deliver improved outcomes:

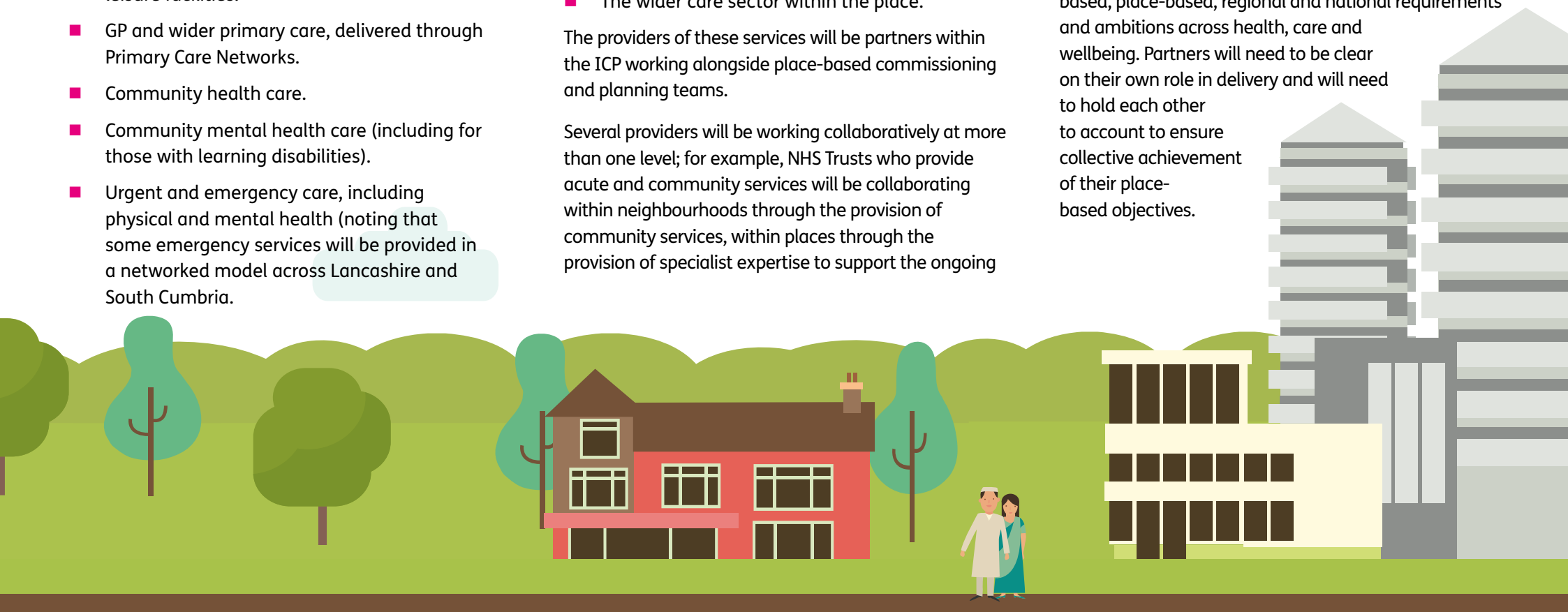
- Public health and wider community development.
- Community-based wellbeing support, including social prescribing activities, VCFSE provision and local access to green spaces, and leisure facilities.
- GP and wider primary care, delivered through Primary Care Networks.
- Community health care.
- Community mental health care (including for those with learning disabilities).
- Urgent and emergency care, including physical and mental health (noting that some emergency services will be provided in a networked model across Lancashire and South Cumbria.
- Ongoing management of long term conditions, including the use of skills, expertise and resources that have historically been accessed via referral to acute care services.
- Local acute hospital services (noting that some services will be provided in a networked model across Lancashire and South Cumbria, and there will be tertiary services provided in some places for the system-wide population).
- Social care, education, housing, employment and training support.
- The wider care sector within the place.

The providers of these services will be partners within the ICP working alongside place-based commissioning and planning teams.

Several providers will be working collaboratively at more than one level; for example, NHS Trusts who provide acute and community services will be collaborating within neighbourhoods through the provision of community services, within places through the provision of specialist expertise to support the ongoing management of long term conditions, and across the system in the networked provision of elective care.

In the future, it is expected that the NHS will move towards organisations within each ICP receiving a financial allocation for the place, based on capitation; the principle that money is allocated per person in each place.

This, along with the potential for increased use of pooled budgets, will mean that partners within the ICP will make collective decisions on how best to invest financial resources in order to deliver neighbourhood-based, place-based, regional and national requirements and ambitions across health, care and wellbeing. Partners will need to be clear on their own role in delivery and will need to hold each other to account to ensure collective achievement of their place-based objectives.



What will we need to do collectively as partners within an ICP?

To achieve the common purpose of an ICP, there are several areas where collaborative working will be needed:

Place-based leadership and collaboration

Effective, collaborative leadership – with a clear, common purpose, and drawn from all parts of the system including democratic, clinical and professional teams – has been shown to be essential to developing the partnership culture needed to create and sustain system-wide improvement. ICPs will:

- Co-create a vision for the place that delivers the system and place strategies through a partnership of equals.
- Provide a 'system management' function that connects the partners within the place, as well as influencing key priorities across the Lancashire and South Cumbria Health and Care Partnership and connecting each place to the wider system. This function will include shaping the culture of the partnership through a population health management approach to the planning and delivery of services; holding each other to account for delivery; acting as place-based and system-wide integrators and catalysts for change; brokering challenging conversations between partners; and ensuring that decisions are made in the best interests

of the place. It will need to encompass the expertise and experience of place-based commissioning and provision.

- Use this system management approach to support a collaboration of providers across different sectors and multiple organisations to build seamless, integrated services that respond to the health and wellbeing needs of local residents.
- Promote social value in our communities by employing a workforce that is drawn from, and representative of, the population in the place; by offering fair pay and conditions of employment; by offering employability programmes that support people to acquire the skills needed to work in health and care; and by offering apprenticeship programmes which assist in providing employment now and creating the workforce of the future.
- Promote, embed and demonstrate compassionate leadership across all services within the place.
- Build a culture of rapid improvement with a shared, consistently applied methodology; a management system that aligns improvement activity to priorities and ways of working; and a set of leadership behaviours which supports an engaged and empowered workforce.
- Implement accountability frameworks that incentivise evidence-based care provision and improved outcomes for individuals and for the population as a whole, shaping priorities and decision-making.
- Support effective place-based organisational development programmes, recognising the need for increased support during large-scale and/or sustained periods of change.
- Ensure systems are in place to provide comprehensive organisational development, coaching and mentoring support for leaders to facilitate the transition from organisational to place-based leadership behaviours and decision-making.

Listening to the voice of our communities

Our residents and communities are a fundamental part of our partnerships and their voice and lived experience is vitally important in creating the culture of a social movement in our neighbourhoods and places, in ensuring that residents' needs are heard and understood, and in shaping services that meet local needs. ICPs will:

- Ensure local engagement is culturally appropriate, in line with the demographics of the place.
- Engage with residents to ensure co-production in health and wellbeing needs assessments, delivery plans, operating models and service redesign / transformation activities.
- Listen to feedback from patients, carers, service users and residents to ensure that services are evaluated from quantitative and qualitative perspectives, and that this feedback is used to inform future service provision.
- Engage with residents (and our workforce, many of whom are residents themselves) to encourage a social movement that fosters and enhances an increased responsibility for health and wellbeing and mobilises communities to support each other better.
- Proactively work with communities to create a greater sense of accountability to the local population for the quality of services provided and the resultant outcomes.
- Seize the short-term benefits in restoration and incentivise change to build the culture and capability for the medium and long term.

Planning integrated services

A more integrated approach to the planning of services across all sectors will support more efficient and effective use of resources. ICPs will:

- Lead the creation of a fully integrated, place-based delivery plan that is able to respond to:
  - National strategies, plans, standards/targets
  - The requirements of national and regional regulators
  - Lancashire and South Cumbria Health and Care Partnership strategies
  - Existing place-based strategies
  - Place and neighbourhood-based health and wellbeing/joint strategic needs assessments
- Join up population intelligence capability, and health and local authority planning, including joint commissioning, transformation and at-scale change programmes, quality improvement, service delivery and empowered communities.
- Ensure that actual and potential inequalities are identified and addressed in all aspects of service planning and provision.

