Board of Directors

5 October 2023 | 1.00pm
Lecture Room 1, Education Centre 1, Royal Preston Hospital, Sharoe Green Lane, Fulwood, Preston, PR2 9HT

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	P White
2.	Apologies for absence	1.01pm	Verbal	Information	P White
3.	Declaration of interests	1.02pm	Verbal	Information	P White
4.	Minutes of the previous meeting held on 3 August 2023	1.03pm	✓	Decision	P White
5.	Matters arising and action log update	1.04pm	✓	Decision	P White
6.	Chair's opening remarks and report	1.05pm (5mins: Pres)	✓	Information	P White
7.	Interim Chief Executive's report	1.10pm (15mins: Q&A)	✓	Information	F Button
8.	Patient Story	1.25pm (10mins: Pres) (10mins: Q&A)	Pres	Assurance	A Tomlinson/ N Clough
9.	Board Assurance Framework	1.45pm (10mins: Disc)	✓	Decision	S Regan
10.	**CONSISTENTLY DELIVER EXCELLENT CARE** (SAFETY AND QUALITY)				
10.1	Safety and Quality Committee Chair's Report	1.55pm (10mins: Q&A)	✓	Information	K Smyth
10.2	**Report recommended for approval**: (a) Patient Safety Investigation Response Framework (PSIRF): Implementation Plan and Policy	2.05pm (10mins: Q&A)	✓	Decision	S Cullen
	Report provided for assurance: (b) Mortality Annual Report	2.15pm (10mins: Q&A)	✓	Assurance	G Skailes
10.3	Maternity and Neonatal Services report	2.25pm (10mins: Q&A)	✓	Assurance	E Ashton
10.4	Response to Letby Report	2.35pm (10mins: Q&A)	✓	Assurance	S Cullen
11.	**GREAT PLACE TO WORK** (WORKFORCE, EDUCATION AND RESEARCH)				
11.1	Education, Training and Research Committee Chair's Report	2.45pm (10mins: Q&A)	✓	Information	P O'Neill
11.2	Workforce Committee Chair's Report	2.55pm (10mins: Q&A)	✓	Information	J Whitaker
11.3	**Report recommended for approval**: (a) Appraisal, Revalidation and Medical Governance Annual Report	3.05pm (10mins: Q&A)	✓	Decision	G Skailes

№	Item	Time	Encl.	Purpose	Presenter
12.	**DELIVER VALUE FOR MONEY** (FINANCE AND PERFORMANCE)				
12.1	Finance and Performance Committee Chair's Report	3.15pm (10mins: Q&A)	✓	Information	T Watkinson
12.2	Integrated Performance Report as at 31 August 2023 including Finance update *(considered by appropriate Committees of the Board)*	3.25pm (5mins: Pres) (10mins Q&A)	✓	Assurance	I Devji
13.	**GOVERNANCE AND COMPLIANCE**				
13.1	Audit Committee Chair's Report	3.40pm (10mins: Q&A)	✓	Information	T Watkinson
13.2	Charitable Funds Committee Chair's Report	3.50pm (10mins: Q&A)	✓	Information	K Smyth
13.3	Risk Management Strategy (2023-26) and Risk Management Policy	4.00pm (10mins: Q&A)	✓	Decision	S Regan
13.4	Implementation of Kark Recommendations – Fit and Proper Persons Test (FPPT) Policy	4.10pm (5mins: Q&A)	✓	Decision	J Foote
14.	**ITEMS FOR INFORMATION**				
14.1	Data Quality Assurance Report		✓		
14.2	Date, time and venue of next meeting: *7 December 2023, 1.00pm, venue to be confirmed*	4.15pm	Verbal	Information	P White

Board of Directors

3 August 2023 | 1.00pm | Microsoft Teams

Part I

PRESENT	06/04/23	01/06/23	03/08/23	05/10/23	07/12/23	01/02/24
NON-EXECUTIVE DIRECTORS						
Professor P O'Neill *(in the Chair)*	P	P	P			
Ms V Crorken	P	P	P			
Ms A Pennell *(until 31 May 2023)*	P					
Ms K Smyth	P	P	P			
Mr T Watkinson	P**	P	P			
Mr J Whitaker	P	P	A			
Mr P White *(with effect from 1 August 2023)*			P			
Mrs T Whiteside	P	P	P			
EXECUTIVE DIRECTORS						
Ms F Button Chief Operating Officer	P	P	P			
Ms S Cullen Chief Nursing, Midwifery and AHP Officer	P	P	P			
Professor N Latham Interim Chief People Officer *(from 1 June 2023)*		P	P			
Mr K McGee Chief Executive Officer	P	P	P			
Dr G Skailes Chief Medical Officer	P	P	P			
Mrs K Swindley Chief People Officer *(until 31 May 2023)*	P					
Mr J Wood Chief Finance Officer/Deputy Chief Executive	P	P	P			
IN ATTENDANCE						
Mrs K Brewin (minutes) Associate Company Secretary	P	P	P			
Mrs A Brotherton Director of Continuous Improvement	P	P**	P			
Mr S Dobson Chief Information Officer	A	A	A			
Mr G Doherty Director of Strategy and Planning	P	P	A			
Mrs N Duggan Director of Communications and Engagement	P	P	P			
Mrs J Foote MBE Company Secretary	P	P	P			
ASSOCIATE NON-EXECUTIVE DIRECTORS						
Mr M Wearden	A	A	P			
Mr P Wilson	A	P	A			

P – present | **A** – apologies | **D** – deputy | ** part meeting

Quorum: *4 Directors and must have at least 2 Executive Directors (one to be the Chief Executive or nominee) and 2 Non-Executive Directors (one to be Chair or Vice-Chair)*

- *Professor P O'Neill was Interim Chair up to and including 31 July 2023 and chaired the August meeting*
- *Mr P White appointed permanent Chair with effect from 1 August 2023*

Governors in attendance: P Akhtar, S Barnes, S Brennan, M France, S Heywood, J Miller, F Robinson and S Sarwar

Observers in attendance: Jennifer Carroll, Sister (Surgery)/Continuous Improvement Lead
Nicola Compton, Corporate Affairs Officer
Paul Faulkner, Lancashire Post and Blackpool Gazette
Jo Lambert, Deputy Divisional Midwifery and Nursing Director
Andrea Nicol, CQC Inspector
Nicola Ross, Matron for Patient Safety
Jo Wiseman, Corporate Affairs Officer

IN ATTENDANCE TO PRESENT THE STAFF STORY (Minute ref 146/23)	
Lisa Elliott	Divisional Nursing Director of Surgery
Danielle Jackson	Ward Manager – Ribblesdale Ward
Samantha Kenny	Senior Organisational Development Practitioner

IN ATTENDANCE TO PRESENT THE BOARD ASSURANCE FRAMEWORK (Minute ref 147/23)	
Hajara Ugradar	Deputy Director of Risk and Assurance

IN ATTENDANCE TO PRESENT THE INFECTION PREVENTION CONTROL ANNUAL REPORT (Minute ref 152/23)	
Dr David Orr	Clinical Director (Immunology)/Director of Infection Prevention and Control

IN ATTENDANCE TO PRESENT THE MATERNITY AND NEONATAL SERVICES REPORT (Minute ref 154/23)	
Emma Ashton	Director of Midwifery and Neonatal Nursing

139/23 Chair and quorum

Having noted that due notice of the meeting had been given to each member and that a quorum was present the meeting was declared duly convened and constituted.

140/23 Apologies for absence

Apologies for absence were received and recorded in the attendance matrix.

141/23 Declaration of interests

There were no conflicts of interest declared by the Board in respect of the business to be transacted during the meeting.

142/23 Minutes of the previous meeting

The minutes of the meeting held on 1 June 2023 were approved as a true and accurate record.

143/23 Matters arising and action log

There was one outstanding action which would be picked up at the December Board meeting.

144/23 Chair's opening remarks and report

The Chair extended a warm welcome to Peter White who had been appointed permanent Chair with effect from 1 August 2023. Recognising the period of transition, it had been agreed that Professor P O'Neill should take the Chair for this meeting.

The report provided a summary of work and activities undertaken during June and July by the Interim Chair, and more broadly reflected on the past 12 months including the challenges faced in respect of winter, performance, and financial pressures. Thanks were extended to Board colleagues, senior management teams, staff, and governors for the support provided during the Interim Chair's tenure.

On behalf of the Board, tribute was also paid to the Chief Executive who was attending his last Board meeting before retiring from the NHS on 30 September and taking up the role of Director General of Gibraltar Health Authority on 1 October. Reference was made to his outstanding leadership, drive, and focus, both internally and externally, the way in which he had enhanced the Trust's reputation, and for being instrumental in helping to secure approval for the new hospital build.

145/23 Chief Executive's report

The report provided an update on key national, regional, and local developments and highlighted a range of messages for information. Key highlights included:

- *National headlines* – the NHS was continuing to deal with strike action and further strikes were planned during August and would continue into the autumn. Management and staff side had worked collaboratively and were commended for their support to help manage the difficult situation. A significant amount of activity had been cancelled over the past six months although the Trust was continuing to focus on elective and cancer patients to ensure waiting lists were reducing. It was noted that innovation on the cancer pathway was commendable and could feed into other pathway work nationally in terms of good practice. Reference was made to the first article on page 3 confirming the ongoing pressure on the emergency pathways and the continuing improvements around ambulance handover times. The NHS celebrated its 75th Birthday on 5 July and a range of celebratory events were held throughout the week with staff attending the Buckingham Palace Garden Party. Reference was made to the expansion of virtual wards, an important piece of work within and outside the Trust to develop support to keep patients safe in their own homes or community residences and there would be further developments going into autumn/winter. The first NHS Long Term Workforce Plan had been published mid-July which would provide a systematic approach to workforce planning. The plan provided a platform on which to move forward to train record numbers of doctors, dentists, nurses, and other healthcare staff in England. The Trust would be working with training partners across the system to identify opportunities to train and bring forward staff for the future.

- *Media and other activity* – on 29 June an ITV film crew visited to undertake an interview to celebrate the NHS 75th Birthday. The broadcaster had chosen the Trust as it had been identified nationally by NHS England to celebrate innovation and positive work that was being undertaken in the NHS and featured on both the main 6 and 10 o'clock news reports. The broadcast included a range of clinical teams and staff and focused on the great work the Trust was delivering. On 28 July the national NHS team visited to look at the Trust's work on quality improvement and quality management systems. Again, the national team identified the Trust to showcase good practice which could be disseminated throughout the country. Clinical teams were thanked for showcasing their work and the Director of Continuous Improvement and team for organising the day.

- *Chief Executive retirement and future arrangements* – the Chief Executive would be retiring from the NHS and whilst it had been a difficult decision it was felt to be the right time to hand over to someone who would be able to lead the planning, thinking and detailed work that would be required over the coming years around the new hospital build. The Chief Executive thanked colleagues and staff for their support and, in particular, commended the support and leadership provided by Professor P O'Neill during his Interim Chair role.

  In respect of a replacement, arrangements had been put in place to recruit through a rigorous competitive selection process. During the intervening period and until the new Chief Executive had taken up post, congratulations were extended to the Chief Operating Officer who would be stepping up as Interim Chief Executive from 1 October. The Chief Executive was confident leaving the Trust in safe hands and support would continue to be provided by the Deputy Chief Executive and other Executive Director colleagues until the substantive arrangements were in place. Congratulations were also extended to the new Chair and a more detailed overview of his background, skills and experience was included on pages 7 and 8 of the report.

- *Provider Collaborative Board (PCB) and Integrated Care Board (ICB)* – reference was made to the meetings of the PCB and ICB on 20 and 5 July respectively. It was emphasised that the Trust played a significant role in both spaces as the major tertiary centre for Lancashire and South Cumbria.

- *CQC Inspections* – during May, June and July the Trust had undergone an intensive inspection by the Care Quality Commission (CQC) including the emergency department, acute medicine, surgical services, maternity services, and an inspection relating to the Well Led domain of the CQC inspection framework. The draft report from the CQC was awaited although high level feedback had been provided to the Trust. In terms of areas of which to be proud, the CQC had recognised the positive culture in the organisation, transparency, and innovation, and highlighted the positive and outstanding staff they met during their inspection. The inspectors recognised that the Board worked well, focused on staff, quality and safety, and partnership working was becoming embedded. They also recognised the work being undertaken on continuous improvement. Maternity triage and staffing and the Trust's financial plans needed further clarity, along with learning around events and incidents. Joint working was also required around ongoing relationships with governors, how mental health patients were managed in the emergency department, and ethnic diversity on the Board. Staff across the Trust were thanked for their input and support over the last three months which, in typical fashion, had been undertaken with dignity, respect, and good humour, alongside the challenges of delivering day to day services for patients, ongoing strike action, pressures in the emergency department, and focus on delivery to reduce elective and cancer waits. The Chief Executive also thanked the CQC for their supportive inspections which allowed staff to be open and transparent during the inspections into each area.

- *Sexual safety of NHS staff and patients* – attention was drawn to the article on page 10 advising of guidance that had been issued outlining a range of initiatives taking place to ensure that the NHS had a zero-tolerance approach to sexual misconduct, violence, harassment, or abuse and was a place of safety for victims of abuse to seek support. Chief Executives had been asked to nominate an Executive to lead the work on domestic violence and abuse, both internally and with the ICB, and it was confirmed that the Chief Nursing Officer had accepted that role.

The remainder of the report recognised the tremendous work across the organisation with a range of recognitions and awards, including the Pastoral Care Quality Award which recognised the support provided to international staff recruited to the Trust.

At this point, the new Chair expressed his personal thanks to Professor P O'Neill for the support provided since his appointment and prior to taking up the role on 1 August which provided clarity and insights about the Trust, and for the sterling job he had done during his interim tenure. The new Chair also thanked the Chief Executive and wished him well for the future.

146/23 Staff Story

The staff story related to the annual 'Our People Awards' with specific reference to the Improving the Patient Experience Award presented to Christine Ryan, housekeeper on Ribblesdale Ward, recognising the additional support provided above and beyond her role to enhance the experience of oncology patients. The Board heard how Christine arranged monthly cocktail and canapes for patients who could spent long periods on the ward or were often regular attendees due to their diagnosis and treatment. Applications had also been submitted for charitable funds to supply ice lollies for patients during the hot weather as patients struggled to eat and the cool treats provided a huge lift for patients. The feedback received regarding Christine was wholly positive and she was frequently named personally in friends and family test feedback. The team also outlined how ward staff celebrated in different ways, including arranging a marriage as part of a patient's dying wish. The patient was sharing goodbyes with her children and was provided with a memory box with personalised memorabilia. Staff recognised patients as individuals and were happy to go the extra mile all the time. A member of the domestic team had created an artificial bouquet which could be used for any future wedding ceremony on the ward. The wider team was also exceptional in supporting the ward team, with the Specialty Business Manager purchasing a bouquet for the bride, the Divisional Nursing Director attending to support the ward, and a member of the Continuous Improvement team bought chocolates for all the ward staff, all of which helped team members to feel valued and happy which had a direct experience on how patients felt. Danielle Jackson, Ribblesdale Ward Manager, was also acknowledged for her inspirational leadership.

It was recognised that the differences being made by the team and the opportunity to share those experiences mattered and evidence was available that where staff were valued and had purpose had a direct positive experience on how patients felt. As a Trust, since receipt of the staff survey results in December 2022, the Organisational Development team had looked at recognition for staff, such as the Thank You tool and the relaunch of Long Service Awards, encouraging local team engagement and to share achievements and hold masterclasses, enhancement of the TED tool, and the portrait competition. In terms of a positive patient experience, the Trust was looking to increase recognition through the LTH Proud Awards to be held every three months. Consideration was being given to how patient feedback was used to reward colleagues. There would be three award categories – one patient-focused; one team-focused (with peer-to-peer nominations), and one service-focused to ensure the awards were inclusive as not all departments or services received patient feedback.

The Board recognised that more than anything else the staff story encapsulated what the Trust was about – focus on clinical care and also the personal patient experience.

The Board also acknowledged the TED tool which supported culture and the Trust was leading on national rollout of the tool which was already being used in 30 NHS organisations.

In response to a question regarding how such positive actions were shared across the Trust, the Board was advised that a significant shift had been seen on social media in terms of teams sharing the positive things they were doing. In addition, as part of TED, a community had been set up this month to bring team leaders together to share ideas and challenges so other team leaders could provide support which would help build culture in their teams.

147/23 Board Assurance Framework

The report provided details of risks that may compromise the achievement of the Trust's high level strategic objectives. It was noted that the risks were scrutinised by Committees of the Board and the strategic risks detailed in appendix 2 were those that had been presented to Committees or had been reviewed in preparation for the next Committee meeting at the time the Board report was produced. It was confirmed that there had been no changes to the risk scores since the June Board meeting. Three operational risks remained escalated to the Board relating to exit block (risk ID 23); elective restoration (risk ID 1125); and ongoing strike action (risk ID 1182).

In respect of the discussion at the last Board meeting regarding whether some current risks had been captured (minute 100/23 refers) it was confirmed that the gaps had been mitigated following recent and ongoing changes to the Board. It was noted that the risks to Consistently Deliver Excellent Care, specifically mitigations around health inequalities, would be discussed further by the Safety and Quality Committee. In respect of risk ID 23, the Board was advised that national guidance had been issued relating to winter planning and the first draft of the ICS winter plan would need to be delivered to the NHS regional team by 11 September.

Discussion was held regarding whether risk ID 1125 and 1182 should be combined as elective restoration closely linked to strike action. It was explained that both risks had been considered in detail and there were different mitigations associated with each of the risks. Therefore, managing the risks separately was deemed to be appropriate whilst recognising that risk ID 1182 was adding additional stress into risk ID 1125.

The Board RESOLVED that the updates to the Board Assurance Framework be approved.

148/23 Finance Strategy *'Knowing the Business'* 2023 actions update

The report provided an update on progress of the refreshed *'Knowing the Business'* medium-term finance strategy which had been presented to the Finance and Performance Committee on 28 March and the Board of Directors on 6 April. It was noted the refreshed strategy retained the core ethos of the original strategy and associated enabling programmes with a renewed focus on delivering recurrent efficiencies. The refreshed strategy included a new enabling programme of work reflecting the importance of other organisational strategies in the delivery of financial sustainability. It was confirmed that good progress had been made against the actions contained within the refreshed strategy with summary highlights contained in the main body of the report and commentary against individual actions included in appendix A.

The Finance and Performance Committee had explored the difference to decision-making processes now there was a hard ceiling of financial controls although the same commitment towards the quality of care, and the Board would need to consider how it operated differently under the new financial regime. It was noted this was part of national policy to engineer and move with the community strategy, keeping patients safe at home or their place or residence. There were pressures on budgets overall and the Trust currently had 120 patients in hospital beds over 21 days with some relating to the need for improved processes to appropriately discharge those patients. The Trust could expect to see greater complex patients in hospitals as population demographics had moved to older/frailer patients and work was needed with the ICB (as the funder of care) to mitigate risks to services under pressure and ensure services were safe.

In response to a question regarding how much scrutiny had been undertaken on the action plan and dates for delivery, it was explained that the reasoning was in line with the planning framework. However, inevitably there was work to be undertaken to complement the strategy and moving to March 2024 there would be a need to determine what was required to be delivered in line with the national ask.

The Board noted the majority of actions had been RAG-rated green and related to process rather than outcome, therefore, it was felt there was a need to stand back and be cautious about rating action delivery in such terms. The Board was advised that there were enabling strategies through the four key improvement programmes (such as unwarranted variation) although the point was noted regarding 'connecting the dots' to show the benefit for the Trust and staff. In respect of unwarranted variation, it was confirmed that data from Getting It Right First Time (GIRFT) and the Model Hospital indicated where the Trust would need to get to against peer. The position was challenging although for the population served there would be an opportunity to look at different ways of working.

149/23 Safety and Quality Committee Chair's report

The Chair's report from the Safety and Quality Committee meetings on 26 May and 30 June 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- Scrutiny of a range of annual reports which had been included on the Board agenda for approval or for information.
- Approval of the Equality Quality Impact Assessment (EQIA) Policy.
- Receipt of the Patient Experience Annual Report providing an update on the outcomes associated with the Patient Experience and Involvement Strategy 2022-25 demonstrating progress achieved over the past 12 months.
- Assurance provided of the safety and quality standards within maternity services with regular review of risks, monitoring and mitigation where possible. The plan for managing the expected number of staff that would be taking maternity leave within the bi-annual maternity staffing report was also scrutinised.
- Assurance of the actions in place to respond to concerns raised by the CQC relating to the management of mental health patients in the emergency department.

Reference was made to the positive escalation on the quarterly Sentinel Stroke National Audit Programme (SNNAP) and the improvement in stroke performance and, as performance had been variable over the years, the Board asked whether there was

confidence that the improved performance would be maintained consistently. It was explained that significant improvements on the pathway had been made and there was high confidence of consistently maintaining the level of performance. The clinical teams were now managing their own beds and SNNAP data was available in real-time which was being constantly reviewed providing the ability to discharge patients from the rehabilitation ward. There were challenges with recruiting sufficient allied health professionals and a risk should staff be lost through turnover. A peer site visit had been held across the ICS and the Trust would be focusing on metrics around the 4-hour emergency standard. There was a clear escalation route through to the Chief Operating Officer to unblock barriers which should help to maintain the improvements already introduced.

150/23 Annual Safe Staffing Review for Nursing (2022-23) – revised proposal

The report presented the outcome of the annual safe staffing review for nursing undertaken in November 2022. The report had been revised following presentation at the Safety and Quality Committee in February and May 2023 due to the financial implications associated with the original review, ongoing transformation work and current levels of vacancies within the healthcare assistant workforce.

Reference was made to the comparator regarding surgery and occupancy levels (June 2020) and whether it was a reasonable comparator as the timing was during the first wave of Covid when a significant amount of surgery needed to be stood down. It was explained that historically the Trust would have seen wards dropping to 70% occupancy, however, wards were occupied and staffed during weekends which needed to be recognised as part of the data.

In response to a query regarding the reason for increased activity in gynaecology (47% over the last two years), it was explained that there were multiple reasons for the increase. Some related to pathway changes and moving patients previously presenting in the emergency department to gynaecology assessment leading to a significant increase in patients within that area. In addition, the complexity of the local population recovering from Covid meant patients were presenting who required additional gynaecology interventions including stabilisation of anxieties and worries.

Discussion was held regarding broader assurance on staff reduction rather than just growth where that was possible, for example underfunded beds where staffing would reduce. In addition, the drivers and underlying issues for increased staffing levels where trends would be addressed by other strategies. In respect of reducing staffing levels, it was clarified that appendix 1 detailed where staffing levels had been removed and invested in other areas (with green showing the reduction and red showing the increase in budget). In respect of how the Trust compared to peer, it was noted that the Trust managed a large hospital with critical and high care beds requiring higher nurse to patient ratio and the organisation sat in the third quartile which was where it would be expected to align. In terms of addressing the underlying issues, some of the health inequalities strategy would include an increase in surgery and occupancy levels. There was a drive for maternity presentation at hospital and there would be growth in that area.

The Board noted that the safe staffing reports dealt with nurse staffing levels not the total staff complement although recognised the bi-annual midwifery staffing report (agenda item 11.2b) contained information on medical staff and clarification was requested on how the Board was gaining assurance around other staff cohorts. In

addition, the Trust was asking the ICB to help to bridge the funding gap and the Board would need to be satisfied of the actions taken to self-fund the staffing budget against other services. Finally, it was noted that out of scope were a range of escalated areas providing the unplanned pressure that safe staffing was under and clarification was requested on how that was balanced whilst additional work was brought forward. It was explained that all areas had received a safe staffing review and escalated areas had not been included as the Trust did not ask for funding for those areas and two of the areas had been reviewed and closed. In respect of looking internally for actions to reduce expenditure, that work would follow once discussions had been held with the ICB. With regard to medical staffing, it was explained there were challenges in compiling similar data as medical staff were not tied to specific wards and covered a host of areas. The report presented was purely looking at inpatient areas and did not address areas such as outpatients and specialist nurses. There were a range of mechanisms in place to ensure safe medical staffing levels including assessment of fill rates against rotas but it was not possible to look at medic to patient ratios. In the case of the information in the midwifery safe staffing report it was slightly easier to report on medical staffing in obstetrics as those roles were defined and confined.

Clarification was requested on whether the admission avoidance plan would allow for the report to be adjusted moving forward. It was confirmed that was the case and there was some rebalancing work to complete due to unfunded beds and post-pandemic and the plan was to ensure that work was completed during the year. In response to a question regarding whether there was confidence around recruiting to vacant post, it was noted that vacancy levels had settled to pre-pandemic levels, there were healthcare assistant vacancies which would take 12-18months to close and following that the Trust should be in a position where there were further adjustments that could be made around funding requirements. It was also noted that a plan was in place to increase activity, including bringing in high value low-cost activity along with six-day working, therefore that plan supported the increased occupancy points highlighted earlier in the discussion.

The Board recognised the need to ensure all potential internal funding streams had been explored, along with any efficiencies to provide additional funding, prior to the discussions with the ICB on bridging the funding gap.

The Board RESOLVED that:

1. **the contents of the revised annual staffing review 2022/23 and the further requirement to agree an approach to funding with the ICB following a review with the ICB Chief Nurse be noted.**
2. **an update on the outcome of the review with the ICB Nurse be received at a future meeting.**
3. **the outcome of the revised annual safe staffing assessment be noted and the Board was satisfied, based on the professional judgement of the Chief Nursing Officer, that staffing was safe, effective, and sustainable, although risks remained.**

151/23 Maternity service bi-annual staffing review

The report detailed the findings of the bi-annual maternity staffing review to provide assurance of safe staffing levels within the maternity service triangulating workforce information with safety, patient experience, and clinical effectiveness indicators.

The Board recognised that, as with the previous report, there would be a need for all internal funding routes to be explored prior to requesting funding from the ICB. Clarification was requested regarding the drivers of case complexity and whether there was anything additional that should be introduced with community service partners to reduce the complexity of presentations/increase in demand. It was explained that complexity was driven by a range of health inequalities which were outlined in the report to be presented later in the meeting (agenda item 11.4) and included issues such as safeguarding and diabetes, which were being captured across the system in numbers not previously seen. The issues had always been present although there was better recognition of them and a lot of national work was being undertaken to ensure the right interventions were introduced. Some of the work being undertaken by the Trust with community partners would show the benefits in years to come as the issues were long-term at the moment. Reference was made to gold command and mutual aid that would be required owing to the 30wte gap and it was confirmed there were team discussions within the PCB and ICB on a daily basis as similar effects were being seen within other organisations in terms of staffing gaps and operational pressures. Where required, Trusts were drawing on mutual aid and this Trust had a robust recruitment plan for midwifery through the ongoing international recruitment programme and work with the Universities on the midwifery career pathway. Reference was also made to the CQC inspection where the recruitment plan had been robustly tested and there had been no negative feedback around fundamentals of care which provided further assurance.

The Board RESOLVED that:

1. **the maternity staffing review be approved.**
2. **the investment requested following the 2022 Birth Rate+ report and the plan to work with the ICB to agree the approach to funding be noted.**

152/23 Infection prevention and control annual report 2022/23

The report provided an overview of progress against the annual infection prevention and control plan for 2022/23 including updates on performance against key standards. The 2023/24 infection prevention and control plan was also presented for approval.

Reference was made to the extension to deadline dates for *C.difficile* in the action plan and clarification requested on whether such changes received appropriate scrutiny and challenge by the Safety and Quality Committee. It was confirmed that the Committee discussed *C.difficile* infection (CDI) at their monthly meeting, a Chair's report from the Infection Prevention and Control Group was received following each meeting, and a report presented twice yearly to ensure scrutiny of CDI. Any changes to timescales for action delivery were also scrutinised by the Committee. The Director of Infection Prevention and Control added that the action plan had been produced by NHS England following their detailed inspection in December 2022. Some of the actions were ongoing, such as local incontinent services, which was a significant piece of work involving the ICB and would require a lengthy lead-in time before the benefits would be realised although it was a key matter receiving dedicated focus. It was also noted that the actions requiring collaboration were often the most challenging to deliver particularly as the ICB was continuing to evolve and was not yet embedded.

The Board RESOLVED that:

1. **the contents of the annual report provided assurance of progress against the 2022/23 annual plan as outlined in appendix 1.**

2. **the infection prevention and control annual plan for 2023/24 as outlined in appendix 2 be approved.**

153/23 Patient Experience Annual Report 2022/23

The report provided an update on the outcomes associated with the patient experience and involvement strategy 2022-25 to demonstrate progress achieved over the last 12 months.

In response to a question regarding people with protected characteristics and whether data could be captured for those cohorts, it was confirmed that currently the Trust was able to capture and analyse data from six of the nine protected characteristics and that was part of the Trust's Always Safety First Strategy. However, it was recognised that such data capture was not yet sophisticated enough to capture the data effectively and that was a key challenge during the coming year.

The Board asked how change of strategy, policy and working practices to embed feedback in the model of care was taken forward to close the loop. The report identified that what mattered to patients was improving communications and shortening the time waiting for care therefore the Board needed to reflect on that in Committee discussions. Patients had also highlighted navigation of the system and around the hospital sites and a question was asked regarding whether that was manifesting itself in terms of the formality of engagement being undertaken or whether it was a more systemic issue. In respect of feedback, it was confirmed that issue was a matter for focus during the coming year and consideration would be given to how that was reflected in the next annual report. With regard to sight and system, it was acknowledged there was some more general work to be undertaken and the Board's comments would be fed back to the appropriate group.

It was noted that the Trust had identified a high number of patient champions and the report referred to Patients as Partners being in place by June 2023 and clarification was requested on progress with those appointments. It was confirmed that the role description and advert had been written and the posts would be advertised within the next six weeks.

The Board RESOLVED that it was assured of progress in year one of the Patient Experience and Involvement Strategy 2022-25.

154/23 Maternity and neonatal services update

The report provided an update in relation to the safety and quality programmes of work within the maternity and neonatal services. The report detailed progress against work streams relating to the ten Clinical Negligence Scheme for Trusts (CNST). NHS Resolution was operating in year five of the maternity incentive scheme and the report also included a summary of the new requirements published in May 2023.

An overview of the report was provided and it was confirmed the report had been scrutinised by the Safety and Quality Committee particularly the gaps in the workforce due to maternity and sickness leave. The Committee was assured that a robust plan was in place to ensure safe staffing levels.

The Board RESOLVED that:

1. **the CNST report and recommendations be approved.**
2. **the expectations of the three-year delivery plan and associated safety bundles be noted.**
3. **assurance of the associated action plans be confirmed.**

155/23 Health inequalities delivery plan

The report, accompanied by a slide presentation, outlined the early work of the Trust's health inequalities delivery plan. The delivery plan was structured around the ICB health inequalities programme and would evolve to link closely with the Preston and Chorley Health and Wellbeing Partnership Boards. There were a range of projects underway to target specific groups of the population to reduce health inequalities. A Trust Health Inequalities Group had been established which would report into the Transformation Boards and Safety and Quality Committee. The Board was reminded that a dedicated health inequalities Board Workshop would be held on 5 September with the ICB Associate Medical Director for Population Health.

The Board was advised that the Safety and Quality Committee had discussed how the Trust engaged with multi-agency partners in terms of topics such as severe and complex mental health and the impact across the partnership sector and how solutions could be identified to address the challenges. Reference was made to the report and discussion at the June Board meeting on Engineering Better Care (EBC) and the work being completed with a variety of groups (minute 110/23 refers). The Trust would be taking the EBC work and scaling up, recognising there would be different partners and their work would be taken through place-based partnership teams. Links to the Academy would also help and provide support around that work.

The importance of the work on health inequalities was emphasised particularly around cancer. It was noted that Lancashire and South Cumbria had the lowest rates of diagnosis of early-stage cancer therefore early diagnosis would be important for hard-to-reach groups at a point where they could be cured so fewer patients were living with long-term conditions or dying. It was also recognised that the work built on what had already been achieved by the Trust on social value and as an anchor institute.

Reference was made to the ICB provider action plan which referred to analysis by deprivation and ethnicity although did not mention other protected characteristics and clarification was requests on whether the action plan would extend to those in the future. The Board was advised that as part of the NHS England Core20+5 framework there was a need to identify the groups most at risk from the available data. The Trust could extract information for deprivation and would then use the data to inform the areas for focus. The two identified characteristics were currently the determining factors although that would not preclude other characteristics being added to the list.

In response to a question regarding whether a strategy was being produced, it was confirmed that the report presented was the delivery plan for 2023/24 and the ICB had started to develop a strategy which would include input from the Trust. At the September Board Workshop a discussion would be held to agree Trust reporting lines until the ICB strategy had been finalised.

The Board RESOLVED that it was assured of the delivery plan and actions underway in respect of the Trust's health inequalities delivery plan.

156/23 Education, Training and Research Committee Chair's report

The Chair's report from the Education, Training and Research Committee meeting on 13 June 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- The Trust had met or exceeded compliance against core skills training in 21 out of 26 subjects.
- Consideration of the GMC survey results and progress against the actions since the April Committee meeting.
- Receipt of the Education Strategy Annual Report which provided a review of the strategy objectives and an overview of achievements in education and training. The strategy would come to an end in 2023-24 and would be refreshed and renewed taking account of the Trust's strategy moving forward to the new hospital build and how the health campus for central Lancashire was developed.
- An update on research and innovation and the positive achievements at year end. The Committee acknowledged that research continued to go from strength to strength with lots of work around building people and infrastructure and recruitment to various research studies. It was recognised that where healthcare was excellent it was associated with centres being active and encouraging patients into trials.
- An update on Edovation and activity during the past 6 months and work would need to be completed on how the company functioned in the future.
- Consideration and agreement of the strategic risk score which remained at 20. The Committee was conscious of some imminent changes, such as the recruitment of a substantive Chief People Officer, realignment of the research portfolio to the Director of Continuous Improvement, and clarity in respect of finance and contracts, which would inform the potential reduction of the risk score at the next meeting.

A question was asked regarding whether research also focused on improving Trust performance, such as robotics. It was explained that there were elements of pure research trials through to matters relating to innovation, and Edovation would be part of that work supported by realignment of the research and innovation portfolio. It was confirmed that there were some good examples of innovation and there would be opportunities to scale them into the work of the Trust. It was noted that a review of Edovation would be starting to look at the strategic direction to ensure any investment was appropriately aligned.

157/23 Workforce Committee Chair's report

The Chair's report from the Workforce Committee meeting on 11 July 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- The annual workforce advice update including progress in reducing the number of formalised disciplinary investigations.
- The equality impact of key workforce policies during 2022-23.
- The annual health and wellbeing strategy report which summarised progress against the strategic health and wellbeing priorities along with an assessment of impact and an update on the Lancashire and South Cumbria collaboration around Occupational Health and Wellbeing.

- An update on the Just Culture strategic aim which provided the findings from the annual 'Our Culture Counts' cultural assessment, a summary of achievements during the year against the strategic aim 'To Create a Positive Organisational Culture' to support cultural transformation, and the proposed actions for the next 12 months.
- Scrutiny of the Workforce Disability Equality Standard (WDES) and Workforce Racial Equality Standard (WRES) submissions which were recommended to the Board for approval.
- Review of the Guardian of Safe Working quarterly report (December 2022 to March 2023) and the annual report (January to December 2022). The reports provided assurance that the issues identified were being addressed by the relevant specialties/departments, through escalation of the concerns to the appropriate teams by the work of the Guardian.
- Consideration and agreement of the strategic risk score which remained at 16.

158/23 Workforce Disability Equality Standard (WDES) submission 2023
159/23 Workforce Race Equality Standard (WRES) submission 2023

The reports provided data which would form the submissions and subsequent publication of the 2023 WDES and WRES standards for the Trust, setting out priority areas for action based on analysis of the results which included workforce data and findings from the latest staff survey.

In terms of the WRES submission, further work was required in terms of representation, particularly in senior roles. The report would be shared with the Ethnic Minority Inclusion Forum for a strategic action plan to be developed and the results would be communicated to the relevant groups.

With regard to the WDES submission, career progression would be important and how colleagues who identified as disabled felt valued at work. The report would be shared with the Living with a Disability Inclusion Forum for an action plan to be developed with feedback on actions to the relevant groups.

Overall, it was noted there had been improvements since the last submissions, further work was required in specific areas, and the Trust had structures and processes in place and understood the areas requiring focus. It was also noted the Trust had a range of Ambassador Forums for protected characteristics and whilst some Executive Directors attended the meetings, all Board members were encouraged to attend if available.

Two of the Non-Executive Directors had attended a northwest equality, diversity and inclusion event along with a number of aspiring colleagues with protected characteristics who had a range of developed skills. Clarification was requested on how that talent pipeline was supported and how the actions would drive that support when vacancies presented. The Board was advised that the Trust had previously tested an 'Inclusive Leadership at Lancs' for future leaders and the programme was currently being evaluated, therefore, evidence would be available regarding whether the programme led to career progression: the results of the evaluation would be presented to the Workforce Committee. Reference was also made to the successful L&SC Inclusive NED Development Programme, with the Shadow Board led by the Interim Chair, with a wide range of committed individuals with lived experiences who would be great assets to NHS Boards going forward. Non-Executive Director K Smyth had joined the Shadow Board to talk about her career and life experiences and had met some of the participants

who were excited about progressing to Non-Executive or Associate Non-Executive Director roles. Reference was also made to the mentoring available through the work of the Disabled NHS Directors Network.

The Board RESOLVED that the priority areas for action and the external publication of the results of the 2023 WDES and WRES submissions be approved.

160/23 Guardian of Safe Working Annual Report 2022 and Guardian of Safe Working quarterly report

The report provided a review of the exception reporting data, vacancies data, the Guardian of Safe Working quarterly reports, and junior doctor forum minutes for the period 1 January to 31 December 2022. The second report provided information on safe rostering for junior doctors within the Trust to evidence they were working hours that were safe and in line with the new safe working rules as set out within the 2016 contract, covering the period 1 December 2022 to 31 March 2023. It was noted the Workforce Committee had scrutinised and discussed the reports in detail.

In respect of feedback and improving processes, clarification was requested on how learning was being shared and junior doctors prepared for taking up their roles. The Board was advised that F1 doctors were invited into the Trust a few days prior to taking up their role to provide the opportunity to shadow their predecessors and the majority of Foundation trainees had been through the Preston training programme. When a purely new junior doctor would be joining the Trust from a student to an NHS role then that was a challenge which the figures in the report reflected.

The Board was ASSURED that the areas of risk identified were being addressed by the relevant specialties/departments through escalation of the concerns to the appropriate teams by the work of the Guardian.

161/23 Finance and Performance Committee Chair's report

The Chair's report from the Finance and Performance Committee meeting on 23 May 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights from the May meeting included:

- The financial target was adrift and had been negatively impacted by strike action and dual running of international nurses. Assurance was provided that the nurse staffing plans were on trajectory and would assist with recovering the position.
- A discussion regarding cyber security which was being managed alongside the Audit Committee.
- An update was received on the 3-year Green Plan and whilst good progress was being made there had been slippage in some areas although nothing unduly concerning about which to alert the Board.
- The estates maintenance backlog was reviewed and it was recognised there were limited capital funds available. It was noted the external survey was used to drive maintenance work. There was detailed scrutiny around how and where the finances were being directed, the requirements around equipment and maintenance of such, meaning some of the estate investment needed to be deprioritised. The Committee agreed to ask the Safety and Quality Committee to look at any safety implications

through reprioritising the capital programme particularly in respect of medical equipment.
- The Committee was assured regarding the actions being taken by the Executive Management team in respect of performance and finance.

The Board noted that the Committee meeting on 27 June had been stood down although a Committee Chair's briefing had been held with a number of Committee members to discuss the reports prepared for the formal meeting, with some reports rolled forward to the July meeting.

162/23 Integrated Performance Report as of 30 June 2023

The integrated performance report as of 30 June 2023 provided an overview of key performance indicators aligned to the Big Plan. Detailed scrutiny of the metrics aligned to the four ambitions was undertaken by respective Committees of the Board. Key messages identified from the report included:

(a) ***Consistently Deliver Excellent Care*** – despite emergency pressures there had been significant improvement in ambulance handover times with 37% fewer patients being held in ambulances and 80% improvement in meeting the 60min turnaround time. The improvements reflected the local work the Trust was undertaking with NWAS colleagues to ensure there were robust plans in place moving into winter. In respect of people waiting in the emergency department, there had been a small number of patients with a mental health condition who had experienced long waits in the department. A weekly Big Room was held to ensure those patients were being cared for safely in the mental health assessment area close to the emergency department until discharged to an appropriate setting. There were a range of changes in the report presented in line with the Trust's plans, i.e. a second ward closure with staff from those areas being redeployed; removal of budgets from escalated areas; and ceasing escalation into the CT area in the emergency department. There was a need to focus on winter planning to develop a safe and affordable plan. In respect of cancer recovery, the month three trajectory had been achieved, numbers were reducing month on month, and the diagnostic standard was now reporting over 75%. A slightly poorer performance had been seen relating to skin cancer and the Trust was working with the system and using technology and artificial intelligence to support that service. In respect of colorectal cancer, the Trust had moved from the worst to the best performing organisation. There remained a small number of 78-week waiters to be treated due to strike action and plans were in place to clear down that activity over the coming weeks. Strike action was putting significant pressure on the elective recovery programme and plans needed to be stress tested to ensure the Trust had sufficient capacity to reduce the waits in line with trajectory.

In respect of safety and quality measures, *Clostridium difficile* infection continued to show variation in the data and weekly oversight meetings were in place to attempt to improve the position.

(b) ***Great Place to Work*** – short-term sickness levels had increased slightly during June although long-term absence had improved when compared to the position in May. The Workforce Committee closely monitored the main reasons for absence (psychological and musculoskeletal absence episodes). There was zero percent for ward nurse vacancy rates and a new rate card was in operation across the ICS.

(c) ***Deliver Value for Money*** – the Trust was reporting a month 3 deficit position of £18.4m against a £15.1m deficit plan with the £3.3m variance attributable, in the main, to under-delivery of the cost improvement plan; the cost of supporting international nurses until fully competent; the cost of strikes and the impact on activity, a 2022/23 accrual gap, and net restoration underspends offset by operation underspends . An overview was provided of the capital and cash positions, cost improvement programme, and use of resources as outlined in the report.

In response to a question regarding when the cost of supporting international nurses would reduce, it was confirmed that there were approximately 60 nurses in the process of completing their preceptorship period (which ranged between 6-12 months) and the cost of double running during that period had been profiled.

Reference was made to the costs being incurred by (a) paying staff to manage through strike action; (b) lost activity; and (c) bringing back the lost activity, and a question was asked regarding whether there was clarity regarding how those three elements would be treated as the cost was being incurred locally at the present time. The Board was advised that mitigation was in place for the first set of strikes which could offset the points raised. It was recognised there was not just one consequence and the recovery piece would be more expensive, particularly if the Trust needed to extend its services to other providers, and the position would need to be closely monitored. A question was also asked regarding the level of recognition of the strikes in terms of the Trust meeting its performance trajectories. It was explained that strike action would likely happen across the rest of the year and the Trust was testing its plans and scenarios and would link with the system regarding their plans. There was potential for more insourcing and support from neighbouring Trusts and attempts would be made to keep on trajectory.

The Board RESOLVED it was assured in respect of the actions being taken to improve performance.

163/23 Audit Committee Chair's report

The Chair's report from the Audit Committee meeting on 23 June 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

The meeting focused on approval of the 2022-23 Annual Report and Financial Accounts which had been recommended for approval by the Board and submitted by the due date. The outcome of the work was positive with a clean audit opinion from the external auditors. For the third consecutive year the Trust had received an overall judgement of substantial assurance from the internal auditors in respect of its governance controls and frameworks.

164/23 Standing Financial Instructions (SFI) and Scheme of Reservation and Delegation (SORD)

A detailed review had been undertaken of the Trust's SFIs and SORD documents and both were presented to the Board for approval. It was noted the documents now reflected the position of the Trust within the ICS and took account of mechanisms to reflect in-year direction from NHS England on financial management. In addition, by resolution of the Board earlier in the year, the new delegation of powers out of the Trust

to the PCB had been articulated with the expectation that the Standing Orders approved by the Board on 2 February could also be updated to reflect the same delegated authority.

The Board asked for assurance around the work to strengthen the feedback loop from the PCB and their delegated powers, i.e. garnering the Board's opinion and receiving feedback. The Board was reminded of its approval of the governance arrangements and delegation to the PCB Joint Committee in March 2023 (minute 35/23 refers). The Board discussed issues which the Chair and Chief Executive would take to the PCB and they would then report back to the Board on the outcome of those discussions, with the same approach being taken by all Trusts operating within the system. The current arrangements could be strengthened through a joint reporting mechanism ensuring a report was generated centrally by the PCB which all organisations would review and provide feedback. For next year, it may be possible to manage arrangements so reporting cycles were consistent. The acute provider Boards generally met around the same time and the PCB meetings would need to be appropriately aligned to ensure consistent feedback so all Trusts were discussing the same outcome at the same time. It had been recognised by this Trust how that could be achieved and work was ongoing with colleagues to agree a consistent approach.

Discussion was held regarding the authority delegated to the Chair and Chief Executive and the need to ensure there was a clear route on how the Board was consulted and how the Joint Committee received the forward view. It was acknowledged that this had been previously agreed, in that the Chair and Chief Executive had a mandate into the PCB from the Board and the PCB meeting followed Trust Board meetings therefore the mandate would come from the discussions in the Board meeting.

It was noted the document contained historic titles (Finance Director and Director of Procurement) and should be Chief Finance Officer and Managing Director of Procurement. It was confirmed the titles would be amended prior to publishing the report.

The Board RESOLVED that:

1. **the revised SFIs and SORD as set out in appendices 1 and 2, subject to two minor amendments to job titles, be adopted.**
2. **Standing Orders be amended to include wording as follows:**
   The Board may delegate such powers and responsibilities for its functions not otherwise reserved to the Joint Committee known as the Provider Collaborative Board. These delegated functions shall be set out in the PCB Terms of Reference and may be amended or rescinded by the Board at its discretion.

165/23 Board Effectiveness Review 2023

The report provided an overview of the outputs from the Board and Committee effectiveness reviews for 2022-23, including areas of good practice and areas for future focus and improvement. An action plan was outlined in the main body of the report on focused areas of improvement during 2023-24. It was noted that work was in progress to reflect the newly appointed Chair who would be consulted on the action plan therefore changes could be made to the plan during the year.

During discussion reference was made to the CQC Well Led Inspection and the potential for recommendations in the final inspection report which may need to be included in the plan. In addition, it was suggested that the Board Development Programme be added into the plan moving forward.

The Board RESOLVED that it had discharged its responsibilities soundly and competently during 2022-23 and adopted the action plan to address areas identified for improvement, recognising the plan would evolve further and be added to during the year.

166/23 Items for information

The following reports were received and noted for information:

(a) Annual Report and Accounts 2022-23 (laid before Paliament)
(b) Quality Account 2022-23
(c) Safeguarding Annual Report 2022-23
(d) Serious Case Thematic Review Annual Report 2022-23
(e) Equality Quality Impact Assessment (EQIA) Policy

The Chair closed by thanking governors, members of the public and the press for attending the meeting.

167/23 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday, 5 October 2023 at 1.00pm, venue to be confirmed.

Signed: _____
Chair

Date: _____

Action log: Board of Directors (part I) – 3 August 2023

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	107/23	1 Jun 2023	*Annual Plan 2023-24* – the plan would be presented to the Board in six months to show refinements, iterations, and movement on the plan.	Director of Strategy and Planning	7 Dec 2023	

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Chair's Report						
Report to:	Board of Directors			**Date:**	5 October 2023	
Report of:	Chair of the Trust			**Prepared by:**	Peter White	
Part I	✓			**Part II**		
Purpose of Report						
For assurance	☐	**For decision**	☐	**For information**	☒	

Executive Summary:

The purpose of this report is to provide a summary of work and activities undertaken during August and September by the Trust Chair.

It is recommended that the Board receives the report and notes the contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

None

Chair's Report

1. Introduction

The purpose of this report is to provide an overview of the work and activities undertaken from 1 August to date.

This is my first Chair's report since commencing in post on 1st August. I am delighted to have been appointed as Chair for Lancashire Teaching Hospitals NHS Foundation Trust and look forward to working with the Board of Directors and Council of Governors to help deliver the excellence in health care that our communities rightly deserve.

As a long-time resident of the area covered by the Trust, I, my family, and friends have relied upon the care and treatment provided by the staff at the Trust - this role for me is therefore a very personal one and it is a great privilege to serve in this way.

I would like to take a moment to acknowledge the significant contributions of both Professor Paul O'Neill and Kevin McGee to the Board and the communities we serve.

Professor Paul O'Neill fulfilled the role of Interim Chair prior to my starting, and I am delighted that Paul now continues in his previous role as a Non-Executive Director and Vice Chair. I look forward to working closely with him in the months ahead.

Kevin McGee, Chief Executive leaves the organisation on 30 September after completing 38 years NHS service in a number of senior roles to commence his new role of Director General of the Gibraltar Health Authority. Colleagues across the system this week reflected on Kevin's fantastic leadership and the significant contribution he has made across Lancashire and South Cumbria and he takes with him our sincere thanks as he starts his new venture in Gibraltar.

Since taking up my appointment, I have been involved in recruitment processes for a number of posts which will further strengthen the Board.

I am very pleased to say that following an internal process our current Chief Operating Officer (COO), Faith Button, has been appointed as Interim CEO with effect from 1 October 2023. We are pleased that Imran Devji has joined us from East Lancashire Hospitals NHS Trust as Interim Chief Operating Officer to back fill Faith's substantive post.

I am sure that you will join me in congratulating Faith, and I know you will provide her with your full support when she formally takes on the role on 1 October 2023.

Two Non-Executive positions have been appointed to; Dr Tim Ballard and Uzair Patel and their respective clinical and financial expertise will very much complement our Board.

More detail on these appointments are included later in my report and in the Interim CEO report.

The interview process for the Chief Executive has now concluded and further information will be shared once all recruitment processes are completed.

2. Summary points from the NHSE Letter issued on the 18 August 2023 – Lucy Letby

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered (and continue to live with) pain and anguish that few of us can imagine.

We have all been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

NHSE has welcomed the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester to ensure we learn every possible lesson from this awful case.

The new Patient Safety Incident Response Framework is being implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

The importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

Last year NHSE rolled out a strengthened Freedom to Speak Up (FTSU) policy.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

- All staff have easy access to information on how to speak up.
- Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
- Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
- Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
- Boards are regularly reporting, reviewing and acting upon available data.

The Board at LTHTR are committed to ensuring that the above measures are in place and that speaking up is actively encouraged within the Trust.

3. Non-Executive Director Update

a. The Chair is currently meeting with each of the Non-Executive Directors to discuss a wide range of issues and challenges for the Trust and ICS and going forward will be participating in structured visits to departments and clinical services.

b. Following a robust recruitment process, the Trust has successfully recruited two new Non-Executive Directors. Both candidates will commence with the Trust on 1 October 2023 and I look forward to working with them. Dr Tim Ballard, an exceptionally

experienced GP, has recently been appointed as a Non Executive Director of the Trust Board, and this additional clinical experience will be much welcomed. Uzair Patel has been appointed as Associate Non-Executive Director and as a Chartered Accountant and senior finance professional his skills will be much appreciated in the challenging climate in which we are operating.

4. Part II Board of Directors' meetings on 3 August and 5 September 2023

The following items were discussed at the part II Board meetings on 3 August and 5 September 2023 and a brief resume of the discussion on each item is provided for information:

3 August 2023:

1. **Corporate Collaboration/Provider Collaboration Board (PCB)** – the Board discussed matters currently under consideration by the PCB including the corporate services collaboration.
2. **Northwest Sub-National Secure Data Environment (SNSDE) Programme** – the Board received an update and approved a proposal on the SNSDE initiative which aimed to promote research and innovation in ICSs through secure data sharing with partners.
3. **Financial Improvement Plan (FIP) update** – the Board received an update on the Trust's FIP and delivery as at month 3 (June 2023).
4. **Confidential Risk Report** – an update was provided on the confidential risk process implemented by the Trust as part of the Risk Management Policy and the Board was assured there continued to be an effective and comprehensive process in place to identify, understand, monitor, and address current and future risks.
5. **Code of Governance** – the Board considered an outstanding action to ensure compliance with the Code of Governance published on 1 April 2023 in respect of sharing part II discussions in the public domain.
6. **Chief Executive's appointment** – the Board received an update on progress with the Chief Executive's recruitment process.
7. **Minutes of meetings** – the Board received copies of relevant approved minutes from meetings of Committees of the Board.

5 September 2023:

1. **Financial Improvement Plan (FIP) update** – the Board received an update on the Trust's FIP and delivery as at month 4 (July 2023).
2. **Emergency Preparedness, Resilience and Response (EPRR) Core Standards Annual Assurance 2023-24** – the Board received the results of the Trust's EPRR self-assessment annual review and associated work plan for the period 2023-24 and approved submission to the Lancashire and South Cumbria ICB by 30 September 2023.
3. **Establishment of Associate Non-Executive Director position** – following the successful appointment of two Non-Executive Directors by the Council of Governors, the Board approved the establishment of an Associate Non-Executive Director position from 1 October 2023 for a term of office until a substantive Non-Executive Director position became vacant.

5. Chair's attendance at meetings

a. Details below are the meetings attended and activities undertaken during August and September 2023.

Date	Activity
August 2023	
3 August	Appointments, Remuneration, Terms of Employment Committee
	1:1 – Company Secretary
	Board of Directors – Part 1 and Part 2
8 August	Provider Chairs Discussion
	2:1 – ICB CEO and Chair
	2:1 – CEO and CPO
9 August	Nominations Committee
	1:1 – Lead Governor
	1:1 – Non-Executive Director
11 August	Chorley Site Tour – Life Centre
	Council Training Session – Chorley General Hospital
	Introductory Meeting – Executive
14 August	CEO Candidate Call
15 August	Introductory Meeting – Executive
	Introductory Meeting – Executive
	Board Development Plan Meeting
16 August	New Hospital Programme Roadshow
18 August	Introductory Meeting – Regional Director
	CEO Candidate Call
	CEO Candidate Call
	Introductory Meeting – Executive
	CEO Candidate Call
	Introductory Meeting – Executive

21 August	Non-Executive Candidate Call
	Non-Executive Candidate Call
22 August	1:1 – CEO
	CEO Candidate Call
	1:1 – Company Secretary
	Non-Executive Candidate Call
	Non-Executive Candidate Call
24 August	Non-Executive Director Interviews
	CPO Candidate Call
25 August	1:1 – ICB CEO
29 August	Non-Executive Director Interviews
	Nominations Committee
	Council of Governors
31 August	NHP Strategic Oversight Group
	1:1 – MBHT Chair
	1:1 – Non-Executive Director
	CPO Candidate Call
	1:1 – LSCFT Chair
September 2023	
4 September	1:1 – CEO
	Provider Collaborative Colleague Briefing
5 September	LTHTR Board Agenda Setting Meeting
	Board Safety and Experience Programme – DCS and Women's – Chorley Hospital
	Non-Executive Discussion Meeting
	Board Workshop
	Special Board Part 2
6 September	1:1 – Chorley Councillor
20 September	1:1 – Executive
22 September	1:1 – Executive MBHT

25 September	1:1 – CEO
	1:1 – Executive
28 September	Chief Executive Officer Interviews
	Appointments, Remuneration, Terms of Employment Committee
29 September	1:1 – Vice Chair
	Council of Governors

6. Financial implications

a. There are no financial implications associated with the recommendations in this report.

7. Legal implications

a) There are no legal implications associated with the recommendations in this report.

8. Risks

b) There are no risks associated with the recommendations in this report.

9. Impact on stakeholders

c) There is no impact on stakeholders associated with the recommendations in this report.

10. Recommendations

It is recommended that the Board received the report and notes the contents for information.

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NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Interim Chief Executive's Report			
Report to:	Board of Directors	**Date:**	5 October 2023
Report of:	Interim Chief Executive	**Prepared by:**	Naomi Duggan, Director of Communications and Engagement
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☐	**For information**	☒

Executive Summary:

The Interim Chief Executive's report provides an update to the Trust Board on key national, regional and local developments with a view to setting the context for the strategic and operational priorities for the Trust.

The Board is requested to receive the report and note its contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Not applicable

INTERIM CHIEF EXECUTIVE'S REPORT

1. INTRODUCTION

a. The purpose of this report is to update the Trust Board on key national, regional and local developments with a view to setting the context for the strategic and operational priorities for the Trust.

2. UNDERSTANDING THE NATIONAL CONTEXT AND EXTERNAL ENVIRONMENT

a. National Headlines

i. Unprecedented walkout as junior doctors and consultants take strike action

September saw a historic walkout as junior doctors and consultants undertook their first ever joint strike.

This round of industrial action saw 96 hours of continuous strikes, starting with consultants striking from 7am on Tuesday 19 September until 7am on Thursday 21 September and junior doctors striking from 7am on Wednesday 20 September until 7am on Saturday 23 September. This meant that both groups were striking together on Wednesday 20 September.

On Wednesday 20 September, from 7am, both junior doctors and consultants delivered Christmas day levels of staffing only, meaning that emergency services were staffed and there was basic level of cover on the wards. Both groups will then strike on 2, 3 and 4 October, again providing Christmas day cover.

Now in the tenth month of industrial action across the NHS, which has seen more than 885,000 inpatient and outpatient appointments rescheduled, staff continue to work hard to provide patients with the best possible care.

The NHS is working to prioritise resources during industrial action to protect emergency treatment, critical care, neonatal care, maternity and trauma, and ensure it prioritises patients who have waited the longest for elective care and cancer surgery. Unfortunately, the hospital consultants and junior doctor strikes has, and will have, a significant impact on planned and routine care.

Previous industrial action by consultants last month saw 45,800 appointments disrupted and around 6,000 staff off per day due to industrial action.

ii. NHS booking opens for life-saving COVID and flu vaccinations

Millions of eligible people in England can now book their life-saving autumn COVID vaccine online as the NHS steps up its winter vaccination programmes early in response to the risk of the new COVID variant.

Anyone eligible can book their COVID vaccinations via the NHS website, by downloading the NHS App, or by calling 119 for free if they can't get online.

Hundreds of thousands of adults who are eligible for winter vaccines – including all aged 65 and over, pregnant women and those with an underlying health condition – will also receive invitations from the NHS to encourage them to get their flu jabs.

GP practices and other local NHS services will also be contacting people to offer both flu and COVID vaccines, and people can book the flu vaccine by searching online for a local pharmacy.

Over 30 million people are eligible to receive a flu vaccine and over 20 million are able to get a COVID jab.

COVID vaccination for those aged under 18 years will begin later in the year – the NHS will let eligible families know when this offer opens.

This year's adult COVID and flu vaccination programme has been brought forward on the advice of scientists following the emergence of a new COVID variant (BA.2.86), which has a high number of mutations.

You can read more on the ICB website.

iii. NHS delivering record number of tests and checks with more one-stop shops in local communities

The NHS has delivered a record number of potentially lifesaving tests and checks with over 25 million carried out in the last year, new data shows.

Figures released in September show NHS staff delivered more than 25 million checks (25,377,280 August – July) in a year for patients – two million more compared to the same period before the pandemic (23,279,609 to July 2019).

Compared to the same period a decade ago, there has been an almost 50% increase – with 17 million carried out in in the same period in 2013 (17,256,061).

The announcement comes as four new one-stop shops for testing are set to open in England, joining 118 centres already operating in local communities.

The approval of the four new community diagnostic centres – two in Wiltshire, one in Thanet and one in Cheshire – will add to the 168 one-stop shops that are already approved.

These centres are playing a key role in carrying out record numbers of tests and checks, with patients able to get tested at convenient locations as close to peoples' homes. Staff have now delivered more than five million tests and checks at the local hubs.

iv. Faster ambulance response times for patients despite summer of record demand for the NHS

Ambulance response times improved for the third month in a row despite A&Es facing their busiest summer ever, figures released in September show.

There were more than 6.5 million attendances in A&Es (6,522,000) across June, July and August – more than 20,000 higher than the previous record in 2019 (6,498,472).

Following the publication of the Urgent and Emergency Care recovery plan earlier this year and thanks to the efforts of NHS staff, ambulance response times for all types of calls improved for the third month in a row.

The figures show category two response times were more than 10 minutes faster in August than the same month last year (31:30, 42:37), and category 1 calls – the most serious incidents – had an average response time of 8:17 (down from 9:08 in August 2022), despite demand for face-to-face responses being up 5% compared to last year.

Despite the disruption of industrial action, NHS staff have continued to make progress to bring down the longest waits for patients. Waits of more than 65 weeks reduced to 96,722 in July, down 59% on the peak of 233,051 in June 2021, and down from 149,770 in July last year.

The latest figures also show an improvement in average waits for elective care, with the median wait for admitted treatment 11.3 weeks in July, the lowest it has been since December, and the median wait for non-admitted elective care down to 8.2 weeks in July.

v. Record numbers of disabled staff on NHS boards

NHS boards have more disabled members than ever before, NHS data published in September shows.

The Workforce Disability Equality Standard (WDES) annual report shows disabled people make up 1 in 20 (4.8%) of voting members on NHS boards – up from 3.8% in 2021, the last time this was measured and the highest number on record.

The report also shows the chance of a disabled candidate being appointed to a job in the NHS is on par with non-disabled applicants, with the relative likelihood of appointment for disabled people improving from 1.18 in 2019 to 1.08 in 2022 – where 1 represents equity of opportunity.

All but one trust in England is taking action to give a platform for disabled staff to be heard. This is an improvement from 2019 when 34 trusts were not doing this.

The publication of the WDES comes after the launch of NHS Long Term Workforce Plan, which set out an expansion of routes to work into the NHS as well as measures to do more to retain existing talent.

Lancashire Teaching Hospitals is proud of the work it does in this area, particularly the work of Non-Executive Director, Kate Smyth, who has been Co-Chair of the Disabled NHS Directors' Network since March 2021.

vi. NHS launches first-ever sexual safety charter to help protect staff

More support will be provided to NHS staff who have suffered harassment or inappropriate behaviour, thanks to a first of its kind sexual safety charter.

The charter is an agreement with 10 pledges including commitments to provide staff with clear reporting mechanisms, training, and support.

NHS chiefs are calling on organisations across the health sector including royal colleges to sign up to the framework to eradicate sexual harassment in the workplace.

As part of the major new action, every NHS trust and local health system in England will also have a domestic abuse and sexual violence lead to support patients and staff to report incidents and access support.

NHS England is creating gold-standard policies and support for local hospitals and health systems to use to address incidents of sexual misconduct. We will track our progress through our workforce and safeguarding teams work.

vii. NHS world first rollout of cancer jab that cuts treatment time by up to 75%

Drug treatment times for some NHS cancer patients will be slashed by up to three quarters, thanks to an anti-cancer injection that takes as little as seven minutes to administer.

Following the green light from the Medicines and Healthcare products Regulatory Agency (MHRA), the NHS in England will be the first health system in the world to roll out the seven-minute injection to hundreds of patients each year.

Currently, patients receive the life-extending immunotherapy atezolizumab (Tencentriq®) in hospital directly into their veins via a drug transfusion. It usually takes around 30 minutes to administer intravenous atezolizumab, but for some patients this can be up to an hour when it can be difficult to access a vein.

But now, hundreds of eligible patients being treated with atezolizumab are set to have their experience improved by switching to the swifter and more comfortable under the skin (or subcutaneous) injection — freeing up valuable time for NHS cancer teams.

It is anticipated the majority of the approximately 3,600 patients starting treatment of atezolizumab annually in England will switch onto the time-saving injection. However, where patients are receiving intravenous chemotherapy in combination with atezolizumab, they may remain on the transfusion.

viii. NHS rolls out world-first programme to transform diabetes care for under 40s

Tens of thousands of people in England living with early onset type 2 diabetes will benefit from more intensive and targeted care, thanks to a world-first initiative being rolled out by the NHS.

Around 140,000 people aged 18 to 39 years old will receive additional tailored health checks from healthcare staff, and support with diabetes management, such as blood sugar level control, weight management and cardiovascular risk minimisation.

Under the ambitious new programme, named ‘T2Day: Type 2 Diabetes in the Young’, patients will benefit from extra one-to-one reviews as well as the option of new medicines and treatments where indicated, to help better manage their diabetes.

Read more on NHS England’s website.

ix. New standards for NHS board members to strengthen leadership and governance

The NHS published a framework and supporting resources in August to help senior board members to strengthen board governance, boost leadership and improve patient safety.

Resources to support current and aspiring board members within the NHS were sent to leaders including information on development programmes and peer support networks to develop and share good practice.

A Fit and Proper Person Test (FPPT) framework for board members has also been published, which will help prevent directors who have been involved in or enabled serious misconduct or mismanagement from joining a new NHS organisation.

NHS England was commissioned to update the framework as part of five recommendations from Tom Kark's KC review of the Fit andf Proper Person Test.

In response, NHS England will introduce the following:

- A new standard reference for people leaving NHS board roles for any reason which will be held on file until the person turns 75, including details on any ongoing or discontinued complaints and disciplinary issues.
- Data fields in the Electronic Staff Record to record board members' Fit and Proper Person Tests.
- An extension of the scope of the FPPT framework to all commissioners including Arms-Length Bodies, Care Quality Commission and NHS England.

The Board will receive assurance on our adherence to these standards in due course.

3. INFLUENCING THE LOCAL HEALTH AND SOCIAL CARE ECONOMY

a. Lancashire and South Cumbria Headlines

i. Kevin McGee retires after 38 years in NHS

On Tuesday 26th September, Kevin McGee OBE was joined by his family and colleagues from across Lancashire and South Cumbria to say goodbye and good luck following his 38-year career in the NHS.

The Trust's Deputy Chief Executive, Jonathan Wood was joined by Chair of the Provider Collaborative Board, Professor Mike Thomas, and Chair of the Lancashire and South Cumbria Integrated Care Board, David Flory, all gave speeches to thank Kevin for his dedicated service to healthcare over many years.

Kevin will soon begin the role of Director General for Healthcare for the Gibraltar Health Authority.

Talking about his time in the NHS, Kevin said: "Being part of the NHS family for all these years has been an absolute privilege and I consider myself extremely fortunate to have worked with so many talented people who have chosen to make patient care their life's work.

"Lancashire Teaching Hospitals plays a pivotal role in the local health system and I am exceptionally pleased that funding has now been secured for new hospitals for Preston and Lancaster as part of the New Hospitals Programme.

“Reaching this important milestone is an ideal time to pass the baton on to someone who can commit the next five years or so to bringing these exciting plans to fruition.”

We would like to wish Kevin all the best and good luck in his new role, he has been a fantastic Chief Executive for Lancashire Teaching Hospitals and will be very much missed.

ii. Trust appoints Imran Devji as Interim Chief Operating Officer

Lancashire Teaching Hospitals are pleased to confirm the appointment of Imran Devji as Interim Chief Operating Officer for a 6 month period beginning 1st October 2023.

Imran has a wealth of NHS experience over many years and has been the Deputy Chief Operating Officer at East Lancashire Hospitals Trust since January 2021.

Imran has previously undertaken the role of Interim COO having been part of the Trust Board and executive team at East Sussex Healthcare NHS Trust.

We are sure colleagues across the Trust will warmly welcome Imran to Lancashire Teaching Hospitals.

iii. Trust appoints Tim Ballard and Uzair Patel

As the Chair has mentioned, Tim Ballard and Uzair Patel who will be taking up the positions of Non-Executive Director and Associate Non-Executive Director respectively from 1 October 2023.

Our new Non-Executive Director, Tim Ballard, was born and brought up in Lancashire and after qualifying in medicine he went into general practice in 1988. He was a GP trainer for about 25 years and was an Examiner for 21 years for the membership examination of the Royal College of GPs and for a period led the Simulated Surgery module assessing the consultation skills of doctors. Tim was a nationally elected member of Council at the Royal College of GPs for 12 years and served as Vice Chair at the RCGP from 2013 to 2016. Since 2016 Tim has been a National Clinical Advisor at CQC giving clinical advice to the commission around the areas of general practice, independent primary care, online and digital health, as well as supporting CQC inspections. Tim is a keen advocate for environmental sustainability especially as it relates to healthcare.

Uzair, appointed to Associate Non-Executive Director, is a Chartered Accountant and senior finance professional with deep and wide-ranging experience across global banking in a range of technical and commercially focused roles. He is a board member at Torus Foundation supporting communities in Liverpool and the surrounding areas. He was previously a board member at the national domestic-violence and abuse charity, Safe Lives, as well as Chair of Audit and Risk at KCLSU. He was co-creator of the award-winning #ThisIsMe mental-health campaign at Barclays and across the City of London in partnership with the Lord Mayor of London. He read Biomedical Sciences at King’s College London with a focus on neuroscience and pharmacology.

iv. Leadership confirmed for the Pathology Service workstream

Martin Hodgson, Chief Executive of East Lancashire Hospital Trust, has now taken over as the lead Chief Executive for the Pathology Workstream following Kevin McGee’s departure. After nearly a year in an interim capacity, Professor Anthony Rowbottom has been appointed as the Managing Director, and Gary Doherty, Lancashire Teaching Hospital’s Director of Strategy and Planning is now the lead Senior Responsible Officer for the development of the capital business case and the Trust will be the lead organisation for the bid.

v. Ailsa Brotherton appointed as Improvement Director of National Improvement Board

Ailsa Brotherton has been appointed by NHSE as Improvement Director for the recently established National Improvement Board to underpin the ongoing work of NHS IMPACT.

As Improvement Director, Ailsa will support the work of the National Improvement Board and the NHS IMPACT Priority Programme Group to champion continuous improvement.

This is alongside her Director role at Lancashire Teaching Hospitals where she has executive level responsibility for Improvement, Research and Innovation. Ailsa is also an Honorary Professor at the University of Central Lancashire.

Ailsa has experience of designing and delivering quality improvement and large-scale change programmes at national, regional and local levels and is currently working with the Improvement Directors and Clinical Leads across Lancashire and South Cumbria in collaboration with Professor John Clarkson FREng, University of Cambridge, to test the Engineering Better Care framework across the Integrated Care System. As part of this collaboration, the team is designing a bespoke Improving Improvement framework, building on the learning from their initial work at system level.

John Ashcroft, Director of NHS IMPACT, said: “Ailsa brings considerable transactional and operational improvement leadership experience. I am delighted that Ailsa will represent NHS IMPACT (Improving Patient Care Together) in an environment where frontline services are under intense pressure and the demands and expectations are increasing. Ailsa’s experience and knowledge will progress our urgent priorities and shape our direction.”

vi. Provider Collaborative Board

The August PCB Board had been stood down, and the meeting on 21 September was kept brief due to the joint industrial action by Consultants and Junior Doctors.

Performance across the PCB in terms of elective and cancer and 4 hour waiting times in UEC was strong compared to many ICS areas, however ambulance waiting time, lengths of stay and Not Meeting Criteria to Reside numbers were growing and would need focus in the weeks ahead.

The Mental Health Trust were in discussions with Place based leaders about housing provision and finding a way to ensure that existing provision is fully utilised as the Trust had 30% of their bed base occupied by people who are suitable for discharge for whom no placements can be found. The Trust are out to tender to the third and fourth sector for autism assessments for children which would help drastically reduce the waiting list which for many was over two years.

The financial situation across the Providers was very challenging with Trusts committed to developing and signing up to a system roadmap which would be reported to the Chief Executives and the next PCB Board meeting as part of the finance update.

Following a competitive process, East Lancashire Hospital Trust had been appointed as the host organisation for central services and work would now take place to determine what the next steps would be in terms of services transferring into One LSC. Each of the Providers have an Executive lead on the programme and

established internal Executive Boards to ensure that colleagues remain fully sighted on progress. Staff side colleagues are also being kept fully in the loop.

Within the Clinical Service Workstream there had been a productive workshop in August which had agreed in principle that the best possible use needed to be made of the opportunities afforded by the New Hospitals Programme, particularly the new hospital in Central Lancashire. A further workshop would take place in October to progress this work and consideration was being given to use of an independent expert facilitator to help develop a detailed plan for the reconfiguration of services in the period between now and the new hospital programme coming to fruition.

Significant funding was available for a pathology clinical model which included a central facility alongside locally retained services. Work on the business case for this was underway and an update was given on this and other programmes including the implementation of the new LIMS system; the digital pathology programme and the development of the workforce strategy.

As this was Kevin McGee's last meeting in his capacity as lead Chief Executive for the Provider Collaborative he was invited to share his reflections.

He thanked colleagues for their support and noted how much he had enjoyed his NHS career which for all its challenges had been a great privilege. He felt very optimistic about the future of LSC and was confident that the work taking place on Quality Improvement and Engineering Better Care would make a huge difference to the success of the system. He spoke about the importance of ensuring that LSC competed with other systems to attract good jobs, research and development, education and training, and maintain as many tertiary services as possible, as this would help build social infrastructure and social cohesion and was optimistic that the current LSC leadership would work together to ensure that this happens. He ended by wishing all colleagues the very best for the future.

All those present reflected on their personal experiences of working with Kevin, and wished him well in his new role as Director General of the Gibraltar Health Authority.

vii. Kevin Lavery's report to ICB Board – 13th September 2023

In light of NHS England's annual assessment of ICB performance, Kevin Lavery's CEO Report celebrates the success of the organisation, acknowledges the hard work of colleagues working across the system, and highlights the need to review progress.

In order to provide a sustainable long-term health and care system, Kevin noted a need to reset and fundamentally change the approach, and transform the system's way of working to promote a community-centric approach, with more prevention and better use of health and care partners. Kevin further highlighted that difficult decisions will need to be made, backed up by evidence that shows that the quality and safety of services will not be compromised.

You can watch the meeting back on their website or you can view the Chief Executive's report in Appendix I.

The ICB also held its first Annual General Meeting (AGM) on 13th September which shared their achievements and challenges in their first year as an Integrated Care Board as well as presenting the annual accounts and annual report. The papers are available on their website.

viii. Lancashire and South Cumbria NHS welcomes New Hospitals Programme roadshow

A summer series of national New Hospital Programme roadshow events visited Preston in August, as Government representatives arrived to discuss the next steps for building two new hospitals in the region.

Then CEO Kevin McGee and Chair Peter White welcomed Health Minister Lord Nick Markham CBE to the Trust following on from the Government's commitment to replace both Royal Preston Hospital and Royal Lancaster Infirmary with new builds on new sites. The roadshow event was an opportunity for Lord Markham to hear first-hand from staff and patients of Lancashire Teaching Hospitals NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust, as well as local NHS leaders, members of parliament and local councils, health and social care colleagues.

In May 2023, the Government announced a record investment of more than £20 billion, ring-fenced for the next phase of the national New Hospital Programme, which brings proposals for new cutting-edge hospital facilities for Lancashire and South Cumbria a step closer.

Replacements for Royal Preston Hospital and Royal Lancaster Infirmary are part of a rolling programme of national investment in capital infrastructure beyond 2030. In addition, Furness General Hospital in Barrow will benefit from investment in improvements.

The existing Preston and Lancaster sites will remain in place and deliver services to our population until new hospital facilities are opened. The local NHS will continue to keep communities involved and provide further updates as more information becomes available. You can read more here.

ix. NHS flu and Covid-19 vaccinations brought forward due to new variant

Flu and Covid-19 vaccination programmes across Lancashire and South Cumbria have been brought forward due to a new Covid-19 variant that has been detected.

The adult COVID-19 and flu vaccination programmes had been due to start in October to maximise protection over the winter months, but now those most at risk including adult care home residents began to be vaccinated from 11 September.

Residents of older adult care homes and those most at risk including those who are immunosuppressed have received their COVID-19 vaccines first.

Adults aged 65 and over will be eligible to receive a COVID-19 vaccine but should wait to receive an invite from their local provider.

Carers, pregnant women, and health and social care staff will also all be among the groups to be offered a COVID-19 jab this winter, however they will not be identified nationally and therefore should book an appointment when they become available. You can read more here.

x. More than 2,500 people in Lancashire and South Cumbria to benefit from on-the-spot liver scans

Community liver health checks are being offered to communities in Lancashire and South Cumbria as part of a pilot to catch more cancers earlier and save lives.

Liver scans will be available at a range of locations including GP practices, addiction services, foodbanks, sexual health clinics, homeless shelters and walk-in events in town centres to encourage the uptake of quick, non-invasive scans. The liver health checks include a Fibroscan which is a quick and painless scan that can detect the signs of chronic liver disease like significant scarring or cirrhosis, which increases the risk of liver cancer.

It means that people at higher risk of liver cancer can be identified and monitored regularly to spot any early signs of the disease.

Checks are being offered to adults with diabetes, high BMI, high levels of alcohol consumption, or diagnosis of previous or current viral hepatitis or non-alcoholic fatty liver disease, as these factors increase the risk of developing cirrhosis of the liver.

A mobile liver scanning unit will be visiting Barrow and Lancaster in October, and Blackburn and Burnley in November. You can read more here.

xi. Parents and guardians urged to ensure children in Lancashire and South Cumbria have MMR vaccine

The NHS in Lancashire and South Cumbria is urging parents and guardians to check that their children are up to date with their MMR (Measles, Mumps and Rubella) vaccinations to reduce the risk of catching the highly infectious disease.

Every region in England has reported confirmed cases of the infectious disease and cases to date are over double that of the whole of last year.

The MMR vaccine is given at one year old and again at around three years and four months in readiness for starting school. Two doses are enough to give lifelong protection from becoming seriously unwell with mumps, measles and rubella. The MMR vaccine is often given at the same time as the pre-school booster including protection against polio. Anyone who has missed any of the vaccinations can catch up at any time.

If any doses have been missed, a vaccination appointment can be made at your GP practice to catch up and become protected. You can read more here.

xii. Waiting lists for children decreasing thanks to new surgery offer

Children across Lancashire and South Cumbria waiting for treatment are now being offered day surgery at Chorley and South Ribble Hospital for the first time.

Previously all children had been treated at the Royal Preston Hospital (RPH), but it has not been possible to increase the number of procedures there. Instead, a paediatric surgical hub has been created at CDGH to tackle waiting lists.

Some children referred to Lancashire Teaching Hospitals (LTH) are now having their surgical procedure at CDGH for specialties, including Dental, Maxillofacial, Ophthalmology, Plastic surgery and Ear, Nose and Throat.

Every fortnight there will be a dedicated day of low-complexity paediatric day surgery. You can read more on our website here.

xiii. NHS Trusts in Lancashire and South Cumbria collaborate to improve digital learning

NHS Trusts in Lancashire and South Cumbria are collaborating to develop a digital education network that will share learning environment approaches across organisations in education and practices, helping to improve digital learning across the region.
This collaboration of sharing digital resources developed as a direct result of the Targeted Practice Education Programme 4.4 objective, which aims to identify key stakeholders to develop a digital education network across Lancashire and South Cumbria, using a programme of online and face to face showcase and networking events, as well as an online space for shared access to resources, discussion, innovations and case studies, to illustrate best practice, new technology and innovative solutions.

As part of the collaborative work, Lancashire Teaching Hospitals NHS Foundation Trust and East Lancashire Hospitals NHS Trust recently joined forces to create an innovative and sustainable way to deliver key clinical skills through 3D printing technology, which will enhance the training and education of healthcare professionals.

By simulating real-life scenarios, students and practitioners can practice critical clinical skills in a safe and controlled environment, ultimately improving patient care and outcomes. You can read more on our website here.

4. 

Consistently deliver excellent care

a) Care Quality Commission (CQC) Inspection of Maternity Services

The CQC carried out an inspection of the Trust's Maternity Service across both Royal Preston and Chorley and South Ribble Hospitals on 3 and 4 July 2023. This was part of a national maternity inspection programme to provide an up-to-date view of the quality of hospital maternity care across the country, and to gain a better understanding of what is working well to support learning and improvement at a local and national level. More information is available about this on the CQC website.

Following the Inspection, the CQC gave us some verbal feedback which was subsequently confirmed in writing.

Key points were as follows:

Following the safety champion and Maternity Voices Partnership interviews it was recognised that service had continued engagement within the local community despite not having an MVP chair. There was innovative outreach within the community for example the work with a local Muslim girls school in Preston.

The continuity and home birth teams are continuing to run services and there was a lot of positive work being achieved within the diabetic team.

It was recognised that there are highly skilled midwives working for the trust who are passionate about their role and providing safe care for women and birthing people.

We currently await the final report to be published and look forward to sharing this.

b) New gym equipment at Royal Preston Hospital to aid patient recovery

Thanks in part to a grant of £15,228 from NHS Charities Together, Lancashire Teaching Hospitals Charity has been able to fund new gym equipment at the Royal Preston Hospital to help patients rehabilitate.