Delivering integrated services

Patients, service users and our own workforce often describe their frustrations at the fragmented nature of our service provision. A key shift in the transition to significantly increased partnership working should be the removal of unnecessary boundaries between services and professions. ICPs will:

- Work with partners to ensure the delivery of high quality, safe, affordable integrated services, tailored across the differing needs within the place footprint at neighbourhood/PCN, district and place.
- Ensure that all partners work together so that services will be predominantly focused on improving health and wellbeing through a population health management approach which will include self-care, preventative action, vulnerability reduction, anticipatory care, community-based models of care and support, long term condition management using digital technology, and addressing the wider determinants of health and wellbeing with clinicians and professional groups working at the top of their licence to support complex care in the community.
- Ensure that all partners work together so there is an operating model for the place that includes standard service offers and minimum standard specifications within a place to reduce health inequalities and unwarranted variation within the place and, where appropriate, across the places within the Lancashire and South Cumbria Health and Care Partnership. These service offers and standard specifications will be outcome focused in order to allow for necessary flexibility in delivery and eliminate asynchronous care. The operating model will include:
  - Primary, community, acute, mental health and social care working as self-directed teams across organisational boundaries, to deliver for populations of 30,000-50,000, driven by data, mobilising prevention and anticipatory care. PCNs will be at the core of these teams.
  - Joining up of civic and community assets, providing partnership multi-disciplinary teams (MDTs) which will include housing, Department for Work and Pensions, voluntary sector support and access to community assets to support people to maintain independence.
  - Long term condition management where the focus of specialist/consultant led support is on holistic continuous condition and exacerbation management, aimed at keeping people at home.
  - More intensive community support when required to keep people at home, including at times of crisis.
  - Elective care, urgent and emergency care, including physical and mental health, providing timely and appropriate access.

- Ensure that all partners work together to provide fully integrated health and care records that are available to all staff involved in the provision of care across the place, with information governance agreements that support and enable integrated working. The ambition is to move towards records that are resident owned.
- Make best use of digital solutions that will support residents staying in their own homes wherever safe and effective, predict need and support effective mobilisation of the workforce, and promote multi-disciplinary working to deliver seamless care.

Population health management

Moving towards a preventative, proactive and holistic approach to the health and wellbeing of our residents is key to improving outcomes and reducing inequalities. ICPs will:

- Ensure plans are in place to implement a population health management infrastructure and culture.
- Ensure that the ICP uses a population health management approach to service planning, i.e. making use of holistic data from multiple sources to identify the health and wellbeing needs of the population (place and neighbourhood).
- Ensure that a risk stratification approach is used to plan how services can meet health and wellbeing needs and reduce inequalities, including addressing the wider determinants of health and wellbeing such as housing, environmental quality and access to good employment and training.
- Use population data to mobilise the workforce, working to accountability frameworks that demonstrate delivery on outcomes and incentivise prevention and anticipatory care.
- Build a collaborative decision-making process that prioritises investment in anticipatory and preventative care to reduce specific risks and vulnerabilities within the local population.
- Ensure the creation of integrated population health management units in neighbourhoods by building on existing neighbourhood working, community hubs and PCNs, whilst also drawing in acute care specialists who focus on long term conditions and the elderly.

Improving quality of services

We know that many services in our system provide good quality care which is rated highly by patients and services users. It is important for us to build on that and learn from these teams / organisations to provide consistent, high quality care across each place. ICPs will:

- Ensure all partners work together so that actual and potential inequalities are identified and addressed in all aspects of service planning and provision.
- Ensure place-based performance and assurance is focused on delivering the required improvements in population health, outcomes and inequalities.
- Ensure all partners use an evidence-based approach to care planning and provision, simplifying and standardising pathways across the place and within neighbourhoods.
- Lead the deployment of improvement science at pace and scale to support rapid cycles of change, allowing freedom to act and promoting innovation.
- Create an integrated, place-based plan for the provision of high quality services that meets the requirements of the regulators across the sectors within the partnership.

- Create and maintain an open and transparent culture that encourages incident reporting, management of serious incidents and the implementation of associated learning from incidents across all sectors within the partnership.
- Ensure there is sufficient capacity and that services are of the highest quality to meet required national standards / targets
- Design and deliver culturally competent personalised care services.

Maximising the use of resources

Resources within each place are scarce and it is therefore important that we use these wisely in order to gain the maximum benefit for our residents. It is therefore proposed that the actions set out below will accelerate the next stage of development. ICPs will:

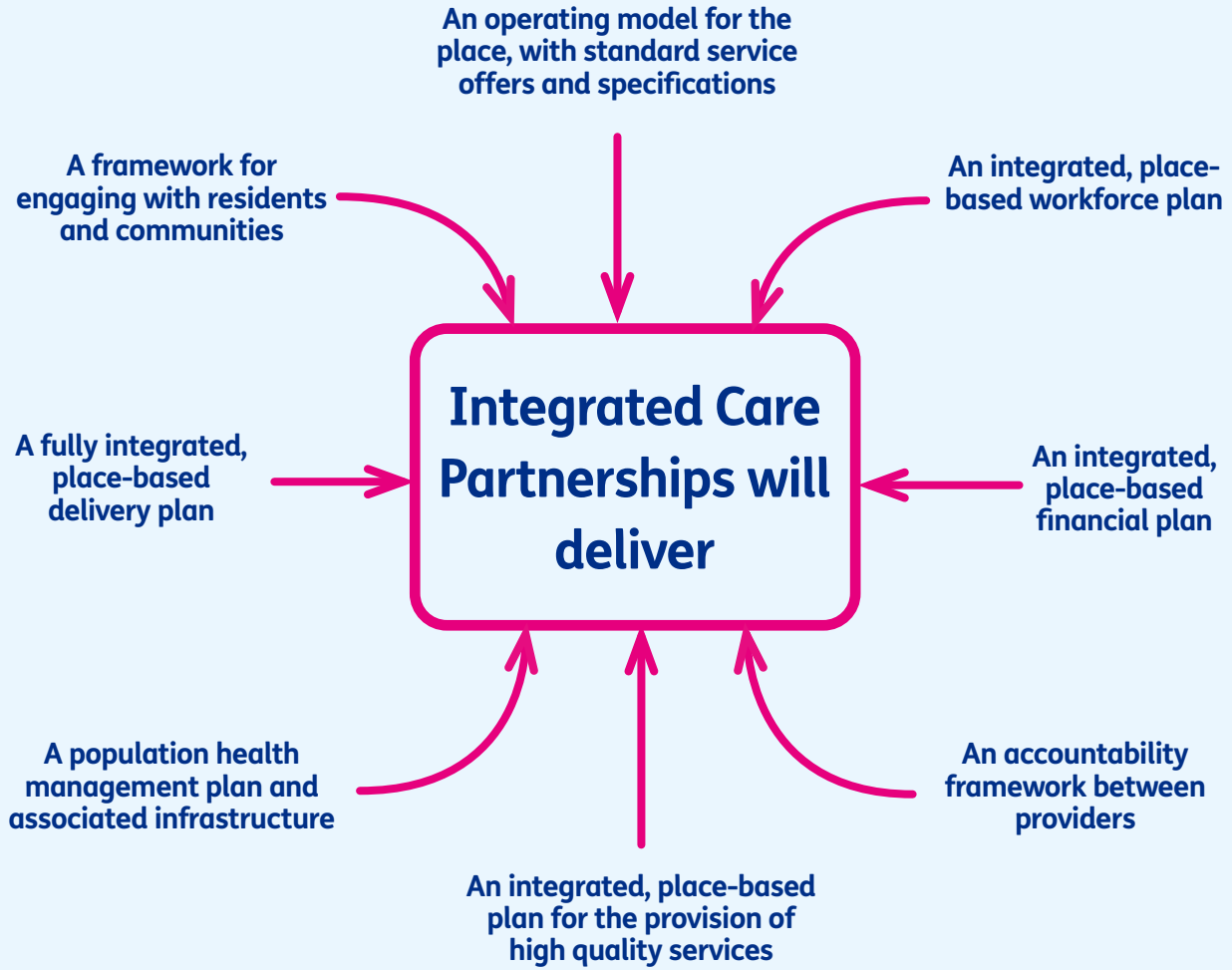
- Be collectively accountable for a place-based capitated NHS budget within an agreed Lancashire and South Cumbria financial framework along with any pooled budgets across the NHS and other partners within the ICP.
- Use a place-based collective prioritisation and decision-making framework to agree the allocation of these financial resources within the place.
- Work with partners to create an integrated, place-based financial plan that supports population-based budgets and demonstrates best value for the 'place pound' whilst maximising impact on population health, health inequalities, quality of service provision and outcomes.
- Use contracting and payment mechanisms within the place that are based on incentives, with agreed shared risk / gain models and aligned financial processes, building on the PCN Directed Enhanced Services and local quality schemes.
- Plan and deliver local cost improvement schemes to ensure best value for money.
- Ensure local understanding of community-based physical assets and influence their collective use across partners within the place.
- Make best use of business intelligence / health informatics resources across the ICP partners, and as appropriate with wider partners across Lancashire and South Cumbria Health and Care Partnership, to provide real time information for use across the place and a single suite of performance / assurance reports.
- Integrate corporate teams to work across the place rather than maintaining separate teams in individual organisations.