The new facilities will enhance patient experience and outcomes when rehabilitating from traumatic injury, surgery or ill-health, including COVID-19.

The gym will also be used to expand the support available for the physical and mental health and wellbeing of staff, through exercise classes and potentially for staff gym memberships.

Dan Hill, Head of Charities at Lancashire Teaching Hospitals NHS Trust said: “We are thrilled that our charity funding has enabled these fantastic facilities at Royal Preston Hospital. The new equipment will make a big difference to the recovery of our patients. We are especially grateful to NHS Charities Together for their grant which helped to make this project a reality, and to all our supporters for their generous donations.”

This is the second phase of a project which saw similar improvements to the gym facilities at Chorley and South Ribble Hospital, also part funded by the grant from NHS Charities Together. You can read the full story on our website here.

c) National Rainbow Baby Day supports families in Lancashire and South Cumbria

A special rainbow babies’ event to celebrate National Rainbow Baby Day was recently held at Royal Preston Hospital with over 40 families from across the region to honour the babies born to families following pregnancy and baby loss, and to remember the babies that are sadly no longer with us.

The event was organised by Specialist Bereavement Midwife, Claire Braithwaite and her team in association with the Lancashire Teaching Hospital Baby Beat charity. This special day was created to recognise all rainbow babies born after a miscarriage, a stillbirth or neonatal death.

The Specialist Midwives at Lancashire Teaching Hospitals support families throughout their rainbow pregnancy in a dedicated antenatal clinic. The rainbow service offers regular appointments, additional key touch points or telephone contacts to support and meet the individual needs of families.

Families can be referred to the Rainbow clinic by their community midwife if they meet certain referral criteria. You can find out more on our website here.

d) Tree of Life organ donation blankets

New Tree of Life blankets were launched at the Trust in September during Organ Donation Awareness Week, to provide recognition to the incredible and selfless act from organ donors that give the gift of life.

ICU staff nurse and clinical educator Emma Edmonds designed and arranged production of 30 beautiful blankets, that will be placed on the beds of all consented organ donors.

Emma then created a bright colour scheme for the logo, to highlight and celebrate the gift donors are giving, and Carol Dryden from Sew Stunning Designs in Leyland kindly embroidered the design onto the blankets. You can read more here.

The Bereavement and Tissue Donation Team at the Trust organised a series of events for Organ Donation Awareness Week (from September 18-24) which culminated in colleagues taking part in a national Race for Recipients campaign to raise awareness of organ donation. Some chose to do this as a 21-mile circular of the Preston Guild Wheel. A big well done to all involved!

You can also read Keith Astbury's story about the importance of organ donation on our website, five years after his daughter Pippa gave the gift of life.

5. A great place to work

a) New memorial Garden opens at Royal Preston Hospital

A new memorial garden at Royal Preston Hospital was officially launched with a public opening at the end of July, created by Lancashire Teaching Hospitals Charity to honour organ donors and those who lost their lives in the Covid-19 pandemic.

The project was made possible thanks to a generous £100,000 grant from NHS Charities Together, which helped fund memorial gardens at both Chorley and South Ribble Hospital and Royal Preston Hospital, along with £5,000 from the Medicash Foundation and £1,000 from David Wilson Homes.

The gardens were designed to remember not only those lives which were sadly lost during the pandemic, but also those who have given the precious gift of life, highlighting the importance of organ and tissue donation across the region.

The tranquil space will serve as an extra place on site for quiet contemplation and reflection to be used for the benefit of all staff, patients, and visitors – somewhere to come together to remember, relax and recharge. You can read the full article here.

b) LTHTR Hero Portrait competition winner announced

In September we celebrated and presented Heidi Rochester with her very own oil portrait as part of our peer recognition initiative – LTHTR Portrait of a Hero.

Earlier this summer, colleagues were invited to nominate someone who they found inspiring, supportive or simply goes the extra mile, living our values and building team spirit.

Heidi's colleagues and family joined in the celebrations and colleagues in her team spoke so warmly and lovingly about her and the positive impact she has due to her cheerful and altruistic nature.

Along with enjoying a light lunch – the event was an opportunity for the team to connect, recognise Heidi and celebrate all the contributions the Prosthetic team bring, making extraordinary things happen each day at Lancashire Teaching Hospitals.

The Organisational Development team would like to thank everyone who attended and contributed to the organising of the event, especially Pete Bourne the artist who was fundamental to the running of this recognition project.

c) Sarah's Great North Run for LTH Children's Appeal

Our Chief Nurse, Sarah Cullen, took part in the Great North Run on 10th September to help raise vital funds for the LTH Children's Appeal.

The funds raised will be used to help improve the experience of all children and their families whilst they're in hospital and will contribute towards creating a calm, peaceful and relaxing space for children and young people who experience mental health or psychological difficulties whilst in our care.

Sarah, who is the Executive lead for the Charity, has decided to raise funds for the LTH Children's Appeal because she wants to help improve the experience that children and young people have when they stay in hospital.

Sarah explains: "Children and young people with mental health issues generally have a poor experience whilst in hospital. Lots has been done in recent years to improve this, but sadly sometimes the only safe place is a physical health hospital until next steps can be arranged. Our hospitals are not designed to provide the therapeutic environment that young people need in these circumstances and it's an area we need to focus on. The funds raised will help provide more spaces with relaxing, therapeutic interventions that help at times of crisis and recovery." You can find out more here.

6. 

Deliver value for money

a) Finance team maintain Level 3 accreditation

The Trust Finance Team have successfully maintained their Level 3 Finance Skills Development accreditation, the highest level available.

The award demonstrates the excellent standard of training, development and culture of the finance team alongside strong governance controls and approach to continuous improvement.

The assessors' feedback was glowing, concluding that: "The team is well led and place great emphasis on developing each team member to their best potential. It was clear to see that everybody has a voice and is able to contribute.

"Since achieving Level 3 accreditation in 2019, they have not stood still. Even with the pandemic, the have continued to develop, improve, and share. They can clearly demonstrate their commitment to themselves, their organisation, and the wider NHS family."

The accreditation adds to a string of awards over the last three years, including the HFMA Governance Award 2020, HFMA NW Team of the Year 2022 and One NHS Finance Value Maker of the Year HFMA National 2021.

7. 

Fit for the future

a) NIHR Research Scholarships awarded to LTHTR Consultants

In August the Trust had three successful candidates commencing Cohort 5 of the North West Coast Research Scholars Programme programme which is highly-competitive programme aimed at equipping tomorrow's clinical research leaders with the skills, knowledge and experience needed to become the Principal (PI) and Chief Investigators (CI) of the future.

The funding associated with the programme enables scholars to have dedicated time for research in addition to monthly face-to-face sessions with experienced CIs and experts in the field. Congratulations to Dr Emma Callery (Immunology Clinical Scientist), Claire Slinger (Speech & Language Therapist) and Dr David Russel (Radiologist) who were all accepted onto the programme.

b) LEAF accreditation for microbiology team

The Microbiology team were awarded the bronze LEAF (Laboratory Efficiency Assessment Framework) accreditation from University College London in August for the brilliant work they're doing to make Lancashire Teaching Hospital laboratories more sustainable.

LEAF is an established audit tool that is used by academic laboratories to reduce their environmental impact. The LEAF team adapted the framework to be used as a pilot in diagnostic laboratories and the microbiology team at LTH jumped at the chance to be involved.

Pathology testing underpins much of the work we do as a Trust and our laboratories contribute significantly to our carbon footprint because of the large amounts of energy and water they consume. An average laboratory uses 3-6 times the amount of electricity of the equivalent size office.

Over 1.1 billion pathology tests are performed annually in England - approximately 20 tests per person. These tests require large volumes of single-use plastic and produce vast quantities of waste. As a result, the LTH Microbiology team wanted to look in more detail at how they could make their operations more environmentally friendly and contribute towards the GreenerNHS target for a net zero health service.

The Microbiology team are now aiming to achieve the silver LEAF accreditation award and are supporting other pathology disciplines at LTH to achieve their bronze LEAF accreditation. You can read the full article on our website here.

8. AWARDS, ACHIEVEMENTS AND OTHER NEWS

a) Professor Muhammed Munavvar shortlisted for Clinical Leader of the Year at the HSJ Awards

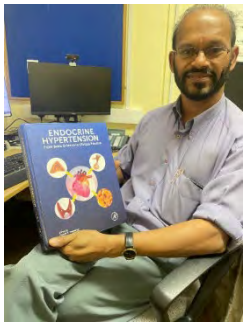
The Trust is delighted to announce that Professor Mohammed Munavvar, Consultant Respiratory Physician and Interventional Pulmonologist, has been shortlisted for Clinical Leader of the Year at the 2023 HSJ Awards, recognising an outstanding contribution to healthcare and securing a place at the prestigious awards ceremony later this year.

Following a thorough judging process, Professor Munavvar was shortlisted, ahead of the official awards ceremony to be held later this year on 16th November. Professor Munavvar's role as a clinical leader at Lancashire Teaching Hospitals stood out as a real success story worthy of a prized place on the panel's shortlist.

Professor Munavvar is an outstanding clinical leader and fantastic ambassador for respiratory medicine around the world. He works incredibly hard to provide the best patient care by introducing the latest, cutting-edge technologies to improve diagnosis, treatment and outcomes for respiratory patients. An internationally renowned expert in COVID-19, interventional pulmonology and tuberculosis, he offers clear leadership, expert advice, training and mentoring to many others globally and dedicates much of his free time to fundraising for new equipment at Rosemere Cancer Foundation Charity.

Professor Munavvar is also shortlisted alongside the Enterprise wide application projects team in the Modernising Diagnostics category due to their hard work in bringing Lung Vision technology to Royal Preston Hospital and the first to the UK. You can read more on our website here.

b) Professor is back in print!



Consultant, Research Lead and Professor Joseph M. Pappachan added to his vast editing experience in August, sharing his most recent academic work - the current issue of Endocrinology & Metabolism Clinics of North America, which you can find here.

The Journal has 12 clinical update review articles covering most aspects of Metabolic-dysfunction associated fatty liver disease (MAFLD) with authors from nine countries across four continents, making this a truly international academic output.

This work will be included in our libraries for colleagues and trainees to use the latest information on this very common disease which affects at least one third of the global population including people within our region.

c) Lancashire Teaching Hospitals' colorectal team Highly Commended at 2023 HSJ Patient Safety Awards

Congratulations to the Trust's colorectal team, whose excellent work with the 'Tell People Quickly that They Don't Have Cancer' initiative was Highly Commended at the HSJ Patient Safety Awards in Manchester in September.

Five initiatives across Lancashire Teaching Hospitals NHS Trust were shortlisted for awards at the prestigious event, which recognises safety, culture and positive experience in patient care, celebrating its worthy finalists on a national scale.

Other nominations included:

- Community Care Initiative of the Year - Lancashire Community Healthcare Hub - Finney House
- Developing a Positive Safety Culture Award - Always Safety First
- Improving Medicines Safety Award - Reducing Medication Omissions
- Quality Improvement Initiative of the Year - Microsystem Coaching to Improve Patient Safety

d) Renal charity walk raises thousands

A big thank you to the group of staff on our Renal Dialysis Unit who raised an incredible £5,846.63 for our hospital charity in August, walking the 11 miles from Chorley and South Ribble Hospital to the Renal Unit at Royal Preston Hospital.

The 25-strong group took on the walk to raise funds to kit out the unit with TVs and radios to help keep patients undergoing kidney dialysis entertained.

Nurse Emma Beeson, who organised the walk with fellow nurse Carley Webster, said: “We wanted to improve patient experience and comfort. Being able to watch TV or listen to the radio will help patients pass the time while they are undergoing dialysis, which typically takes around four hours per session.” You can read more here.

e) Amazing results for the Trust after Manchester Medical School Annual Performance Review

Lancashire Teaching Hospitals received glowing feedback from Manchester Medical School during their 2023 Annual Performance Review in late August.

Supporting up to 350 medical students at any one given time, the Trust is one of the largest medical teaching facilities in the county and after what was described as an ‘extremely positive session’ and a ‘massive team effort’ by Chief Medical Officer, Dr Geraldine Scales, the school have discerned that they are ‘very pleased’ with the training resources on offer.

The Performance review is structured around Real Time Centric Feedback from each of the Year 3 - Year 5 students themselves, given at the end of each of their clinical placements they have undergone that year.

It has been found that the results of all placements have increased substantially since the previous academic year, scoring at least 4/5 in all levels of feedback. You can read more on our website here.

f) Gregg wins World gold to qualify for Paris Paralympics

Gregg Stevenson – formerly Lead Physical Training Instructor and Mental Health Practitioner at the Trust’s Specialist Mobility and Rehabilitation Centre (SMRC) - helped win the World Rowing Championship’s PR2 mixed double sculls in Belgrade in September, qualifying for the Paralympics in Paris next summer in the process.

The veteran, from Foulridge, near Burnley – still supported by SMRC - joined Double Paralympic champion Lauren Rowles as they won a tight race, pulling away from China in the final strokes to cross the line first to continue their dominance in this boat class this season.

The former Royal Engineer is a double amputee after losing his legs to an IED blast while on patrol in Helmand Province in 2009, when he was referred to the SMRC at Preston Business Centre and fitted with the world’s most advanced bionic high-tech Genium X3 knee, which works with Wii gaming technology - worth £70,000.

Gregg ended up working in the gym at SMRC - which provides specialist wheelchair, prosthetic limb and orthotic rehabilitation services throughout Lancashire and South Cumbria – before becoming Gym Assistant Manager, and then Lead Physical Training Instructor, and then progressing to be a Mental Health Practitioner.

You can read more about Gregg's win here.

g) Premier League side Burnley FC and Championship duo Preston North End and Blackburn Rovers back ICON Week 2023

The third annual ICON week (25 to 29 September 2023) was held in September to raise awareness of infant crying and how to cope to support parents/carers and prevent serious injury, illness and even death of young babies as a result of Abusive Head Trauma that happens when someone shakes a baby.

ICON is a programme to raise awareness of infant crying and how to cope to support parents and carers, and prevent serious injury, illness and even death of young babies as a result of abusive head trauma from shaking a baby. For more information, please visit www.iconcope.org/iconweek2023

See which players supported the awareness raising on our website.

h) Trust midwife Deborah awarded NHS Safeguarding Star

A midwife at Lancashire Teaching Hospitals NHS Trust has been awarded an NHS Safeguarding Star Award for her work to promote safer sleep for babies.

Deborah Gibbons, Lead Midwife for Safeguarding at the Trust, was awarded the prestigious accolade for her work around Sudden Unexplained Death in Childhood (SUDC), which is the sudden and unexplained death of a child aged 1-18, as well as her work to embed safer sleep assessments across the Trust.

An emotional Deborah – unaware of her nomination - was surprised with the award at the SUDC group by Catherine Randall from NHS England (National Associate Director of Safeguarding), with Elizabeth Radcliffe (Deputy Director of Quality, Regional Safeguarding & Investigations Lead, (NHS England North West Clinical Directorate) and Jane Jones (Deputy Director for Safeguarding, NHS Lancashire and South Cumbria Integrated Care Board) also present.

She was rewarded for her work around SUDC prevention and championing safer sleep, where she has embedded a safer sleep assessment. Read the full story on our website.

i) Trust recognises World Sepsis Week

In mid-September the Trust recognised World Sepsis Week with a series of events to promote awareness.

Over the week, there was a Sepsis van in The Health Academy car park at Royal Preston Hospital, supported by Rachel Lea from the Infection, Prevention and Control Nurse team, as well as a special fundraising effort for World Sepsis Awareness UK, with lunch in the Critical Care clinical skills room, sponsored by Joy's Kitchen, Kashmir Watan Foods and Barkat Food Store.

On World Sepsis Day itself, there was a pop-up stand in Charters Restaurant at Royal Preston Hospital, with 'Sepsis Champions', a cake bake, raffle, quiz, and more, with all funds going to the UK Sepsis Trust, and over at Chorley and South Ribble Hospital the following day, there was a Sepsis Awareness session, with a walk round wards and areas to raise awareness.

Read the full story on our website.

9. RECOMMENDATIONS

It is recommended that:

I. The Board receive the report and note its contents for information.

Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	13 September 2023
Title of paper	Chief executives' board report
Presented by	Kevin Lavery, chief executive officer, Integrated Care Board
Author	Hannah Brooks, communications and engagement manager and executive team lead contributors
Agenda item	5
Confidential	No

Executive summary

Ahead of the ICB's annual general meeting, and in light of NHS England's annual assessment of our performance, this report celebrates the success of the organisation, acknowledges the hard work of colleagues working across the system, and highlights the need to review our progress.

In order to provide a sustainable long-term health and care system, we need to reset and fundamentally change our approach, and transform our way of working to promote a community-centric approach, with more prevention and better use of our health and care partners.

Difficult decisions will need to be made, backed up by the evidence that shows that the quality and safety of our services will not be compromised.

Recommendations

The Lancashire and South Cumbria Integrated Care Board are requested to note the updates provided.

Which Strategic Objective/s does the report relate to:		Tick
SO1	Improve quality, including safety, clinical outcomes, and patient experience	**x**
SO2	To equalise opportunities and clinical outcomes across the area	**x**
SO3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	**x**
SO4	Meet financial targets and deliver improved productivity	**x**
SO5	Meet national and locally determined performance standards and targets	**x**
SO6	To develop and implement ambitious, deliverable strategies	**x**

Implications	Yes	No	N/A	Comments
Associated risks			x	

Are associated risks detailed on the ICB Risk Register?			x	
Financial Implications			x	

Where paper has been discussed (list other committees/forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**
n/a	n/a	n/a

Conflicts of interest associated with this report
n/a

Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed			x	
Equality impact assessment completed			x	
Data privacy impact assessment completed			x	

Report authorised by:	Kevin Lavery, chief executive officer

Integrated Care Board – 13 September 2023

Chief executives' board report

1. Introduction

"Progress is impossible without change, and those who cannot change their minds cannot change anything."

1.1 As we approach our annual general meeting and consider the feedback from NHS England's annual assessment of the ICB 2022-23, we are faced with an opportunity to reflect on the great work and progress that has been made since the establishment of the ICB.

1.2 It is clear that colleagues across the system are working hard to improve the quality of our care provision and outcomes for people in Lancashire and South Cumbria. There is much to be proud of, but this is also a good time to review our progress. There is more that we need to focus on across our health and care system and fundamentally change the way we do things around here to ensure that our health and care system is affordable in the future.

1.3 There are several items on the agenda for today's board meeting that lend themselves to the forward view that we must take, for both the short and medium term. This includes the New Hospitals Programme, the system recovery and transformation plan and the Working in Partnership with People and Communities strategy 2023-2026.

2. NHS England's annual assessment of the ICB

2.1 In late July, we received a letter from NHS England with the annual assessment of our performance in 2022-23. The letter acknowledged that it was a year of transition and there will be many challenges ahead. We received positive feedback around our governance arrangements, for example our board's inclusion of partner members from the wider health and social care system and professional leadership from a medical and nursing perspective.

2.2 The feedback was split into the four fundamental purposes of an ICS.

Improving population health and healthcare

Performance in areas such as 104-week waits, 78-week waits and plans to eliminate 65-week waits by March 2024 were praised. Urgent and emergency care was noted as more challenged, though it was highlighted that performance exceeds the national average.

Our Quality Committee was also observed as delivering its functions in a way that secures continuous improvement in the quality of services.

Our working with people and communities strategy, along with the establishment of our Public Involvement and Engagement Advisory Committee, was highlighted as ensuring the voice of local people and resident is actively embedded and valued in decision making.

Tackling unequal outcomes, access and experience

It was recognised that we include prevention and improving population health as a cross-cutting priority and that we are focused in driving down inequalities in access, outcomes and experience for people in Core20plus communities.

Enhancing productivity and value for money

We were recognised for remaining within our cash limit and within our capital resource limit, as well as maintaining within our running cost allowance.

Unsurprisingly, it was acknowledged that the year ahead is already proving challenging from a financial aspect, with the need for all system partners to work together. We were also encouraged to begin developing our medium-term financial plans to achieve our system clinical ambitions in a sustainable manner.

Helping the NHS support broader social and economic development

The ICB's work with providers and place-based partners to embed anchor approaches and share good practice was recognised. The Lancashire and South Cumbria ICB Green Plan was also referenced as outlining how the ICB will support NHS England and the UK government to fulfil the emission goals.

2.3 The main recommendation for us as an ICB was the need to focus on driving continued improvement in access to services, both physical and mental health, and in both primary and secondary care – alongside a relentless focus on productivity and value for money.

2.4 Table 1 (see next page) sets out how we are performing as an ICB against the national targets, national average and north west average.

2.5 Performance on most key metrics is generally a little above average or good. Cancer has been a problem area for us, but is now fast improving.

2.6 This is a testament to the hard work of staff working across the Lancashire and South Cumbria health and care system over the last year; we are making real progress and it is being recognised regionally and nationally, so I would like to thank all colleagues for their efforts.

Table 1: ICB performance

Performance metric	Target	Lancashire and South Cumbria ICB	North west average	National average	Comments
Winter and UEC					
Not meeting medical criteria to reside		8.57%	15.61%	14.13%	Jun-23
A&E 4 Hour Standard (76% Recovery Target)	76.00%	77.49%	73.00%	73.99%	Jul-23
Average ambulance response time: Category 2	00:18:00	00:25:22	00:25:22	00:31:50	NWAS Aggregate
Virtual ward occupancy	80%	45.30%	45.92%	64.10%	28/07/23 Snapshot
Virtual ward Capacity per 100k		26.0	20.19	18.9	28/07/23 Snapshot
Cancer					
2 week wait referrals (93% Standard)	93%	89.36%	84.47%	80.52%	Jun-23
31 Day First Treatment (96% Standard)	96%	88.07%	91.31%	91.35%	Jun-23
62 Day referral to treatment (85% Standard)	85%	52.31%	59.44%	59.24%	Jun-23
% meeting faster diagnosis standard	75%	76.14%	70.25%	71.35%	Jun-23
Elective recovery					
65-week wait (% waiting 65+ weeks)	0% (by Mar-24)	0.93%	1.76%	1.29%	Jun-23
Day case rate [BADS Procedures]		82.50%	77.90%	80.40%	Feb-Apr23
Capped theatre utilisation	85%	77.60%	75.00%	76.40%	Rolling 3 months to 30/07/23
Discharge to patient initiated follow-up		3.31%	2.27%	2.57%	Jun-23
Mental health					
Under 18s supported through NHS funded mental health with at least one contact	24,118 contacts in 1 year	26,120 (+8.3% above trajectory)	GM: +1.1% above trajectory C&M: -19.2% below trajectory		May-23
Dementia diagnosis	66.7%	68.8%	GM: 71.5% C&M: 65.8%		July-23
SMI health checks		58%	GM: 63% C&M: 52%		% against LTP
Primary care					
GP patient survey: positive experience		75%	73%	71%	2023 survey
GP patient survey: ease of getting through to GP practice by phone		54%	51%	50%	2023 survey

3. New Hospitals Programme

3.1 Since my last report, we have taken a big step forward for Lancashire and South Cumbria, now that we have funding envelopes for the two new builds.

3.2 The key next stage is to complete land acquisition. We are in the process of submitting a business case to enable us to drawdown capital funds so that we are able to acquire land, which will enable works to starter at the earliest opportunity. This will put Lancashire and South Cumbria in a very strong position to progress the project and, if the opportunity arises in due course to accelerate it, then land ownership would be vital.

3.3 Today's agenda includes a report on the latest position of the New Hospitals Programme, with more detail about the timelines and key milestones. As the programme progresses there will be a number of key decisions for us to take as a board and we will continue to receive updates as the programme develops.

3.4 In August, our New Hospitals Programme team facilitated a ministerial visit from Lord Markham, Parliamentary under-secretary of state for health and social care, and other members of NHS England and the Department of Health and Social Care as part of a roadshow taking place across the country.

3.5 The aim of the event was to update stakeholders on the national programme and what this means for Lancashire and South Cumbria. The day also gave us an opportunity to update national colleagues on the work happening in Lancashire and South Cumbria and to share the experiences of what it is currently like to work and be treated in our current facilities, as well as talk about the programme and any issues or barriers to our progress.

3.6 An afternoon stakeholder session included an invitation to non-executive directors of the ICB and trusts, and I know that many of you attended the session. I would like to extend my thanks to everyone involved in helping the day to run smoothly.

3.7 The New Hospitals Programme timeframe marks out the progress we need to make in those 12 years. By then, we need to have transformed our delivery model to fit the growing needs of the population; so that the demand for services does not overwhelm the system.

4. The need to reset

4.1 What we need in the period between now and when we begin the design of the new hospitals, is to reset our system and reinvent to promote a

community-centric approach, with more prevention and better use of our health and care partners. If we do not change our delivery model, in 12 years we would have an unaffordable challenge.

4.2 We currently deliver a £4 billion budget via a hospital-centric delivery platform, with 60% of our money spent on hospitals. We have some key drivers of this, such as people over 85 with multiple long-term conditions, a generally ageing population with greater health need, increased demand and longer waits for treatment as a result of long COVID, population growth, poverty and the cost-of-living crisis.

4.3 This is why we need to press the reset button now. We need to look at a major expansion over the next few years of hospital at home care (virtual wards). In fact, we need to start thinking about a virtual hospital, with a single platform, and single provider rather than four separate operations.

4.4 We also need a significant expansion of intermediate care, with a dynamic model so that people do not end up institutionalised in care. This needs to be a system that aids early discharge, using care to get people back into the community as soon as possible, or to get them appropriate support to avoid admission in the first place.

4.5 The emphasis will need to be on population health, risk-based primary care and the very frail elderly. People over 85 with multiple long-term conditions are a critical driver of our whole health and care system and that population is due to increase significantly in the next 12 years.

4.6 If we do not change our delivery model, we will not be able to provide the care that will be needed by our population in 2035. Approaches like the Jean Bishop Integrated Care Centre in Hull and East Riding, which I mentioned in my last board report, are the kinds of examples of integration that we quickly need to explore and find ways to implement in Lancashire and South Cumbria, at pace and at scale.

5. The need for tough decisions

5.1 Although the way we are configured is the reason behind our challenged financial situation, we do need to change our approach to health and care because without change, outcomes and care for our residents and communities will only get worse.

5.2 In June, we received negative publicity due to the ICB not providing inflationary uplift for hospices. These are the sorts of choices we are going to need to make as a board. We recognise the important role that hospices play

in our health and care system and essentially the most important thing for us to do is work with the hospices to support the work they do for people in Lancashire and South Cumbria. Our conversation with the hospice leaders has been more around our long-term model and how we can provide more certainty and clarity, focusing on a outcomes-based specification with more flexibility for delivery.

5.3 We know that the scale of cuts is significant; for the ICB alone we are being asked to cut our running cost allowance by 30% by 2025/26.

5.4 As Irish playwright, George Bernard Shaw, said: “Progress is impossible without change, and those who cannot change their minds cannot change anything.”

5.5 All the decisions we make will be backed up by the evidence that shows that the quality and safety of our services will not be compromised, and that certain communities will not be unfairly disadvantaged by those decisions. We are committed to engaging, involving and consulting our residents and communities.

5.6 In July we revised our strategy for working in partnership with people and communities which builds upon engagement with public and partners throughout the past year, with support from the Public Involvement and Engagement Advisory Committee. We have processes in place to involve and engage, and our Working in Partnership with People and Communities strategy will support with keeping the public, patients, carers, staff and partners informed and involved in service change and transformation, including how we reach and involve those who are affected most by health inequalities.

5.7 The fact remains, we cannot continue the way we are. We must make difficult choices and we will have to stand by those choices when challenged. This does not mean that we will never review our decisions, but we must continue to make these choices in the best interests of our residents and communities and, in doing so, be aware of the need to manage media interest or political pressure. That is the only way we will be ready for our new hospitals in 2035.

6. Finance and recovery

6.1 At the end of July, we had a catch-up meeting with NHS England’s chief operating officer for the NHS, Sir David Sloman, urgent and emergency care director, Sarah-Jane Marsh, deputy CEO and director of finance, Julian Kelly, and regional director, Richard Barker.

6.2 We received strong support for the recovery approach that we have adopted, with a focus on clinical and non-clinical transformation and a three-to-four year timeframe. It is recognised that there is a significant amount of change and a high degree of risk in some aspects of the programme.

6.3 The budget remains very challenging for the ICB and for the wider system. What I can say, is that I have been really pleased with the quality of the cost improvement programmes (CIPs) and our quality innovation, productivity and prevention (QIPP). We have got better plans in all places that are being robustly monitored and assured, and I am assured that we are doing all the right things. It is such a big ask, that there remains a lot of risk.

6.4 I have been really impressed with senior middle managers, in our hospitals, mental health trust and in our ICB, rising to the challenge in the most difficult circumstances.

7. Specialised Services Commissioning

7.1 Further to the update in my last report, delegation of a large portion of specialised services commissioning from NHSE to ICBs continues with the completion of the LSC ICB Pre-Delegation Assessment Framework in August. The Finance and Performance Committee approved the framework for submission to the regional NHSE team, on behalf of the ICB board at their meeting on 29 August. This submission will now be moderated by the regional team and then considered by the NHS England board in December 2023.

7.2 This delegation will enable ICBs to join up the specialist elements of pathways with the prevention activity and primary, community and secondary care services they are responsible for.

7.3 Staff who commission the services being delegated from April 2024, or support related activity, will come together throughout England, in commissioning hubs, with LSC ICB as the host organisation for the north west hub. Given the different timeframes for delegating services and to ensure there is a stable support for delegation, the hub teams will continue to be employed by NHSE during 2024/25, whilst supporting the services delegated to ICBs as well as those retained by NHS England. This will allow us to achieve a smooth transition for NHS staff and for the people who rely on these services. All other delegation preparations and hub arrangements continue to ensure we as an ICB and host of the north west hub are ‘ready to receive’ delegated services from 1 April 2024.

8. Ensuring our staff have freedom to speak up

8.1 For many people working across the NHS, the trial of Lucy Letby highlighted a shocking and awful series of events, and our thoughts are with the families at this difficult time.

8.2 A letter from Amanda Pritchard, Sir David Sloman, Dame Ruth May and Professor Sir Stephen Powis, following the verdict in the trial of Lucy Letby, included a number of actions being focused on nationally to prevent anything like this from happening again. In particular:

- The national roll-out of medical examiners provides additional safeguards by ensuring independent scrutiny of deaths not investigated by a coroner;
- The new Patient Safety Incident Response Framework will be implemented this autumn and will provide a sharper focus on data and understanding how incidents happen, engaging with families and taking effective steps to improve and deliver safer care;
- The importance of Freedom to Speak up; which you will note is an item on today's agenda;
- The strengthened Fit and Proper Person Test Framework, an assessment to ensure no individual is appointed as a board director unless they satisfy the requirements, which includes that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not).

8.3 As the statutory inquiry is carried out, we will begin to understand what went wrong and consider how we can learn our own lessons from this tragedy. We will also use this opportunity to look at our arrangements for how we engage, to ensure that all colleagues have freedom to speak up.

8.4 This is important for us as an organisation, not just in the wake of recent events; we have been developing this process over several months and want to continue to build an inclusive and compassionate culture. We want staff to feel safe and comfortable to raise any concerns that they have.

8.5 As the inquiry develops, I am sure we will revisit some of this and give careful consideration to how we can make improvements in our own health and care system.

9. Recommendations

9.1 The Lancashire and South Cumbria Integrated Care Board is requested to note the updates provided.

Kevin Lavery

5 September 2023

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Board Assurance Framework (BAF) Risk Report							
Report to:	Board of Directors			**Date:**	5th October 2023		
Report of:	Associate Director of Risk and Assurance			**Prepared by:**	K Clay		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☐	**For decision**	☒	**For information**	☐		

Executive Summary:

The Well Led Framework by NHS Improvement and the Care Quality Commission (CQC) require Boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. This includes a Board Assurance Framework (BAF) which provides a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of its high level strategic objectives.

The purpose of this paper is to provide the Board of Directors with details of those risks that may compromise the achievement of the Trust's high level strategic objectives.

Strategic Risks

A copy of the Trust's BAF can be found in Appendix 1, whilst Appendix 2 provides the Strategic Risks with full details of the controls, assurances, any gaps and actions that are being undertaken to mitigate the strategic risks. Due to scheduling of committees, the strategic risks that are detailed in Appendix 2 are those that have been presented to Committees of the Board or reviewed in preparation for the next Committee at the time of writing this paper.

The BAF in Appendix 1 identifies the strategic risks that threaten the delivery of the strategic aims and ambitions of the Trust. There has been no change in score for the strategic risks since the last report. Any changes to the content of the Strategic Risks since the previous update to Board are highlighted in yellow within the strategic risk template. The BAF in Appendix 1 also includes updated Trust Ambition and Aims infographics reflecting the updates to sub ambitions and incorporation of the Risk Tolerance scores.

Operational High Risks for Escalation to Board

There are three operational high risks that continue to be escalated to the Board within the BAF this month. These are:

- Risk ID 25 (scoring 20), Impact on exit block on patient safety, which has been escalated to Board since December 2020 due to the change in occupancy levels within the Emergency Department at Royal Preston Hospital.
- Risk ID 1125 (scoring 20), Elective Restoration following Covid-19 Pandemic, which has been escalated to Board since June 2021 and relates to the recovery of cancer, and non-cancer backlogs.

- Risk ID 1182 (scoring 20) Probability of ongoing strike action and the impact of strikes on patient safety following announcement of national pay award, which has been escalated to Board since October 2022.

It is recommended that Board of Directors:

i. Note and approve the updates to the BAF.

Appendix 1 – Board Assurance Framework
Appendix 2 – Strategic Risks

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Committees of the Board in line with cycles of business

1. Background

1.1 The Well Led Framework by NHS Improvement and the Care Quality Commission (CQC) require Boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. It extends to include a Board Assurance Framework (BAF) which provides a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives.

1.2 This paper provides the Board of Directors with details of those risks that may compromise the achievement of the Trust's high level strategic objectives.

2. Discussion

2.1 Board Assurance Framework (BAF)

2.1.1 The BAF in Appendix 1 identifies the strategic risks that threaten the delivery of the strategic aims and ambitions of the Trust. The BAF in Appendix 1 also includes updated Trust Ambition and Aims infographics reflecting the updates to sub ambitions and incorporation of the Risk Tolerance scores.

2.2 Strategic Risk Register

2.2.1 There has been no change in score for the strategic risks since the last report.

2.2.2 Any changes to the content of the Strategic Risks since the previous update to Board are highlighted in yellow within the strategic risk template in Appendix 2.

2.2.3 It should be noted due to scheduling of committees, the strategic risks detailed in Appendix 2 are those that have been presented to Committees of the Board or reviewed in preparation for the next Committee at the time of writing this paper.

2.3 Operational Risk Register

2.3.1 There are three operational high risks that continue to remain escalated to the Board within the BAF this month. These are:

- Risk ID 25 (scoring 20), Impact on exit block on patient safety, which has been escalated to Board since December 2020 due to the change in occupancy levels within the Emergency Department at Royal Preston Hospital.
- Risk ID 1125 (scoring 20), Elective Restoration following Covid-19 Pandemic, which has been escalated to Board since June 2021 and relates to recovery of cancer, and non-cancer backlogs.
- Risk ID 1182 (scoring 20), Probability of ongoing strike action and the impact of strikes on patient safety following announcement of national pay award, which has been escalated to Board since October 2022.

2.3.2 Further details on the operational high risks escalated to Board can be found in the BAF in Appendix 1.

3. Financial implications

3.1 Any financial implications are captured within the Risk Register records and managed accordingly.

4 Legal implications

4.1 Any legal implications are captured within the Risk Register records and managed accordingly.

5. Risks

5.1 The paper identifies Strategic and Operational Risks that may compromise the achievement of the Trust's high level strategic objectives and therefore, the entirety of the paper is risk focused.

6. Impact on stakeholders

6.1 A robust and well managed BAF reduces the negative impact on patients and staff and the reputation of the organisation and its purpose is to mitigate and reduce, as far as is reasonably practical, the level of risk to that identified in the trust risk appetite statement.

6.2 All risk records impact upon patient experience, staff experience, Integrated Care System and cross divisional work. This is captured within individual risk register entries on Datix.

7. Recommendations

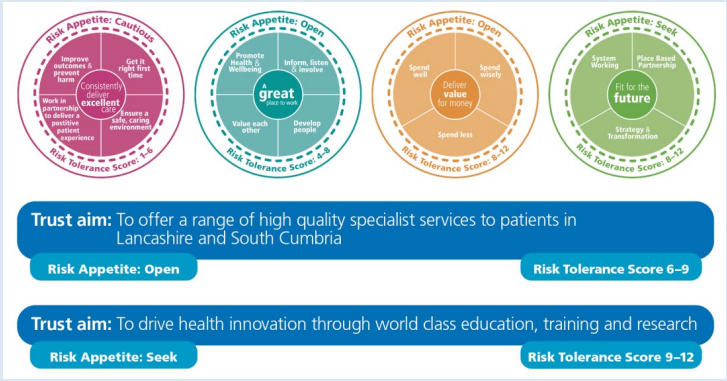
7.1 **It is recommended that Board of Directors:**

i. Note and approve the updates to the BAF.

Appendix 1 - Board Assurance Framework 2023/2024 – Risks to achievement of Trust Aims & Ambitions

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Trust Aims and Ambitions



Current principal risks on the Strategic Risk Register – October 2023

Following a review of the Board Assurance Framework, the following Strategic Risks were identified in June 2020. These are detailed below:

Strategic Risks		Risk ID	Initial Score	Risk Appetite	Risk Tolerance	Aug 2022 Score	Oct 2022 Score	Dec 2022 Score	Feb 2023 Score	Apr 2023 Score	June 2023 Score	Aug 2023 Score	Oct 2023 Score	Change
Risk to delivery of Strategic Aim to offer a range of high quality specialist services to patients in Lancashire and South Cumbria		859	8	Open	6-9	8	8	8	8	8	8	8	8	→
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research		860	6	Seek	9-12	12	12	12	20	20	20	20	20	→
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities &…	Risk to delivery of Strategic Ambition: Consistently Deliver Excellent Care	855	20	Cautious	1-6	20	20	20	20	20	20	20	20	→
	Risk to delivery of Strategic Ambition: A Great Place to Work	856	20	Open	4-8	12	12	12	12	12	16	16	16	→
	Risk to delivery of Strategic Ambition: Deliver Value for Money	857	20	Open	8-12	20	20	20	20	20	20	20	20	→
	Risk to delivery of Strategic Ambition: Fit for the Future	858	20	Seek	8-12	15	15	15	15	15	15	15	15	→

Board Assurance Framework 2023/2024 – Risks to achievement of Trust Aims & Ambitions

Lancashire Teaching Hospitals NHS Foundation Trust

Strategic Risk Summary

Risk		Risk ID	Risk Summary
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research.		860	There is a risk that we are unable to deliver world class education, training and research due to challenges in effectively implementing high quality, appropriately funded and well-marketed education, training and research opportunities due to a range of internal and external constraints. This impacts on our ability to develop our reputation as a provider of choice sustaining our position in the market, supporting business growth and retaining our status as a teaching hospital.
Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service		859	There is a risk to the Trust's ability to continue delivering its strategic aim of providing high quality specialist services due to integration and reconfiguration of specialist services across the ICS. This may impact on our reputation as a specialist services provider and commissioning decisions leading to a loss of services from the Trust portfolio and further unintended consequences affecting staff and patients.
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities	**Risk to delivery of Strategic Ambitions.. Consistently Delivering Excellent Care**	855	There is a risk that we are unable to deliver the Trust's strategic aim of offering excellent health care and treatment to our local communities, as well as the strategic objective of consistently delivering excellent care in inpatient, outpatient and community services due to: a) Availability of staff b) High Occupancy levels c) Fluctuating ability to consistently meet the constitutional and specialty standards d) Constrained financial resources impacting on the wider system, the deficit position facing the Trust and the significant costs of operating the current configuration of services. e) Health inequalities across the system.
	Risk to delivery of Strategic Ambitions.. Great Place to Work	856	There is a risk to the delivery of the Trust's Strategic ambition to be a great place to work due to the inability to offer a good working environment; inability to treat staff fairly and equitably; poor leadership; inability to support staff development. This could lead to staff losing confidence in the Trust as an employer and result in poor staff satisfaction levels, impacting on the organisations reputation and culture subsequently affecting the ability to attract and retain staff, causing key workforce shortages, increasing the use of temporary staffing and poor patient care.
	Risk to delivery of Strategic Ambitions.. Deliver Value for Money	857	There is a risk that we are unable to deliver the Trust's strategic objective 'deliver value for money' due to the inability of the Trust to transform given the range of internal and external constraints (relating to complex models of care, workforce transformation, planning processes, capital resources and dealing with high levels of backlog maintenance) which could result in a failure to move toward segment 2 of SOF and less than a 'good' rating from the use of resources of inspection.
	Risk to delivery of Strategic Ambitions.. Fit For the Future	858	There is a risk to the delivery of the Trust's Strategic Objective to be fit for the future due to the challenges of effectively implementing and developing Place and System (i.e. Integrated Care System and Provider Collaborative) level working we fail to deliver integrated, pathways and services which may result in Lancashire Teaching Hospitals no longer being fit for purpose and our healthcare system becoming unsustainable.

See next slide for key operational risks that are for escalation to Board.

Board Assurance Framework 2023/2024 – Risks to achievement of Trust Aims & Ambitions

Lancashire Teaching Hospitals NHS Foundation Trust

Key Operational Risk Summary for Escalation to the Boards

This details those operational risks that pose a significant threat to achieving organisational objectives

- **Impact of Emergency Department Block on Patient Safety (Risk ID 25 – Initial Score 20, Current Score 20)** – The data measured through the ED Dashboard continues to demonstrate a department under significant pressure with sustained attendances and high numbers of patients waiting over 12 hours to be admitted to a ward or mental health facility. In July 2022, a 24 bedded medical ward opened on the CDH site, whilst this has increased the number of beds on the CDH site, analysis demonstrates that at the same time there was an increase in attends through the ED at CDH site, resulting in the additional beds preventing a further escalation of risk rather than reducing the risk overall. Further actions to address the risk include:
  - Converting the former ED COVID Majors space into a new 20 bedded Acute Assessment Unit
  - 64 beds now open in the Community Health Care Hub to reduce the number of patients in acute beds who no longer meet the criteria to reside in hospital.
  - Continued development of virtual wards to reduce length of stay and avoid admission.
  - Strengthened site management arrangements with 8a Tactical Operational Officers now in place 7.30am – 10.00pm 7 days a week.
  - Joint bid in place with Lancashire South Cumbria Foundation Trust to implement a Mental Health Urgent Assessment Centre co-located to the ED to reduce the number of patients with mental health needs in the ED.
  - Urgent and Emergency Care Transformation Board established with Executive level leadership which will focus on delivering:
    - Newly developed Urgent Emergency Care strategy
    - Therapy admission avoidance 7/7 team ED and MAU/SAU
    - 40% reduction in ambulance conveyances to the ED
    - 10% reduction in length of stay for inpatients.
    - 5% reduction in the patients not meeting the criteria to reside in hospital.

  Assumptions in the Urgent and Emergency Care Transformation Plan indicate material improvements are expected to be seen in Quarter 2 of 2023/2024 and therefore this risk remains escalated to Board.

- **Elective restoration (Risk ID 1125 – Initial Score 20, Current Score 20**) - Patients continue to wait for a significant amount of time to receive non-urgent surgery. The plan to eliminate 104+ week waits has been achieved. The plan to eliminate 78 week waits by March 2023 has not been achieved due to the displacement of activity during industrial action, however the Trust is now working towards elimination of 78 week waits by the end of October 2023 (extended from July 2023 due to industrial action) and is continuing to reduce the number of patients waiting over 78 weeks despite ongoing industrial action. Achievement of the plan and performance against the trajectory is reviewed weekly. All specialties have target plans to work to and are being supported through divisional meetings and the wider Performance Recovery Group. In addition to this there is an Elective Care Transformation Board established with Executive level leadership which is focusing on delivering:
  - Repatriation of services
  - Diagnostic efficiency
  - Sustainable workforce models
  - Theatre productivity
  - Streamlining elective pathways

- **Probability of ongoing strike action and the impact of strikes on patient safety following announcement of national pay award (Risk ID 1182 – Initial score 16, Current Score 20) -** Strikes have taken place for nursing, ambulance, physiotherapists and junior doctors. In May 2023, a National Pay deal was signed off at a meeting between the government and 14 health unions representing all NHS staff apart from doctors and dentists. In June 2023 the Royal College of Nursing did not meet the required number of votes to implement further strike action, however the British Medical Association (BMA) continues to ballot and schedule strike action for junior doctors and consultants. The Unite Union (on behalf of hospital porters) are also currently undertaking strike ballots. The risks associated with this are being managed in partnership with staff side, workforce, and clinical leaders at the Strike Action Emergency Planning Group. The risk score was reduced in March 2023 from 20 to 16 based on multiple strikes having taken place and these having been managed effectively due to the significant planning undertaken in preparation. In June 2023, however, the score was increased back to 20 in reflection of the ongoing industrial action amongst junior doctors and Consultant's which is having an impact on the hospital's activity. Further strike action by junior doctors took place 11th – 15th August 2023 and Consultants 19th – 21st September. Additional strike action is currently scheduled for 2nd – 5th October 2023 for Consultants and junior doctors. Radiographer strike action is currently scheduled for 3rd – 4th October 2023. The risk is further compounded by the future inability to use agency staff during strike action.

Risk Title: Risk to delivery of the Trust's Strategic Objective to Consistently Deliver Excellent Care

Risk ID: 855
Risk owner: Chief Nursing Officer (updated by Associate Director of Risk & Assurance in Chief Nursing Officer absence)
Date last reviewed: 19th September 2023

Risk
There is a risk that we are unable to deliver the Trust's strategic aim of offering excellent health care and treatment to our local communities, as well as the strategic objective of consistently delivering excellent care in inpatient, outpatient and community services due to:
a) Availability of staff
b) High Occupancy levels
c) Fluctuating ability to consistently meet the constitutional and specialty standards
d) Constrained financial resources impacting on the wider system, the deficit position facing the Trust and the significant costs of operating the current configuration of services.
e) Health inequalities across the system

This may, result in adverse patient outcomes and experiences.

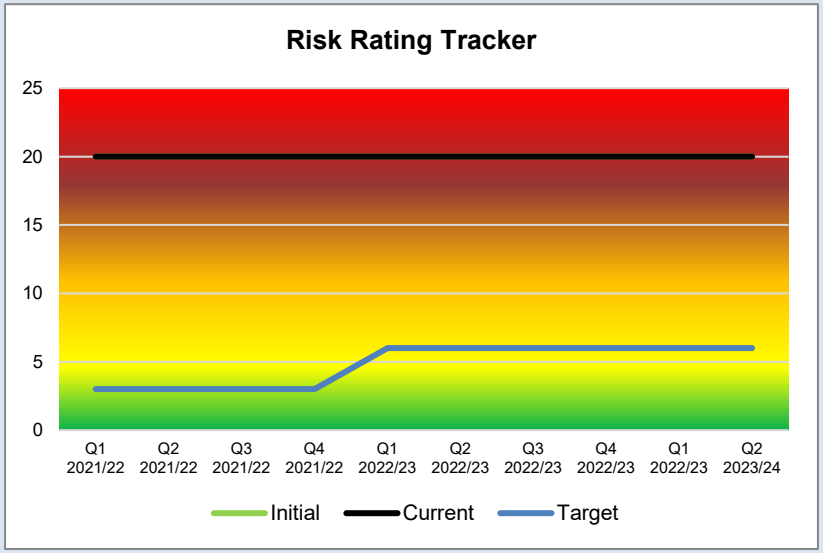
Risk Appetite:
Cautious to Risk – Willing to accept some low risk, whilst maintaining an overall preference of safe delivery options.

Risk Tolerance
1-6

Rationale for Current Score

- There is currently a reliance on temporary workforce due to sickness levels in excess of 4% and greater than 5% vacancy levels resulting in variation in care delivery.
- The requirement to deliver a Cost Improvement Programme of 5.5% and an overall Financial Improvement Plan of 8.5%.
- Continued deterioration in the backlog maintenance position and the impact on both buildings and equipment.
- Estate does not meet HTN standards, limiting consistent adherence to safety and aesthetic estate standards.
- Excess waiting times in elective services remain evident for patients.
- Occupancy levels are in excess of 95%.
- Patients are routinely waiting longer than some national standards for treatments and in the Emergency Department.
- Adult inpatient experience feedback is identifying room for improvement.
- There is national acknowledgement that health inequalities exist in all heath and care systems and contribute to poorer outcomes of citizens.
- The ability to live within the resources available is dependent upon scalable system wide transformation. The foundations for this work remain formative.
- C.*Difficile* rates exceed expected rates and allocated trajectory (managed through Risk ID 1157 – Increased C. Difficile Infection)
- Recognised health inequalities in the communities we serve

Risk Rating Tracker * (Likelihood x Consequence)
Initial: 4x5 = 20 Current: 4x5 = 20 Target: 1-6



*Initial score also 20 throughout but covered by current score line on above graph

Future Risks

- Risk of New Hospital Programme not progressing.
- Risk that the backlog maintenance of the estate may reach a point where closures of departments is required due to unsatisfactory estate conditions.
- Failure to improve existing operational flow arrangements.
- Failure to address system health inequalities.
- Failure to progress with transformation at scale to live within resources available to us.

Future Opportunities

- ICS networks and collaboration leading to reconfiguration of vulnerable services.
- New Hospital Programme delivery.
- Reduction in vacancy and sickness levels will present an increase likelihood of improved outcomes and experiences for patients and staff.
- Closer working relationship across the health and care system in partnership with public health presents opportunities to level up access to services and design out system inequalities.
- Mobilisation of transformation at scale across the system.

Controls

- Workstream related strategies and plans in place
  - Always Safety First
  - Clinical Strategy

Gaps in Control

- Equitable access to health and care is disproportionately more challenging for

Assurances
Internal

- STAR Assurance Framework
- Always Safety First Group

Gaps in Assurances

- Gaps identified within the revised IPC BAF version 1.11. ***(Ref CDEC 013)***

○ STAR Quality Assurance Framework ○ Patient Experience and Involvement Strategy ○ Risk Management Policy ○ Our Big Plan ○ Continuous Improvement Strategy ○ Equality, Diversity and Inclusion Strategy ○ Workforce and OD Strategy ○ Education, Training and Research Strategy ○ Financial Strategy ○ Health and Wellbeing Strategy ○ Communication Strategy ○ Targeted recruitment & plans and temporary staffing arrangements (inc international and healthcare support workers) ○ Safety and Quality Policies and Procedures ○ Workforce Policies and Procedures ○ Health & Safety Plan ○ Operational Plan ○ Restoration and Recovery Plan ○ Safe staffing reviews ○ Safeguarding Board • Accountability Framework • Freedom to Speak Up, Guardian of Safe Working and Person in Position of Trust (PIPOT) arrangements • Safety Forums • GIRFT programme of work. • Capital planning process • EQIA policy and procedures • Transformation programme • Integration of services and pathways and effective system-based working • Confirmation received of progression to the next stage of the NHP in May 2023 • Capital investment case created expand the MAU and SAU. • Health Inequalities delivery plan - Core20PLUS5 adults and children. • Medical device and replacement programme and process in place with increased oversight through Finance & Performance Committee	citizens with protected characteristics and those in the CORE20PLUS5 groups ***(Ref CDEC 015).*** • The age and condition of the estate places additional risk associated with the design of clinical services and the control of infection. ***(Ref CDEC 008)*** • The current environment within the ED requires upgrading to reduce the risk of environmental decontamination. ***(Ref CDEC 012)*** • The current environment within medical and surgical assessment units does not meet demand. ***(CDEC 014)***	• Safety and Learning Group • Divisional Governance Structures and arrangements • Divisional Improvement Forums • Safety and Quality Committee • Workforce Committee • Finance and Performance Committee • Education, Training and Research Committee • Audit Committee assurance processes to test effectiveness of safety and quality infrastructure and internal control system • CNST internal assurance reporting • Medical Staffing Review Plan in place to strengthen assurance of testing safe medical staffing • Equality Quality Impact Assessment (EQIA) procedure and reporting in place. • Transformation programme Board **External** • National Surveys • Clinical Negligence Schemes for Trust • External regulators and benchmarking • Medical Examiner's Office, Perinatal Mortality Tool • Internal Audit • External system assurances, PLACE based arrangements, ICB and PCB • NHS England performance monitoring	

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
CDEC 002	Create a Long term Urgent and Emergency Care Strategy	Chief Nurse/Director of Continuous Improvement	30 June 2023	10 June 2023	Completed	Control	• Integration of services and pathways and effective Place and system-based working
CDEC 007	Create a local plan to respond to the national Core20PLUS5 approach to equitable healthcare for adults and children.	Chief Nursing Officer	31 July 2023	31 July 2023	Completed	Control	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristic or those living in deprived areas.
CDEC 008	Progress to the next stage of the New Hospitals Programme.	Chief Medical Officer/Chief Financial Officer	30 June 2023	31 May 2023	Completed	Control	• The age and condition of the estate places additional risk associated with the design of clinical services and the control of infection.
CDEC 009	Increase oversight of medical device replacement programme and process through Finance and Performance Committee.	Chief Financial Officer	31 August 2023	11 August 2023	Completed	Control	• The demand for medical device replacement exceeds available capital. • Lack of available capital funds to support all medical device requirements
CDEC 010	Review of EQIA policy to extend to wider change and transformation programmes.	Chief Nursing Officer	31 May 2023	31 May 2023	Completed	Assurance	• EQIA policy requires extending to wider programmes of change and not exclusively Cost Improvement programmes.
CDEC 011	Development of a capital investment case to right size the medical and surgical assessment unit.	Director of Strategy	30 June 2023	30 June 2023	Completed	Control	• The current environment within medical and surgical assessment units does not meet demand.
CDEC 012	Development of an ED capital investment case to improve the environment until NHP is delivered.	Chief Operating Officer	31 December 2023		Ongoing	Control	• The current environment within the ED requires upgrading to reduce the risk of environmental decontamination.
CDEC 013	Weekly executive oversight of progress against updated IPC BAF v 1.11.	Chief Nursing Officer	30 September 2023		Ongoing	Assurance	• Gaps identified within the revised IPC BAF version 1.11.
CDEC 014	Completion of planned expansion of MAU and SAU	Chief Nursing Officer	31 July 2024		Ongoing	Control	• The current environment within medical and surgical assessment units does not meet demand.
CDEC 015	The Board should extend its knowledge in relation to addressing health inequalities through specific Board development activity in this area.	Chief Nursing Officer	5 September 2023	5 September 2023	Completed	Control	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups.

Summary of review – August and September 2023

- Action CDEC 009 noted as completed, which has led to the identification of a new control measure and removal of previously documented gaps in controls around medical device replacement programmes and capital availability.
- Discussion around Action CDEC 013 is scheduled at Safety & Quality Committee in August 2023
- New Action CDEC 015 identified to address the remaining gap regarding equitable access to health and care, following completion of Action CDEC 007 in July 2023. This action is noted as completed in September 2023, with an interactive session with Health Inequalities leads from the system carried out. Although this marks an action completed, the gap in control regarding Equitable access to health and care being disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups remains in place at the current time until such assurance is gleaned that challenges are improving.
- Update to rationale for current score to include recognised health inequalities.

Risk Title: Risk to delivery of the Trust's Strategic Objective of Delivering Value for Money

Risk ID: 857
Risk owner: Chief Finance Officer
Date last reviewed: 12th September 2023

Risk

There is a risk that we are unable to deliver the Trust's strategic objective 'deliver value for money' due to the inability of the Trust to transform given the range of internal and external constraints (relating to complex models of care, workforce transformation, planning processes, capital resources and dealing with high levels of backlog maintenance) which could result in a failure to move toward segment 2 of SOF and less than a 'good' rating from the use of resources of inspection

Risk Appetite:

Open to Risk – willing to consider all potential delivery options and choose while also providing an acceptable level of reward.

Risk Tolerance

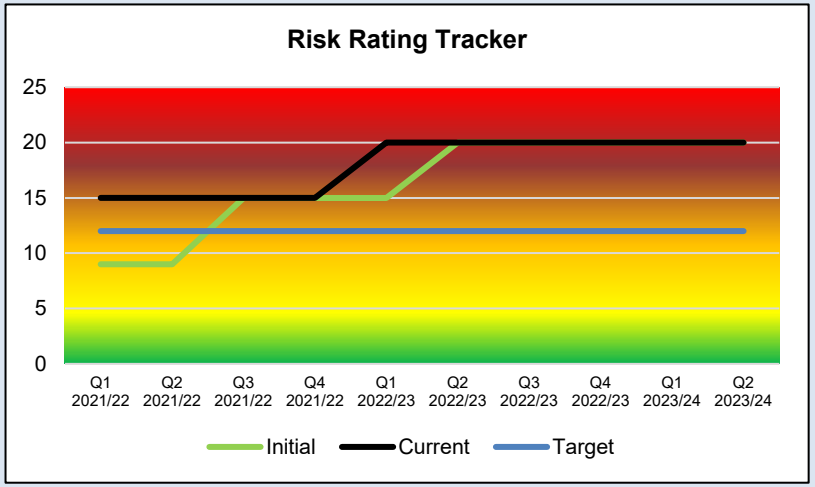
8-12

Rationale for Current Score

- **Undertakings** The Trust is in segment three for the System Oversight Framework (SOF). Undertakings applied by NHSE to the Trust include the need for the Trust to agree its financial plans with the Integrated Care Board, a requirement to deliver that plan and a supporting need to deliver the associated cost improvement plan. The Trust must deliver a challenging costing improvement target of 5.5% in 2023-24. In addition, unless a solution can be found to offset the cost of excess unfunded capacity (c3% of operational expenditure), the Trust will fail to meet its financial plan. The Trust has enforcement undertakings relating to its financial position. This may result in a move to SOF four.
- **Excess urgent care demand** – Excess flow related demand on the non-elective pathways have resulted in additional unfunded beds being opened. Despite this additional capacity, the Trust's performance standards are being impacted negatively due mainly to the excess patient demand for hospital beds.
- **Industrial relations** – Increased industrial tension is giving rise to additional financial and performance pressures which will further hamper the delivery of VFM. The Trusts ability to mitigate the impact of these tensions is limited, without some further consequence.
- **Financial recovery (Trust)** – The Trust is unable to deliver a balanced plan for 2023-24 and will aim to rebalance its finances over a three-year period. The Trust has set a challenging financial improvement target for 2023-24 and it needs to ensure that the associated change is managed through an effective equality and quality impact assessment process.
- **Financial Recovery (system)** – In setting plans for 2023-24 all NHS organisations in Lancashire and South Cumbria will be challenged to deliver their financial trajectories. To do so will inevitably lead to changes in the commissioning and provision of services. Some of these changes will inevitably impact on arrangements with partners which may impact further on delivering value for money.
- **Dependencies** – Whilst there are many improvements to be driven internally, to further improve value for money there are many dependencies on partners, e.g. to develop a clear out of hospital strategy, to help tackle not-meeting criteria to reside, to support the reorganisation of services or to fund the alternatives to hospitalised care.

Risk Rating Tracker (Likelihood x Consequence)

Initial: 4x5 = 20 Current: 4x5 = 20 Target: 8-12



The score of 20 reflects the underlying financial position of the Trust.

	Future and Escalating Risks • **Investment** – The Trust in the meantime has an underlying overspend which will need to be addressed. The failure to improve financial performance is likely to impact on future major investment decisions facing the Trust. • **Placed based leadership** – The place-based roles are continuing to form and are considered to be pivotal in the optimisation of the health and care 'eco-system'. There is a risk that the evolution of these arrangements do not sufficiently impact on the optimisation processes and that leadership arrangements between sub place, place and system are confusing with unclear accountability. • **Rising demand** – Failure to develop a credible and meaningful urgent and emergency care strategy at system and place to respond to a growing population with increased complexity/comorbidity will result in residents accessing inappropriate services which could impact detrimentally on value for money for public services as a whole. • **Planned care -** The failure to reorganise planned care across the system will result in waste and unwarranted variation, resulting in impact on overall value for money.	**Future Opportunities** • Benchmarking indicates opportunities remain to reduce waste and the underlying overspend. • There is an opportunity to reduce financial risk through reorganisation, adoption of technologies, automation and the removal of unnecessary duplication and waste. • There remains an opportunity to increase margins through non-NHS activities. • There remains opportunity through the ICS and the place-based arrangements to reduce the unnecessary duplication of NHS services. • There is an opportunity to work with the Provider Collaboration Board to identify and pursue collaboration opportunities at scale. • There remains an opportunity to commission more effective services to mitigate hospital attendances. • There remains a partnership opportunity at system and place to better manage patient pathways and reduce inappropriate demand and unnecessary cost escalation. • There remains an opportunity for partners to support more timely discharge from hospital, reducing the overall cost to the taxpayer and improve outcomes. • To meet increasing demand and complexity the ICB will need to determine what commissioned services will be afforded for its population and whether some services will need wider reconfiguration to support sustainability.

Controls	**Gaps in Control**	**Assurances**	**Gaps in Assurance**
• Workstream related strategies in place ○ Workforce and OD Strategy, ○ Continuous Improvement Strategy ○ Clinical Strategy ○ Financial Strategy ○ IM&T Strategy, ○ Estates Strategy, ○ Our Big Plan, Annual Business Plan Planning framework established to track delivery of schemes. ○ Always safety first • Scheme of delegation/Standing Financial Instruction • Accountability Framework • Long term case for change the New Hospitals Programme • CCG funding for additional plans in Stroke and Palliative care	• Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand and evolving complexity of patient needs. • Service disruption due to ongoing industrial tensions (Managed through operational risk ID 1182 (probability of strike action) escalated to Board) • Inability to sufficiently influence externally impacting directly on services provided by LTH (e.g., partner organisation strategies and decision taking, financial rules for NHS services, NHS wide workforce development and investment and some processes and decision making at system and PLACE such as priority setting in development and deployment of system and PLACE Urgent and Emergency Care Strategy)	**Internal** • Specialty Performance meetings • Divisional Improvement Forums • Integrated Performance reporting at Finance and Performance Committee and Board • Audit Committee assurance processes to test effectiveness of financial infrastructure and internal control system • Temporary monitoring of undertakings internally (The Trust has been placed in segment three for the System Oversight Framework (SOF)). • Use of Resources assessments now reported through Finance & Performance Committee. • Regular embedded cycle of sharing information relating to the wider programme of change in place • Report on elective productivity and plans for improvement completed to better understand the impact on elective	• The Trust needs to identify how it will return its services to financial balance and deliver a challenging cost improvement programme whilst closing unfunded infrastructure or securing the associated funding. (***DVFM 010)*** • The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better. ***(DVFM 014, DVFM 015, DVFM 016, DVFM 017 and DVFM 018)*** • To support the drive for improved delivery the governance arrangements require some amendment. ***(DVFM 019 and DVFM 020)*** • The trust has an opportunity to improve the rigour and robustness of its decision-making processes. ***(DVFM 021)*** • There is an opportunity to better describe how partnering/collaborative arrangements, e.g. through the Provider Collaborative Board, can help to improve value for money ***(DVFM 022)*** • Whilst temporary workforce controls have been reviewed by internal audit and has gained a substantial assurance, consideration now need to be given to the adequacy of those controls, particularly with regard to budgetary

• Contract management and activity under regular monitoring • National Planning Framework and Capital now given to ICS areas. • Planning guidance now reflective of current operational pressures secondary to Covid-19 with revised Big Plan and annual business plans in place • Stocktake of senior leadership engagement in place or system decision making processes • Clear and regular updates to/discussions at Board Subcommittees and Board meetings to ensure robust assumptions underpin our planning returns/templates • Vacancy freeze for non-essential posts now in place • Virement policy revised and in place. • Role of the vacancy control process extended to put greater challenge into replacement posts. • A system wide vacancy and control panel introduced providing additional oversight of the roles that are being recruited to across the system, particularly but not exclusively in non-clinical areas, consultancy, leases and contracts.		productivity together with movements in the underlying drivers together with plans for improvement. • Action plans relating to overspending costs centres are overseen through DIF processes and are reported to FPC. • A monthly update is provided on transformation programmes and the progress on the Financial Improvement Programme **External** • Head of Internal Audit Opinion/Going concern review • Benchmarking model hospital/GIRFT • External Auditor review • External system assurances, PLACE, ICB and PCB • Contract monitoring report to provide stronger assurances on the underlying trading position and associated activity now reintroduced. • Considering the deteriorating financial position faced by NHS providers, NHS England have issued a series of checklist with an updated protocol for a deterioration in financial forecast. Now complete and submitted.	control. These will be reviewed and reported back to FPC in quarter three 23/24. ***(DVFM 023)*** • Whilst the Trust and ICB have introduced workforce and non pay controls, these need to be shared with the Committee for assurance. These will be reported for information to FPC from October 2023 ***(DVFM 024)*** • The Trust stopped the routine monitoring and action plans associated with Use of Resources. Routine reporting needs to be reintroduced in quarter three ***(DVFM 025)*** • In relation to its transformation programmes, the Trust needs to improve its identification and release of benefits ***(DVFM 026)*** • To supplement its existing transformation programmes two further programmes with be added to the assurance framework: Workforce and Digital ***(DVFM 027)***

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
DVFM 010	Develop a medium-term plan with a supporting financial model to outline the route to recovery	Chief Financial Officer and Director of Strategy and Planning	30.09.23		Ongoing	Assurance	The Trust needs to identify how it will return its services to financial balance and deliver a challenging cost improvement programme whilst closing unfunded infrastructure or securing the associated funding.
DVFM 014	Clinical strategy (urgent care)	Director of Transformation & Chief Nursing Officer	30.11.23		Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 015	Clinical strategy (scheduled care)	~~Chief of Operations~~ Chief Medical Officer	~~31.07.23~~ 30.09.23		Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 016	Clinical strategy (provision)	Director of Strategy and Planning	30.09.23		Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 017	Income strategy	Chief Financial Officer	30.09.23		Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 018	Digital strategy	Chief Information Officer	30.09.23		Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 019	Strengthen executive oversight of transformation and subsequent reporting to Committee	Director of Transformation	31.05.23	31.05.23	Complete	Assurance	To support the drive for improved deliver the governance arrangement require some amendment.
DVFM 020	Evolve performance accountability framework	Director of Strategy and Planning	30.09.23		Ongoing	Assurance	To support the drive for improved deliver the governance arrangement require some amendment.
DVFM 021	Develop a set of strategic decision-making criteria	Director of Strategy and Planning	31.05.23	31.05.23	New - Complete (STA)	Assurance	The trust has an opportunity to improve the rigour and robustness of its decision-making processes
DVFM 022	Develop a 'value add' reporting for collaborative arrangements	Chief Financial Officer	30.09.23		Ongoing	Assurance	There is an opportunity to better describe how partnering/ collaborative arrangements e.g. through the Provider Collaborative Board can help to improve value for money
DVFM 023	Review of effectiveness of internal controls (e.g. budget constraint) relating to temporary workforce	Chief People Officer	31.10.23		New	Assurance	Whilst temporary workforce controls have been reviewed by internal audit and has gained a substantial assurance, consideration now need to be given to the adequacy of those controls, particularly with regard to budgetary control. These will be reviewed and reported back to FPC in quarter three 23/24.
DVFM 024	New workforce and non pay controls Assurance	Chief Finance Officer	31.10.23		New	Assurance	Whilst the Trust and ICB have introduced workforce and non pay controls, these need to be shared with the Committee for assurance. These will be reported for information to FPC from October 2023.
DVFM 025	Use of Resources report to be presented to F&P Committee	Director of Strategy and Planning	31.10.23		New	Assurance	The Trust stopped the routine monitoring and action plans associated with Use of Resources. Routine reporting needs to be reintroduced in quarter three
DVFM 026	Refine approach to benefits realisation and embedding in	Director of Improvement and Transformation	31.10.23		New	Assurance	In relation to its transformation programmes, the Trust needs to improve its identification and release of benefits

	arrangements for programme assurance						
DVFM 027	Increase the scope of the Transformation Programmes to include workforce and digital	Director of Improvement and Transformation	30.03.24		New	Assurance	To supplement its existing transformation programmes two further programmes with be added to the assurance framework: Workforce and Digital

Summary of updates to risk – August and September 2023

- Updates to the narrative within Future and Escalating Risks and Future Opportunities added
- New control measure identified regarding system wide vacancy control panel being established
- Action DVFM 015 reallocated to the Chief Medical Officer who is overseeing the clinical strategy for elective care, work remains ongoing and thus the due date extended.
- Action DVFM 020 updated with Action Owner detail
- Identification of 2 new assurance measures
  - Action plans relating to overspending costs centres are overseen through DIF processes and are reported to FPC.
  - A monthly update is provided on transformation programmes and the progress on the Financial Improvement Programme.
- Identification of 5 new gaps in assurance, which in turn have led to the generation of 5 new actions within the action plan (DVFM 023, DVFM 024, DVFM 025, DVFM 026 and DVFM 027) to address gaps in effectiveness of new workforce and non pay controls, gaps in routine monitoring of Use of Resources, improvement in identification and release of benefits and to increase the core of the Transformation Programmes to include workforce and digital.
- Action DVFM 014 was previously marked as completed due to the urgent care element of the clinical strategy being completed, however further review has highlighted that there remains requirement for the urgent care element of the clinical strategy to be updated further to address the sustainability challenge. As such, the action has been re-opened and re-documented against gaps in assurance.

Risk Title: Risk to delivery of the Trust's Strategic Objective to be a Great Place to Work

Risk ID: 856
Risk owner: Interim Chief People Officer
Date last reviewed: 28th August 2023

Risk

There is a risk to the delivery of the Trust's Strategic ambition to be a great place to work due to the inability to offer a good working environment; inability to treat staff fairly and equitably; poor leadership; inability to support staff development.

This could lead to staff losing confidence in the Trust as an employer and result in poor staff satisfaction levels, impacting on the organisations reputation and culture subsequently affecting the ability to attract and retain staff, causing key workforce shortages, increasing the use of temporary staffing and poor patient care.

Risk Appetite:

Open to Risk – willing to consider all potential delivery options and choose while also providing an acceptable level of reward.

Risk Tolerance

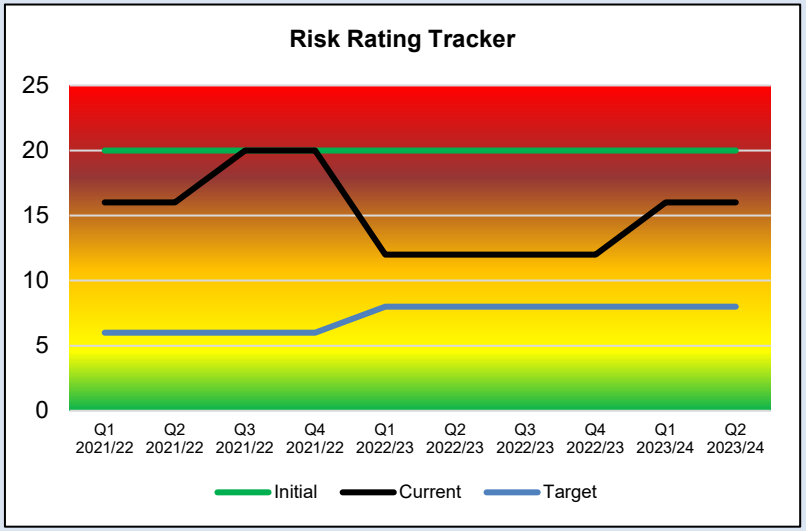
4-8

Rationale for Current Score

- Workforce shortages in some key professional groups, which creates vacancies and creates pressure on existing staff in particular registered nurses and some medical specialties.
- High turnover of less than 12 months in some staff groups particularly support workers and ability to recruit from local labour market.
- Staff engagement score is currently at the national average and has reduced in year.
- Staff advocacy scores currently below the national average and have deteriorated over the last four quarters.
- Physical environment, colleague facilities (catering) and car parking cited as a concern by departments and teams for having an impact on morale, wellbeing and ability to work effectively.
- Leadership ability and capacity impacting on levels of staff satisfaction, cultural transformation and workforce metrics in a number of areas.
- High levels of sickness absence related to mental health issues and musculoskeletal injuries and lack of capacity in health and wellbeing service to respond to needs in a timely way.
- Increase pressure from restoration leading to staff burn out post COVID and ability to participate in wider engagement and development activities.
- Gap between the desired and the current culture indicates improvements are needed.
- Staff not feeling valued due to inconsistency in employment offers internally and across the region.
- Impact of cost of living pressures on staff which are further compounded in some grades by implications from pension scheme as a result of levels of contribution levels and tax implications.
- The impact of uncertainty and clear direction from PCB plans is leading to higher levels of turnover, inability to recruit to vacancies, reduced engagement and morale levels in teams potentially affected by the changes, making it difficult to deliver on strategic plans described in Our People Plan.
- Insufficient resource within the Workforce and OD team to deliver change programmes at pace and respond to changing directions from the PCB.
- Vacancy freeze for all non-clinical roles along with a competitive recruitment market will mean vacant posts will be unable to be filled, leading to non-delivery of core objectives and business as usual.
- 3% reduction in establishment is likely to create additional pressures on existing staff impacting on sickness, well being and morale

Risk Rating Tracker (Likelihood x Consequence)

Initial: 4x5 = 20 Current: 4x4 = 16 Target: 4-8



	• Local onboarding processes do not consistently provide new recruits with a positive employment experience. • National unrest regarding cost of living and national pay deals leading to strike action taking place in most professional groups. • National pay and reward contract negotiations outcomes not seen as favourable by Unions leading to continuing strike action taking place. • The junior doctor strike action will have an impact on the delivery of planned activity due to consultants required to act down to provide strike cover. • The British Medical Association (BMA) rate card challenge will have a significant impact on the overall pay bill if implemented. If not implemented this could create a significant resourcing challenges and inability to deliver on planned activity and restoration plans as it is likely Consultants will withdraw from supporting waiting list initiatives. • Due to the BMA rate card challenge we are seeing an increased appetite for the establishment of Limited Liability Partnership (LLPs) by our Consultant workforce, at present there is limited governance in place to ensure adequate controls and regulation.	
	Future Risks • Ageing workforce profile in some services, leading to significant gaps post retirements. • Development of new roles may be hindered by inability to fund training posts and service posts simultaneously. • Impact of training and support for international new recruits on current staff and the retention of the new recruits. • Inability to source additional temporary workforce to support restoration and recovery plans • Further reduction in staff morale given focus on need to deliver financial turnaround • Non-delivery of New Hospital Programme impacting on ability to utilise available workforce effectively. • ICS transformations on corporate services benchmarking identified significant opportunity for saving in HR/OD workforce which is in direct contrast to the significant service pressures on the teams and ability to deliver transformational culture and OD programmes • Continued deterioration of the working environment and hygiene factors impacting on staff satisfaction	**Future Opportunities** • There are opportunities to work across the ICS to support workforce supply, i.e., international recruitment, creation of new roles. • Changes to models of care present opportunities to remodel workforce. • Continued opportunity to use the multi professional skills of our workforce in different ways to help tackle specific workforce shortages. • Opportunity to adequately resource an OD programme to increase staff engagement and cultural transformation at pace. • Create a first-class working environment as part of the New Hospitals Programme • Redesign and implementation of more effective and consistent off boarding processes in order to retain a positive perception of leavers with regards to their employment experience.

Controls	**Gaps in Control**	**Assurances**	**Gaps in Assurances**

• Workforce and OD strategy related strategies and plans in place
  ○ Trust Values
  ○ Workforce Plan
  ○ Targeted recruitment & plans (international and
	• Limited funding to address all hygiene factors and workforce demand in excess of supply resulting in unsustainable clinical service models/opportunity to improve productivity through benchmarking and action plans to reduce unwanted	**Internal**
		• Divisional Governance Structure and Arrangements
		• Divisional Improvement Forums (including Part II process to address cultural concerns)
		• Raising Concerns Group
			[None]

healthcare support workers) ○ Workforce policies with EIA embedded ○ Health and Wellbeing strategy ○ Just culture ○ Regular temperature checks in place for staff satisfaction, culture, with action plans e.g., Staff Survey, NQPS, HWB, TED, Cultural survey ○ Leadership and Management Programmes ○ Appraisal and mentoring process ○ Workforce business partner model and advice line in place ○ Staff representatives in place, including union representatives, staff governors ○ Vacancy control panel in place and meeting weekly ○ Strike Action Emergency Planning Group weekly meeting • Equality, Diversity, and Inclusion strategy • Freedom to Speak Up and Guardian of Safe working arrangements • Education & Training strategy • Risk Management Strategy • Health and Safety Plan • Always Safety Strategy • Safe staffing reviews • Our Big Plan • Communications strategy • Accountability Framework • Safety Forums	variation in existing strategies. ***(GPTW001/DVFM002)*** • Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design. ***(GPTW002)*** • Ability to influence the direction of the Provider Collaborative Board with regards to programmes of work, desired impact measures and methods for achieving aims. • Sufficient staffing within workforce and OD to support work required to deliver transformation and deliver of the Trust's People Plan	• Workforce Committee • Education Training and Research Committee • Safety and Quality Committee • Audit Committee assurance processes. • Regular schedule of reporting arrangements for cultural risks at Committees of the Board and Board now in place and covered within the Risk Management Policy **<u>External</u>** • National Surveys and benchmarking including staff satisfaction survey, workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) • Internal audit and external reviews e.g. • External regulatory oversight e.g., Re-accreditation of Workplace wellbeing charter (5 out of 8 domains sitting as excellent) • rostering review by NHSI indicating excellence in rostering practice	

• New Hospitals Programme • Resourcing plan for Workforce and OD staffing to support the delivery of Workforce and OD strategy and meet demands on current service provision included within the revised People Plan launched in April 2023			

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
GPTW001	Review strategies considering financial pressures and delivering value for money as part of committee cycles of business.	Executive Leads	31st March 2023	1st April 2023	Complete	Control	• Limited funding to address all hygiene factors and workforce demand in excess of supply resulting in unsustainable clinical service models/opportunity to improve productivity through benchmarking and action plans to reduce unwanted variation in existing strategies. • Resourcing plan for Workforce and OD staffing to support the delivery of Workforce and OD strategy and meet demands on current service provision.
GPTW002	Incorporate transformational schemes that support long term sustainability and workforce re-modelling as part of annual planning cycle	Director of Strategy and Planning	31st May 2024		Ongoing	Control	• Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design.

Risk updates – August and September 2023

- No updates required at the current time.

Risk Title: Risk to delivery of the Trust's Strategic Objective of Fit for the Future

Risk ID: 858
Risk owner: Director of Strategy and Planning/Chief Medical Officer
Date last reviewed: 27th September 2023

Risk

There is a risk to the delivery of the Trust's Strategic Objective to be fit for the future due to the challenges of effectively implementing and developing Place and System (i.e. Integrated Care System and Provider Collaborative) level working we fail to deliver integrated, pathways and services which may result in Lancashire Teaching Hospitals no longer being fit for purpose and our healthcare system becoming unsustainable.

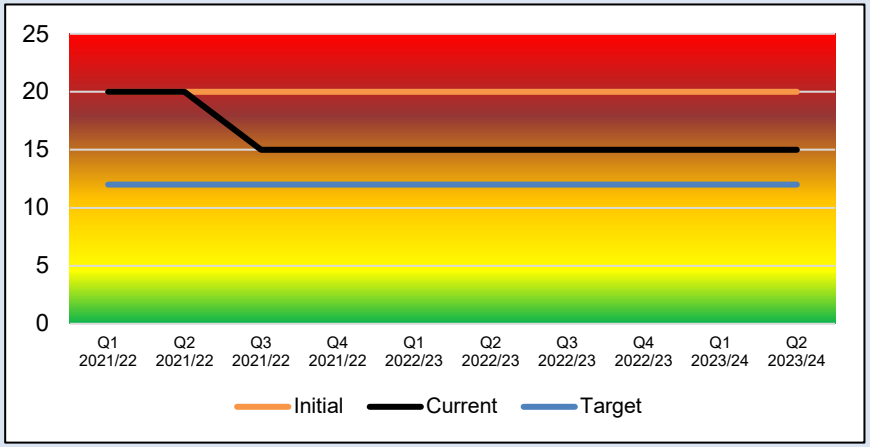
Risk Appetite: Seek – Eager to be innovative and to choose options offering higher rewards, despite inherent business risk.