Valuing and developing the workforce

The partners within each ICP employ a significant number of people, many of whom are also residents within the place where they work. Partners have a duty to support their workforce and to contribute to the socioeconomic development of the place. There are a significant number of volunteers in each place who make invaluable contributions that should be supported and recognised. ICPs will:

- Recognise that key partners are anchor institutions in each place, acknowledging the fundamental role they have in advancing the welfare of the populations they serve and the way in which they can support local community wealth and development.
- Be a partnership of employers that proactively supports the employment of our local people by providing equity of access to opportunities and employing a workforce that is drawn from, and representative of, the population served by the place.
- Support fair and equitable pay and conditions of employment including paying a living wage and providing stable employment which offers fair working conditions and promotes the health and wellbeing of all staff.

- Ensure that partners develop and offer employability programmes that provide training and support to help local people acquire the skills needed to work in health and care, and work with community partners to support residents who might otherwise face barriers to work.
- Work with local Academies, schools, Further Education colleges and Higher Education institutions to offer apprenticeship programmes which assist in providing employment for the local community and in supporting the creation of the workforce of the future.
- Work with partners to create a place-based people plan for the recruitment, retention and ongoing development of an integrated workforce.
- Integrate the workforce to support seamless service provision and minimise handovers between individuals and organisations across the partners within the place.
- Provide joint appointments and rotational posts across multiple care settings in order to make best use of, and/or further enhance, skills and experience.
- Support professional development and career progression to staff at all levels and across all aspects of provision.



How will we need to work together as partners within an ICP?

It must be recognised that without legislative change, certain types of organisations are accountable to specific regulators, with ring-fenced budgets, and will be held to account for delivering certain services and/or functions.

Therefore, we need to consider what can and cannot be undertaken collectively, how we will organise ourselves to manage this locally, and how we will respond to our respective regulators. This will require liaison with regional and national teams to support the shift from organisational accountabilities to place-based accountabilities.

This is likely to require a new and explicit mechanism for holding ICPs to account for what is in scope of place-based, collective delivery.

Partners within an ICP will share responsibilities, risks and resources. This will require some delegation of decision-making to the place rather than organisations, clarity on which partners are delivering which services / functions within the ICP, and changes to current organisational-based leadership structures and governance arrangements.

Delegated decision making

Each ICP will require a framework that defines the scope within which decision-making happens by place-based system leaders operating within parameters agreed by the partner organisations.

This is likely to be achieved via a scheme of delegation that is explicit about what will be managed via organisations and what will be managed via the ICP. This will include decision-making across all of the functions of the ICP, and all partners within the ICP.

Supporting governance arrangements

Each ICP will require a structure where it can exercise this delegated decision-making, ensuring that partners deliver what has been agreed, and maintaining appropriate levels of lay/non-executive oversight and clinical engagement.

As part of this process each ICP will need to consider the following requirements:

- The use of formal memoranda of understanding, partnership agreements or alliances to provide clarity on the role and responsibilities of each partner organisation within the ICP.
- A place where delegated decision making from the statutory bodies can be discharged, i.e. a place-based ICP Board that is the decision-making group of the ICP, as outlined by a scheme of delegation and enacted by the members of the ICP Board. This may need to be supported by other place-based committees, which could function using a Committees in Common approach.
- A cross-organisational, multi-professional clinical and professional leadership body that allows senior clinicians / practitioners from across the partners within health, social care and third sector within the ICP to make decisions / recommendations on clinical practice, pathways, etc.
- Meaningful clinical, professional and democratic leadership and engagement, to ensure that there is appropriate representation and engagement across neighbourhoods, districts and the place.
- A mechanism for identifying and managing risk for the ICP, with proportionate distribution of risk across partners, and clarity on which partner within the ICP owns the risk along with which partners contribute to the mitigations.
- Systems and processes for partners in the place to hold each other to account for performance and support each other where necessary. These will need to align to the accountability framework within the Lancashire and South Cumbria Health and Care Partnership and the approach agreed with regulators.

It should be noted that effective implementation of these governance arrangements may require changes to current organisational constitutions and Terms of Reference of existing organisational groups.

Supporting leadership arrangements

Each ICP will require a leadership team for the place that will be acting independently of any single organisation (albeit that they may continue to hold organisational leadership roles) working to deliver the core aims of an ICP.

Each ICP will need to consider the following:

- An ICP Chair who will be responsible for creating productive collaborative relationships within the ICP and across the Lancashire and South Cumbria Health and Care Partnership, and for effective leadership of the ICP Board and its role in ensuring delivery of the core aims of the ICP.
- An executive leadership team with members who have responsibilities across the place (albeit that they may continue to hold organisational leadership roles).
- High levels of clinical and professional leadership and influence, where leaders are acting as a collective voice on behalf of the health and care system.
- Shared purpose and values that have been adopted by the ICP partners.
- Leaders who demonstrate high levels of trust, collectively overcome challenges, celebrate shared success and drive continuous improvement to shared objectives through adaptive change and a learning culture.
- Leaders who role model values and behaviours and cascade down through their teams.
- Leaders who respect that the voice of all partners has equal weight and value.

It is suggested that there will be a need for an 'Integration Lead' within each ICP. It is intended that this role will work alongside the senior executives from the partners within the ICP and local communities to:

- Ensure effective integrated approaches are taken to the health needs of the local population – using population health management techniques and building on the experience and expertise within communities.
- Support the development of integration across all services (primary / community / care / hospital / VCFSE) in the place and ensuring that PCNs work effectively to support each neighbourhood of 30,000 to 50,000 residents.

Work with health partners and local authorities to identify joint opportunities for health and care services to be transformed, building on lessons learned through the response to the Covid-19 pandemic and the potential to use new technology.

Coordinate local contributions to health, social and economic development – set as appropriate within the context of wider system strategies.

Next steps

We will continue to keep colleagues, partners and members of the public informed about any developments as early as possible.

If you have any questions, please contact healthier.lsc@nhs.net.

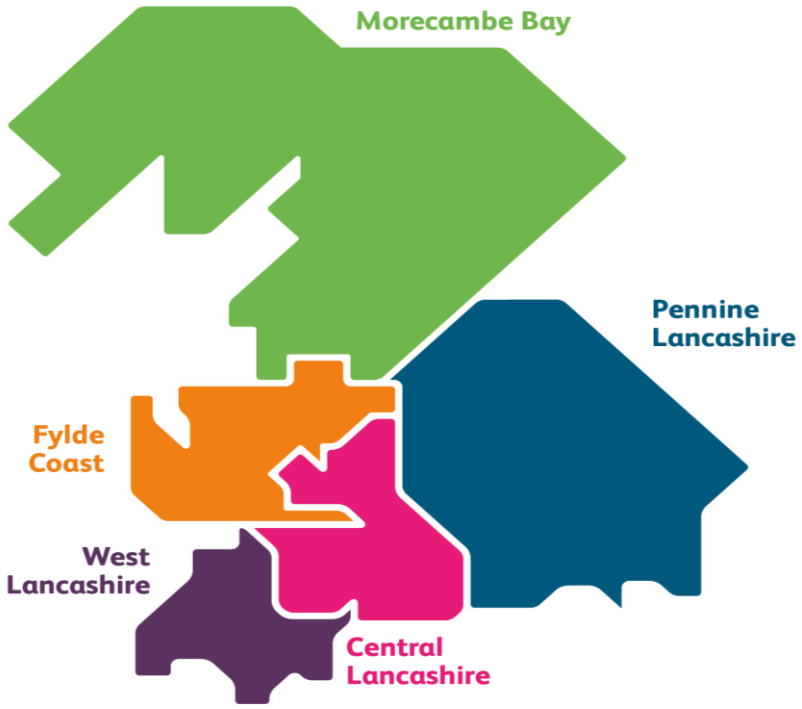
To find out more about how we are developing integrated care in Lancashire and South Cumbria please visit: healthierlsc.co.uk/IntegratedCare.