Risk Tolerance 8-12

Rationale for Current Score

- Place and System based working are developing both in terms of personnel, roles, governance, strategies, and plans and within this context LTH has reputational/performance challenges that are challenges to our ability to work effectively at both levels. System working has progressed to a clearer position though there is still a need for greater clarity particularly in relation to driving benefit across the quadruple aim. Place Based working is still being fully established. Whilst governance processes and operational oversight are being fully established as a Board, we are placing significant reliance for our assurance/decision making on our CEO & Chair.
- The Clinical Programme Board (CPB) is established, meeting regularly to oversee the PCB clinical transformation programme with a range of Programme plans, Trackers and Toolkits in place. The Benefit Tracker for the CPB is shared with the Trust's Finance & Performance Committee – progress is being made but there remains work to be done to show clear contribution against all the quadruple aims.
- Even when a greater level of maturity is reached the delivery of more effective, integrated pathways and services is a major challenge and will require both LTH and its partners to work differently and to successfully balance organisational interests alongside Place/System interests and commitments. In addition to ways of working/partnership culture capacity/time is a major challenge in relation to Place/System working.
- Within Central Lancashire there are a relatively high number of service providers and LTH is the Tertiary Centre for L&SC – as such we have a particular opportunity but also a particular challenge in relation to partnership working.
- Digital transformation will be a major enabler for partnership working, pathway/service integration and ensuring we are fit for future. We have an ambitious Digital Northern Star strategy but delivering this will be a major challenge in terms of resources, organisational change and system working.
- LTH has a particular challenge and a particular opportunity in relation to our service configuration and estate – unless we are able to address these, we will be unable to meet delivery of the services our partners rightly expect and our staff will be focused on immediate operational challenges rather than service and pathway integration. The New Hospitals Programme is a once in a lifetime opportunity to work as a system level to access the funding needed to create a high quality, sustainable estate/service configuration.
- Delivering the above will be a major challenge which will require the highest levels of staff engagement and communication, areas where the Trust scores

Risk Rating Tracker (Likelihood x Consequence)
Initial: 4x5 = 20 Current: 3x5 = 15 Target: 8-12



Future Risks

- Demographic pressures
- Population health and Health inequalities challenges
- Estates challenges/backlog maintenance
- Workforce gaps/challenges

Future Opportunities

- System and Place working
- Service transformation/integration
- Digital
- New Hospitals Programme

	relatively well compared to our peers but we will need significant improvement in future to deliver our ambitions • Delivering the above will require the Trust to develop its capacity, capability and governance to robustly deliver major change programmes	

Controls	Gaps in Control	Assurances	Gaps in Assurances

• Workstream related strategies in place
  ○ Clinical Strategy
  ○ Digital Strategy,
  ○ Estates Strategy, including New Hospital Programme
  ○ Comms and engagement
• New Hospitals Programme operational groups established and named executive lead.
• Place and system delivery boards established, where LTHTR continue to link own strategies with Place and System plans. A Central Lancashire Executive Oversight Group has been set up and discussions are underway regarding the options for the Lancashire Place Partnership. The ICB have established a new Recovery Board, with a focus on system wide recovery and transformation
• LTHTR executive leads with Place/ICS responsibilities.
• Director of Communications & Engagement and Head of Communications in roles of SRO and Chairs of professional networks and providing significant contribution to the Provider Collaborative
• Clinical Programme Board (CPB) in place meeting monthly overseeing the PCB clinical transformation programme
• ICB has published 5 Year Joint Forward Plan
• Transformation Programmes developed and being led by Executive Team
• LTH Transformation & Recovery Board in place chaired by CEO, strengthening oversight of delivery of transformation programmes against agreed trajectories and addressing barriers for progress.
• Digital Northern Star working groups in place to deliver the Digital Northern Star programme
• Organisations within Digital Northern Star are sharing information regarding infrastructure digital contracts for a collaborative approach to networking and data centres.
• Improved communications Trustwide and External – HeaLTH matters, In Case You Missed It and Exec
	• Integration of services and pathways. ***(FFTF 001, FFTF 003, FFTF 004, FFTF 005, FFTF 006, FFTF 008)***
	• Effective Place and system based working. ***(FFTF 001, FFTF 005, FFTF 007, FFTF 008)***
		<u>Internal</u>
		• Executive Transformation Group
		• Planning Framework updates to Finance and Performance Committee.
		• New Hospitals Programme assurance to Board
		• Audit Committee assurance processes to test effectiveness of infrastructure and internal control system.
		• Strategic element of Board discussions has been strengthened with dedicated sessions to focus on specific strategies
		• Northern Star Programme shared approaches developed leading to £1M in cash realising or cost avoidance savings
		• Online presence seen to increase over the period March 2023 – May 2023 with 23,000 new users to the Trust website in that period demonstrating continuing upward trend of engagement with the local population. Increase in Twitter and Facebook interaction and internal intranet interaction also.
		
		<u>External</u>
		• New Hospitals Programme Oversight Group
		• ICS Digital Board
		• Clinical Programme Board
		• Central Services Board
			• Benefit realisation plans need to be more robust and to explicitly deliver against the quadruple aim ***(FFTF 001, FFTF 003, FFTF 004, FFTF 008)***
			• Gaps in Clinical Programme Board Benefit Tracker to show clear contribution against all the quadruple aims ***(FFTF 001)***

Q&A session all put in place to enhance staff engagement and External newsletter reinstated for key stakeholders across our communities.			

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
FFTF 001	Link LTHTR strategies with Place, Provider Collaborative and ICS Strategies	Executive Leads	31st March 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.
FFTF 002	Strengthen Board discussions on key strategic issues including relevant ICS/PCB/Place matters	Director of Strategy and Planning	31st March 2024		Ongoing	Assurance	• The Board requires dedicated time to fully discuss the wide range of system issues/changes that will be a key element in our being Fit for the Future
FFTF 003	Ensure maximum LTH influence on/contribution to Place and System working	Executive Leads	31st March 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.
FFTF 004	Develop and deliver Digital Northern Star strategy	Chief Information Officer	31st March 2024		Ongoing	Control	• Integration of services and pathways
FFTF 005	Deliver staff engagement/comms strategy (including reputation monitoring/management)	Director of Communication & Engagement and Chief People Officer	31st March 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.
FFTF 006	Deliver New Hospitals Programme	Chief Finance Officer	31st March 2024		Ongoing	Control	• Integration of services and pathways
FFTF 007	Deliver our Social Value Strategy	Director of Strategy & Planning,	31st March 2024		Ongoing	Control	• Effective Place and system based working.
FFTF 008	Strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change	Director of Strategy & Planning, Director of Continuous Improvement & Transformation	31st March 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.

Updates – October 2023

- Narrative in Rationale for current risk score updated
- Updates to Controls to include a Central Lancashire Executive Oversight Group being established

Action Plan updates

- FFTF 001 Link LTHTR strategies with wider Place, Provider Collaborative and ICS Strategies and FFTF 002 Strengthen Board discussions on key strategic issues including relevant ICS/PCB/Place matters: A review of our 2021-2024 Clinical Services Strategy is underway which will give us the opportunity to better reflect the latest Place, Provider Collaborative and ICS Strategies.
- FFTF 003 Ensure maximum LTH influence on/contribution to Place and System working: LTH continue to deliver a very substantial commitment/contribution to system working both at Place and System level eg taking on formal system roles, leading on System/Place projects etc. Recent examples include the LTH Director of Strategy & Planning being asked to take the lead in driving and coordinating the production of the Pathology Collaboration capital Business Case. FFTF 004 Develop and deliver Digital Northern Star strategy: Northwest Secure data Environment Revenue has been accepted and the project team are commencing with the programme. The Observational Medical Outcomes partnership (OMOP) Data Model has been chosen Nationally and LTH are ahead of the game with one of the largest OMOP mapped datasets in the NHS. This is already contributing to the research system for clinical trials cohort identification and is starting to attract research and evaluation proposals. Central services collaborations are increasing with early adopters identified and greater infrastructure sharing underway, including completion of the initial stages of an ICS wide cloud-based architecture to support collaborative data sharing. Initial go live for the patient engagement portal is expected third quarter 2023.
- FFTF 005 Deliver staff engagement/comms strategy. We continue to support press coverage of the ongoing industrial action, and have welcomed BBC, ITV and Sky onto our sites to discuss how we are managing the current pressures. Other notable media opportunities include extensive filming with ITV Granada on our breast care unit, following the journey of one of our breast care patients – from diagnosis through to treatment; Channel 5 on elective recovery and the BBC filming the UK-first Lungvision technology being used at the Trust. Series two of Cause of Death is also now nearing completion. For us TV coverage is a way of reaching large numbers of people in a cost effective way and this can be life changing for individuals – for example a patient who watched an item on LungVision and was able to access transformative care as a result. The Director of Communications and Engagement and the Head of Communications in their roles as SRO and Chairs of their professional networks and the wider team continue to make a significant contribution to the Provider Collaborative by hosting the quarterly Provider Collaborative and Pathology Colleague Briefings; shaping messages and producing collateral; contributing to the system winter comms plan and the soon to be launched Engagement HQ platform. Internal virtual engagement sessions continue to be well received with the monthly Executive Q&A sessions and weekly Strategic Operation Group updates accessible to staff from across the Trust complemented by a range of internal communications. Alongside this, the team have also recently produced the latest version of Trust Matters and Connect magazines, ensuring stakeholders are kept up-to-date. The team has also supported in the submission of nominations for the annual HSJ Awards and co-created presentations for two HSJ Patient Safety Award categories one of which was highly commended at the recent awards ceremony in Manchester. Our online presence has continued to grow with a continuing upwards trend of engaging with more of our local population. Our social media channels are also continuing to do well, and more colleagues are choosing to use the new intranet to source information.
- FFTF 006 Deliver New Hospitals Programme: On the 26th May the Secretary of State for Health announced confirmation of two new hospitals to replace Royal Preston Hospital and Royal Lancaster Infirmary as part of a rolling programme of national investment in capital infrastructure beyond 2030. Further detailed work is underway to assess the viability of potential locations for new hospital builds for both Royal Lancaster Infirmary and Royal Preston Hospital and to develop the required business cases.
- FFTF 007 Deliver our Social Value Strategy: An update is on the Board Agenda.
- FFTF 008 Strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change: Progress continues to be made to develop and strengthen our governance and processes. In 2023/24 the transformation programmes are being further strengthened, maximising the focus on delivery and recovery.

Risk Title: Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Services

Risk ID: 859
Risk owner: Chief Medical Officer
Date last reviewed: 28th September 2023

Risk Description:
There is a risk to the Trust's ability to continue delivering its strategic aim of providing high quality specialist services due to integration and reconfiguration of specialist services across the ICS. This may impact on our reputation as a specialist services provider and commissioning decisions leading to a loss of services from the Trust portfolio and further unintended consequences affecting staff and patients.

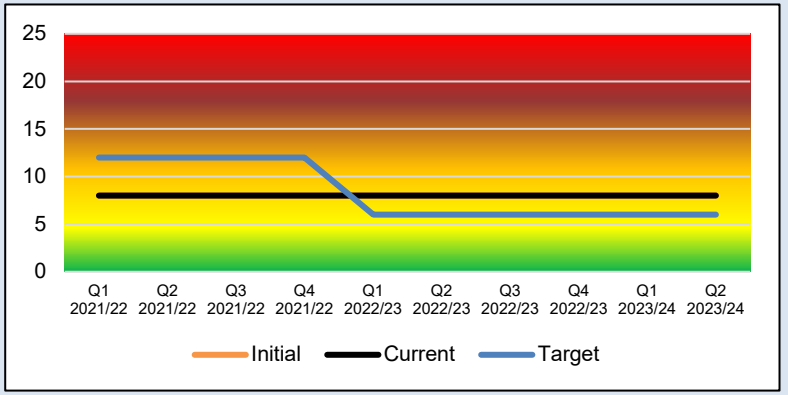
Risk Appetite: Open to Risk - prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risk.

Risk Tolerance
6-9

Rationale for Current Score

- Place and System based working are developing both in terms of personnel, roles, governance, strategies, and plans.
- Even when a greater level of maturity is reached the delivery of more effective, integrated pathways and services is a major challenge and will require both LTH and its partners to work differently and to successfully balance organisational interests alongside Place/System interests and commitments. In addition to ways of working/partnership culture capacity/time is a major challenge in relation to Place/System working.
- Within Central Lancashire there are a relatively high number of service providers and LTH is the Tertiary Centre for L&SC – as such we have a particular opportunity but also a particular challenge in relation to partnership working.
- LTH has a particular challenge and a particular opportunity in relation to our service configuration and estate – unless we are able to address these, we will be unable to deliver the services our patients and partners rightly expect, and our staff will be focused on immediate operational challenges rather than service and pathway integration.
- The New Hospitals Programme is a once in a lifetime opportunity to work as a system level to access the funding needed to create a high quality, sustainable estate/service configuration.
- ICS and LTH Clinical Strategy developed.
- Provider Collaborative Board Clinical Strategy approved.
- Limited availability of NHS capital prevents further rationalisation of the estate to more effectively provide specialist services (i.e. Neurosciences, Trauma Services, Stroke Services, and Vascular Services).
- Aging estate with significant backlog of maintenance will produce ongoing limitations with implementing options for service developments in the interim before the new hospitals programme.
- Geography and mutually dependent infrastructure.
- With the transition to the new year the financial rules which apply resource allocation within the NHS in England have transitioned. These rules give some clarity in the allocations awarded to Integrated Care Systems but not to how allocations will be distributed across those systems. The Trust will need to monitor funding allocations and patient access as the changes begin to take shape. Any changes in the commissioning arrangements may cause challenges in developing a future state operating model.

Risk Rating Tracker * (Likelihood x consequence)
Initial: 2x4 = 8 Current: 2x4 = 8 Target 6-9



*Initial score also 8 throughout but covered by current score line on above graph

	Future Risks • Risk of New Hospital Programme not progressing. • Commissioning risks to lower volume/low priority services. • Potential risks associated with changes in specialised commissioning arrangements.	**Future Opportunities** • ICS networks and collaboration leading to reconfiguration of services. • New Hospitals Programme investment leading to establishment of Lancashire Specialist Hospital which may include additional specialist services. • Increasing research and innovation profile of specialist services. • Harnessing innovative ways of working using technology

Controls	**Gaps in Control**	**Assurances**	**Gaps in Assurances**
• Workstream related strategies in place - LTHTR Clinical Strategy - ICS Clinical Strategy - PCB Clinical Strategy - Estates Strategy - Finance Strategy and Plans • New Hospitals Programme • LTHTR Executive leads with Place/ICS responsibilities e.g. Chief Medical Officer located on a number of network bodies e.g. Chair of Cancer Alliance, Chair of Clinical Oversight Group for New Hospitals Programme, Lead Medical Director for the PCB • Quality and safety controls support the retention of specialist services. *Full details of controls associated with quality and safety of specialist services will be noted in the Strategic Risk associated with the Strategic Ambition to Consistently Deliver Excellent Care. • ICS Speciality Boards in place for a number of specialist services • Statutory development of the ICS. • Capital Planning Group arrangements in place to provide structure and organised approach to capital investment. • Specialist services included within the planning framework.	• *Services being compliant with the service specification* ***(SPEC 002)***	**Internal** • Speciality Boards • Divisional Governance Structures and Arrangements • Divisional Improvement Forums • Safety and Quality Committee • Finance and Performance Committee • Strengthened updates to Board and Audit Committee regarding Specialised Services risk **External** • Scheduled contractual reviews with Specialised Commissioners including Executive Management Team forums to progress and resolve issues. • New Hospitals Programme Oversight Group • ICS and ICB system delivery Boards	• None documented.

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
SPEC 001	Link LTHTR and ICB Clinical strategies with PCB Clinical Strategy	Chief Medical Officer	30th September 2023	25th September 2023	Complete	Control	• Integration of services and pathway and effective Place and system-based working • PCB clinical strategy still in development
SPEC 002	Agree interim and longer term plan for reconfiguration of specialised services across Lancashire and South Cumbria, aligned to the New Hospitals Programme.	Chief Medical Officer	31st March 2024		Ongoing	Control	• Services being compliant with the service specification

Updates to risk – September 2023

- Risk reviewed following deep dive into this risk at Audit Committee. Updated to reflect the potential challenges associated with new specialised commissioning arrangements.
- Action SPEC 001 complete with the finalisation of the PCB clinical strategy and therefore added as a control.
- New action SPEC 002 added to agree interim and longer term plans for reconfiguration across Lancashire and South Cumbria, aligned to New Hospitals Programme. This links with new gap in control identified regarding services not being compliant with the service specification

Risk Title: Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research

Risk ID: 860
Risk owner: Chief People Officer (updated by Deputy Director of Education and Deputy Director of Research & Innovation)
Date last reviewed: 25th September 2023

Risk

There is a risk that we are unable to deliver world class education, training and research due to challenges in effectively implementing high quality, appropriately funded and well-marketed education, training and research opportunities due to a range of internal and external constraints. This impacts on our ability to develop our reputation as a provider of choice sustaining our position in the market, supporting business growth and retaining our status as a teaching hospital.

Risk Appetite:

Seek – Eager to be innovative and to choose options offering higher rewards despite inherent business risks.

Risk Tolerance

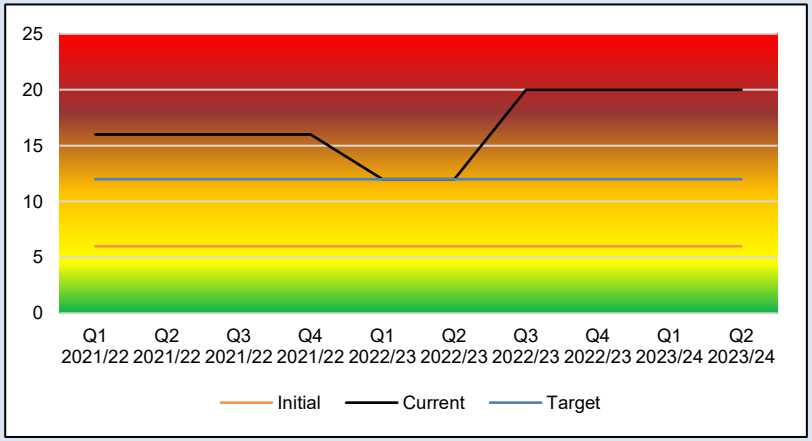
9-12

Rationale for Current Score

- Inability to invest educational income in capital development programmes to expand our education infrastructure.
- NHS Education Contract Tariff changes effective from September 2022 resulting in a review and removal of roles previously funded through education income.
- Ongoing capacity challenges to support education and R&I activity.
- Workforce shortages impacting on capacity and educational quality.
- Increasing evidence of health and wellbeing concerns in student and learner community.
- Ongoing challenges to achieve optimum faculty for specialist teaching requirements.
- Impact of economic climate/loss of work due to diagnostic/aseptic backlogs on commercial research income.
- Not meeting compliance in all training subjects and medical device competencies.
- While being managed by NIHR, ongoing backlog in research study start-up due to 2-year Covid disruption (Covid studies vs re-start vs new) and significant impact on commercial research portfolio, investigator time to dedicate and set-up. Therefore, NIHR guidance changes to re-prioritise studies and rectify necessitates revision of the portfolio. As a result of these R&I running at reducing loss, year on year. The O'Shaughnessy Report (2023) encourages more active prioritisation of commercial work which will assist ongoing mitigation.
- There are opportunities to lead on education, innovation and research programmes in NHP and ICB programmes of work. Presentation of present work has commenced in the PCB.
- Inability to influence essential release of staff for education activity due to service pressures.
- Audit requirements for management of educational income limit flexibility to deliver educational activity which is based on academic years or to support innovative developments funded through income generation

Risk Rating Tracker (Likelihood x Consequence)

Initial: 2x3= 6 Current: 5x4 = 20 Target: 9-12



Future Risks

- Capacity for effective marketing and communications.
- Impact of the New Hospitals Programme on Education estate
- Impact of the increased allowance for simulated placements for nursing students delivered by HEIs – this could result in a reduction in NMET tariff income.
- Impact of place-based placement allocation systems (currently emerging) – this could result in a reduction in NMET tariff income.
- UK becoming less competitive/losing commercial research trials

Future Opportunities

- Continued participation and development of funded COVID/respiratory/UKCRF Network sourced related research activities.
- Expansion of undergraduate programmes.
- Increase in the use of advanced digital/AI solutions to provide education and research programmes.
- Launch of Trust innovation hub and external funding opportunity.
- Development of hi-tech education programmes including robotics and simulation learning.
- Development of joint appointments with HEIs.

	• Impact of UGME capacity scoping exercise being undertaken by HEE • Potential income deficit position for education as a result of tariff changes and audit requirements for income deferral • Innovation opportunities may be stifled due to reluctance to accept in-year funding developments where income cannot be flexibly utilised across multiple financial years • Potential impact of shared service development across ICS • Potential reduction in CPD/Workforce Development funding and/or potential bid income	• Re-focus of research activity on key national clinical priorities. • Opportunity to bid for capital to update Health Academies to provide hi tech simulation and education. • Opportunity for LTH to become apprentice provider for ICS • Opportunity to manage income generation via Edovation • Potential to expand student placement offer to HEIs within and outside region. • Provision of a range of educational services to primary care • Potential to lead a range of education activity as part of ICS shared service development

Controls	**Gaps in Control**	**Assurances**	**Gaps in Assurances**

• Workstream related strategies in place:
  ○ Education & Training Strategy
  ○ Apprenticeship Strategy
  ○ Digital Education Strategy
  ○ Research Strategy
  ○ Our Big Plan, Annual Business Plan Planning framework
  ○ Workforce & OD Strategy
• Ring-fencing of education and research funding.
• Divisional education contracts.
• NHS Education Contract with HEE.
• Policies in place with review cycle.
• Business continuity plans in place.
• Head of R&I now part of New Hospitals Programme and ICB programme working parties.
• Enhanced plans identified within Research & Innovation Strategy to leverage more opportunity to increase funding and assist recovery processes
• Full review of deferred income has been conducted by finance evidencing and ensuring drawdown of income from deferred position/reserves is matched in line with expenditure and the Education Contract on an ongoing basis
• Categorised investment requirements for education infrastructure now in place, which is being worked through with Capital Investment Team
	• Lack of research leads embedded in divisions ***(ETR 007)***
	• No mechanism to utilise educational income to support capital developments ***(ETR 004)***.
		Internal
		• Sub-committees for education, training and research incorporating risk reviews.
		• Quality assurance and performance management of education activity.
		• Learner improvement forum.
		• Monthly training compliance reports.
		• Divisional performance reviews
		• Paper to include R&I involvement at DIFs and Divisional Boards has been drafted for approval by the CMO
		• Monthly finance reviews.
		• Education, Training & Research Committee
		• Audit Committee assurance processes to test effectiveness of safety and quality infrastructure and internal control system.
		• Board.
		
		External
		• Full OFSTED inspection completed August 2022 with 'Good' rating achieved.
		• ESFA audits
		• HEE self-assessment return.
		• Matrix accreditation.
		• Annual performance reviews with Manchester Medical School
		• National Student Surveys.
		• National Education Trainee Surveys.
		• STAR accreditation for Clinical Research Facility.
		• Engagement in range of external forums and committees.
		• Quarterly strategy meetings with local HEIs
		• Trust Involvement/leadership in ICS discussions re education and R&I
			• None currently identified.

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
ETR 001	Reset research provision to develop an affordable portfolio and refer to this in the refreshed Research and Innovation Strategy.	Head of Research & Innovation	30.04.23	30.04.23	Complete	Control	• Ongoing losses in research income which necessitate a recovery plan.
ETR 004	Include development of international education programmes post-Covid in Education and Training Strategy.	Deputy Director of Education	31.12.23		Ongoing	Control	• No mechanism to utilise educational income to support capital developments
ETR 005	Identify solutions to facilitate and support creation and delivery of a capital programme for education.	Chief Finance Officer, Associate Director of Education	30.07.23	25.07.23	Complete	Control	• No mechanism to utilise educational income to support capital developments • Ability to income generate in current economic climate
ETR 006	Identify a plan to mitigate identified risks associated with change in deferred income	Chief People Officer/Chief Finance Officer	30.04.23	30.04.23	Complete	Control	• Control of in-year adjustments relating to income deferral
ETR 007	Have Research roles in place within 2 Divisions	Head of Research & Innovation	~~31.08.23~~ 31.03.24		Ongoing	Control	• Lack of research leads embedded in divisions.

Summary of Updates – September 2023

- From an education perspective, no updates this month and risk score remains at 20 until full time Chief People Officer in post.
- From a research perspective, some updates made to rationale for current score, gaps in controls and assurances
- Action ETR 007 due date extended as work continues to ensure Research roles in place. A paper has been drafted and is awaiting Chief Medical Officer approval for an agreed approach to R&I and Divisional working.

Chair's Report

Committee:	Safety and Quality Committee
Chairperson and role:	Kate Smyth, Non-Executive Director
Date(s) of Committee meeting(s):	28 July 2023 and 25 August 2023
Purpose of report:	To update the Board on the business discussed by the Safety and Quality Committee. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

28 July 2023

Following the meeting held on the 28 July 2023, the Committee conducted a comprehensive review of the scheduled items on the agenda.

The Committee approved the following items:

- Minutes and actions
- Strategic risk register
- Exception Report from Divisional Improvement Forums

The Committee received presentations and reports and discussed the position on the following:

- Safety and Quality Dashboard including Nursing and Midwifery staffing reports for adult inpatients (including the Emergency Department); maternity; and neonatal and children and young people services.
- Health Inequalities Delivery Plan.
- Civil Claims Report.
- MHRA Haematology Report.

25 August 2023

Following the meeting held on the 25 August 2023, the Committee conducted a comprehensive review of the scheduled items on the agenda.

The Committee approved the following items:

- Minutes and actions
- Strategic risk register
- Exception Report from Divisional Improvement Forums

The Committee held a brief discussion following the verdict of the Letby trial.

The Committee received presentations and reports and discussed the position on the following:

- Safety and Quality Dashboard including Nursing and Midwifery staffing reports for adult inpatients (including the Emergency Department and Finney House) maternity; and neonatal and children and young people services.
- Annual AHP Staffing Report.
- Quarterly Serious Case Thematic Review and Learning Report.
- Thrombectomy Update.
- CQC Maternity Inspection High Level feedback
- Maternity Litigation Case.

	- PHSO Review.
Items for the Board's attention	
The Committee received an outline of the early work of the LTH Health Inequalities Delivery Plan. It was advised that the delivery plan was structured around the ICB's health inequalities programme and in time would link closely with the health and wellbeing Boards. This would be presented to board in August. The MHRA Haematology Report provided an overview of the findings and response, to the Medicines and Healthcare Product Regulatory Agency (MHRA) inspection of the Blood Bank, at the Royal Preston Hospital in relation to compliance with the Blood Safety and Quality Regulations. The inspection took place on 9 February 2023 and the MHRA released their final report on 11 May 2023, an action plan is in place and being monitored.	The annual Allied Health Professionals Staffing Report provided details of the findings of the Lancashire Teaching Hospitals bi-annual Allied Health Professionals workforce safeguards review for the reporting period of December 2022 to May 2023. The Thrombectomy update provided an update on progress against the project plan for thrombectomy expansion, following the recommendations from the previous report to the Committee in February 2023. The report included details of the alternative options that had been explored to expedite expansion, alongside the mitigations that were in place and a plan to expand the availability of services to 7 days on 25 September 23. The Committee were provided with an update following a High Court Clinical Negligence Trial ruling against the Trust in relation to a maternity case that concluded on 28 July 2023.
Positive escalation	
28 July 2023	**25 August 2023**
- The Committee endorsed the developing Health and Inequalities Delivery Plan acknowledging the requirement to develop a deeper internal knowledge of current practice that contributes towards CORE20PLUS5 delivery. The organisation would continue to develop links with the new PLACE and ICB Health Inequalities teams and agreed to receive a further update in January 2024. - The Civil Claims report provided a wider thematic look at the last five financial years for an overview and context to consider alongside the current year's position. The work and knowledge of the legal team in managing the clinical claims within the NHS setting was commended. It was noted that their work was hugely beneficial for the Trust. - The friends and family tests for ED had sustained improved results.	- The maternity services had provided 100% of one-to-one care in labour for the second consecutive month. - The progression of a 7-day admission avoidance service for the ED and assessment areas has progressed expected to have a positive impact on several key areas that require improvement. - Several successes and improvements within the annual Allied Health Professionals report were noted. Some of which were: there had been 13 AHP departments that received STAR accreditation, full recruitment to the new AHP neonatal posts from the Ockenden funding, development of the in-house level 3 AHP support worker apprenticeship and development of Cancer Clinical Nurse Specialist roles being opened up to AHPs and Pre-op Practitioner roles opened up to ODPs.

- STAR metrics were showing improvements around the fluid balance and vital signs compliance. - Following the transformation work in the ED there were improvements to ambulance handover times achieving a 50% reduction in handovers of 60 minutes demonstrating sustained improvement. - The development of the Acute Admissions Unit (AAU) in the former Covid Majors area had continued to lead to a reduction in very long lengths of stay for patients in ED. - The registered nurse fill rates had shown a positive increase, higher than expected within normal variation and above target for the last two months.	- From the 25 September 2023, there would be an increase in hours for the Thrombectomy service provision from a 5-day to a 7-day service.
Negative escalation	
28 July 2023	**25 August 2023**
- Clostridium difficile infection had consistently been above the monthly tolerance of 10, for the last 18 months. Enhanced oversight of the modifiable factors attributed to C.*difficile* was underway with 6 monthly reporting in place to the committee. - Pressure ulcers were showing early signs of improvement however remain above the tolerance. A review had been undertaken to understand what was leading to the improvements and those benefits were being shared across the organisation. - A never event incident occurred in the Orthopaedics theatre that was reported for June, early learning had been identified and shared with the teams across theatres and an ongoing investigation was underway.	- The World Health Organisation (WHO) checklist reduction in compliance was noted by the Committee. Improvement work was ongoing following the MIAA audit and monitored monthly by the Surgery Divisional Improvement Forum. - Clostridium Difficile Infection rates continue to exceed the expected trajectory. There was weekly Executive oversight of the action plans including a fundamental overview of all standards to ensure consistent application, sharing best practice learning from peers and working collaboratively with the estates team reviewing cleaning standards and products.
Committee to Committee referral	
28 July 2023	**25 August 2023**
No referrals.	No referrals.
Items recommended to the Board for approval	
28 July 2023	**25 August 2023**
None	None
Committee Chairs reports received	

28 July 2023	25 August 2023
(a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Always Safety First Committee (d) Medicines Governance Committee (e) Safety and Learning Group (f) Patient Experience and Involvement	(a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Always Safety First Committee (d) Safety and Learning Group (e) Medicines Governance Committee (f) Patient Experience and Involvement (g) Mortality and End of Life (h) Health and Safety Governance (i) Health inequalities group
Items where assurance was provided and/or for information	
28 July 2023	**25 August 2023**
The Committee received the Safety and Quality dashboard and was assured of the actions being taken to address areas for negative escalation. The Civil Claims Report provided an update on activity related to clinical negligence claims and non-clinical claims against Lancashire Teaching Hospitals NHS Foundation Trust in the period 1 April 2022 to 31 March 2023. The Committee were assured of the programmes of work that support robust systems and processes for managing clinical and non-clinical claims Assurance was provided of safe staffing and the safety and quality of Children and Young People services and that the risks were being regularly reviewed, monitored, and mitigated where possible.	The Committee received the Safety and Quality dashboard and was assured of the actions being taken to address areas for negative escalation. The Committee received the following items for information: a) The maternity CQC Well Led High Level Feedback LTH Response b) The CQC Mental Health and Self Harm Return c) The terms of reference for: ○ IPC Committee ○ Safeguarding Board ○ Safety and Learning Group ○ Health Inequalities Group The Committee were provided assurance of the safety and quality standards within the maternity services and the new additional local perinatal surveillance parameters for monitoring safety. Risks were being regularly reviewed, monitored, and mitigated where possible. The Committee were assured of the management of the serious incidents. The Quarterly Serious Case Thematic Review and Learning Report provided a high-level overview of Level 3/Strategic Executive Information System (StEIS) serious incident investigations reported, any emerging concerns in relation to ongoing cases, and the actions and learning from completed cases for the reporting period of the 1 April 2023 to 30 June 2023 inclusive. The Committee were assured of the immediate actions that had been undertaken following the recent Care Quality Commission inspection of Maternity Services at Lancashire Teaching

	Hospitals undertaken on the 3 and 4 July 2023 at Preston and Chorley.
Progress against the Committee's cycle of business	
The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 29 September 2023 using Microsoft Teams.	

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Safety and Quality Committee agenda (28 July 2023)

Appendix 2 – Safety and Quality Committee agenda (25 August 2023)

Safety and Quality Committee

28 July 2023 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	1.00pm	Verbal	Information	K Smyth
2.	Apologies for absence	1.01pm	Verbal	Information	K Smyth
3.	Declaration of interests	1.02pm	Verbal	Information	K Smyth
4.	Minutes of the previous meeting held on 30 June 2023	1.03pm	✓	Decision	K Smyth
5.	Matters arising and action log	1.05pm	✓	Decision	K Smyth
6.	Strategic Risk Register	1.10pm	✓	Assurance	H Ugradar
7.	QUALITY AND PERFORMANCE				
7.1	Health Inequalities Delivery Plan	1.20pm	✓	Decision	S Cullen
7.2	Children and Young People Staffing Report	1.35pm	✓	Assurance	S Cullen
7.3	Safety and Quality Dashboard including Adult Safe Staffing Report	1.45pm	✓	Assurance	C Gregory
7.4	Civil Claims Report	2.05pm	✓	Assurance	C Morris
8.	GOVERNANCE AND COMPLIANCE				
8.1	MHRA - Haematology Report	2.20pm	✓	Decision	R Dineley
8.2	Strategic risk register review	2.30pm	Verbal	Decision	K Smyth
8.3	Items for referral to the Board or to/from other Committees	2.35pm	Verbal	Information	K Smyth
8.4	Reflections on the meeting and adherence to the Board Compact	2.40pm	✓	Assurance	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Exception report from Divisional Improvement Forums		✓		

№	Item	Time	Encl.	Purpose	Presenter
9.2	**Chairs' reports from feeder groups**: (a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Always Safety First Committee (d) Medicines Governance Committee (e) Safety and Learning Group (f) Patient Experience and Involvement		✓		
9.3	Date, time and venue of next meeting: *25 August 2023, 12.30pm, Microsoft Teams*	2.45pm	Verbal	Information	K Smyth

Safety and Quality Committee

25 August 2023 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Information	K Smyth
2.	Apologies for absence	12.31pm	Verbal	Information	K Smyth
3.	Declaration of interests	12.32pm	Verbal	Information	K Smyth
4.	Minutes of the previous meeting held on 28 July 2023	12.33pm	✓	Decision	K Smyth
5.	Matters arising and action log	12.35pm	✓	Decision	K Smyth
6.	Strategic Risk Register	12.40pm	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard including Adult Safe Staffing Report	12.50pm	✓	Assurance	C Gregory
7.2	Maternity and Neonatal Report	1.00pm	✓	Assurance	E Ashton
7.3	Children and Young People Staffing Report	1.10pm	✓	Assurance	C Gregory
7.4	Annual AHP Staffing Report	1.20pm	✓	Assurance	C Granato
7.5	Quarterly Serious Case Thematic Review and Learning Report	1.30pm	✓	Assurance	C Morris
7.6	Thrombectomy Update	1.40pm	✓	Assurance	C. Granato
8.	GOVERNANCE AND COMPLIANCE				
8.1	CQC Maternity Inspection High Level feedback	1.50pm	✓	Assurance	C Gregory
8.2	Strategic risk register review	2.00pm	Verbal	Decision	K Smyth
8.3	Litigation case – maternity (Datix number 122880)	2.10pm	✓	Assurance	S Regan E Ashton
8.4	Ward 8 Report	2.20pm	✓	Assurance	C Gregory J Connolly
8.5	PHSO Review	2.30pm	✓	Assurance	S Canty

№	Item	Time	Encl.	Purpose	Presenter
8.6	Items for referral to the Board or to/from other Committees	2.40pm	Verbal	Information	K Smyth
8.7	Reflections on the meeting and adherence to the Board Compact	2.50pm	✓	Assurance	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	CQC Well Led High Level Feedback LTH Response		✓		
9.2	CQC Mental Health and Self Harm Return		✓		
9.3	Terms of Reference for: a) IPC Committee b) Safeguarding Board c) Safety and Learning Group d) Health Inequalities Group		✓		
9.4	Exception report from Divisional Improvement Forums		✓		
9.5	**Chairs' reports from feeder groups**: (a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Always Safety First Committee (d) Safety and Learning Group (e) Medicines Governance Committee (f) Patient Experience and Involvement (g) Mortality and End of Life (h) Health and Safety Governance (i) Health inequalities group		✓		
9.6	Date, time and venue of next meeting: *29 September 2023, 12.30pm, Microsoft Teams*	2.55pm	Verbal	Information	K Smyth

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Patient Safety Incident Response Framework			
Report to:	Board of Directors	**Date:**	5th October 2023
Report of:	Chief Nursing Officer	**Prepared by:**	H. Ugradar
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary:

The purpose of this paper is to provide the Board of Directors with an update on the implementation of the Patient Safety Incident Response Framework (PSIRF).

The Patient Safety Incident Response Framework (PSIRF) is a key component of the new National Patient Safety Strategy and will replace the NHS Serious Incident Framework. As part of transition to PSIRF, all Trusts are required to produce a Patient Safety Incident Response Framework Policy and a Patient Safety Incident Response Plan (PSIRP). Both the policy and the PSIRP will be published on the Trust's external facing website.

PSIRF Policy

The policy sets out Lancashire Teaching Hospitals NHS Foundation Trust's (LTHTR) approach to developing and maintaining effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety and has been developed in line with NHS England's PSIRF policy template guidance.

Patient Safety Incident Response Plan (PSIRP)

The PSIRP has been developed in line with NHS England's PSIRP template guidance and sets out how LTHTR intends to respond to patient safety events over a period of 12 to 18 months. The plan describes how we defined our patient safety event profile and how we identified and agreed our local priorities.

The plan is not a permanent rule that cannot be changed. The Trust will therefore remain flexible and consider the specific circumstances in which patient safety events and issues occur and the needs of those affected.

Transition Plans

The Trust aims to commence transition to PSIRF from 6th November 2023, with the aim for this to be fully embedded by 31st March 2024. To enable transition, the following critical steps must be achieved:

- Internal Policy and PSIRP sign-off at Board of Directors 5th October 2023.
- Integrated Care Board (ICB) Policy and PSIRP sign-off at ICB Quality Committee 18th October 2023.

- Programme delivery commencing 6th November 2023.

Until fully transitioned, there will be a period where the Trust is working against the PSIRF as well as the Serious Incident Framework.

Training

In line with NHS England's Patient Safety Response Standards, staff are required to complete a range of training depending on their role within PSIRF. It should be noted that some training does need to be provided by an accredited training provider with spaces currently limited. The Trust is therefore trying to source training via alternative methods to meet the training requirements as outlined within the NHS England Patient Safety Response Standards.

The Role of the Safety and Quality Committee

The Safety and Quality Committee will play a key role in ensuring that the Trust is responding to patient safety events in line with the PSIRF and is also responsible for providing assurance to the Board of Directors that the plan (PSIRP) is being implemented, that lessons are being learnt, and areas of vulnerability are improving. Further details are included in Section 2.5 of this paper, as well as the PSIRF policy and plan.

The Role of the Board of Directors

The Board of Directors have a responsibility to ensure that they receive assurance that the Trust is responding to patient safety events in line with the PSIRF, that the PSIRP is being implemented, that lessons are being learnt, and areas of vulnerability are improving. Further details are included in Section 2.6 of this paper, as well as the PSIRF policy and plan.

To support the Board of Directors, specific face-to-face training for the Board by the Health Services Safety Investigations Body (HSSIB) has been scheduled in November 2023.

Risks with implementation of PSIRF

The Trust has identified a new risk on the risk register that the Trust may not be fully compliant with the implementation of PSIRF within agreed timescales based on a number of factors. This risk has been scored at a 12 = significant risk (based on the likelihood score 3 (possible) x consequence score 4 (major)). To ensure the Trust meets agreed timescales, the Trust has set up a weekly PSIRF Implementation Group where the delivery of the implementation plan is being monitored alongside the Safety and Learning Group. The Trust is also working with neighbouring Trusts and the ICB to ensure that learning from others is considered and adopted where possible.

Impact on stakeholders

Engagement with patients, families, carers and staff forms a key component within the policy and plan. The Board of Directors are therefore asked to refer to Appendix 1 and Appendix 2 for further information on engagement arrangements with stakeholders.

Version Control of PSIRF and PSIRP

It should be noted that the iterations of the PSIRF policy and plan (Appendix 1 and 2) within the Board pack may be subject to further changes following presentation to the ICB Quality Committee on the 18th October 2023. The documents may also be subject to further amendments and updates throughout the year as we adopt this new way of responding to patient safety events. It is therefore recommended that the Board of Directors, delegate responsibility to the Safety and Quality Committee to approve any critical changes to the Policy and the PSIRP throughout the year.

It is recommended that the Board of Directors:

i. Receive and note the updates in relation to the implementation of PSIRF and confirm they are assured with the actions taken in order to commence the transition from the Serious Incident Framework to PSIRF from the 6th November 2023.
ii. Approve the PSIRF Policy and Plan prior to approval at the ICB Quality Committee on 18th October 2023.
iii. Delegate responsibility to the Safety and Quality Committee to approve any critical changes to the Policy and the PSIRP throughout the year.

Appendix 1 – Patient Safety Incident Response Framework (PSIRF) Policy
Appendix 2 – Patient Safety Incident Response Plan (PSIRP)

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☐
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For The Future	☐

Previous consideration

Safety and Quality Committee – 29th September 2023

1. Background

1.1. The purpose of this paper is to provide the Board of Directors with an update on the implementation of the Patient Safety Incident Response Framework (PSIRF).

1.2. The PSIRF is a key component of the new National Patient Safety Strategy and will replace the NHS Serious Incident Framework. As part of transition to PSIRF, all Trusts are required to produce a PSIRF Policy and a Patient Safety Incident Response Plan (PSIRP). Both the policy and the PSIRP will be published on the Trusts external facing website.

1.3. One of the underpinning principles of PSIRF is to do fewer 'investigations' but to do them better. This means taking the time to conduct system-based investigations by people that have been trained to do them. The policy and associated implementation plan describe how it will work.

2. Discussion

2.1. Patient Safety Incident Response Framework (PSIRF) Policy

2.1.1. The policy sets out Lancashire Teaching Hospitals NHS Foundation Trust's (LTHTR) approach to developing and maintaining effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety and has been developed in line with NHS England's PSIRF policy template guidance.

2.1.2. The policy describes:

- our current patient safety culture,
- the role of the patient safety partners,
- how the Trust addresses health inequalities,
- how the Trust will engage and involve patients, families and staff following a patient safety event,
- the Trust's patient incident response planning,
- how the Trust will respond to patient safety events,
- roles and responsibilities of staff in relation to PSIRF.

2.1.3. As per the guidance template, the policy affirms that responses that seek to find liability, accountability or causality are beyond the scope of this policy as it is intended that patient safety responses are conducted for the purpose of learning and improvement. However, the policy acknowledges that during the process of conducting a patient safety investigation, the Trust may identify the need to initiate another type of response. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response. The Trust also recognises that there may be some overlap in processes when engaging with patients, families, carers and staff and will endeavour to ensure a streamlined approach to create a positive experience and reduce unnecessary distress.

2.2. Patient Safety Incident Response Plan (PSIRP)

2.2.1. The PSIRP has been developed in line with NHS England's PSIRP template guidance and sets out how LTHTR intends to respond to patient safety events over a period of 12 to 18 months.

2.2.2. The plan is not a permanent rule that cannot be changed. The Trust will therefore remain flexible and consider the specific circumstances in which patient safety events and issues occur and the needs of those affected.

2.2.3. The plan describes:

- our service profile,
- how the Trust has defined its patient safety event profile and how the local priorities were identified,
- how the Trust will respond to patient safety events that fit the national priorities,
- how the Trust will respond to patient safety events that fit the local priorities and local profile,
- how the Trust will learn from patient safety events,
- how the Trust will align PSIRF with continuous improvement and
- how the Trust will transition to PSIRF.

2.3. Transition Plan

2.3.1. The Trust aims to commence transition to PSIRF from 6th November 2023, with the aim for this to be fully embedded by 31st March 2024. To enable transition, the following critical steps must be achieved:

- Internal Policy and PSIRP sign-off at Board of Directors 5th October 2023.
- ICB Policy and PSIRP sign-off Quality Committee 18th October 2023.
- Programme delivery commencing 6th November 2023.

2.3.2. Until fully transitioned, there will be a period where the Trust is working against the PSIRF as well as the Serious Incident Response Framework.

2.4. Training

2.4.1. In line with NHS England's Patient Safety Response Standards, staff are required to complete a range of training depending on their role within PSIRF. The training requirements and the Training Needs Analyses are detailed within the PSIRF policy, with a schedule of training currently underway to ensure staff are compliant ahead of the Trust implementing PSIRF.

2.4.2. It should be noted that some training does need to be provided by an accredited training provider with spaces currently limited. The Trust is therefore trying to source training via alternative methods to meet the training requirements as outlined within the NHS England Patient Safety Response Standards.

2.4.3. To support the Board of Directors, specific face-to-face training for the Board by the Health Services Safety Investigations Body (HSSIB) has been scheduled in November 2023.

2.5. The role of the Safety and Quality Committee

2.5.1. The Safety and Quality Committee will play a key role in ensuring that the Trust is responding to patient safety events in line with the PSIRF and is also responsible for providing assurance to the Board of Directors that the plan (PSIRP) is being implemented, that lessons are being learnt, and areas of vulnerability are improving.

2.5.2. Going forward, the Safety and Quality Committee will receive assurance on the implementation of the PSIRP and ongoing and emerging issues related to patient safety events from the Safety and Learning Group by escalation through monthly chairs reports and through quarterly and annual PSIRF reports.

2.5.3. Quarterly PSIRF reports to the Safety and Quality Committee will contain a summary of learning from patient safety incident investigations and assurance regarding the implementation of PSIRF and associated standards.

2.5.4. Where concerns are identified relating to the implementation of the PSIRP, compliance with PSIRF standards and robustness of lessons learned and associated improvement plans, the Safety and Quality Committee will seek assurances that these concerns are being acted upon. Where there are remaining concerns, these will be escalated to the Trust Board.

2.6. The role of the Board of Directors

2.6.1. The Board of Directors have a responsibility to ensure that they receive assurance that the Trust is responding to patient safety events in line with the PSIRF, that the PSIRP is being implemented, that lessons are being learnt, and areas of vulnerability are improving.

2.6.2. The Trust Board will receive assurance on the implementation of the PSIRP and ongoing and emerging issues related to patient safety events from the weekly Safety and Learning Group by escalation through monthly chairs reports to the Safety and Quality Committee, through quarterly and annual reports to the Safety and Quality Committee and by escalation from the Safety and Quality Committee to the bi-monthly Trust Board meeting.

2.6.3. The Trust Board will also receive assurance regarding the implementation of PSIRF and associated standards through an annual PSIRF report to the Trust Board of Directors meeting. This will contain sufficient information to ensure that the Trust Board has a formative and continuous understanding of organisational safety.

2.6.4. Where concerns are identified relating to the Trust's response to patient safety events in line with PSIRF, the implementation of the PSIRP, compliance with PSIRF standards and robustness of lessons learned and associated improvement plans, the Trust Board will seek assurances that these concerns are being acted upon.

3. Financial implications

3.1. The NHS England Patient Safety Incident Response standards state that:

> *"Learning response leads should have an appropriate level of seniority and influence within an organisation – this may depend on the nature and complexity of the incident and response required, but it is recommended that learning responses are led by staff at Band 8a and above."*

This is a fundamental change to how investigations are currently conducted within the organisation and therefore a workforce gap analysis and review of skill mix is currently underway.

The PSIRF Implementation Group recognises the organisations financial challenges and will ensure this is carefully considered as part of any actions and recommendations.

3.2. Some training requirements identified within NHS England's Patient Safety Response Standards do need to be provided by an accredited training provider with spaces currently limited. The Trust is therefore having to source training via alternative methods to meet the training requirements. There may be some financial implications with this but where possible, the Trust will endeavour to utilise CPD funding. The

Trust is also working with external providers to design an e-learning package that meets the training requirements set out in the Response Standards to reduce and prevent any financial impact to the Trust.

4. Legal implications

4.1. The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute healthcare providers.

5. Risks

5.1. The Trust has identified a new risk on the risk register that the Trust may not be fully compliant with the implementation of PSIRF within agreed timescales due to multiple factors. This risk has been scored at a 12 = significant risk (based on the likelihood score 3 (possible) x consequence score 4 (major)). To ensure the Trust meets agreed timescales, the Trust has set up a weekly PSIRF Implementation Group where the delivery of the implementation plan is being monitored alongside the weekly Safety and Learning Group.

5.2. The Trust is also working with neighbouring Trusts and the ICB to ensure that learning from others is considered and adopted where possible.

6. Impact on stakeholders

6.1. The PSIRF is a new and innovative approach to how the NHS responds to patient safety events. This is not a change which involves us doing the same thing. It is a cultural and system shift which fundamentally changes our thinking and response to patient safety events and how we work to prevent an incident happening again. This change will have a significant impact on stakeholders including patients, families, carers and staff.

6.2. Engagement with patients, families, carers and staff forms a key component within the policy and plan. The Board are therefore asked to refer to Appendix 1 and Appendix 2 for further information on engagement arrangements with stakeholders.

7. Recommendations

7.1. It is recommended that the Board of Directors:

i. Receive and note the updates in relation to the implementation of PSIRF and confirm they are assured with the actions taken in order to commence the transition from the Serious Incident Framework to PSIRF from the 6th November 2023.
ii. Approve the PSIRF Policy and Plan prior to approval at the ICB Quality Committee on 18th October 2023.
iii. Delegate responsibility to the Safety and Quality Committee to approve any critical changes to the Policy and the PSIRP throughout the year.

Patient safety incident response policy

Effective date: TBC

Estimated refresh date: TBC

	NAME	TITLE	SIGNATURE	DATE
Author	**Hajara Ugradar**	**Deputy Associate Director of Risk and Assurance**	**To be added**	**12th September 2023**
Reviewer	**TBC**	**TBC**	**TBC**	**TBC**
Authoriser	**TBC**	**TBC**	**TBC**	**TBC**

Contents

Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out **Lancashire Teaching Hospitals NHS Foundation Trusts** approach to developing and maintaining effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety.

Patient safety incidents are unintended of unexpected events (including omissions) in healthcare that could have, or did, harm one or more patients.

The PSIRF replaces the Serious Incident Framework (SIF), (2015) and makes no distinction between “patient safety incidents” and “serious incidents”. It removes the “serious incidents” classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety events by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The new framework is not a different way of describing what came before; it fundamentally changes how the NHS responds to patient safety events for learning and improvement.

The PSIRF advocates a co-ordinated and data-driven response to patient safety events. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety events,
- application of a range of system-based approaches to learning from patient safety events,
- considered and proportionate responses to patient safety events and safety issues,
- supportive oversight focused on strengthening response system functioning and improvement.

This policy should be read in conjunction with our current patient safety incident response plan (PSIRP), which is a separate document setting out how this policy will be implemented.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across or involving **Lancashire Teaching Hospitals NHS Foundation Trust.**

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

Where other processes exist with a remit of determining liability or to apportion blame, preventability or cause of death, their principal aims differ from that of a patient safety response which is conducted for the purpose of learning and improvement. Such processes as those listed below are therefore outside of the scope of the policy.

- claims management,
- investigations into employment concerns,
- professional standards investigations,
- information governance concerns,
- estates and facilities concerns,
- financial investigations and audits,
- safeguarding concerns,
- coronial inquests and criminal investigations,
- complaints (except where a significant patient safety concern is highlighted).

For clarity, whilst the Trust considers these processes as separate from any patient safety investigation, the Trust acknowledges that during the process of conducting a patient safety investigation, the Trust may identify the need to initiate another type of response. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response. The Trust also recognises that there may be some overlap in these processes when engaging with patients, families, carers and staff and will endeavour to ensure a streamlined approach to create a positive experience and reduce unnecessary distress.

Our patient safety culture

Always Safety First

Over the last few years, Lancashire Teaching Hospitals NHS Foundation Trust has developed an 'Always Safety First' philosophy and mindset which has made patient safety everyone's priority. This commitment is owned by the Trust Board who have embedded patient safety into their board development programme and board visibility programme.

The goals and initiatives set for improvement are set through the Trust's Always Safety-First Strategy, which is the Trust's response to the NHS National Patient Safety Strategy. This ambitious strategy outlines the Trust plans and aspirations to improve quality of care and safety for our patients, service users and staff through the development of high reliable systems and processes to reduce avoidable harm using robust improvement methodology.

Always Safety First is based on a proactive regular review of our safety metrics and safety intelligence including systematic data from harms, incidents, risks, complaints, mortality and other intelligence to inform our priorities, improvement co-designed with our staff and patients, shared governance, collaborative working across divisions and clinical specialties, and learning to improve. Always Safety First is focused on achieving high reliability through standardisation, system redesign and ongoing development of pathways of care, built on a philosophy of continuous improvement led by frontline clinical staff. Staff are supported by a real-time safety surveillance system making our data visible from Ward to Board and through collaborative learning sessions which bring teams together to learn about the improvement interventions to be embedded through shared learning and best practice, building improvement capability and actively participating, thereby forming a positive safety and continuous improvement culture.

The Trust Board and wider senior leadership team are committed to adopting a robust improvement methodology across the organisation and wider system. Improvement is organised at macro (system and organisation), meso (pathway) and micro (individual ward and department) levels as outlined in the Trust's Continuous Improvement Strategy.

Patient Experience and Involvement

Improving patient experience is also a key ambition for the Trust underpinned by the mission to provide 'Excellent Care with Compassion' and is considered a core component of safety culture. Acquiring and acting upon the feedback provided by our patients, families and carers on their experience is an important component to achieving that ambition. In 2022, the Trust co-produced a new three-year Patient Experience and Involvement Strategy. The strategy was developed and co-produced with patients, families, carers, governors, and staff. The Trust has actively sought the views of patient groups who represent those people who have protected characteristics and recognises the importance of intersectionality when considering the feedback. The strategy closely links to a number of Trust strategies, including Equality and Inclusion, Leadership and Organisational Development, Mental Health, Learning Disability and Autism, Dementia, as well as Always Safety First. The delivery of the Patient Experience and Involvement strategy is monitored through the Patient Experience and Involvement Group, which is a diverse group consisting of governors, patient representatives, carers, voluntary sector organisations and staff members and provides assurance to the Trust Safety and Quality Committee.

Alignment with the PSIRF

Both the Always Safety First and Patient Experience and Involvement Strategies focus on three areas of work. These are:

- **insight** – improving understanding of safety, patient experience and involvement by listening and drawing insights from multiple sources of information,
- **involvement** – to equip patients, colleagues and partners with the skills and opportunities to improve safety and patient experience throughout the whole system,
- i**mprovement** – to design and support improvement programmes that deliver effective and sustainable change.

Lancashire Teaching Hospitals NHS Foundation Trust believes these three work areas outlined in the Always Safety First and Patient Experience and Involvement Strategies align to the aims within the PSIRF. Through this policy, any associated policies and the PSIRP, the Trust will:

- continue to draw on data and intelligence to identify PSIRF priorities (insight),

- further improve the involvement of our patients, staff and stakeholders in learning responses and equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system ('involvement') and
- design and support programmes that deliver effective and sustainable change in the most important areas including reducing patient harms and improving our safety culture ('improvement').

Reporting Culture

The Trust has a healthy reporting culture and staff are actively encouraged to report patient safety events that they witness. The Trust encourages staff to view the reporting of patient safety events as a learning opportunity to stop the reoccurrence of similar events.

Safety Training

In recognising the vital role staff play in speaking up, the Trust introduced 'Speak Up – Core Training' via the Trusts E-learning platform for all staff, including bank and agency staff. This mandatory training was introduced in May 2023 to raise awareness of the support available for staff to raise concerns and to encourage a healthy speaking up culture for the benefit of patients and workers.

This new training is supported by a range of other safety training across the organisation, including the Level 1 Essentials of Patient Safety E-learning Training, which focusses on the essentials for creating patient safety. The training is mandated for all staff, including bank and agency staff and includes the following content:

- listening to patients and raising concerns,
- the systems approach to safety, where instead of focusing on the performance of individual members of staff, we try to improve the way we work,
- avoiding inappropriate blame when things don't go well,
- creating a just culture that prioritises safety and is open to learning about risk and safety.

Board and Senior Leadership Teams are also expected to complete the Level 1 Essentials of Patient Safety for Boards and Senior Leadership Teams E-learning Training. The session builds on the 'Essentials of Patient Safety for All' session and introduces patient safety measurement, monitoring, and governance for patient safety for

Boards and Senior Leaders. It also focuses on Board opportunities and responsibilities in patient safety, human and financial costs, and safety aspects.

As an extension to this and as part of the commitment to be an Always Safety First organisation, the Board has had a development session led by Professor Charles Vincent from the Health Foundation to explore how the Board can review their thinking on measurement and monitoring of patient safety. Alongside this, a wide range of multi professional senior leaders have had bespoke training on Safety II, which considers variations in everyday performance to understand how the organisation can learn from things that have gone well.

The Trust's Safety and Learning Team have also been delivering bespoke face to face Serious Incident Investigation Training for Consultants, Senior leaders and Governance Teams. The aims of the training are:

- to provide an understanding of what a serious incident is, and how the Health Service investigates them,
- to provide an understanding of the serious investigation process, methodologies and tools used,
- to provide insight into the internal and external stakeholders in a serious incident investigation and the effects on patients, families and staff involved.
- to provide information on the upcoming changes to way the NHS investigates serious incidents, adapting to a broader, proactive, risk-based approach and the compassionate engagement of those affected by patient safety events.

Just Culture

As a learning organisation, the Trust is dedicated to ongoing organisational wide cultural change through compassionate and inclusive leadership to encourage a culture of psychological safety. This is essential to underpin the ongoing development of a high-quality safe patient care system and a just, fair learning culture. The Trust has fully adopted the principles of 'Just Culture' which is detailed in the 'A Just Culture Guide' published by NHS England.

A 'Just Culture' states that actions of staff involved in a patient safety event should not automatically be examined using the Just Culture guide but that it can be a useful tool if an

investigation suggests a concern about an individual. The Trust aims to do this through embracing change in how we support our staff members through an event with a compassionate and just approach, ensuring there is no focus on blame or punitive measures for individuals involved. The Trust encourages working collaboratively across services and teams to ensure a supportive, fair, and just approach in the management of safety events that is consistent across all areas and teams.

The Trust is committed to promoting a restorative culture and applies a 'Just Culture' approach to its learning response methodology and will explore the full range of factors which may have contributed to the situation to fully understand what has happened in order to learn from patient safety events, ensure the right support is provided to staff and to prevent harm in the future.

In this context the wellbeing of our workforce is paramount and as such staff involved in safety events will be signposted to our Health and Wellbeing Service, which includes a Psychological Wellbeing Service.

Although staff should feel confident reporting patient safety events, it is recognised that reporting concerns may be difficult and a stressful process. Therefore, the Trust does have other routes where concerns can be raised and is summarised in the flow chart in Appendix 1.

Learning From Patient Safety Events

Our safety culture will further mature with the adoption of the new Learn From Patient Safety Events (LFPSE) system and will migrate from the previous National Reporting and Learning System to the new LFPSE system, a new national NHS system for the recording and analysis of patient safety events that occur in healthcare in September 2023. This system enables the Trust to immediately share patient safety events with the national Patient Safety Team to inform system wide learning through an upgrade in DatixWeb technology. To emphasise the Trust's commitment to being 'open and honest', this system also provides regulators immediate access to patient safety events reported through LFPSE.

It will introduce a number of changes that will support better understanding of the reporter and patients experience associated with a patient safety event. Notably, the reporter will now be asked how concerned they are about the patient safety event they are reporting, what the perceived psychological harm is, what the perceived physical harm is and what the perceived attributable harm is. The change will result in patient safety events being sent directly to the national LFPSE system enabling earlier thematic oversight of patient safety events occurring in the live system at a national level.

LFPSE will also:

- make it easier for staff across all healthcare settings to record safety events, with automated uploads from local systems to save time and effort and introducing new tools for non-hospital care where reporting levels have historically been lower.
- collect information that is better suited to learning for improvement than what is currently gathered by existing systems.
- make data on safety events easier to access, to support local and specialty-specific improvement work.
- utilise new technology to support higher quality and more timely data, machine learning, and provide better feedback for staff and organisations.

To ensure staff are aware and understand the change, a comprehensive education and communication plan is in place.

Working collaboratively

To support the delivery of the Trust's Always Safety First strategy, an Always Safety First Committee is in place and is chaired by our Trust Patient Safety Specialists with representation from a wide group of staff across the organisation. This specialist multidisciplinary group enables a culture of continuous improvement and cross-system working to build the will to improve safety, making safety everyone's role. Going forward, we will continue to build on these relationships and bring these groups together to support the successful implementation of this policy and the PSIRP. These groups will include, but is not limited to:

- Patients, families and carers, visitors and partners and advocacy services.

- Clinical Specialities and frontline teams
- Divisional Leadership teams
- Education and Training
- Organisational Development
- Human Factors
- Governance Professionals
- Digital and technology
- Research and innovation
- Continuous Improvement
- Patient Safety Specialists
- Medicines Safety Officer
- Medical Examiner and Mortality
- Safeguarding, Mental Health, Learning Disability and Autism

Testing our Safety Culture

The Trust has been participating in a four year Magnet4Europe research study. The aim of the research programme is to gain insight into how hospital care may be improved by implementing the Magnet pillars of excellence from the American Nursing Credentialing Centre in European hospital settings. As a part of the research programme staff are surveyed annually focussing on staff health and wellbeing and the impact on care delivery and patient safety in their hospital. Clinical staff from nursing and medical professions are invited to participate in the survey to benchmark our organisation against the other 14 Trusts taking part from England and organisations from across Europe.

The outcomes from both the 2021 and 2022 survey showed that the Trust was the top scoring UK hospital and third of sixty seven European hospitals for nurses rating overall safety on their ward or unit. When rating the quality of care delivered nurses rated the Trust second of fourteen UK hospitals and fifth of sixty seven European hospitals. Although these findings are a good temperature check against other organisations, the Trust is committed to seek opportunities for further learning. To ensure we continue to strengthen our safety culture, we will triangulate learning from other reviews, including our staff survey metrics for specific patient and staff safety questions.

Patient safety partners

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England to help improve patient safety across the NHS in the UK.

At Lancashire Teaching Hospitals NHS Foundation Trust, we are excited to welcome three PSPs from November 2023. The PSPs will offer support alongside our staff, patients, families and carers to influence and improve safety across our range of services. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

This exciting new role across the NHS will evolve over time and at Lancashire Teaching Hospitals NHS Foundation Trust, the main purpose of the role is to be a voice for the patients and community who utilise our services and ensure that patient safety is at the forefront of all that we do.

PSPs will communicate rational and objective feedback focused on ensuring that patient safety is maintained, improved and remains our priority, this will include attendance at governance meetings (including the Trust's Safety and Learning Group and Patient Experience and Involvement Group) to contribute and support the patient safety agenda, participation in investigation oversight groups, review and analysis of safety related information and being involved with contributing to documentation including policies, investigations, and reports. As the role evolves, we may ask PSPs to participate in staff and patient safety training, assist in the implementation of patient safety improvement initiatives and develop patient safety resources which will be underpinned by training and support specific to this new role.

Once in post, the PSPs will play a pivotal role in the contribution of the PSIRP including the identification of future local priorities by ensuring the voice of patients, families and carers is heard at all levels of the organisation in relation to patient safety activity.

The PSPs will be supported by the Associate Director of Quality and Experience and the Matron for Patient Safety for the Trust who will provide expectations and guidance for the role.

PSPs will have regular scheduled reviews and regular one-to-one sessions with the Associate Director of Quality and Experience and Matron for Patient Safety and training needs will be agreed together based on the experience and knowledge of each PSP. PSPs will also have access to the Trust's Health and Wellbeing and Psychological Wellbeing Services, to ensure they are afforded appropriate support, acknowledging some of the sensitivity of issues they will be involved with.

The PSP placements are on an honorary basis and will be reviewed after 18 months to ensure we keep the role aligned to the patient safety agenda as this develops.

In addition to the PSPs, the Trust will also work closely with the Maternity Voices Partnership, the Children's Youth Forum and a range of advocacy services in relation to PSIRF, providing updates on the implementation of PSIRF as well as engaging with patients, families and carers in relation to our local priorities.

Addressing health inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. The Trust recognises that at both a national and local level the NHS has a pivotal role in reducing health inequalities through a focus on:

- providing equity of access to healthcare services,
- providing equity of experience of healthcare services,
- providing equity of outcomes from healthcare services.

The conditions in which we are born, grow, live, work and age can impact our health and wellbeing. These are sometimes referred to as wider or social determinants of health.

Wider determinants of health are often interlinked. For example, someone who is unemployed may be more likely to live in poorer quality housing with less access to green space and less access to fresh, healthy food. This means some groups and communities are more likely to experience poorer health than the general population. These groups are also more likely to experience challenges in accessing care.

People living in areas of high deprivation, those from Black, Asian and minority ethnic communities and those from other inclusion health group, for example the homeless, are most at risk of experiencing these inequalities.

The Trust is situated in an area where a high proportion of its population are at risk of experiencing inequalities, with 20% of the population being 10% of the most deprived nationally and up to 25% of children and 20% of over 65s living in poverty. The area where the Trust is situated also has high levels of long-term conditions including mental health, cardiovascular disease, asthma, and dementia and is an area where there is a high proportion of people from a Black, Asian and minority ethnic background.

As an anchor institution in Lancashire and South Cumbria, Lancashire Teaching Hospitals NHS Foundation Trust has a significant social, economic and environmental impact on the local community during its day-to-day activities. The Trust is committed to ensuring that it makes a positive impact, or at least reduces any negative impact that it has on the local community. As part of the Trusts Level 1 Social Value Quality Mark accreditation, the Trust has made several pledges, including a pledge to reduce the health inequalities affecting the wellbeing of our patients and local communities.

The Trust will achieve this through delivering on its statutory obligations under the Equality Act, (2010) and will use data intelligently to assess any disproportionate patient safety risk to patients from across the range of protected characteristics. Currently, the Trust captures sex, disability, religion or belief and marriage and civil partnership status through the Trust's Electronic Patient Records. This will be further supported through the introduction of the new national LFPSE system, which will allow for the details of patients age, sex and ethnicity protected characteristics to be recorded in patient safety incident records on our incident and risk management system Datix. This will enable the Trust to undertake analysis of intelligence of these protected characteristics, providing insight into apparent inequalities.

In our response toolkit, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when

constructing safety improvement actions and this will inform our system learning and improvement priorities.

We will also address health inequalities as part of our safety incident response, utilising the national NHS England ‘Core20PLUS5’ approach. The approach defines a target population – the ‘Core20PLUS’ – and identifies ‘5’ focus clinical areas requiring accelerated improvement. As one of the 7 accelerator sites across the country, the Trust is working collaboratively with the Integrated Care System (ICS) Population Health Management Team and the Cancer Alliance co-lead the ICS Core20PLUS5 programme, working with partners to improve access to cancer screening and cancer care. An action plan in response to Core20PLUS5 has also been developed with the Chief Nursing Officer as the executive lead for Core20PLUS5 who the executive lead for PSIRF is also.

The Trust is also engaging with organisations from across the ICS including the voluntary sector to work collaboratively to reduce health inequalities. Examples include, working with primary care networks, participation in local conferences for system partners and participation in place based boards.

By establishing our local priorities, plan and policies aligned to the PSIRF we will work to triangulate intelligence, ensuring that potential inequalities are considered. Where data suggests additional areas for improvement this will be aligned to future PSIRF plans and this policy. As a Trust we are aware that data continuously provides up-to-date intelligence in association with addressing health inequalities and therefore the use of our incident management system, aligned to patient characteristics and local intelligence, is pivotal to supporting health equality and the reduction of inequalities.

Engagement of patient, families, carers and staff following a patient safety incident is critical to review of patient safety events and their response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

The Trust is committed to ‘consistently providing excellent care’ and ‘being a great place to work’. This means as a Trust, we do not tolerate, under any circumstances, any form of racial abuse, discrimination or unacceptable behaviours from and towards, our patients, families, carers and our staff. This includes all protected characteristics as our focus is to deliver the best care to our patients, regardless of, their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. This commitment is led by our Trust Board supported by our Trust Equality and Inclusion Strategy and other supporting strategies, with staff encouraged to report safety events using our incident reporting system. We will use this commitment to underpin future patient safety training, communications and the rollout of our local priorities and plan. In addition, this will continue to feature as part of our wider organisational cultural change programmes. Recognising this, we will ensure that this is pivotal to upholding a system-based approach to reducing health inequalities and poor experience of our staff and ultimately patient outcomes based on individuals’ specific characteristics.

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Engaging and involving patients, families and staff following a patient safety event

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety events (including patients, families and staff).

This involves working with those affected by patient safety events to understand and answer any questions they have in relation to the incident and signpost them to support as required.

We are committed to continuous improvement throughout the services we provide. We want to learn from any event where care does not go as planned or expected by our staff, patients, their families, carers, and other organisations.

Patient and Family Liaison

Getting involvement right with patients and families in how we respond to safety events is crucial, particularly to support improving the services we provide. Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake or an omission in care has been made.

The statutory Duty of Candour was brought into law in 2014 for NHS Trusts and is now seen as a crucial, underpinning aspect of a safe, open and transparent culture. It is fundamentally linked to concepts of openness and transparency and must be applied to all notifiable patient safety events.

The Duty of Candour is a general duty to be open and transparent with people in receipt of care.

If Duty of Candour applies to a patient safety incident, the Trust must undertake the following:

1. Tell the person/people involved (including family where appropriate) that the patient safety incident has taken place.
2. Apologise. For example, “we are very sorry that this happened”
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
6. Keep a secure written record of all meetings and communications.

The Trust encourages all staff to meet the regulatory and professional requirements of Duty of Candour, by being open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident. As part of our new policy framework, we will be outlining procedures that support patients, families, and carers – based on our existing Duty of Candour Policy. This will set out the responsibilities for overseeing, implementing and applying Duty of Candour.

It is expected that an ‘Engagement Lead’ is appointed following each incident. This would be a senior member of staff or a member of our multi-professional governance team who is nominated to be the key contact for communication with patients, families and carers during a patient safety incident review.

The Patient Experience and Patient Advice and Liaison Service

The Trust has a Patient Experience and Patient Advice and Liaison Service (PALS). Our Patient Experience and PALS work with patients to find solutions early in patient pathways that contribute towards avoiding safety events and reducing the need to complain, accepting that when this occurs, we have failed to take the action required to prevent an adverse experience. People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of the care team. Should the care team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends.

Our Patient Experience and PALS team provide confidential support to patients, their families and carers and can:

- Actively listen and respond to concerns, suggestions or queries to help improve patients' experiences.
- Provide information on NHS Services.
- Offer advice on the NHS Complaints process and provide information on how to seek independent advice if you wish to make a complaint.
- Feedback views to relevant staff, including the Chief Executive.
- Help the organisation learn from feedback and concerns to improve your experience.

Our Patient Experience and PALS team can be contacted Monday to Friday, 9am – 4pm (excluding Bank Holidays). The team can be contacted by calling 01772 522972 or emailing PALS@lthtr.nhs.uk.

Further information about how to raise a concern or complaint can be found on our website.

Information resources for patients, families and carers

The information provided to patients and their relatives has also been reviewed with new resources created, including a new PSIRF page on the Trust's website along with a series of public facing PSIRF resources to make it easy for patients, families and their carers to understand PSIRF and our local priorities. These resources have been developed in conjunction with the Trust's Patient Experience and Involvement Group and other advocacy groups who have contributed to the design and development of these resources.

National sources of support

We recognise that there might also be other forms of support that can help those affected by a patient safety incident and will work with patients, families, and carers to

signpost to their preferred source for this. The table below provides an overview of the additional support available:

Support Available	Link	Detail
Learning from Deaths – Information for Families	NHS England >> Learning from deaths: Information for families	This will explain what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.
Help is at Hand – For those Bereaved by Suicide	https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf	This guidance is specifically for those bereaved by suicide and offers practical support and guidance to those who have suffered loss in this way.
Mental Health Homicide Support	NHS England – London >> Mental health homicide support	This guidance is aimed at staff and families. This information has been developed by the London region's independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.
Child Death Support	Grieving for a child of any age| Child Bereavement UK	Both sites offer support and practical guidance for those who have lost a

	Bereavement support after the death of a baby or child – The Lullaby Trust	child in infancy or at any age.
Complaint's Advocacy	VoiceAbility | NHS complaints advocacy	The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints process.
Healthwatch	https://www.healthwatch.co.uk/ You can find your local Healthwatch from the listing (arranged by council area) here: https://www.healthwatch.co.uk/your-local-healthwatch/list	Healthwatch are an independent statutory body who can provide information to help make a complaint - including sample letters.
Parliamentary and Health Service Ombudsman	https://www.ombudsman.org.uk/	**T**he Parliamentary and Health Service Ombudsman makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations
Citizens Advice Bureau	https://www.citizensadvice.org.uk/	The Citizens Advice Bureau provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

Supporting staff following Patient Safety Events

The Trust is committed to the principles of the NHS Just Culture Guide for ensuring the fair, open and transparent treatment of staff who are involved in patient safety events. The Trust recognises the significant impact being involved in a patient safety event can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place.

All staff with knowledge of the events being reviewed are encouraged to actively participate in learning responses. That may be through submitting written information, joining a debrief meeting or a one-to-one conversation with the incident review team.

Review teams will agree with staff the timescales for feedback of progress and findings in accordance with the type of review method being utilised. All contact with staff will involve the collection of their account of the events along with their views and opinions on how systems can be improved.

When a colleague reports a patient safety event or is providing their insights into the care of a patient for an investigation, the Trust will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement, using the nationally recognised National Patient Safety Agency (NPSA) Just Culture Guide to ensure fair and equitable treatment when undertaking learning responses.

Local managers, with support from our multi-professional governance teams, will advise and signpost staff involved in patient safety events to the most appropriate information about the patient safety incident review process and further support functions.

There are a variety of psychological interventions available for staff at the Trust through the Trust's Health and Wellbeing Service, which includes a Psychological Wellbeing Service. Information on how to access these services can be found in the **Trust's Work Related Incidents and Staff Debrief and Support Policy.**

The Trust's Freedom to Speak Up Guardian also provides a confidential service for staff if they have concerns about the organisation's response to a patient safety event.

Appendix 1 within this document describes how staff can raise concerns to the Freedom to Speak Up team.

Second Victim (https://secondvictim.co.uk) is a website resource for healthcare staff and managers involved in patient safety events.

Information resources for staff

The information provided to staff has also been reviewed with new resources developed in line with the national resources to support staff in understanding their role in PSIRF and our local priorities. This includes a series of supporting policies, templates and standard operating procedures which will sit alongside the PSIRF Policy and this plan.

Going forward, updates, training and information for staff will continue to be cascaded through the PSIRF Implementation Group, the weekly Safety and Learning Group, the weekly Nursing, Midwifery and Allied Health Professions meeting, the Clinical Reference Group, Trust wide communications and via a range of governance professionals through Divisional Forums. The Trust is also committed to a programme of wider engagement on the implementation of PSIRF and future local priorities with plans for these captured within the Trust's PSIRF stakeholder engagement plan.

Patient safety incident response planning

The PSIRF supports organisations to respond to patient safety events and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety events relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

The Trust will take a proportionate approach to its response to patient safety events to ensure that the focus is on maximising improvement. To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Our PSIRP details how this has been achieved, as well as how the Trust will meet both national and local focus for patient safety incident responses and any specific contractually required variations to these.

Resources and training to support patient safety incident response

The Trust will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

Responsibility for the proposal to designate leadership of any learning response sits within the senior leadership team of the relevant Division and the Trust Safety and Learning Team. A learning response lead will be nominated by the Division, and the individual should have an appropriate level of seniority and influence within the Trust, this may depend on the nature and complexity of the incident and response required, and learning responses are led by staff at Band 8a and above or equivalent.

The Trust will have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. Divisional leadership leads will manage the selection of an appropriate learning response lead to ensure the rigour of approach to the review and will maintain records to ensure an equitable allocation. The Trust Safety and Learning team will support learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.

Those staff affected by patient safety events will be afforded the necessary managerial support and be given time to participate in learning responses. All Trust managers will work within our just and restorative culture principles and utilise other teams such as Health and Wellbeing to ensure that there is a dedicated staff resource to support such engagement and involvement. Divisions will have processes in place to ensure that managers work within this framework to ensure psychological safety.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

Training

The Trust recognises that meaningful learning and improvement following a patient safety event can only be achieved if supportive systems and processes are in place. To do this effectively, appropriate training and education will be provided to staff to ensure safety events are investigated in line with PSIRF guidance and the experiences of those affected by patient safety events is managed in line with best practice.

The Trust has committed to ensuring that we fully embed the PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

The Trust has already implemented a series of patient safety training packages to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety events and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows:

Level 1 - Essentials of Patient Safety	The Trust provides Essentials of Patient Safety for all training via the Trusts eLearning platform. It is a mandated training requirement for all staff, including substantive, bank and agency staff and focuses on the essentials for creating patient safety. The content includes: • listening to patients and raising concerns. • the systems approach to safety, where instead of focusing on the performance of individual members of staff, we try to improve the way we work. • avoiding inappropriate blame when things don't go well. • creating a just culture that prioritises safety and is open to learning about risk and safety.
Level 1 - The Essentials of Patient Safety for Boards and Senior Leadership teams	The session builds on the Essentials of Patient Safety for All' session and introduces patient safety measurement, monitoring, and governance for patient safety to Board and Senior Leaders. It is mandated training requirement for all staff 8a and above or equivalent including middle grade medical staff, Consultants and Board members and captures the following: • The human, organisational and financial costs of patient safety

	• The benefits of a framework for governance in patient safety • Understanding the need for proactive safety management and a focus on risk in addition to past harm • Key factors in leadership for patient safety • The harmful effects of safety events on staff at all levels. The training can be accessed via the Trust's e-learning platform.

As part of the Trust's Training Needs Analyses all staff, including substantive, bank and agency staff are mandated to complete Speak Up – Core Training' via the Trusts E-learning platform.

The table below provides an overview of the specific mandated training requirements for staff involved in patient safety investigations:

Topic	Minimum Duration	Content	Learning Response Leads	Engagement Leads	PSIRF Oversight Role Leads
Systems approach to learning from patient safety events	2 Days / 12 Hours	- Introduction to complex systems, systems thinking and human factors. - Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews. - Safety action development, measurement, and monitoring in co-produced with the improvement team	**Yes**		**Yes**

Oversight of learning from patient safety incidents	1 Day / 6 Hours	- NHS Patient Safety Incident Response Framework and associated documents.			**Yes**
Involving those affected by patient safety incidents in the learning process	1 Day / 6 Hours	- Duty of Candour. - Just culture. - Being open and apologising. - Effective communication. - Effective involvement. - Sharing findings. - Signposting and support.		**Yes**	**Yes**
Patient safety syllabus level 1: Essentials for patient safety	eLearning – mandatory for all Trust staff	- Listening to patients and raising concerns The systems approach to safety: improving the way we work, rather than the performance of individual members of staff. - Avoiding inappropriate blame when things do not go well	**Yes**	**Yes**	**Yes**
Patient safety syllabus level 2: Access to practice	eLearning - mandatory for all Trust staff	- Introduction to systems thinking and risk expertise: • Human factors • Safety culture	**Yes**	**Yes**	**Yes**
Continuing professional development (CPD)	At least annually	- To stay up to date with best practice (e.g., through conferences, webinars etc.) - Contribute to a minimum of two learning responses	**Yes**	**Yes**	**Yes**

Staff must be compliant with the above training requirements to fulfil their respective roles within a patient safety investigation. A training delivery plan is in place, with training compliance records being held centrally by the Trust's Education and Training team and being monitored at both Corporate and Divisional Level.

Board members will also receive specific face-to-face training from the Healthcare Services Safety Investigation Body (HSSIB) on Safety Investigation for Strategic Decision Makers and Senior Leaders in Healthcare.