Healthier Pennine Lancashire

Pennine Lancashire ICP

Development and Delivery Proposition for 2021/22

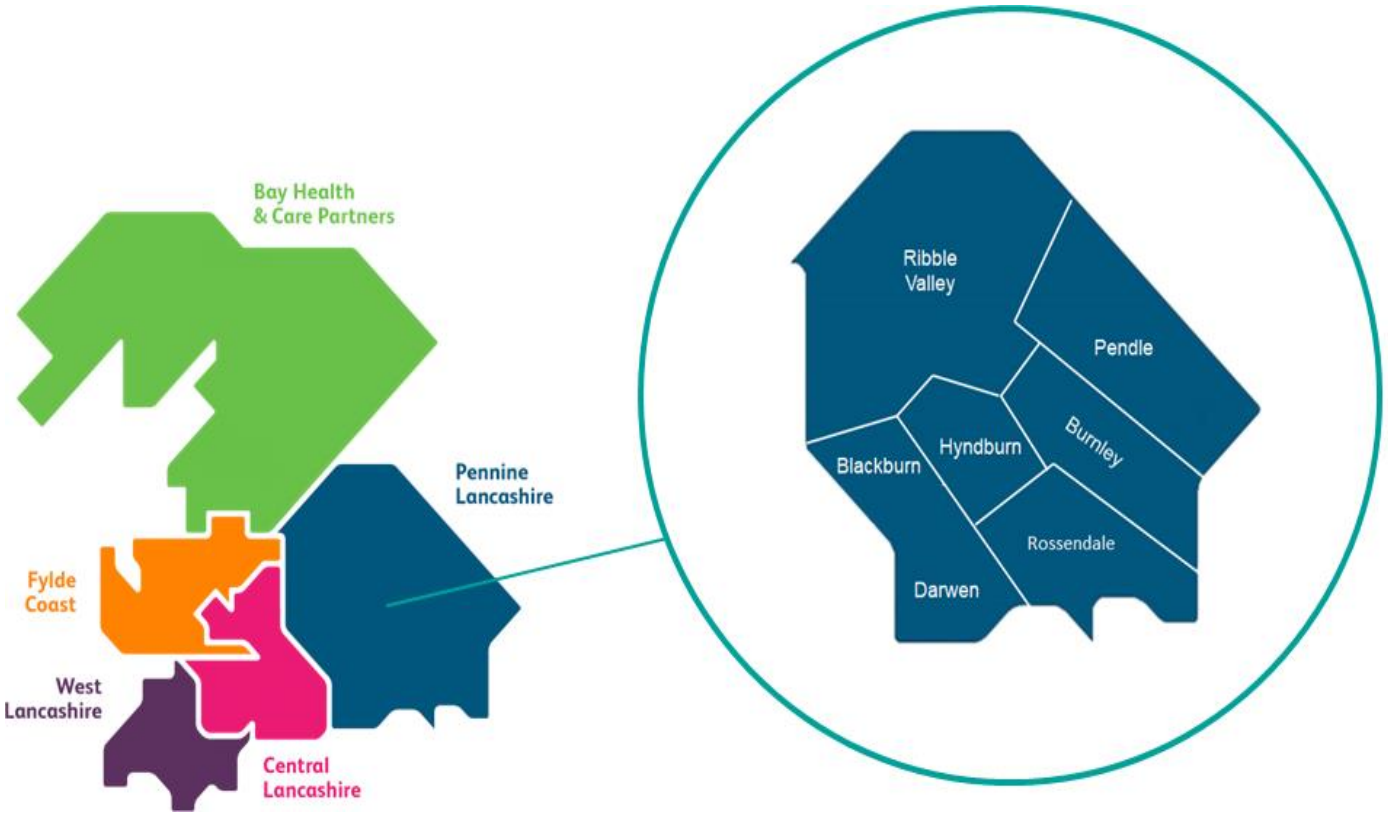
Health and Care System Reform – What we know



While legislation can help to create the right conditions, it will be our hard work that will make the biggest difference.

- **Integrated Care System (ICS) NHS Body serving 1.8m people** - will become a legal body and receive government funding for health services
- Accountability for the **health and wellbeing outcomes** of the population in Lancashire and South Cumbria
- **Lancashire and South Cumbria Health and Care Partnership –** brings together health, local authorities, VCFSE and other partners to address health, social care and public health
- **Health and wellbeing boards (HWBs)** will remain in place and will continue to develop the joint strategic needs assessment and joint health and wellbeing strategy, which both HWBs and the ICS will have to regard.
- **Five Place Based Partnerships (ICPs) -** between local authorities, the NHS and between providers of health and care services, incl. VCFSE these will be left to local partners to arrange
- 42 **Primary Care Networks** – most care will be delivered here. Health and care services will be built around local communities, with services responsive to local need.
- Population health approaches will increasingly be used to **improve health outcomes and reduce inequalities**.
- **Providers of health, care and support services** will increasingly collaborate at all levels of the system and different providers will collaborate at different levels

Pennine Lancashire Integrated Care Partnership



- Healthier Pennine Lancashire represents all of the health and care organisations in the Pennine Lancashire region as well as local councils and the voluntary, community and faith and social sector
- We have worked together for many years with a focus on improving care and support for the people that live here
- Our population across Pennine Lancashire is 531,000 and we have the largest population of all the Lancashire and South Cumbria ICPs
- We have 13 Primary Care Networks (PCNs) serving 30-50,000 people encompassing 76 GP practices
- Our workforce includes anyone who plays a role in the health and care sector including clinicians, nurses, social services, community services, regulated care and volunteers.

Pennine Lancashire Integrated Care Partnership – Our purpose

In February 2021 the Government published a White Paper outlining how the NHS in England needs to change to enable health and care to work more closely together. It has long been our aspiration to improve the way services work together and to be excellent partners to each other, but bureaucracy has sometimes got in the way. The reforms therefore support our local ambitions by removing some of the current legal rules that can get in the way of joined up working.

The reforms outline the need for Place Based Partnerships to be established in local areas, to coordinate care for up to 500,000 people who live there. In Lancashire and South Cumbria we call these Integrated Care Partnerships.

Collectively, we have agreed that the common purpose of our Integrated Care Partnerships (ICPs) is to be a collaboration of people who plan and provide services across health, local authority and the wider community, who take collective responsibility for improving the health and wellbeing of residents within their place.

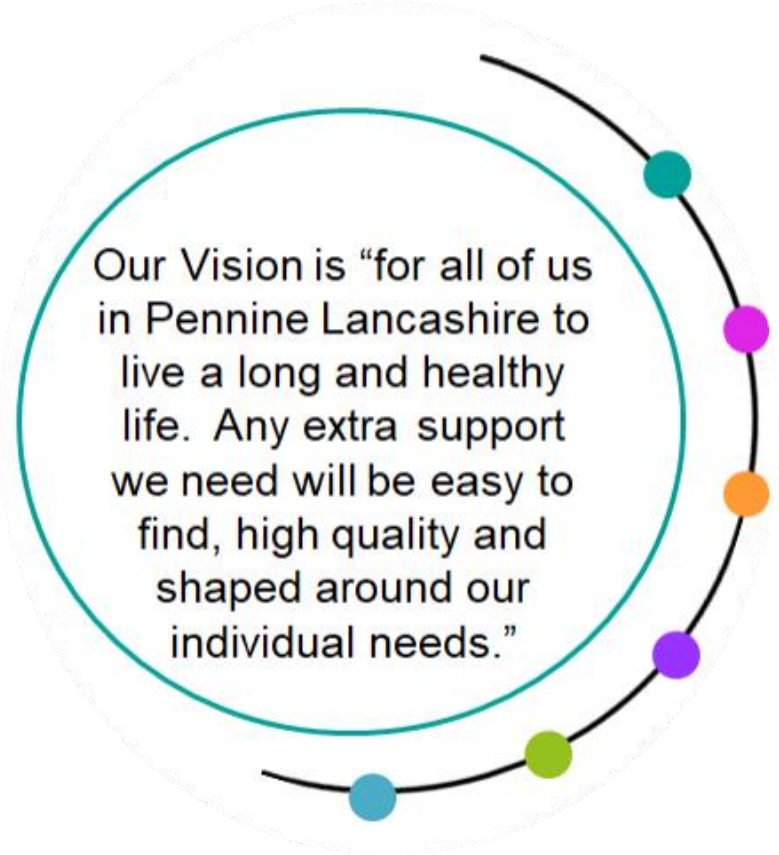
In Pennine Lancashire our ICP will oversee all age service provision and all partners will work together to simplify and modernise care and implement service models which deliver improved outcomes.

It is our ambition to ensure that our residents are co-partners in the continued evolution of ICPs, and that social movements in communities can increase people's ownership of their own health and wellbeing and mobilise communities to support each other.

The services and partners who work within our ICP include:

- Public health and wider community development
- Community-based wellbeing support, incl. social prescribing activities, VCFSE provision and local access to green spaces, and leisure facilities
- GP and wider primary care, delivered through PCNs
- Community health care and mental health care (including learning disabilities)
- Urgent and emergency care physical and mental (noting some emergency services will be provided in a networked model across ICS, e.g. trauma)
- Services providing ongoing management of long-term conditions, incl. use of skills, expertise and resources historically been accessed via referral to acute care services
- Local acute hospital services (some hospital based services will be provided in a networked model across Lancashire and South Cumbria, and there will be some specialist tertiary services provided in a single place for the whole population of Lancashire & South Cumbria)
- Social care, education, housing, employment and training support
- The wider care sector within the place

Our Vision



Our Vision was developed through discussions with our residents and our workforce and reflects what they told us they wanted care and support to be like in the future.

What our vision means for local people and their families

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.

What our ICP will do

Within our Integrated Care Partnership we will continue to work together so that services will be predominantly focused on improving health and wellbeing through a population health management approach which will include promoting self-care, preventative action, vulnerability reduction, anticipatory care, community-based models of care and support, long term condition management using digital technology, and addressing the wider determinants of health and wellbeing with clinicians and professional groups working at the top of their licence to support complex care in the community.

We will ensure that our service offers are outcome focused and delivered flexibly to meet the needs of our residents in a way that avoids duplication of support offers.

Through working together we aim to:

- Improve the health and wellbeing of the population and reduce inequalities
- Provide consistent, high quality services that remove unwarranted variation in outcomes
- Consistently achieve national standards / targets across the sectors within the partnership
- Maximise the use of our Pennine Lancashire financial allocation and resource

Together we will plan and deliver care and support for people of all ages, which will include:

- Joining up of civic and community assets, providing whole partnership support for residents, which will include housing, Department for Work and Pensions, voluntary sector support and access to community assets to support people to maintain their independence.
- Primary, community, acute, mental health and social care working as self-directed teams across organisational boundaries, to deliver services to 30-50k populations, driven by data, mobilising prevention and anticipatory care. Our Primary Care Networks will be at the core of these teams.
- Aiming to support people who suffer from long term conditions, to remain within their own home for as long as possible, by ensuring that the focus of any specialist/consultant led support is on holistic continuous condition and exacerbation management
- More intensive community support when required to keep people at home, including at times of crisis
- Providing timely and appropriate access to planned care and urgent and emergency care, including physical and mental health

The transitional structure of our Place Based Delivery Collaborative has been agreed as below, it is noted that this will be iterative and that we will revise as we need to over the next six to twelve months

Healthier Pennine Lancashire

Place Based Partnership Board

Agrees high level, shared ambitions for place

Confirms the place-based budget and provides shared oversight of the Pennine Pound

Ensures a focus on population health and outcomes

Ensures mutual accountability for delivery

Empowers the collaborative to deliver

Population Health

Informs on priorities for health outcomes, inequalities and improvement

Oversees delivery of strategic actions to improve outcomes and address inequalities

Role and remit to be developed

PCNs with District Partnerships

Networks with primary care and other providers

Enabling greater provision of proactive, personalised, coordinated and more integrated health and social care for their population

District partnerships wrap LAs, VCFSE and others around PCNs, to address district priorities holistically

Collaborative Workstreams

Primary, Community & Social Care

Intermediate Care

Urgent & Emergency Care

Restoration & Recovery

Mental Health

Learning Disabilities & Autism

Care System

Children & Maternity

Clinical, Professional & Civic Leadership

Full engagement and system leadership. Connectivity between neighbourhoods, place and ICS

Role and remit to be developed

Supporting functions

A People Board to oversee workforce development and redesign

Collaborative working around estates, business intelligence and digital solutions

Our ICP delivery arrangements will involve all key stakeholders and as a minimum will include:

- ***Public health & wider community development***
- ***Local authorities***
- ***VCFSE & Healthwatch***
- ***General practice***
- ***Community health care incl. mental health***
- ***Social care***
- ***Urgent and emergency care services***
- ***Local acute hospital***
- ***CCG leaders will remain throughout the transition***

Legal Framework

How we make decisions, share resources/pool budgets and ensure accountability (to be developed prior to end of March 2022). Assurance likely through a Quality & Safeguarding & Finance and Performance Committee

Communication, engagement & co-design

Staff, stakeholders, residents and communities

Organisational Development

Behaviours, culture and ways of working

Leadership for mobilisation

Nominated leads to oversee and coordinate the mobilisation of the ICP and its component parts, including an interim senior leader for place. (NB these will not be substantive roles and not part of any formal leadership structures that will be implemented to support the new ways of working and/or new organisational structures that are outlined in the White Paper (all of which are subject to legislation).

Leadership for development

National legislation and guidance is expected to confirm formal leadership roles for our place based partnership and these roles will be subject to full and open recruitment processes.

Whilst we wait for this guidance, it is important that we have people working together to oversee the continued development of our collaborative working arrangements. As such, over the next two months, we will be working to establish clear leadership for our collaborative delivery.

The ICP Chairs and Chief Officers Group will take on the role of the **ICP Senior Leadership Team –** to take collective responsibility for developing our collaborative arrangements.

We will also work to establish a Leadership Triad for each of our agreed collaborative delivery workstreams, which will ensure there is chief officer level sponsorship, along with clinical/professional and executive level leadership

These are not “new jobs”, but instead people will take on these responsibilities on behalf of the ICP, in addition to the responsibilities they already have to their organisations. Where such arrangements already exist for a workstream, these arrangements will continue.

Delivering on our development

Over the next 3-6 months we will:

- Conduct further engagement on our governance and delivery and identify any additional changes
- Begin to mobilise our new arrangements, particularly working with the agreed collaborative delivery workstreams to identify key delivery priorities for the remainder of 2021-22 and bring forward workstream plans
- Confirm our clinical and professional leadership model
- Agree the role and remit of our Population Health Board
- Begin delivery against our agreed development priorities to in order to test new ways of working and develop a greater understanding of the changes we need to make to support collaborative delivery
- Work to communicate with and engage our key stakeholders and workforce, planning in greater detail for resident engagement towards the latter part of the year.
- Work collaboratively with the other ICPs in Lancashire and South Cumbria to identify frameworks for finance, decision making, accountability and clinical/professional leadership

Most importantly, in doing all of this, we will continue to work together to respond to the on-going impacts of Covid-19, address inequalities and deliver an integrated service offer for all of our residents

Appendix

Roles and Functions

Place Based Partnership Board - functions

The Place Partnership Board is likely to oversee budget delegated from NHS Lancashire and South Cumbria. It could also have other budgets directly aligned to it from local organisations.

Ultimately it is likely that the Partnership Board, with the Place Leader, would delegate spend to the place based delivery collaborative and ensure accountability for delivery against requirements. This delegation could be to the delivery collaborative as a whole, or it could be to a thematic delivery collaborative. As such transparent and robust, yet effective, governance will be required in order to ensure all partners are able to influence decisions.
The Partnership Board will have representation from all local partners and an appropriate balance of executives / officers, clinicians / professionals, non-executives and elected members.

The role and functions of the Board will evolve during 2021/22 as we further understand the future financial flows, subsequent required delegations and the evolution of commissioning reform. Within this evolution it will be important to ensure transparency of prioritisation, accountability for delivery and avoid overly complex or duplicative commissioning arrangements.

The role of ICP Partnership Board in 2021/22 will be fulfilled by the current Partnership Leaders' Forum in the interim period. This will be reviewed again in quarter 3 to ensure this remains fit for purpose in 2022/23.

Population Health and Reducing Inequalities

Healthier Pennine Lancashire

Population Health Board

Informs on priorities for health outcomes, inequalities and improvement.

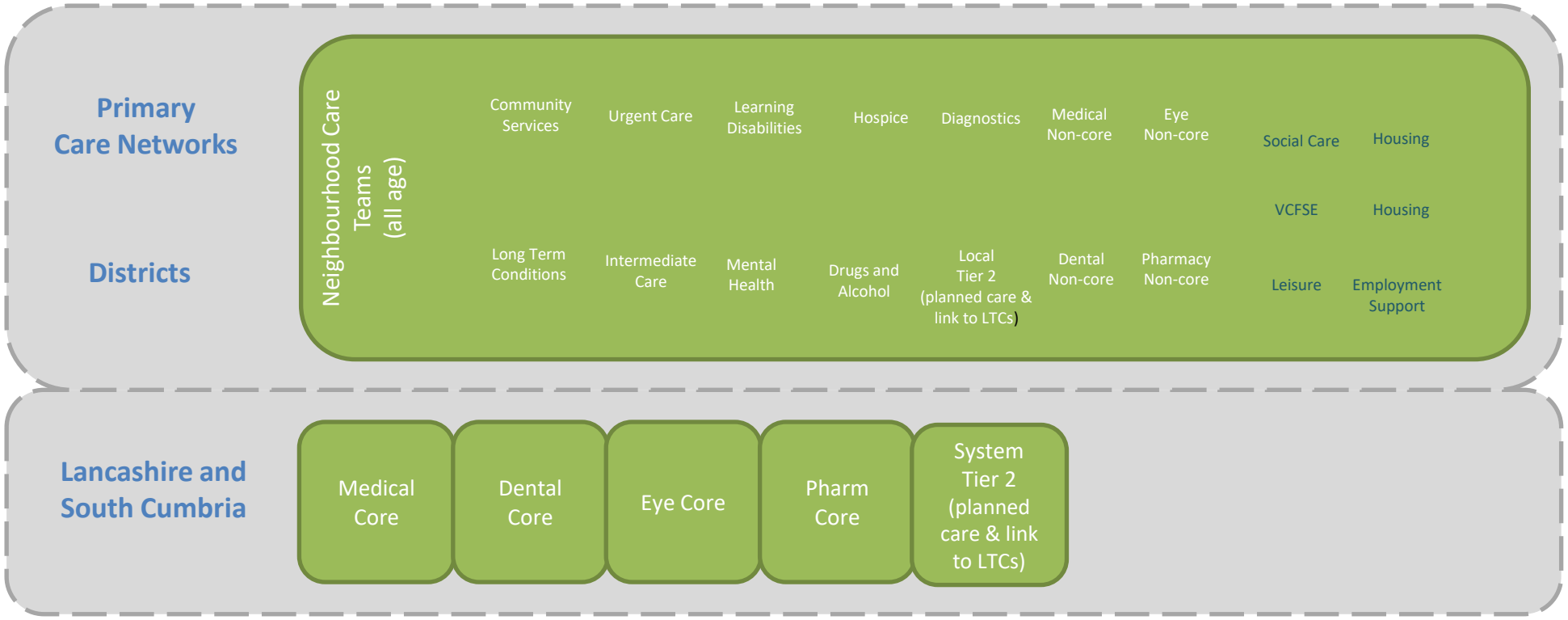
Oversees delivery of strategic actions to improve outcomes and address inequalities.