Our patient safety incident response plan

Our plan sets out how **Lancashire Teaching Hospitals NHS Foundation Trust** intends to respond to patient safety events over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

Reviewing our patient safety incident response policy and plan

Our PSIRP is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety events. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement

Responding to patient safety events

Patient safety incident reporting arrangements

All staff are responsible for recording and reporting potential or actual patient safety events on our Trust incident reporting system (Datix) when it is identified. This includes safety events that may have been identified during mortality or coronial processes. Further information on the reporting and management of safety events can be found in our **Adverse Incident Reporting Policy.**

Support and advice are available from the Divisional governance teams, who will also share reminders on key timescales and support interpretation of the Trust's Standard Operating Procedures.

Divisions will highlight to the Trust Safety and Learning Team any incident which appears to meet the requirement for external referral. This will allow the Trust to work in a transparent and collaborative way with our ICB or regional NHS teams if an incident meets the national criteria for a Patient Safety Incident Investigation (PSII) of if supportive co-ordination of a cross-system learning response is required.

The Trust Safety and Learning Team will act as a liaison with external bodies and partner providers to ensure effective communication.

The Trust has a defined Governance Structure which details the decision-making process for patient safety incidents. This is detailed in Appendix 2.

Patient safety incident response decision-making

Daily Triage

The Trust will have daily review mechanisms in place to ensure that patient safety events are responded to proportionately and in a timely manner and will involve a two tier approach. This will include consideration and prompting to service teams where Duty of Candour applies.

Triage – Level 1 (Divisional Level – led by the Divisional Governance Teams)	All reported patient safety events will be reviewed at the next working day's 'Daily Triage' meeting for each Division by their respective Governance Teams. All patient safety events meeting the local and national priorities will automatically be escalated to the same day Trust wide PSIRF Triage meeting led by the Trust Safety and Learning Team. All other remaining patient safety events will be assessed to determine whether the event will be managed locally or whether a 'learning response' is required and a summary of decision-making presented to the to the same day Trust wide PSIRF Triage meeting led by the Trust Safety and Learning Team.
Triage – Level 2 (Trust wide Level – led by the Trust Safety and Learning Team)	The Trust wide PSIRF Triage meeting will approve decisions made by the Divisional Governance Teams and will also allow for consideration of any concerns raised via other processes (e.g., complaints, coronial processes, or safeguarding events) that may also require a learning response. The meeting will enable staff to escalate events of concern and will agree whether a safety event will be managed at a local level or agree the appropriate learning response. Events of concern will be escalated to the Trust's weekly Safety and Learning Group for oversight, challenge, and support. If a safety critical event occurs outside of meeting timeframe, this will be escalated immediately to the Chief Nursing Officer, Chief Medical Officer, Deputy Associate Director for Safety and Learning and Patient Safety Specialists.

Learning Response Types

Learning Responses available include:

Patient Safety Incident Investigation (PSII)	A PSII offers an in-depth review of a single patient safety event or cluster of safety events to understand what happened and how. These will be undertaken using Systems Engineering Initiative for Patient Safety (SEIPS) methodology.
Multidisciplinary (MDT) Team Review	An MDT review supports health and social care teams to learn from patient safety events that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care
SWARM	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future
After action review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as safety events. **It is based around four questions:**

	1. What was the expected outcome/expected to happen? 2. What was the actual outcome/what actually happened? 3. What was the difference between the expected outcome and the event? 4. What is the learning?
Thematic Review	A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative (I.e., Incident reports, Complaints data etc.) rather than quantitative data to identify safety themes and issues. Thematic Reviews can be used for multiple purposes, including: • Developing or revising our Safety Improvement Profile • Aggregating information from many diverse sources of safety intelligence datasets. • Gathering insight about gaps / safety issues across a pathway or as part of an overarching safety theme to direct further analysis • Aggregating findings from multiple incident responses to identify interlinked contributory factors to inform / direct improvement efforts. • • Presenting summary data to show the impact of ongoing safety improvement work.

The Trust's weekly Safety and Learning Group will ensure all safety events are assessed against the PSIRP. The Safety and Learning Group will assess safety events against the focus areas and take a decision on which merit the additional resource a systems level response requires. This meeting will support the identification and dissemination of learning.

Where decision making is not clear, this will be escalated to the Chief Nursing Officer and Chief Medical Officer.

Responding to cross-system safety events/issues

As a tertiary service, the Trust is committed to taking a system wide approach to learning from patient safety events and this, on occasion, may involve working closely with other organisations.

If it is identified that a patient safety incident requires input from another organisation, this will be flagged immediately to the Trust's Safety and Learning Team. The Safety and Learning Team will contact the organisation in question and arrange for a cross-system review to take place.

When contacting another organisation for input into a patient safety event staff must provide the following:

- A clear rationale for involving the organisation.
- A clear explanation as to why we are making contact – This could be for information sharing purposes or for collaborative working on an investigation.
- Any questions should be clearly articulated by the staff member requesting involvement.

The Trust will also support any organisation that requires our involvement. The Safety and Learning Team will agree an appropriate response time with the partner organisation which staff across the Trust must adhere to.

The Trust will also support any organisation that requires our involvement. The Patient Safety Team will agree an appropriate response time with the partner organisation which staff across the Trust must adhere to.

Wherever possible the Trust will work collaboratively with local partners to ensure system wide learning.

As a Trust we are committed to the ICB cross organisation patient safety event operating principles which are outlined below:

- We will all commit to one learning response rather than silo working for cross organisational patient safety events. We will agree collaboratively through a multidisciplinary approach how to allocate defined roles and responsibilities across

all organisations involved including leadership/oversight, co-ordination and will agree a method of escalation.

- We will ensure patient, family and staff involvement as part of cross Trust delivery of the PSIRF, ensuring co-design of a jointly owned safety culture within a well-functioning safety system.
- We will promote openness and transparency to share concerns and allow for growth with clearly defined roles/leads for each area to promote consistency and adapt as required.
- We will be flexible and adapt our communication methods to ensure that everyone is included and has access and will encourage sharing of information and ideas, promoting kind provocation.
- We will create a safe space where we can have open and honest discussions and we will demonstrate mutual respect focussing on the collective goal embracing what other organisations can bring.
- We will provide a safe environment for all to be open/transparent to share learning from safety events.
- Compassion and empathy will underpin our approach, ensuring we provide support with kindness when interacting with patients, families, staff and colleagues.
- We will commit to being honest and disclose all relevant information. We will be upfront about challenges we have faced and what we have learned and make our goals and outcomes visible to all who are affected.
- We will agree our shared goals and the principles and values we need in place to make these happen and we will adapt as we learn and progress.
- We will actively connect and collaborate on these shared goals. To help us achieve this we will collectively create a safe, responsive space where a culture of civility and constructive feedback is the norm.
- We will continue to reflect on and respond to the lessons we learn to ensure we are continuously improving our health system at scale.

Timeframes for learning responses

Timeframes must be set where possible for all response methods. A response must start as soon as possible after an event is identified. The specific timeframe must be agreed with the patient, family or carers in line with timeframes set out in the PSIRP.

The timeframe for completing a Patient Safety Incident Investigation (PSII) should be agreed with those affected by the incident, including patients, families and carers as part of setting the terms of reference – assuming they are willing to be involved in that decision.

PSIIs should take no longer than 6 months and not exceed timeframes agreed with those affected. If these are exceeded processes must be reviewed to understand how timeliness can be improved.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused), a longer timeframe may be needed to respond to an event. In this case, any extension should be agreed with those affected (patient, family, carers and staff).

The time needed to conduct a response must be balanced against the impact of long timescales on those affected by the event. This should also consider the risk that for as long as findings are not described, action may not be taken to improve safety or further checks will be required to ensure the recommended actions remain relevant.

Where external bodies (or those affected by patient safety events) cannot provide information, to enable completion within six months or the agreed timeframe, the local response leads should work with all the information they have to complete the response to the best of their ability. The response may be revisited later, should new information indicate the need for further investigative activity.

Safety action development and monitoring improvement

The Trust adopts the view that the first step when embarking on a process to learn and improve after a patient safety incident is to make efforts to understand the context and

develop a deep understanding of work processes. A thorough understanding of the work system using a learning response method is therefore vital but only the first step.

Trust templates will support staff to take the next step from identifying the learning to implementation of the lessons. The final stages of investigation will therefore focus on the process for designing, implementing, and monitoring safety actions, alongside how to reduce risk and limit the potential for future harm.

After identifying and agreeing those aspects of the system where change could reduce risk and potential for harm, learning actions to reduce risk will be generated in relation to each defined area for improvement. Following this, measures to monitor safety learning actions will be defined. The term ‘areas for improvement’ will be used instead of ‘recommendations’ to reduce the likelihood of alighting on a solution at an early stage of the safety action development process.

Understanding contributory factors and work as done should not be confused with developing safety actions. Areas for improvement set out where improvement is needed without defining how that improvement is to be achieved. Safety actions in response to a defined area for improvement depend on factors and constraints outside the scope of a learning response.

The Trust emphasises the importance of a collaborative approach throughout, including involvement of those beyond the immediate professional groups involved in the event and working closely with those with improvement expertise, particularly the Safety and Learning and Continuous Improvement Teams. The Trust is clear that imposed solutions fail to engage staff and lack sustainability as a result.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety events and issues. The Trust has several improvement and transformation groups in place, many of which are aligned to Always Safety First Programmes of work or Continuous Improvement workstreams and have been adapted to respond to the outcomes of improvement efforts and other influences such as national safety improvement programmes.

The Trust's PSIRP has outlined local priorities for focus or response under the PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in risk or harm.

At the conclusion of the appropriate 'learning responses', a summary of the report and its findings will be presented to the Trust Safety and Learning Group for discussion of the improvement plan and agreement on whether 'areas for improvement' will be monitored at local or organisational level. The trust will use the outcomes from existing patient safety reviews and any relevant learning response to inform future improvement plans and Divisions and Corporate Teams will work together to ensure there is an aligned approach to development of plans and resultant improvement efforts.

Improvement Plans aligned to the Trust's Patient Safety Priorities and Thematic analysis reports will also be overseen by this Group. This Group will review these, provide appropriate support and ensure appropriate improvement methodology is used. The Group will monitor and measure progress against agreed learning actions and outcomes to ensure effective improvements are implemented and sustained.

In response to safety events where complex organisational learning and improvements are needed, the Safety and Learning Group will commission new Always Safety First Improvement Groups or triangulate learning with existing groups. Existing groups may include existing Always Safety First Improvement Groups, Flow Coaching Academy Big Rooms, Microsystem Coaching Academy Big Rooms or existing Transformation Programmes. Learning and outputs from these related to PSIRF will be overseen by the

Safety and Learning Group. Where necessary, if factors relating to culture and leadership are identified, the Safety and Learning Group will work with the workforce and organisational development or appropriate colleagues to triangulate or identify new learning.

This will also enable Trust-wide lessons to be identified and agreement made on how best to facilitate cascade of relevant information across the Trust. This may include the use of Always Safety-First Bulletins or learning through corporate governance meetings, Divisional Always Safety First meetings, Divisional Safety and Quality meetings, Speciality Governance meetings, Ward meetings, Safety Huddles and a range of improvement groups. This may begin from the point a patient safety incident is reported.

Where appropriate, local monitoring of actions via audit should be considered when improvement plans are complete, to ensure that changes are embedded and continue to deliver the desired outcomes.

Oversight roles and responsibilities

The leadership and management functions of PSIRF oversight are wider and more multifaceted compared to previous response approaches. When working under PSIRF, organisations are advised to design oversight systems to demonstrate improvement rather than compliance with centrally mandated measures.

The Trust will work with partners to develop a local board-led and commissioner and integrated care system assured architecture around investigations and seek alternative responses to patient safety events, which promote ownership, rigour, expertise and efficacy. The Trust will adhere to NHS England's specification on oversight roles and responsibilities.

1. Roles and responsibilities

In order to meet these ambitions, the Trust has identified a number of key internal roles and responsibilities:

Role	Responsibility
Chief Executive Officer	The Chief Executive Officer has the ultimate responsibility for all aspects of patient safety which includes the management of safety events. This includes ensuring that appropriate structures are in place to enable appropriate investigation, analysis and learning and ensuring resources are available to comply with this policy. The Chief Executive is responsible for the provision of appropriate policies and procedures for all aspects of health and safety (Health and Safety at Work Act 1974).
Chief Nursing Officer	The Chief Nursing Officer is the Executive Lead for PSIRF and responsible for ensuring the organisation meets national patient safety incident response standards. The Executive Lead will ensure PSIRF is central to overarching safety governance arrangements and is responsible for ensuring there is an Executive review of all PSII reports in line with the patient safety incident response standards and that each is signed off as finalised. The Executive Lead alongside the Chief Medical Officer will also provide direct leadership, advice, and support in complex/high profile cases, and liaise with external bodies as required.
All Other Executive / Non-Executive Directors	All Directors who sit on the Trust Board (either Executive or Non-Executive) have responsibility for adhering to, championing and supporting the implementation of this patient safety policy within the remits of their identified portfolios.
Associate Director of Safety and Learning (also	The Associate Director of Safety and Learning will support the Chief Nursing Officer with all elements of their portfolio in relation to Patient Safety and Learning. The Associate Director of Safety and Learning has overall responsibility as the lead

Patient Safety Specialist)	manager for the Trust's Patient Safety and Learning function and will provide strategic direction in relation to the development and implementation of this policy. This includes: • defining the Trust's patient safety and safety improvement profile, • ensuring thorough review of available patient safety incident insight, • engagement with internal and external stakeholders, • ensuring the voice of patients, families and carers is heard at all levels of the organisations in relation to patient safety activity, • ensuring necessary training is sourced in relation to PSIRF, • ensuring sufficient support is given to those undertaking patient safety incident investigations and learning responses. They will also provide leadership and direction to the Trust Safety and Learning Team to maintain this policy and ensuring emerging themes and trends relating to patient safety are incorporated into this document.
Patient Safety Specialists (Deputy Chief Nursing Officer and Deputy Chief Medical Officer)	The Patient Safety Specialists will support the Associate Director of Safety and Learning with all elements of their portfolios and provide senior day-to-day leadership in relation to patient safety and learning which includes ensuring the successful implementation of this policy.
Associate Director of Risk and Assurance and Deputy Associate Director of Risk and Assurance,	The Associate Director of Risk and Assurance and Deputy Associate Director of Risk and Assurance will support the Associate Director of Safety and Learning with all elements of their portfolios in relation to the successful implementation of this policy. This will include identifying patient safety priorities based on current and emerging risks to the organisation.

Deputy Associate Director of Safety and Learning and Head of Investigation and Learning	The Deputy Associate Director of Safety and Learning and Head of Investigation and Learning will operationally manage the patient safety and learning function within the Trust. This includes ensuring an appropriate system is in place for staff to report, manage and investigate patient safety events in line with this policy. They will also be responsible for maintaining this policy and ensuring emerging themes and trends relating to patient safety are incorporated into this document. They will also provide senior day-to-day leadership to the Associate Director of Safety and Learning in relation to patient safety and learning which includes ensuring the successful implementation of this policy.
Head of Datix and Risk Systems and the Corporate Governance and Risk Team	The Head of Datix and Risk Systems and the Corporate Governance and Risk Team are responsible for ensuring the Learning From Patient Safety Events (LFPSE) system functions effectively in line with expectations whilst working in partnership with Divisional Management Teams and governance professionals to implement PSIRF within the organisation.
Head of Safeguarding	The Head of Safeguarding will be responsible for operationally leading the Trust's established Safeguarding processes. In addition to this, the Head of Safeguarding will be responsible for ensuring appropriate safeguarding cases, which meet the national requirements for investigation are identified and escalated as appropriate.
Medical Examiners / Deputy Chief Medical Officer (leading Mortality)/ Head of Mortality and Coronial Management	The Medical Examiners and Deputy Chief Medical Officer (leading Mortality) and Head of Mortality and Coronial Management will ensure deaths are reviewed in accordance with national policy. Any learning identified through these processes will feed into established processes and any deaths felt to be preventable will be escalated for review in line with the national priorities set out in this policy.

Associate Director of Quality and Experience	The Associate Director of Quality and Experience will support the Safety and Learning Team with the implementation of this document by ensuring the voice of patients, families and carers is heard at all levels of the organisations in relation to patient safety activity. They will also support the Associate Director of Safety and Learning with all elements of their portfolios in relation to the successful implementation of this policy.
Patient Safety Partners (PSPs)	The Patient Safety Partners (PSPs) will play a pivotal role in the implementation of this policy by ensuring the voice of patients, families and carers is heard at all levels of the organisation in relation to patient safety activity. Patient Safety Partners will: • Participate and join key conversations and meetings within the Trust that address patient safety. • Support compliance monitoring and how safety issues should be addressed, providing appropriate challenge to ensure learning and change. • Represent the patient's/family voice, to ensure the Trust is 'walking in the patient's shoes'. • Co-design the developments of Patient Safety initiatives. Ensure that learning responses consider and prioritise the service user, patient, carer and family perspective and champion a diversity of views
Divisional Leadership Team and other senior leaders	The Divisional Leadership Team and other senior leaders have responsibility for adhering to, championing and supporting the implementation of this policy within the remits of their identified portfolios.
Divisional Governance and Risk Managers/Leads	Divisional Governance and Risk Managers/Leads are responsible for acting as the conduit between their allocated Division and the Trust Safety and Learning Team. They will proactively champion the policy and will flag any emerging themes. The Divisional Governance Risk Managers/Leads will

	ensure Divisions proactively respond to patient safety events appropriately and proportionately. Any learning identified as part of any patient safety activity will be assessed and shared through established routes as appropriate.
Divisional Governance Professionals	Divisional Governance Professionals are responsible for promoting an open, honest, just and fair culture and ensuring that the Policy is implemented consistently throughout their sphere of responsibility. Divisional Governance and Risk Managers/Leads will provide practical support during the identification of suitable incident, review learning responses, support investigations, monitor implementation of safety actions and ensure relevant learning is discussed at local meetings and disseminated. Emerging themes and trends will be escalated as and when appropriate
Learning Response Leads (Lead Investigator)	Learning response leads are responsible for completing appropriate training and continuous professional development in incident response skills and knowledge. Learning response leads will contribute to a minimum of two learning responses per year, gathering qualitative and quantitative information from a wide range of sources and summarising their findings in a clear and logical report.
Engagement leads	Engagement leads are responsible for completing appropriate training and continuous professional development in incident response skills and knowledge. Engagement leads will communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way. They will maintain clear records of contact with those affected, identify key risks affecting the involvement of patients, families, and staff and will recognise when those affected by patient safety events require onward signposting or referral to support services.

All Other Staff	All staff across the organisation are responsible: • For promoting an open, honest, just and fair culture. • completing all relevant training in relation to PSIRF for their role. • ensuring any patient safety incident is reported within 24 hours of occurrence or becoming aware of the incident. • adhering to this policy.

2. Committee/Group Roles and Responsibilities

Committee/Group	Responsibility
Trust Board	The Trust Board has a responsibility to ensure that it receives assurance that the PSIRF policy and plan is being implemented, that lessons are being learnt, and areas of vulnerability are improving. The Trust Board will receive assurance on the implementation of PSIRF and ongoing and emerging issues from the Safety and Learning Group by escalation through monthly chairs reports to the Safety and Quality Committee and by escalation from the Safety and Quality Committee to the bi-monthly Trust Board meeting. The Trust Board will also receive assurance regarding the implementation of PSIRF and associated standards through an annual PSIRF report to the Trust Board of Directors meeting. This will contain sufficient information to ensure that the Trust Board has a formative and continuous understanding of organisational safety. Where concerns are identified relating to the implementation of PSIRF, compliance with PSIRF standards and robustness of lessons learned and associated improvement plans, the Trust Board will seek assurances that these concerns are being acted upon.
Safety and Quality Committee	The Safety and Quality Committee is responsible for providing assurance to the Board of Directors that PSIRF is being implemented, that lessons are being learnt, and areas of

	vulnerability are improving. The Trust Board will receive assurance on the implementation PSIRF and ongoing and emerging issues from the Safety and Learning Group by escalation through monthly chairs reports and a quarterly report to the Trust Safety and Quality Committee. The quarterly reports will contain a summary of learning from patient safety incident investigations and assurance regarding the implementation of PSIRF and associated standards. Where concerns are identified relating to the implementation of PSIRF, compliance with PSIRF standards and robustness of lessons learned and associated improvement plans, the Safety and Quality Committee will seek assurances that these concerns are being acted upon. Where there are remaining concerns, these will be escalated to the Trust Board.
Safety and Learning Group	The Trust weekly Safety and Learning Group ensure that 'learning responses' are conducted to the highest standards and will support the executive sign off processes for learning responses and ensure that learning is shared, and safety improvement work is adequately directed. The Safety and Learning Group will oversee the implementation of PSIRF, associated policies and the PSIRP and provide assurance to the Trust Safety and Quality Committee of its progress and escalate any ongoing or emerging issues.
Divisions	Divisions will report their patient safety event learning responses and outcomes at the weekly Safety and Learning Group. This will include reporting on ongoing monitoring and delivery of safety actions and improvement. Divisions will have arrangements in place to manage the local response to patient safety events and ensure that escalation procedures as described in the patient safety incident response section of the PSIRF policy are effective. Divisions will also be responsible for sharing identified learning.

Integrated Care Board (ICB)	The ICB is responsible for approving this policy and the PSIRP and ensuring collaborative work across the local integrated care system (ICS). The ICB will act as a key stakeholder providing oversight and support to the Trust in the implementation of this plan. A representative from the ICB will attend the Trust's Safety and Learning Group to oversee and ensure the quality of investigations undertaken by the Trust.

The Trust will source necessary training such as the Health Education England patient safety syllabus and other patient safety training across the organisation as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to safety events.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years to comply with Trust guidance on policy development alongside a review of all safety actions.

3. Quality assuring learning response outputs.

The Trust weekly Safety and Learning Group will ensure that 'learning responses' are conducted to the highest standards and will support the executive sign off processes and ensure that learning is shared, and safety improvement work is adequately directed.

A representative from the ICB will attend the Trust's Safety and Learning Group to oversee and ensure the quality of investigations undertaken by the Trust.

Complaints and appeals

Lancashire Teaching Hospitals NHS Foundation Trust always aim to provide excellent care with compassion and communicate effectively with all our patients, their relatives and carers in line with our Trust values.

Although the Trust works hard to offer a high standard of service, sometimes things do not always go to plan and patients, their relatives and carers may have questions that need answers. If this happens, we welcome the opportunity to make things better and ask that patients, their relatives and carers tell us about what their concerns are, and we will do our best to make things better. This includes affording the opportunity for complaints and appeals relating to the organisation's response to patient safety events. In the event a patient, carer or relative has concerns regarding any aspect of the investigation process, it is recommended that the following steps are followed:

1. If appropriate, seek to resolve the matter locally through a discussion between the patient, family or carer, the Patient Safety Incident Investigator and the nominated engagement lead.
2. Escalate the concern to the Divisional Leadership Team for local resolution.
3. Refer the matter to the Trust's Patient Experience and PALS Team.

Further information is available on the Trust's website.

Glossary

Relevant to both PSIRF policy and PSIRP.

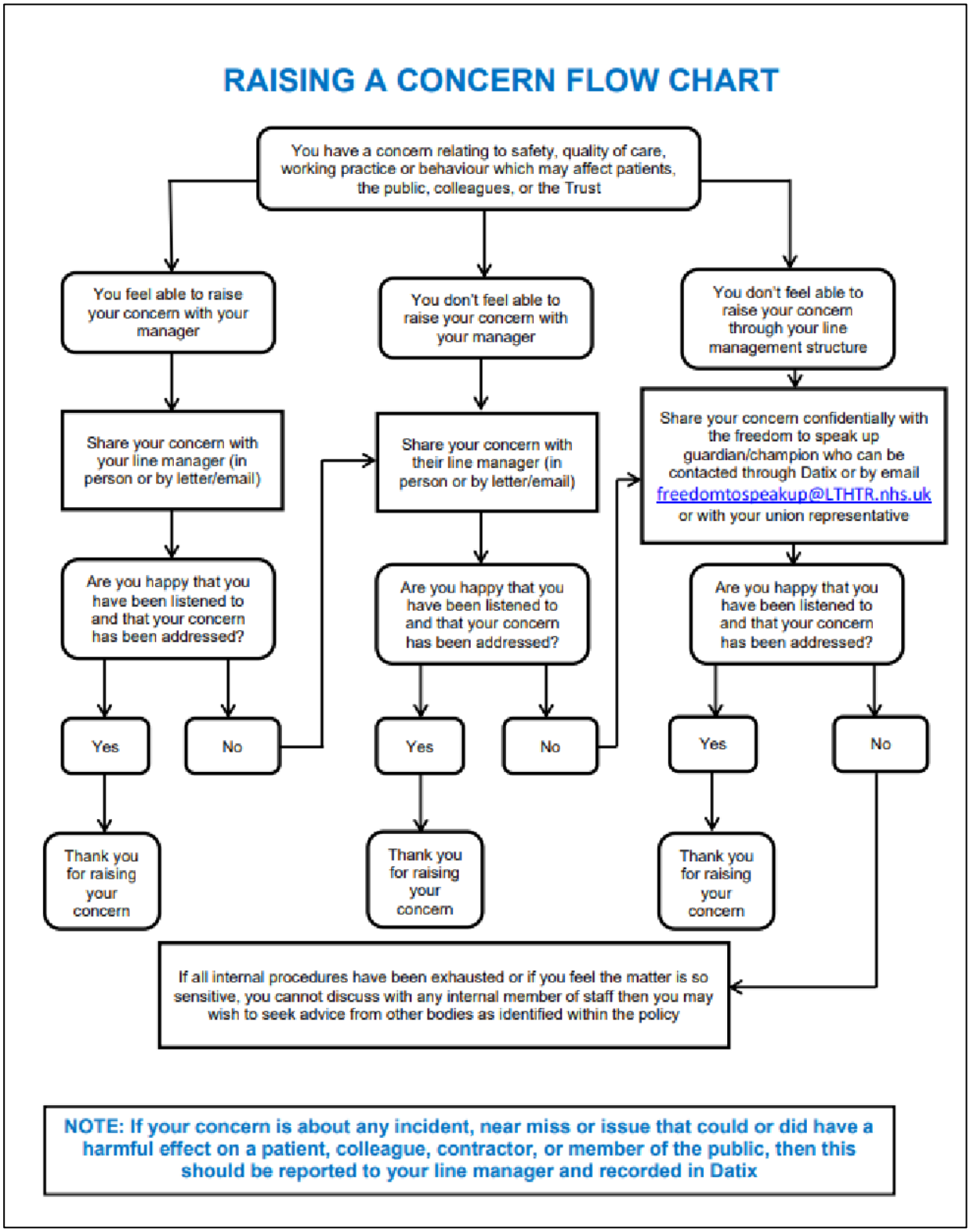
Abbreviation of Term	Definition
AAR	**After Action Review** A learning response tool consisting of a structured facilitated discussion of an event/incident
CQC	**Care Quality Commission** Independent regulator for health and social care in England
CSP	**Community Safety Partnership** Statutory partnerships of organisations who work together in an area to reduce crime and the fear of crime, anti-social behaviour, alcohol, and drug misuse and reducing re-offending
Core20PLUS5	**Core20PLUS5** A national NHS England approach to inform action and reduce healthcare inequalities at both national and system levels, focused initially on the experience of adults, but has now been adapted to apply to children and young people
DHR	**Domestic Homicide Review** A review into the circumstances around a death of a person following domestic abuse
HealthWatch	**HealthWatch** A health and social care champion service who obtain the views of people about their needs and experience of local health and social care services
HSSIB	**Healthcare Services Safety Investigation Body** The independent national investigator for patient safety in England
ICB	**Integrated Care Board** A statutory organisation who are responsible for developing a plan for meeting the health needs of the local population,

Abbreviation of Term	Definition
	managing the NHS budget, and arranging for the provision of NHS services in a geographical area
ICS	**Integrated Care System** Partnerships of organisations which come together to deliver joined up health care services and improve the lives of people who live in the area
IOPC	**Independent Office for Police Conduct** A non-departmental public body in England and Wales who are responsible for overseeing the system for handling complaints made against police forces in England and Wales
LeDeR	**Learning Disability and Mortality Review** A service improvement programme for people with a learning disability and autistic people who look at key episodes of health and social care the person received that may have been relevant to their overall health outcomes
LFPSE	**Learning from Patient Safety Events** The new national NHS service for the recording and analysis of patient safety events
LTHTR	**Lancashire Teaching Hospitals NHS Foundation Trust**
Magnet4Europe	**Magnet4Europe** A four-year Horizon project that aims to improve mental health and wellbeing among health professionals in Europe
MDT	**Multi-Disciplinary Team** A group of staff from different areas in healthcare
NRLS	**National Reporting and Learning System** The current national central database for recording and analysing patient safety incident reports
PALS	**Patient Experience and Liaison Service** The Trust's team which provides support for patients, families, and carers
PPO	**Prison and Probation Ombudsman**

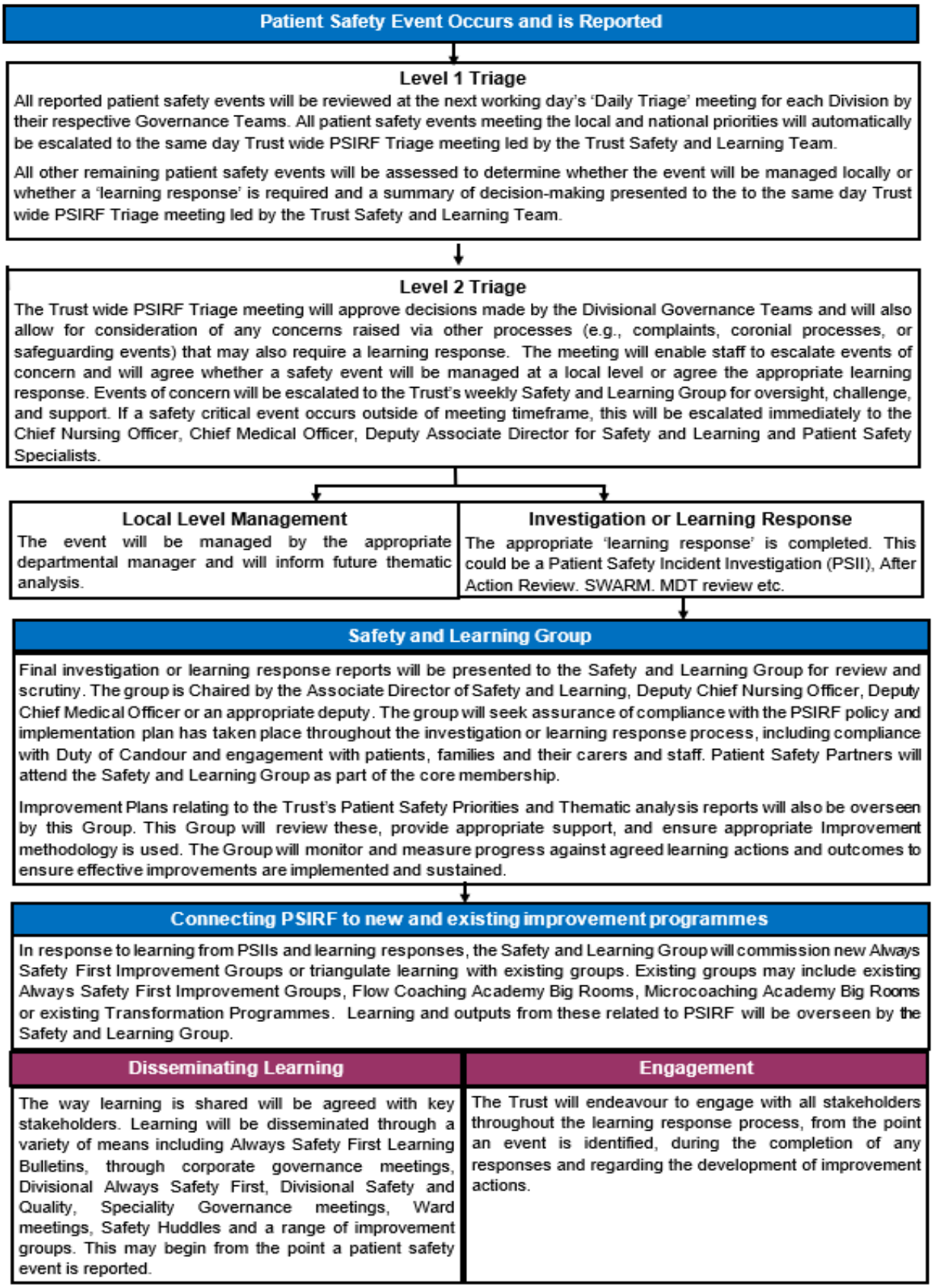
Abbreviation of Term	Definition
	A public body that carries out independent investigations into complaints and deaths in custody
PSIRF	**Patient Safety Incident Response Framework** A new and innovative approach to the way the NHS responds to patient safety incidents/events.
PSIRP	**Patient Safety Incident Response Plan** The plan which sets out how NHS organisations intend to respond to patient safety incidents/events under PSIRF
PSP	**Patient Safety Partners** The role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisations' governance and management processes for patient safety
PSII	**Patient Safety Incident Investigation** A learning response tool which is undertaken when an incident or near miss indicates significant patient safety risks and the potential for new learning
Safety I	**Safety I** Identifying causes and contributing factors in patient safety events as the focus point in an attempt to stop them occurring
Safety II	**Safety II** Considering variations in everyday performance to understand how things usually go right
SEIPS	**Systems Engineering Initiative for Patient Safety** A methodology for understanding outcomes within complex socio-technical systems
SIF	**Serious Incident Framework** The current process by which the NHS ensures serious incidents are identified, investigated, and learned from to prevent the likelihood of similar incidents happening again. This framework will be replaced by PSIRF
SOP	**Standard Operating Procedure**

Abbreviation of Term	Definition
	A guide/step by step instructions compiled by an organisation to help staff to carry out routine tasks/processes
SpHA	**Special Healthcare Authority** An authority who provides a health service to the whole of England, not solely to a local community
STP	**Sustainability and Transformation Partnership** Where local NHS organisations and Local Authorities draw up shared proposals to improve health and care in the areas they serve

Appendix 1 – Raising a Concern Flow Chart



Appendix 2 – Governance arrangements in relation to how the Trust will respond to a Patient Safety



Patient safety incident response plan

Effective date: TBC

Estimated refresh date: TBC

	NAME	TITLE	SIGNATURE	DATE
Author	**Hajara Ugradar**	**Deputy Associate Director of Risk and Assurance**	**To be added**	**21st September 2023**
Reviewer	**TBC**	**TBC**	**TBC**	**TBC**
Authoriser	**TBC**	**TBC**	**TBC**	**TBC**

Contents

Foreword

We are delighted to present our first Patient Safety Incident Response Plan (PSIRP) for Lancashire Teaching Hospitals NHS Foundation Trust. This plan sets out how we intend to respond to patient safety events in line with the National Patient Safety Strategy for England and the Patient Safety Incident Response Framework (PSIRF).

The PSIRF is a new and innovative approach to how the NHS responds to patient safety events. This is not a change which involves us doing the same thing. It is a cultural and system shift which fundamentally changes our thinking and response to patient safety events and how we work to prevent a safety event happening again.

Our challenge is to move the focus away from investigating safety events to produce a report because it might meet specific criteria in a framework and instead, towards an emphasis on the outcomes of patient safety incident responses that support our learning and continuous improvement methodologies to prevent safety events happening again.

Where previously we have had set timescales and external organisations have needed to approve what we do, PSIRF gives us a set of principles that we will work to and although this could seem daunting, we welcome the opportunity to take accountability for the management of our responses to patient safety events with the aim of learning and improvement.

We know that we investigate safety events to learn but acknowledge that the focus on this may have been lost due to the previous emphasis on the production of a report, as that is how we have been measured, rather than on showing how we have made meaningful changes to keep our patients safe.

Through the implementation of PSIRF we commit to meaningfully engaging with our patients, service users, families and carers to ensure that their voice is the golden thread in all of our patient safety investigations. PSIRF sets out best principles for this involvement and our move to engaging with patient safety partners will make sure that the patient voice is heard at all stages of our patient safety processes.

Our recent work in moving towards a restorative and just culture underpins how we will approach our response to patient safety events. We are an organisation who fosters a

culture in which people feel they can highlight patient safety events knowing they will be psychologically safe.

PSIRF asks that we have conversations where people have been affected by a patient safety event, no matter how difficult that is, and we will continue work on how we can equip and support those affected to best hear the voice of those involved. The process of reviewing a safety event can help our staff validate the decisions they made in caring for and treating a patient and facilitate psychological closure, these are part of our PSIRF core objectives.

As we move into adopting this new way of managing our patient safety learning responses, we accept that we may not get it right at the beginning, however we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to. In this we have been supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change.

Most importantly though, PSIRF offers us the opportunity to learn and improve to promote the safe, effective and compassionate care of our patients, service users, their families and carers whilst also protecting the wellbeing of our staff. We welcome PSIRF's implementation and are ready for the challenges ahead.

Purpose

This patient safety incident response plan sets out how **Lancashire Teaching Hospitals NHS Foundation Trust** intends to respond to patient safety events over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and safety events occurred and the needs of those affected.

This document should be read in conjunction with the Trust's Patient Safety Incident Response Policy which supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how the Trust will approach the development and maintenance of effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety. One key aim of PSIRF is to ensure considered and proportionate responses to patient safety events.

Scope

This patient safety incident response plan (PSIRP) will detail the Trust's approach to responding to patient safety events and should be followed by all staff across the organisation. This plan is not a permanent tenet that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and safety events occur and the needs of those affected.

Our services

Lancashire Teaching Hospitals NHS Foundation Trust is a large acute NHS Trust consisting of Chorley and South Ribble District General Hospital, Royal Preston Hospital, the Specialist Mobility Rehabilitation Centre, Finney House Community Care Hub and a range of community and satellite services.

We serve a core population of around 395,000 people across Chorley, Preston and South Ribble as well as providing a range of highly specialist services to 1.8 million people across Lancashire and South Cumbria.

Our organisation has a workforce of approximately 9000 substantive staff, making it one of the largest employers in the region and a successful volunteers scheme, with nearly 600 volunteers providing support in a variety of roles.

Royal Preston Hospital provides a full range of district general hospital services including emergency medicine, critical care, general medicine including elderly care, general surgery, oral and maxillo-facial surgery, ear nose and throat surgery, anaesthetics, children's services, neonatal intensive care, women's health and maternity, and several specialist regional services including cancer, neurosurgery,, renal, plastics and burns, rehabilitation, and the major trauma centre for Lancashire and South Cumbria. The urgent care centre on the site is directly commissioned by the ICB and is not provided by this Trust.

Chorley and South Ribble Hospital provides a full range of district general hospital services including emergency department for adults (8am-8pm) coronary care, general medicine including elderly care, general surgery, orthopaedics, anaesthetics, stroke rehabilitation, midwifery-led maternity care, and a breast service. The urgent care centre on the site is directly commissioned by the ICB and is not provided by this Trust.

The Trust is a regional specialist centre for cancer, child neurology, disablement services, immunology, neonatal intensive care, neurosciences, major trauma, renal, respiratory, vascular and maternal medicine.

The Surgical Elective Care Hub based at Chorley and South Ribble Hospital is where patients come for day case or short inpatient surgery stays and has received the highly

accredited ‘NHS Surgical Hub status’, meaning that our patients can be assured of the highest standards of patient care and safety, with the Getting it Right First Approach (GIRFT).

Our specialist mobility rehabilitation centre provides specialist wheelchair, prosthetic limb and orthotic services for people across the Northwest, including war veterans and is one of just nine centres of excellence in the UK.

Lancashire Community Healthcare Hub, also known as Finney House, provides residential and nursing care services in a purpose-built home. The Trust took over the lease of the building in November 2022 to become the CQC-registered provider of services, taking on all 96 beds at the facility. The first floor (Buttercup) and second floor (Meadow) allows the Trust to discharge patients from both Chorley and Royal Preston Hospitals who no longer need the specialist care provided in an acute bed, freeing up much needed space for those who need urgent and emergency medical care. There are a further 32 beds on the top floor (Orchard) which allow the Trust to continue to provide care for Local Authority or private residents. People with dementia are also looked after at the facility.

Our community services are provided in people’s homes, community centres, clinics, GP Practices, community hospitals and our main hospitals.

We are the only National Institute for Health and Care Research (NIHR) Clinical Research Facility in Lancashire and South Cumbria. The Centre for Health Research and Innovation is based within the Lancashire Clinical Research Facility at Royal Preston Hospital. However, the Research team work across both the Preston and Chorley sites as well as a number of community and satellite units. The Trust is also a leading provider of undergraduate education and a leading partner in the Lancashire and South Cumbria Provider Collaborative.