Influences and learns from the collaborative delivery workstreams to ensure best impact on outcomes and inequalities.

The full role, remit and scope of this Board is currently being developed.

Primary Care Networks and Neighbourhood Care Teams

Primary Care Networks enable greater provision of proactive, personalised, coordinated and more integrated health and social care for their population. The outline below identifies current thinking on the scope of neighbourhood care teams by the ICS Primary Care Sub Cell, alongside our own ambitions for wider service inclusion from our local authorities and other partners.



Our neighbourhood accelerator pilots are currently testing out new ways of joint working to wrap care around local people who are in greatest need.

The learning from these pathfinders can help shape our model.

Our ambitions for District partnerships

- Build on the partnership working that has flourished between our local authorities, VCFSE and PCNs through the COVID response
- Develop and deliver partnership plans that take account of local needs and assets, based on local council geography which is more readily understood by residents
- Create a shared community and partner owned vision of the future state for each area, which aims to align local ambitions with those of the ICP and ICS – critically engages local politicians in creating this
- Align short term operational delivery with longer term transformation plans
- Recognise and build on existing local district and community plans, assets and initiatives
- Re-define the relationship between the community and partners, supporting genuine community engagement and local calls to action, which are best coordinated by local authorities and VCFSE

The evolution of our district partnerships will be iterative and will be informed and guided by close engagement with our district councils.

Healthier Pennine Lancashire

Functions

- Takes a localised approach to population health management and reducing inequalities, engaging all partners relevant to that district
- Agrees priorities based on local needs, assets and inequalities
- Holds a delegated and capitated budget devolved from ICP (for population health in the first instance)
- Joins up civic and community assets, providing partnership MDTs which will likely include housing, Department for Work and Pensions, voluntary sector support and access to community assets to support people to maintain independence
- Supports PCNs to deliver the agreed operating model for out of hospital health, care and wellbeing
- Implements agreed Pennine Lancashire delivery plans and enacts 'top down' requirements, tailored to the relevant local populations e.g. extra care, economic developments, UTCs
- Manages local community engagement work and call to action.
- Develops and delivers local partnership plans that aim address the wider determinants of health
- Work to strengthen and empower local community assets
- Delivers community development initiatives
- Monitors delivery against plan, unblocking where needed
- Provides assurance on delivery and outcomes to Place Based Delivery Board and local constituents

Place Based Delivery Collaborative – functions

Functions
• Brings together health, local authority and VCFSE providers, alongside commissioners to undertake collaborative strategy, planning and transformative delivery
• Sets overall strategy (3-5 year) and annual business plan for place based delivery and coordinates delivery against this
• Determines how local services should be organised and delivered to achieve best value and improved outcomes – maximising the collective skills of providers within the place
• Involves all providers required to deliver the agreed service provision and create the conditions for effective neighbourhood working
• Leads on public and patient engagement and communications strategy
• Focused on delivering population health improvement and person-centred care, overseeing a delegated Population Health Budget
• Reviews investment/disinvestment cases
• Develops and delivers system wide savings/efficiency programme
• Enacts agreed risk share mechanisms (potentially developed at ICS level)
• Delivers against the agreed integrated quality assurance approach
• Identifies and delivers against system quality improvement priorities, deploying the ICP improvement approach to achieve them
• Develops its social value strategy and delivers this to contribute to wider economic recovery

Our priority workstreams

Healthier Pennine Lancashire

The workstreams identified here reflect our key priorities for collaborative strategy, planning and transformative delivery between providers and place teams (i.e. retained CCG resource in place) to deliver the agreed service model.

These workstreams will be focused around addressing challenges / driving improvements that can only be achieved by integrated working.

Each workstream will also clearly identify actions they will take to improve health outcomes and reduce inequalities.

Accountability for delivery will be through the ICP Partnership Board (Partnership Leaders' Forum).

Pennine Lancashire Integrated Care Partnership

Partnership Agreement 2021-2022

1. Purpose of the Partnership Agreement

The purpose of the Partnership Agreement is to:

- Strengthen collaborative relationships and understanding between decision makers and partners
- Enable and encourage the development of better integration across local health, wellbeing and care systems in Pennine Lancashire, helping to improve quality and financial efficiency
- Enable a system that is robust in its delivery of population health approaches that support long term well-being for the population and help to delivery greater financial sustainability
- Take advantage of all interdependencies and opportunities offered through greater collaborative and partnership working to drive a life-long learning and development, culture and economic improvement
- Enable decision making to take place as close to the citizen or neighbourhood community as possible.

2. Key aims of our Integrated Care Partnership

The key aims of a place-based partnership are:

- Improve the health and wellbeing of the population and reduce inequalities
- Provide consistent, high quality services that remove unwarranted variation in outcomes
- Consistently achieve national standards / targets across the sectors within the partnership
- Maximise the use of a place-based financial allocation and resources and help the NHS to support broader social and economic development.

3. Our partners

The partners within our Integrated Care Partnership are:

- Blackburn with Darwen Borough Council
- Blackburn with Darwen Clinical Commissioning Group
- The District Councils of Pennine Lancashire - Burnley, Hyndburn, Pendle, Ribble Valley, Rossendale
- East Lancashire Clinical Commissioning Groups
- East Lancashire Hospitals NHS Trust
- Healthwatch Together, as represented by Blackburn with Darwen Healthwatch
- Lancashire County Council
- Lancashire and South Cumbria Foundation Trust
- The Pennine Lancashire Primary Care Networks
- The Pennine Lancashire Voluntary, Community, Faith and Social Enterprise Sector

4. Our principles of working together

4.1. Put our residents at the heart of what we do

We will…

- Create a sense of belonging to a place, working on behalf of residents rather than organisations
- Engage with, and work alongside communities to understand and address what matters most to them
- Increase our engagement with residents to create a greater sense of local accountability
- Collaboratively design new cost-effective health and social care processes that place people at the centre, improve the quality of service provision and improve outcomes for individuals and communities
- Make decisions as close as possible to the place where the impact of that decision will be felt
- Put the needs of our residents before the individual interests of professionals and organisations.

4.2. Address inequalities

We will…

- Ensure that we understand, acknowledge and address inequalities for individuals and communities across all aspects of health and care
- Ensure that our collaborative delivery has a clear focus on reducing health inequalities and improving population health
- Ensure that we understand and address our role in the social and economic development of our place and use this to address inequalities for individuals and communities.

4.3. Be good partners to each other

We will…

- Treat all partners with parity of esteem and respect the voice of all partners
- Work together, have joined up conversations and influence wider leadership (across organisations, neighbourhoods, other places and the system) on future ways of working
- Ensure collective decision making, transparency and a culture of co-production
- Where decision-making is not collective, each organisation will be mindful of the impact of its decisions on other partners and will involve partners in consideration of options, impact assessments, etc
- Adopt an open-door policy across organisational committees / groups.

4.4. Adhere to our agreements and hold each other to account

We will…

- Be clear on our individual and collective roles in delivery of actions to achieve the key aims
- Ensure that we have a clear understanding of risks and impact assessments

- Spend within our means and ensure that investment decisions are values-based and transformative.

4.5. Distributed leadership model

We will…

- Ensure that our leadership demonstrates a real sense of purpose for the place
- Create a leadership model that is collaborative, distributed and democratic, creating equity of voice from all partners and engendering high levels of trust
- Ensure we have the right people with the right skills and abilities, undertaking the right work to benefit our communities.

4.6. Recognise our role in the wider Lancashire and South Cumbria system

We will…

- Be active members of our Lancashire and South Cumbria health and care system, recognising that we are all members of our health and care partnership with common aims
- Understand that our Lancashire and South Cumbria system will only be successful when all partners are successful – we will support all organisations and partnerships to be the best that they can be.

5. The behaviours and values we expect to see from each other

We will…

- Act with honesty, integrity and authenticity and trust each other to do the same
- Be compassionate leaders, willing to listen and understand different perspectives
- Foster a reflective and learning culture
- Be ambitious and bold, encouraging risk-taking and experimentation within the confines of clinical and professional safety
- Have a ‘can do’ approach, focusing on opportunities and possibilities rather than barriers or difficulties
- Be an inclusive team, ensuring that we respect the opinions of all our partners and the needs of our diverse workforce and local population
- Challenge constructively when we need to do so
- Lead by example, adhering to behaviours that are reflective of our commitment to collaborative working, and encouraging these behaviours in our wider workforce.

6. Our commitments to each other

We will…

- Put time, energy and focus into developing our partnership and delivering service improvements through collaboration
- Shift our collective focus from episodic treatment of illness / disease to long-term prevention, wellness and wellbeing
- Work as a team, respecting and recognising each other’s experience, knowledge and skills and strengths, whilst supporting appropriate development opportunities for individual members and the partnership as a whole

- Develop and use a common language and support the use of plain English, avoiding the use of jargon, acronyms and other terms that are profession or organisation specific.

7. How partners will come together to do this

The Pennine Lancashire Partnership Leaders' Forum (PLF) will act as our place-based partnership board setting strategic direction, agreeing priorities and coordinating collaborative planning and delivery for Pennine Lancashire's health, social care and wellbeing services. The PLF will oversee the progress of delivery and ensure that partners hold each other mutually accountable for the implementation of the agreed ICP Delivery Plan and the continued development of the ICP.

The Pennine Lancashire Partnership Leaders' Forum will have appropriate representation from partners, with members who are able to represent the views of their organisations/sectors and who take responsibility for cascading messaging in and out of their organisations / sectors.

It is anticipated that formal delegation for decision making within ICPs will be developed and agreed during the course of 2021-22 and at which point more formal agreements will be put in place. Until formal agreements are in place, the PLF recognises that individual organisational Boards and Governing Bodies retain statutory status (where applicable) and existing accountability. The PLF will, therefore, be a forum where partners will agree recommendations to statutory organisations, for those matters that require financial, service or workforce changes that are essential for the furthering of the aims and the vision of the ICP as outlined within this Agreement.

The ICP will work with organisational bodies to identify opportunities for joint decision making processes to be delegated to ICP groups, to enable programmes to progress at pace and facilitate the delivery of the agreed ICP plan and further develop the arrangements for integrating care.

We will have formal place-based groups that have responsibility for planning and delivering an integrated approach to:

- Population health
- Primary care and community-based services delivered in neighbourhoods, including long-term condition management and social care
- Urgent and emergency care (via an A&E Delivery Board)
- Workforce / People (via a People Board)
- Improving quality
- Children and Maternity
- Intermediate Care
- Restoration and Recovery
- Care Sector (including regulated care and wider care)
- Mental Health
- Learning Disabilities and Autism

We will adopt an open-door policy within our Partnership. As outlined above, we now have many collaborative system forums in which we share ideas, information and data. We will expand on this partnership approach by welcoming all of our partners to attend organisational committees which are currently held in public, in line with existing individual

organisational administrative arrangements. For those meetings not held in public, this request will be considered through a conversation with the Chair of the committee in the spirit of openness and transparency.

Functional support

We will have agile and responsive functional support from our Pennine Lancashire Business Intelligence Leadership Team and our network of estates leads and digital leads. These teams/networks will act in an advisory capacity and influence the development of change proposals with intelligence and latest national requirements and developments, in order to ensure robust, viable delivery plans are developed. Should formal groups/meetings need to be established to support collaborative planning and delivery, then proposals for establishing these groups will be agreed with the Partnership Leaders' Forum.

Relationship to Primary Care Networks (PCNs)

It is intended that the ICP and its agreed sub-groups will work closely with and deliver through, the thirteen PCNs in Pennine Lancashire. As such, this Partnership Agreement is not intended to preclude or supersede the requirements on PCNs, which are agreed through the PCN Network Contract DES Specification for 2021/22 and any locally defined Supplementary Network Services.

It is envisaged that furthering the development of the ICP will support the PCNs and particularly the PCN Clinical Directors to fulfil some of the requirements of the Network Contract, by providing an environment where collaborative, multi-organisational delivery, can be planned, influenced and coordinated.

8. How we will manage areas of conflict that require resolution

Partners will attempt to resolve in good faith any dispute between them in respect of Partnership Board (or other Partnership-related) decisions, in line with the Principles, Values and Behaviours as set out in the Partnership Agreement.

Where necessary, place or sector-based arrangements will be used to resolve any disputes which cannot be dealt with directly between individual Partners.

The Partnership may need to apply a dispute resolution process to resolve any issues which cannot otherwise be agreed through these arrangements; any such process should be convened and overseen by the partnership Chair.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 114

8 September 2021

Purpose Information

Title	Finance and Performance Committee Update Report
Author	Mr M Pugh, Corporate Governance Officer
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 4 August 2021.

Recommendation: The Board is asked to note the content of the report.

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Finance and Performance Committee Update

At the meeting of the Finance and Performance Committee held on 4 August 2021 members considered the following matters:

1. The Committee received a presentation on the Community Services Transformation Programme. Members noted that this is a wider reaching project with strong links to system partners. Highlights included the Urgent Care response, with the aim to deliver a 2 hour response in the community to prevent admissions. In addition, the Ageing Well programme was discussed, along with the COVID virtual ward model, work with care homes, the frailty pathway and challenges involved with providing these services through one single point of access whilst ensuring there is an equitable service offer across Blackburn with Darwen and East Lancashire.
2. The Committee received a presentation on the Model Hospital Programme, including Patient Level Information and Costing System (PLICS) data and Get It Right First Time (GIRFT). Members noted that a group has been formed that covers all three benchmarking systems and to provide assurance to the Committee. It was noted that the data generated will be used to drive efficiencies and show where process are being used that provides no benefit to the Trust.
3. Members received the financial performance report for the month 3 financial position. Members noted the month 3 position was aiming to reach breakeven for the end of H1, and at present, was showing a £500,000 surplus at Q1 and in line with plan. It was noted that there is confidence that the H1 financial plan will be met. They noted that the Trust cash balance was £42 million and there is a focus on paying all invoices within 30 days and meeting the 95% target for the Better Payment Plan (BPP). Members noted that the Waste Reduction Plan (WRP) for month 3 had met the plan, although not all targets had been met by the divisions. It was noted that bids had been submitted and approved for new emergency generators and an oxygen back up system and that the capital plan is tight but is being monitored closely.
4. The members received the Quarterly Workforce Update, noting that the Pathology staff who had been striking returned to work on 28 July and a lot of support had been provided to ensure a smooth transition back to work. It was noted that a further ballot had been issued which could lead to more strike action. Furthermore, the current support from Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) was to be kept in place to allow staff to take annual leave and have respite. Members were

advised that two themes had arisen from the People Strategy. The first, Recruitment and Retention, showed that the temporary ban on international recruitment had been lifted and the Trust was on track to hire 92 whole time equivalent nursing and medical staff by April 2022. The second theme was on Leadership Organisational Development and Talent, noting that the Trust appraisal process had been restarted with a focus on health and wellbeing conversations. As part of the appraisal, a new talent management tool was being used to help identify those staff that are ready for progression or may need support.

5. The Committee received the Integrated Performance Report, noting that the Trust continued to receive an exceptional number of patients attending A&E. Members noted that there had been some issues with transferring people between sites due to pressure experienced by the North West Ambulance Service (NWAS). It was noted that Trust was working to achieve the 120% Accelerator target as part of the restoration plans, however, since the change to lockdown rules, patients were no longer wanting to isolate prior to surgery and instead, taking part in other activities. Members noted that with the exception of Outpatient restoration, the Trust was performing better than the national average.
6. The members were updated on the Corporate Risk Register, noting that the Paediatric High Dependency Unit (HDU) was not currently funded and with an expected Respiratory Syncytial Virus (RSV) surge, the Trust was planning to be prepared. Members noted that patients were regularly transferred from Greater Manchester due to insufficient capacity there and the Trust is working to enable this vital service could be fully funded in the future.
7. In the interest of time, the item on the Trust's Private Finance Initiative (PFI) partners was deferred to be discussed at the next meeting.
8. As part of Any Other Business, a brief update was provided on the current arrangement with PWE Healthcare.

Martyn Pugh, Corporate Governance Officer, 8 September 2021

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 115

8 September 2021

Purpose Information

Title	Quality Committee Information Report
Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mrs P Anderson, Committee Chair

Summary: The report sets out the summary of the papers considered and discussions held at the Quality Committee meetings held on 28 July 2021.

Recommendation: The Board is asked to note the report.

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Quality Committee Update

At the meeting of the Quality Committee held on 28 July 2021 members considered the following matters:

1. Members received an update on the transmission rates of COVID-19 in the local community and the numbers of COVID positive patients being treated in the Trust. Members noted that the number of patient attendances in the Trust's Emergency Department remained high and that there had been a surge paediatric attendances due both to the spread of the Delta variant of COVID-19 and more cases of Respiratory Syncytial Virus (RSV).
2. The Committee received an update on a number of developments and innovations taking place in the Trust's Community Services. Members noted that a significant amount of activity was taking place with care homes and partner organisations to improve the health of the local population whilst also reducing the reliance on healthcare services.
3. The Committee received an update from the Trust's Infection Prevention and Control (IPC) team. Members noted that several new cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) had been identified since the previous meeting but that the Trust was performing well in relation to nosocomial infections.
4. Committee members received an update on clinical effectiveness matters. Members noted that an additional Never Event had now been reported since the previous meeting but were informed that three were likely to be stood down at a later date following discussions with Clinical Commissioning Groups. It was also noted that other activity was taking place to improve meal delivery times on wards and assess the nutritional needs of patients more effectively.
5. Members noted that mortality performance continued to be closely monitored through the Trusts Mortality Steering Group. The Committee was also informed that the process for the review of nosocomial COVID-19 deaths in the Trust was currently being formalised and that further updates would be provided at a later date.
6. An update was provided on progress made with the Trust's Medical Examiner service. Members noted that the role of the Medical Examiners was due to be expanded over the coming months to start reviewing deaths that occurred outside of a hospital setting.
7. The Committee received an update on the ongoing CQC transitional monitoring process and that a recent review of the Trust's Urgent and Emergency Care cire

service had been positive. Members were informed that the next area to be reviewed would be the Trust's maternity services.

8. Members received an update on the Trust's Nursing Assessment Performance Framework (NAPF) measure. It was noted that a number of areas had fallen below expected levels in June 2021 and that a revamp of relevant documentation and the audit process had taken place to address this.

9. The Committee received an update on the activity taking place within the Trust's maternity services. It was confirmed that all ten safety actions in relation to the Clinical Negligence Scheme for Trusts (CNST) had been successfully submitted and members noted that a significant amount of work was taking place to prepare for the review of the service by the CQC the following month.

Dan Byrne, Corporate Governance Officer, 01 September 2021

East Lancashire Hospitals NHS Trust
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TRUST BOARD REPORT

Item 116

8 September 2021

Purpose Information

Title	Audit Committee Information Report
Author	Mr M Pugh, Corporate Governance Officer
Executive sponsor	Mr R Smyth, Non-Executive Director, Committee Chair

Summary: The report sets out the matters discussed and decisions made at the Audit Committee meeting held on 16 August 2021.

Recommendation: The Board is asked to note the content of the report.

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Audit Committee Update

At the meeting of the Audit Committee held on 16 August 2021 members considered the following matters:

1. The Committee received the Management Response to Translation Services, noting that since the previous report which highlighted the poor service, lack of controls and increase in costs, and as a result of the COVID pandemic, the translation service was now provided virtually via one provider. It was noted that there had been some increase in costs due to the temporary halt of visitors to the Trust and the service will be monitored through the Financial Assurance Board.
2. Members received the Internal Audit Progress Report, noting that during April – June 2021, any outstanding work from the previous financial year was completed. It was noted that the 2021/22 audits were underway, with Duty of Candour completed and work continuing with the Waiver audit. Permission was granted to defer the Conflicts of Interest review and the SIRI review until Q3 due to current operational activities.
3. Members received the Consultant Job Planning Update, noting that since the issues were raised in the Mersey Internal Audit Agency (MIAA) report, work had progressed to rectify these and a job planning policy has been agreed and is in the process of being ratified and used. Members noted the significant progress made and asked for a further update to be provided at the January 2022 meeting.
4. Members received a verbal update on sustainability, noting that there has been a number of discussions with the Executive team on how to take this forward and an overall strategy is being developed, commencing with the Clinical Strategy and how to get things right the first time for patients so they do not need to come back to the Trust. It was noted that the Lancashire Procurement Cluster is looking to use local suppliers and reduce single use plastics where possible and the PFI partners are also using local suppliers when they can. Members noted that the Trust is looking to reduce the carbon footprint further by investing in its workforce, increasing the use of electric vehicles and by using local suppliers and seasonal items for food and nutrition. Furthermore, a number of staff had identified that significant recycling does not take place and this will be a key focus in the future. Members requested the Sustainability Update to become a standing item on the agenda to ensure that the progress can be tracked.
5. Members received the External Audit Progress Report, noting that since the previous meeting, the signed accounts had been submitted and the oversight framework for 2021/22 had been published.

6. Members received the Anti-Fraud Service Progress Report and noted the progress being made in relation to referrals and investigations. In addition, members were informed about 3 recent fraud notices that had been circulated to the Trust and that 2 assurances exercises commenced on 21 June. The first looking at purchase order vs non-purchase order spend and the second to look at COVID PAYE spend. It was noted that the deadline for these exercise is 21 August.
7. Members were provided a copy of the Waivers Report. It was noted that MIAA will be undertaking a review on the waiver process to provide assurance.
8. Committee members commented that the Board Assurance Framework is due to be formally reviewed in due course and proposed discussing this further at the next meeting.
9. A presentation on the Declaration of Interests Register was provided. Members were informed that during the COVID pandemic, operational activities was prioritised and although some reminders to submit declarations were sent, on the whole, chasing of declarations was suspended. Members noted that during the 2021/22 financial year this work will be picked up, with all previous plans brought forward to improve the compliance rate.
10. A review of the effectiveness of the meeting was held. Members felt that significant assurance was offered and that the Audit Committee was both supportive and challenging in equal measures.
11. Committee members also received copies of the minutes from the Quality Committee and the Finance and Performance Committee.

Martyn Pugh, Corporate Governance Officer, 8 September 2021

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 117

8 September 2021

Purpose Information

Title	Trust Charitable Funds Committee Information Report
Author	Mr D Byrne, Corporate Governance Officer
Executive sponsor	Mr S Barnes, Non-Executive Director

Summary: The report sets out the matters discussed and decisions made at the Trust Charitable Funds Committee meetings held on 4 August 2021.

Recommendation: The Board is asked to note the content of the report.

Report linkages

Related strategic aim and corporate objective	NA
Related to key risks identified on assurance framework	NA

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

(117) Trust Charitable Funds Committee Information Report

Trust Charitable Funds Committee Update

At the meeting of the Trust Charitable Funds Committee held on 4 August 2021 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.

1. The Committee received an update on the progress made with a proposed transfer of funds from the Mackenzie Medical Centre charity. Members confirmed that they were content for the funds to be transferred to two restricted funds which would be overseen by the Trust's Deputy Director of Education, Julia Owen.
2. Members were updated on recent applications to use funds requests and the overall performance of the charitable funds.
3. An update on the recent activities of the ELHT&me Charity Manager was presented to members. It was confirmed that discussions were ongoing with the EG Group regarding potential funding for a number of the Trust's activities and that the digital fundraiser post discussed at previous meetings had now been successfully recruited to.
4. The Committee received an update on a proposed Charity Hub that would be based at the main entrance of the Royal Blackburn Teaching Hospital (RBTH) site. Members noted that this would provide a number of opportunities to expand the Charity's presence throughout the Trust and that work was taking place to develop products and merchandise to be sold there.
5. An update on the options available for the funding of the Trust's surgical robots was provided to the Committee. Members supported the proposal for funding to be provided using the balance available in the Alan Shorrock Legacy for medical equipment and for the remaining amount required to be 'top sliced' from all other unrestricted charitable funds.
6. Members were updated on the progress made with the previously proposed changes to the Trust's staff lottery funds. It was agreed that further discussions would need to take place outside of the Committee and that a full update would be provided at the next meeting.

Dan Byrne, Corporate Governance Officer, 01 September 2021.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 118

8 September 2021

Purpose Information

Title	Trust Board Part Two Information Report
Author	Miss K Ingham, Head of Corporate Governance
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 14 July 2021.

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Trust Board Part Two Information Report

1. At the meeting of the Trust Board on 14 July 2021, the following matters were discussed in private:
   a) Round Table Discussion: ICP/ICS Update
   b) Round Table Discussion: Provider Collaboration Update
   c) Critical Care Business Case
   d) Risk Appetite Statement Review
   e) H1 Financial Position 2021-22
   f) Planned CQC Review Update
   g) Fire Safety Update
   h) Nosocomial Infection Update Report
2. The matters discussed were private and confidential and/or identified individuals and/or were commercially sensitive at this time and so the decision was taken that these items should not be discussed in the public domain. As these items progress, reports will be presented to part 1 of Board Meetings at the appropriate time.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Item 119

8 September 2021

Purpose Information

Title	Remuneration Committee Information Report
Author	Miss K Ingham, Acting Head of Corporate Governance
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The list of matters discussed at the Remuneration Committee held on 14 July 2021 are presented for Board members' information.

Recommendation: This paper is brought to the Board for information.

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Remuneration Committee Information Report

1. At the meeting of the Remuneration Committee held on 14 July 2021 members considered the following matter:

   a) Arrangements for Interim CEO Appointment