We are registered with the Care Quality Commission (CQC) without conditions to provide the following regulated activities:

- diagnostic and screening services
- maternity and midwifery services
- surgical procedures

- termination of pregnancies
- treatment of disease, disorder or injury
- management of supply of blood and blood-derived products
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- accommodation for persons who require nursing or personal care.

Our mission is to always provide excellent care with compassion and our strategic aims are:

- To provide outstanding and sustainable healthcare to our local communities
- To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria
- To drive health innovation through world class education, training, and research

These are underpinned by our four strategic ambitions which are as follows:

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<tr><th colspan="2">Consistently Deliver Excellent Care</th><th colspan="2">Fit for the Future</th></tr>
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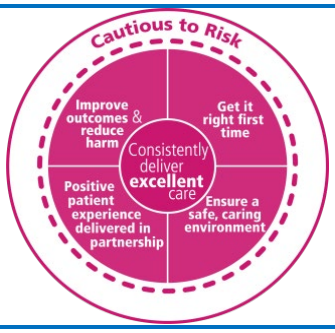
<td> 
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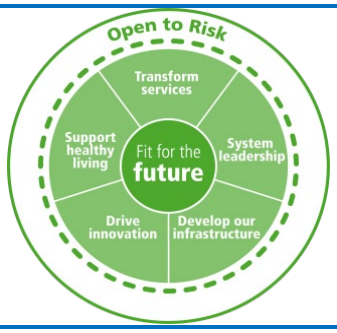
<td>Improve outcomes and reduce harm

Get it right first time

Positive patient experience delivered in partnership

Ensure a safe, caring environment</td>
<td> 
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<td>Transform services

System leadership

Develop our infrastructure

Drive innovation

Support healthy living</td>
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<tr><th colspan="2">Deliver Value for Money</th><th colspan="2">Great Place to Work</th></tr>
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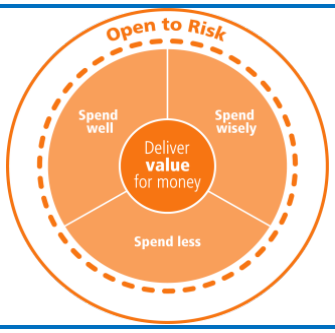
<td> 
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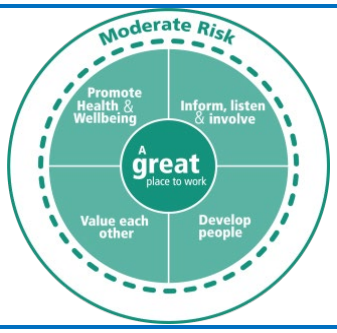
<td>Spend well

Spend wisely

Spend less</td>
<td> 
</td>
<td>Promote health and wellbeing

Inform, listen, and involve

Develop people

Value each other</td>
</tr>
</table>

We are a values-driven organisation. Our values were designed by our staff and patients and are embedded in the way we work on a day-to-day basis:

- Caring and compassionate: We treat everyone with dignity and respect, doing everything we can to show we care.
- Recognising individuality: We respect, value, and respond to every person's individual needs.
- Seeking to involve: We will always involve you in making decisions about your care and treatment and are always open and honest.
- Team working: We work together as one team, and involve patients, families, and other services, to provide the best care possible.
- Taking personal responsibility: We each take personal responsibility to give the highest standards of care and deliver a service we can always be proud.

To align specialities and services with clinical pathways and professional relationships, streamline processes and strengthen collaborative working the Trust has four clinical divisions. These are the Division of Medicine, Division of Surgery, Division of Women and Children Services and the Division of Diagnostics and Clinical Support Services and are supported by the Estates and Facilities Division and Corporate Services Division.

This highlights the variety and complexity of services provided by the Trust. It is therefore imperative for the successful implementation of the PSIRF that the plan reflects the breadth of patient safety concerns relevant to these services and that everyone is clear about how their individual role, responsibility and behaviour supports the delivery of this plan.

This will be achieved by drawing on data and intelligence to identify our PSIRF priorities (insights), by engaging with our patients, their families and carers, staff and stakeholders in our plans, equipping them with the skills and opportunities to improve patient safety throughout the whole system ('involvement') and designing and supporting programmes that deliver effective and sustainable change in the most important areas including reducing patient harms and improving our safety culture ('improvement').

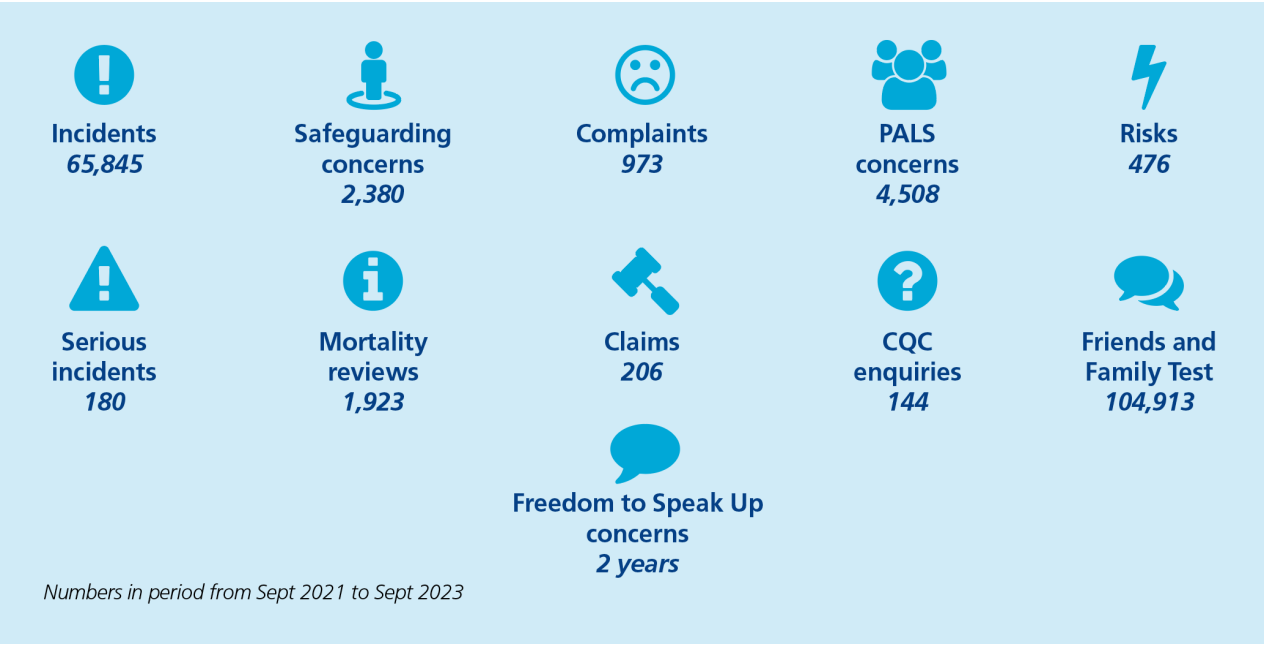
Defining our patient safety events profile

The Trust is committed to undertaking high quality learning responses following a patient safety event to ensure continuous improvement across our services and sustainable reductions in the frequency of incidents and their associated opportunity to harm our patients.

The national PSIRF sets out the opportunity for us to ascertain own local highest risk areas, and to ensure both investigation focus, and improvement resource is directed towards those areas of greatest risk and therefore need. These local priorities sit alongside national priorities that require continued focus, for example, safety events that meets the criteria of a 'never event'.

Data Sources

The Trust recognises that in order to truly understand its patient safety profile it must review data from a variety of sources. A core element of the development of our PSIRP was to undertake a retrospective analysis of a minimum of two years of data, to include previously reported safety events and data sets such as claims, complaints and information from any relevant surveys. The summary below provides an overview of the sources and numbers of data analysed between September 2021 and September 2023.



The results from the retrospective analysis output identified twenty two patient safety event themes as potential areas for further investigation.

Stakeholder Engagement

The twenty two patient safety event types were circulated to a stakeholder group with representation from a range of groups and professions including staff, patients and external partners. Groups represented included patient groups (e.g., Healthwatch), governors, equality, diversity and inclusion ambassadors, workforce teams, a range of governance professionals, nurses, medical staff, allied health professions, the Integrated Care Board (ICB) and other key stakeholders.

The table gives an overview of the groups that took part in the stakeholder engagement with a total of 43 individuals taking part.

Group Represented	Numbers of people
Lancashire and South Cumbria ICB	1
Patient Safety Team	2
Infection, Prevention and Control	1
Senior Medical and Nursing Leadership	3
Corporate Governance Professionals	7
Divisional Governance Professionals	8
Patient Experience Team	3
Pharmacy	2
Equality, Diversity and Inclusion Representative	1
Clinical Placement and Support Team	1
Continuous Improvement Team	1
Safeguarding Team	1
Critical Care Outreach Representative	1
Workforce and Organisational Development	1
Divisional Management Team	4
Patient Representative	2
Patient Forum Representative	1
Healthwatch Representative	1
Governor Representative	1
Allied Health Professions Leadership Team	1

At the engagement session, stakeholders were invited to score the identified themes, using the criteria below to determine which local priorities would invoke the greatest amount of learning to improving patient safety.

Criteria	Considerations
Likelihood of Harm	Staff were required to review the likelihood of harm based on a scale of 1 (Rare) – 5 (Almost Certain) Staff were required to consider the frequency of previous events in addition to the probability of events occurring in the future.
Impact of Harm	Staff were required to review the likelihood of harm based on a scale of 1 (Insignificant) – 5 (Catastrophic) Staff were advised to consider both the physical and psychological impact of harm if an incident was to occur.
Confidence in Existing Improvement Work	Staff were required to review the confidence in existing improvement work on a scale of 1 (Extremely Confident) – 5 (No Confidence at All) Staff were made aware of existing improvement work in relation to identified themes and were asked to consider their effectiveness.
Potential for New Learning	Staff were required to review the potential for new learning on a scale of 1 (No Potential for Learning) – 5 (Significant Potential for Learning) Staff were asked to consider what the potential for learning was within each identified theme.

**criteria adopted from University Hospitals Morecambe Bay*

The full scoring guidance is available in Appendix 1.

The scoring was undertaken by individuals via a Microsoft Forms survey and the results subsequently analysed. From the analysis, a priority order emerged based on potential for learning.

The themes were then considered in further detail using previous quantitative and qualitative analysis to identify five key themes. Although some themes had a greater potential for learning, there were several themes where opportunities for learning could be considered as part of a different theme. From this exercise, five local priorities emerged.

When identifying the final five local priorities where possible, the Trust considered:

- any elements of the data that told us about inequalities in patient safety,
- pathways, processes or systems that cross-cut our services,
- existing improvement programmes and
- any new and emergent risks relating to future service changes and changes in demand that the historical data did not reveal.

Local Priorities

Through our analysis and stakeholder engagement, the Trust has determined 5 patient safety priorities. These priorities will be the focus of the Trust's Patient Safety activity over the next 12-18 months but will be reviewed sooner if appropriate.

These patient safety priorities form the foundation for how the Trust will decide to conduct Patient Safety Incident Investigations (PSII) and other appropriate patient safety reviews.

The Patient Safety Priorities and rationale for selecting them are detailed as follows:

No.	Local Priorities	Rationale
1	Delayed recognition of a deteriorating patient, due to gaps in monitoring (including all pregnant women)	- 'Earlier recognition of deterioration' identified as high potential for learning in stakeholder engagement. - Potential to identify learning related to: • Communication between staff/teams • Delays in treatment • Failure/incomplete/insufficient monitoring of patient • Nutrition and hydration fluid balance • Maternity incidents • Communication – incorrect or insufficient monitoring

No.	Local Priorities	Rationale
		which were all identified as other top areas with potential for learning. - Relates to pathways, processes or systems that crosscut our services.
2	Delayed, missed or incorrect cancer diagnosis	- 'Delay in diagnosis' identified as high potential for learning in stakeholder engagement. - Potential to identify learning related to: • Communication between staff/teams • Delays in treatment • Communication – incorrect or insufficient monitoring which were all identified as other top areas with potential for learning. - **Focus on cancer diagnosis based on quantitative and qualitative feedback and insight of data.** - Relates to pathways, processes or systems that crosscut our services.
3	Prescribing or administration error or near miss of anticoagulation medication	- 'Medication errors-administration and prescribing' identified as high potential for learning in stakeholder engagement. - Potential to identify learning related to: • Communication between staff/teams • Delays in treatment • Communication – incorrect or insufficient monitoring which were all identified as other top areas with potential for learning. - **Focus on anticoagulation based on quantitative and qualitative feedback and insight of data.** - Relates to pathways, processes or systems that crosscut our services.
4	Adverse Discharge due to gaps in communication or misinformation	- 'Discharge' 'Communication between staff/teams incomplete' and 'Communication-incorrect or insufficient information' identified as high potential area learning in stakeholder engagement.

No.	Local Priorities	Rationale
		- Relates to pathways, processes or systems that crosscut our services.
5	Delay in responding to a critical pathology finding	- 'Diagnostic incidents, including missed diagnosis' identified as high potential for learning in stakeholder engagement. - Potential to identify learning related to: • Communication between staff/teams • Communication – incorrect or insufficient monitoring which were all identified as other top areas with potential for learning. - **Focus on pathology findings based on quantitative and qualitative feedback and insight of data. There is also an existing continuous improvement programme of work related to radiology findings and hence the decision to focus on pathology findings.** - Relates to pathways, processes or systems that crosscut our services.

Our patient safety incident response plan: national requirements

In addition to the five local patient safety priorities, the Trust must comply with the following national patient safety event response requirements.

No.	National Priorities	Action Required	Lead Body for response
1.	Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Locally Led PSII.	The Trust
2.	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally Led PSII.	The Trust
3	Incidents meeting the Never Events criteria 2018, or its replacement.	Locally Led PSII.	The Trust
4	Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. Locally-led PSII may be required.	As decided by the RIIT

5	Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place HSSIB will investigate the following maternity safety incidents; • Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life. • Early neonatal death: the baby died, from any cause, within the first week of life (0 to 6 days). • Potentially severe brain injury diagnosed in the first seven days of life and the baby was diagnosed with grade III hypoxic–ischaemic encephalopathy; or was therapeutically cooled (active cooling only); or – had decreased central tone, was comatose and had seizures of any kind. • • Maternal deaths: death while pregnant or within 42 days of the end of the pregnancy	Refer to HSSIB or SpHA for independent PSII. Where such an investigation is undertaken, a separate local patient safety learning response is not required. However, organisations should complete Duty of Candour requirements (ahead of handover to HSSIB for further involvement of patients/families in the investigation) as set out below, and report on the relevant incident reporting system(s) as described below. Organisations must also take any immediate actions identified as necessary to avoid and/or mitigate further serious and imminent danger to patients, staff and the public. In relevant cases, the organisation should also use the Perinatal Mortality Review Tool (in parallel with and with the assistance of HSSIB as it works through its independent investigation).	HSSIB (or SpHA)

	from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excludes suicides).		
7	Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel.	Child Death Overview Panel
8	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this.	LeDeR programme
9	Safeguarding incidents in which: • Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. • Adults (over 18 years old) are in receipt of care and support needs from their local authority. • The incident relates to FGM, Prevent (radicalisation to terrorism), modern	Refer to local authority safeguarding lead. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.	Refer to the local designated professionals for child and adult safeguarding

	slavery and human trafficking or domestic abuse/violence		
10	Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programme.	The organisation in which the event occurred
11	Deaths in custody (e.g., police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare organisations must fully support these investigations where required to do so.	PPO or IOPC
12	Domestic homicide	A domestic homicide is identified by the police usually in partnership. with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations	CSP

		and commissioners of health services in relation to DHRs.	

Our patient safety incident response plan: local focus

The Trust will be flexible with its investigative approach, informed by the national and local priorities detailed within this plan. An established 'Daily Triage' group will triangulate events captured through a variety of routes (i.e., incidents, complaints etc.) and agree the most appropriate response based on the potential for learning, improvement and systemic risk.

National Guidance recommends that 3 – 6 investigations per priority are conducted. The table below details the number of Patient Safety Incident Investigations (PSII) which will be undertaken for the Trust's identified priorities:

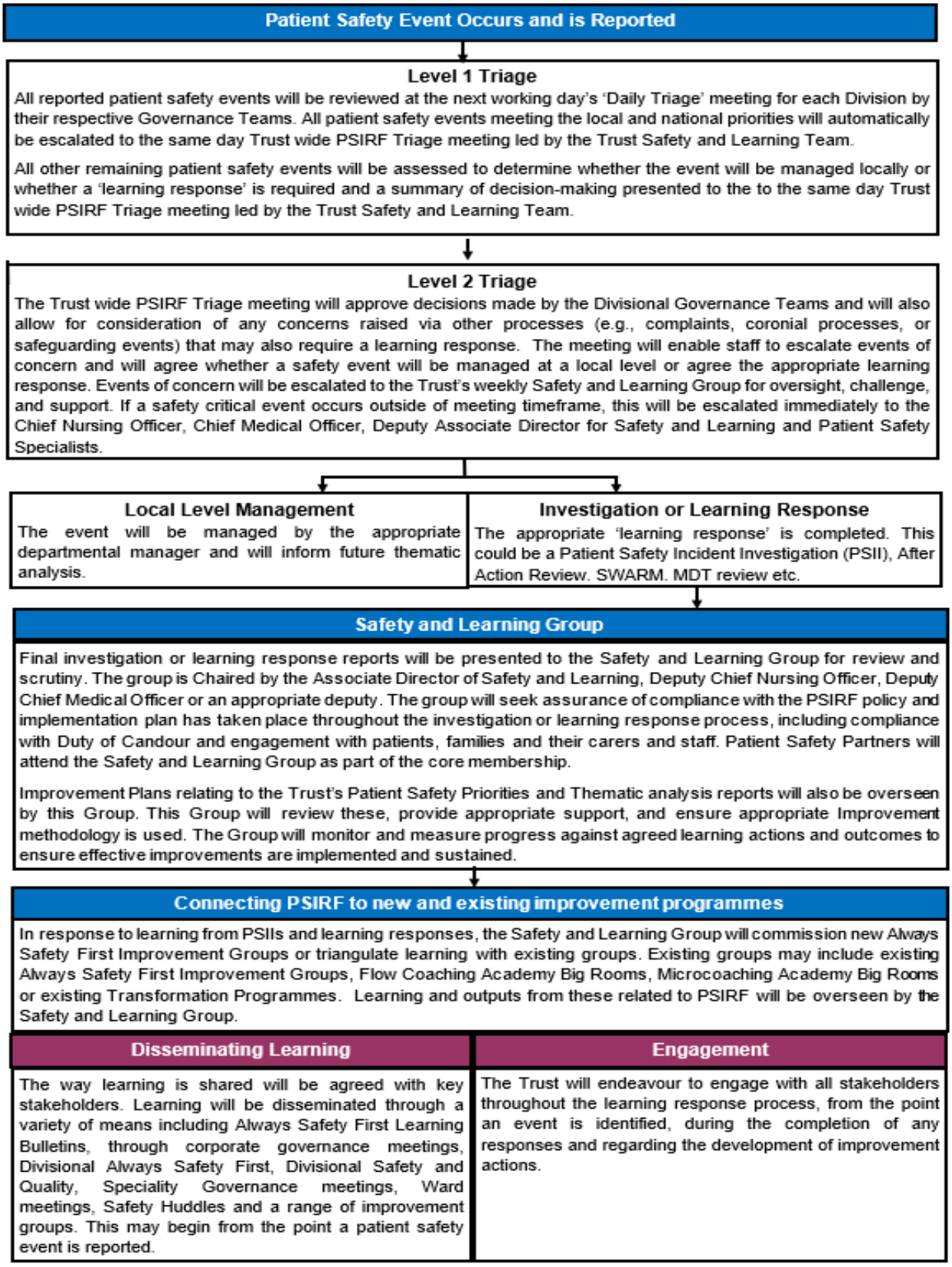
No	Priority	Planned response	Number of PSIIs
1	Delayed recognition of a deteriorating patient, due to gaps in monitoring (including all pregnant women)	Patient Safety Incident Investigation (PSII)	5
2	Delayed, missed or incorrect cancer diagnosis	Patient Safety Incident Investigation (PSII)	5
3	Prescribing or administration error or near miss of anticoagulation medication	Patient Safety Incident Investigation (PSII)	5
4	Adverse Discharge due to gaps in communication or misinformation	Patient Safety Incident Investigation (PSII)	5
5	Delay in responding to a critical pathology finding	Patient Safety Incident Investigation (PSII)	5

Safety events which previously met the Serious Incident Framework's definition of a 'serious incident' do not need to be routinely investigated using the PSII process.

By undertaking PSII investigations for events that do not meet the criteria of the identified patient safety priorities, the Trust runs the risk of recreating the Serious Incident Framework.

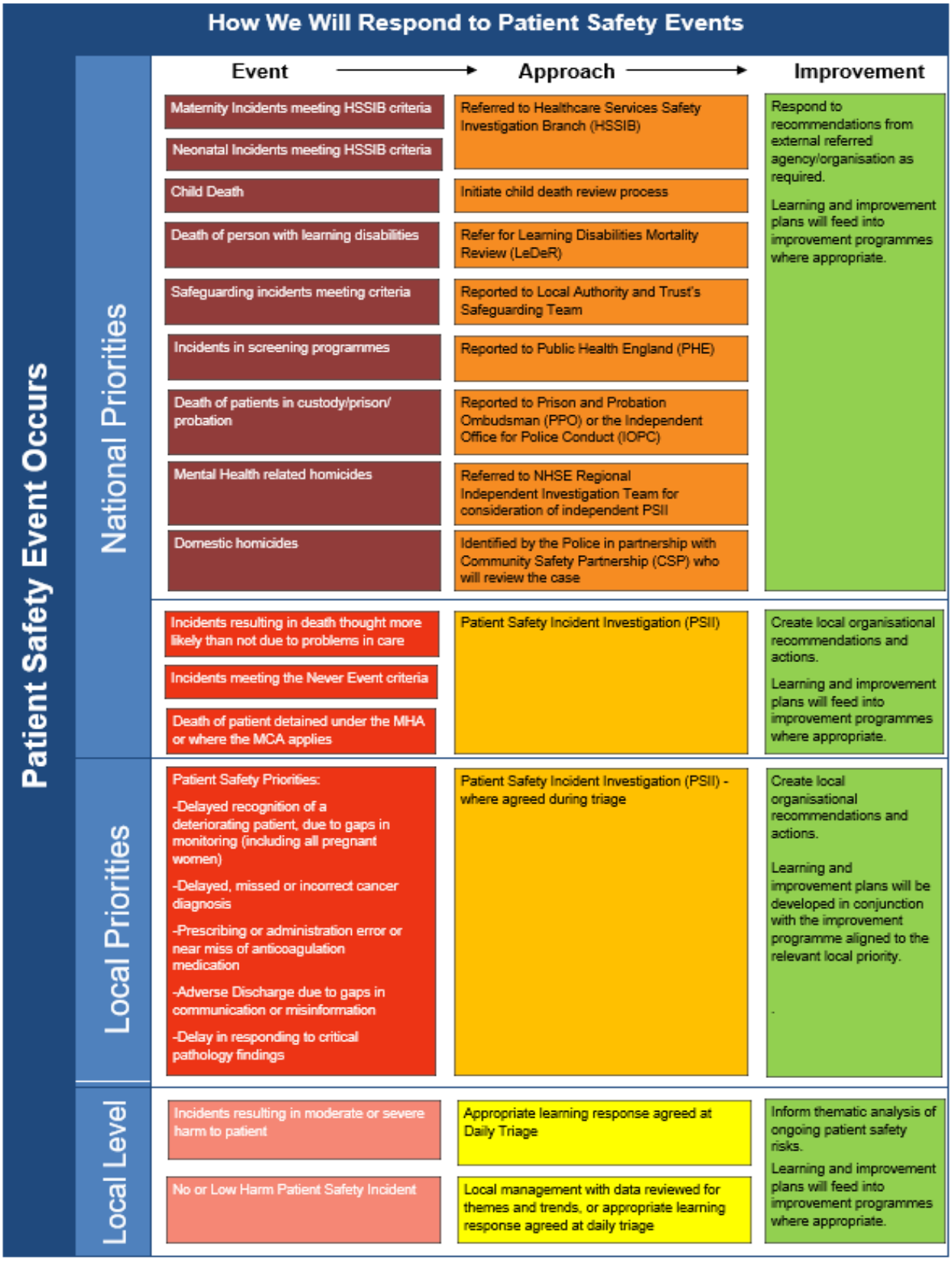
How we will respond to patient safety events

The infographic below describes the governance arrangements in relation to how the Trust will respond to a patient safety event.



Patient safety incident response plan

The infographic below describes how patient safety events assessed under the national priorities, local priorities and local level criteria will be managed and how improvement plans will be developed.



Patient safety incident response plan

Learning Responses

Some patient safety events will not require a PSII but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff. A clear distinction is made between the activity, aims and outputs from reviews and those from PSIIs.

The timeframes set are intended to be used as a guide and should be flexible if there are circumstances that require more in depth understanding.

The table below gives an overview of the different types of learning responses.

Type of learning response	Description	Timeframe
Patient Safety Incident Investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. These will be undertaken using Systems Engineering Initiative for Patient Safety (SEIPS) methodology.	Ordinarily completed within 3 months, maximum 6 months
Multidisciplinary (MDT) Team Review	An MDT review supports health and social care teams to learn from patient safety events that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care	Maximum 4 weeks
SWARM	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and	Maximum 1 week

	why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future	
After action review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. **It is based around four questions:** 1. What was the expected outcome/expected to happen? 2. What was the actual outcome/what actually happened? 3. What was the difference between the expected outcome and the event? 4. What is the learning?	Maximum 2 weeks after the event
Thematic Review	A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative (I.e., Incident reports, Complaints data etc.) rather than quantitative data to identify safety themes and issues. Thematic Reviews can be used for multiple purposes, including: • Developing or revising our Safety Improvement Profile	As agreed by the Safety and Learning Group or Divisional Management Team.

	• Aggregating information from many diverse sources of safety intelligence datasets. • Gathering insight about gaps / safety issues across a pathway or as part of an overarching safety theme to direct further analysis • Aggregating findings from multiple incident responses to identify interlinked contributory factors to inform / direct improvement efforts. • Presenting summary data to show the impact of ongoing safety improvement work.	

Anticipated time commitment for completion of learning responses

The table describes the estimated time commitment for each category response type. This has been calculated using guidance from peer organisations.

Response type	Category	Time Commitment
PSII	Local Priorities defined PSIIs	**Minimum 60 hours per investigation for:** • 1 lead investigator • 1 support investigator **Up to 30 hours per investigation for:** • subject matter expertise • family liaison ***Plus*** **Up to 30 hours per investigation for:** • investigation oversight and support • administration support • interview and statement time of staff involved in the incident Time commitments may vary per PSII and therefore subject to further review.

PSII	National Priorities	**Minimum 60 hours per investigation for:** • 1 lead investigator • 1 support investigator **Up to 30 hours per investigation for:** • subject matter expertise • family liaison ***Plus*** **Up to 30 hours per investigation for:** • investigation oversight and support • administration support • interview and statement time of staff involved in the incident. Time commitments may vary per PSII and therefore subject to further review.
Various	Local Level	**Maximum eighteen hours per response review**

Anticipated number of learning responses

Based on a comparison of data between September 2021 and August 2023, the trust has also calculated the anticipated number of learning responses.

Response type	Category	Anticipated Number of Responses
PSII	Local Priorities defined PSIIs	25 (Based on this plan)
PSII	National Priorities	Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII) Approximately 22 per year based on an average of incidents graded as 'Death' and reported to Strategic Executive

		Information System (StEIS) over the past 2 years.
PSII	National Priorities	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria) The Trust does not currently categorise incidents in this group and therefore difficult to estimate this number.
PSII	National Priorities	Incidents meeting the Never Events criteria 2018, or its replacement. 2-4 per year based on range of Never Events over the past 2 years,
Various	Local Level	<u>Incidents Resulting in Moderate or Severe Harm to Patient.</u> ***Average Investigations Undertaken:*** The below provides an average number of investigations initiated in a financial year based on severe and moderate harm level (calculated based on the previous 2 years). 135 (72 Hour Review) 82 (RCAs) = equivalent to 217 learning responses ***Local RCAs:*** The below provides an average number of Local RCAs initiated in a financial year (based on data from the previous 2 years). 48 (Inpatient Falls) 1 (Delay for Cancer Treatment) 148 (Clostridium Difficile)

		1 (MRSA PIR) 166 (Acute Tissue Viability Cat 2 and above) 5 (VTE) 5 (Section 42 Safeguarding) 3 (Maternity Incidents – 3rd/4th degree tears and PPH >1500mls) = equivalent to 377 learning responses. Learning responses for these categories may include: • Thematic Review • PIR • MDT round table discussion • SWARM • After Action Review <u>Incidents Resulting in low or no harm</u> ***Average Investigations Undertaken:*** The below provides an average number of investigations initiated in a financial year based on low or no harm level (calculated based on the previous 2 years). 23 (Section 42 Safeguarding) 1008 (Violence and Aggression incidents) 218 (Absconding/Missing patients) 609 (Patient safety events linked to communication between staff/teams) 24 (Maternity Incidents – 3rd/4th degree tears and PPH >1500mls) = equivalent to 1882 learning responses* *However, in line with PSIRF it is likely that for 'violence and aggression' and 'patient safety events linked to

		communication between staff/teams', the Trust will undertake a series of thematic reviews where appropriate. Due to the broad categorisation of this incidents, the Trust will also consider as part of the triage process whether categorisation of the incidents reported are appropriate. Learning responses for these categories may include: • Thematic Review • PIR • MDT round table discussion • SWARM • After Action Review The numbers of anticipated thematic reviews under PSIRF are difficult to estimate at this current time.

The table above does not capture learning responses for those patient safety events that may need to be reported externally that do not fit into the current PSIRF national and local priorities criteria. The table is also based on data at the time of producing this incident response plan and likely to be subject to some variation. Therefore, it is anticipated that the number of learning responses managed at local level may be higher than the numbers currently estimated above**.**

Capacity assessment

To ensure learning responses are conducted in line with the PSIRF professional standards and to understand the organisation's capacity to respond to patient safety events, a skill mix review has been undertaken. This has been supported by an analysis of the numbers and training of staff with a specific role in patient safety incident responses, as well as how other staff will be expected to support such responses.

Our patient safety improvement approach

The Trust is committed to ensuring PSIRF implementation is intrinsically linked to the Trust's programmes of improvement so that learning outcomes utilise evidence-based improvement methodology to create sustainable change in the delivery of safe care for our patients and to build on the existing culture of continuous improvement within the organisation.

In line with the Trust's Continuous Improvement Strategy, improvement programmes at Lancashire Teaching Hospitals NHS Foundation Trust are organised at macro (system and organisation), meso (pathway) and micro (individual ward and department) levels.

Where opportunities for learning are identified from PSIIs or other learning responses, these will be connected to improvement programmes of work if appropriate. This will not only be undertaken reactively when things have not gone well but also proactively whilst considering the principles of Safety II by learning from things that have gone well and exploring how more of this can be achieved. Where existing improvement programmes of work do not exist, the Safety and Learning Group will determine whether a new improvement programme is required.

Each local priority will have an associated improvement programme. These programmes will be co-designed with frontline teams who are delivering the services with a patient and staff focused outcome at their core and will have an aim, driver diagram, project outline, recognised continuous methodology, baseline measures and measurement and evaluation plans. The programmes will also be tailored to fit the circumstances of the programme utilising a variety of approaches such as: Break Through Series Collaborative to individual support, guidance and coaching maximising the use of technology where appropriate to help achieve the greatest benefit.

At the point that an improvement need has been identified, improvement plans will be co-produced with members from the associated improvement group, including patients, carers and families and staff with support from the continuous improvement teams if required to identify outcome measures and actions to then be shared.

Progress against agreed learning actions and outcomes will be overseen and monitored by the Trust's Safety and Learning Group to ensure effective improvements are implemented and sustained.

Transition to PSIRF

The implementation of PSIRF will commence on 06 November 2023 in a phased approach following Board and ICB approval. There will be a period of transition from the previous Serious Incident Framework and the new PSIRF with a plan for full implementation of PSIRF expected by the 31 March 2024.

To ensure successful implementation of the PSIRF policy and plan, the Trust has engaged and will continue to engage with a number of stakeholders including patients, families, carers and staff, other acute Trusts within the ICS to capture learning, the Care Quality Commission (CQC), our regulators, the ICB who are responsible for approving this plan and ensuring collaborative work across the local ICS and a range of advocacy groups such as Healthwatch.

It is recognised the implementation of PSIRF will require continued review, reflection and learning across the NHS. This document is intended to be evolving in nature and sets out the pertinent parts of the implementation process. It is supported by a project plan that is monitored by a PSIRF implementation group reporting into the Trust's Safety and Learning Group. This will continue for the first 4-6 months of PSIRF until assurances are in place that processes are embedded and skills deployment is in line with the required standards.

Glossary

Relevant to both PSIRF policy and PSIRP.

Abbreviation of Term	Definition
AAR	**After Action Review** A learning response tool consisting of a structured facilitated discussion of an event/incident
CQC	**Care Quality Commission** Independent regulator for health and social care in England
CSP	**Community Safety Partnership** Statutory partnerships of organisations who work together in an area to reduce crime and the fear of crime, anti-social behaviour, alcohol, and drug misuse and reducing re-offending
Core20PLUS5	**Core20PLUS5** A national NHS England approach to inform action and reduce healthcare inequalities at both national and system levels, focused initially on the experience of adults, but has now been adapted to apply to children and young people
DHR	**Domestic Homicide Review** A review into the circumstances around a death of a person following domestic abuse
HealthWatch	**HealthWatch** A health and social care champion service who obtain the views of people about their needs and experience of local health and social care services
HSSIB	**Healthcare Services Safety Investigation Body** The independent national investigator for patient safety in England
ICB	**Integrated Care Board** A statutory organisation who are responsible for developing a plan for meeting the health needs of the local population,

Abbreviation of Term	Definition
	managing the NHS budget, and arranging for the provision of NHS services in a geographical area
ICS	**Integrated Care System** Partnerships of organisations which come together to deliver joined up health care services and improve the lives of people who live in the area
IOPC	**Independent Office for Police Conduct** A non-departmental public body in England and Wales who are responsible for overseeing the system for handling complaints made against police forces in England and Wales
LeDeR	**Learning Disability and Mortality Review** A service improvement programme for people with a learning disability and autistic people who look at key episodes of health and social care the person received that may have been relevant to their overall health outcomes
LFPSE	**Learning from Patient Safety Events** The new national NHS service for the recording and analysis of patient safety events
LTHTR	**Lancashire Teaching Hospitals NHS Foundation Trust**
Magnet4Europe	**Magnet4Europe** A four-year Horizon project that aims to improve mental health and wellbeing among health professionals in Europe
MDT	**Multi-Disciplinary Team** A group of staff from different areas in healthcare
NRLS	**National Reporting and Learning System** The current national central database for recording and analysing patient safety incident reports
PALS	**Patient Experience and Liaison Service** The Trust's team which provides support for patients, families, and carers
PPO	**Prison and Probation Ombudsman**

Abbreviation of Term	Definition
	A public body that carries out independent investigations into complaints and deaths in custody
PSIRF	**Patient Safety Incident Response Framework** A new and innovative approach to the way the NHS responds to patient safety incidents
PSIRP	**Patient Safety Incident Response Plan** The plan which sets out how NHS organisations intend to respond to patient safety incidents under PSIRF
PSP	**Patient Safety Partners** The role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisations' governance and management processes for patient safety
PSII	**Patient Safety Incident Investigation** A learning response tool which is undertaken when an incident or near miss indicates significant patient safety risks and the potential for new learning
Safety I	**Safety I** Identifying causes and contributing factors in patient safety events as the focus point in an attempt to stop them occurring
Safety II	**Safety II** Considering variations in everyday performance to understand how things usually go right
SEIPS	**Systems Engineering Initiative for Patient Safety** A methodology for understanding outcomes within complex socio-technical systems
SIF	**Serious Incident Framework** The current process by which the NHS ensures serious incidents are identified, investigated, and learned from to prevent the likelihood of similar incidents happening again. This framework will be replaced by PSIRF
SOP	**Standard Operating Procedure**

Abbreviation of Term	Definition
	A guide/step by step instructions compiled by an organisation to help staff to carry out routine tasks/processes
SpHA	**Special Healthcare Authority** An authority who provides a health service to the whole of England, not solely to a local community
STP	**Sustainability and Transformation Partnership** Where local NHS organisations and Local Authorities draw up shared proposals to improve health and care in the areas they serve

Appendices

Appendix 1 – Assessment criteria for identifying local priorities.

Likelihood of Harm

1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
This will probably never happen/recur Not expected to occur for years Probability = <0.1% (<1 in 1000)	Do not expect it to happen/recur but it is possible it may do so. Expected to occur at least annually. Probability = 0.1 – 1% (1 in 1000 to 1 in 100)	Might happen or recur occasionally Expected to occur at least monthly Probability = 1 – 10% (1 in 100 to 1 in 10)	Will probably happen / recur but it is not a persisting issue Expected to occur at least weekly Probability = 10 – 50% (1 in 10 – 1 in 2)	Will undoubtedly happen/recur, possibly frequently Expected to occur at least daily Probability = >50% (more than 1 in 2)

Impact of Harm

1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention Increase in length of hospital stay by 1-3 days.	Moderate injury requiring professional intervention Increase in length of hospital stay by 4-15 days	Major incident leading to long-term incapacity/disability Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Confidence in Existing Improvement Work

1 Extremely Confident	2 Very Confident	3 Some Confidence	4 Low Level of Confidence	5 No Confidence at All
You are aware of existing improvement work. The improvement work had eradicated patient safety events.	You are aware of existing improvement work. The improvement work has almost eradicated patient safety events/or significantly reduces these. However, I these do occasionally occur.	You are aware of some existing improvement work. The improvement work has made an impact and significant events have reduced but do continue to happen but are significantly less frequent.	You are aware of some existing improvement work. The improvement work has resulted in some reduction in patient safety events but significant events continue to happen.	You are not aware of any existing improvement work. You are aware of existing improvement work but patient safety events continue to happen at a similar rate/severity.

Potential for New Learning

1 No Potential for Learning	2 Slight Potential for Learning	3 Some Potential for Learning	4 Low Level of Confidence	5 Significant Potential or Learning
The theme is well known throughout the Trust and the Trust has exhausted all improvement / learning opportunities.	The theme is well known throughout the Trust and the Trust has existing improvement measures in place which are addressing the learning from this theme.	The theme is known and there may have historically been improvement work that made an impact. However, this was not sustained.	The theme is known but there is no existing improvement work or no evidence that existing improvement work is having an impact.	The theme is unknown and there is no pre-existing improvement work within the Trust.

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Annual Mortality Report 2022-23			
Report to:	Board of Directors	**Date:**	5 October 2023
Report of:	Chief Medical Officer	**Prepared by:**	K Flinn/M Clarke
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of this annual mortality report is to provide an update and assurance to the Board of Directors that the Trust has robust governance arrangements in place to review, report and learn from patient deaths. The report has been considered by the Mortality and End of Life Committee and scrutinised by the Safety and Quality Committee in June 2023.

This report presents a range of information and benchmarking data to provide assurance to the Board in the following areas:

- Mortality benchmarking – HSMR
- COVID-19 Mortality Data
- COVID-19 benchmarking
- Adult SJR Mortality Reviews & Learning
- Learning from Inquests
- LeDeR Deaths, Reviews & Learning
- StEIS Deaths & Learning
- Perinatal, Neonatal & Child Deaths
- Medical Examiner Service Activity
- Improvement projects and training

- This annual mortality report presents mortality benchmarking, demonstrating that the Trust **HSMR** of **82.1** and SMR of **83.6** are significantly lower than expected for the 12 month period of January 2022 / December 2022.

- The **SMR for children** is **90.6.** The latest 12-month SMR for neonatal deaths (excluding still births) is **53.2** and below the expected range. The latest data reveals a stable relative risk, following a period where the trusts figures had decreased. Please see the time-series analysis in figure 5a.

- The **SMR** for Covid-19 deaths has been within the expected range when compared to peers with a similar bed base, case mix and volume of Covid-19 admissions.

- The Trust completed SJRs (Structured Judgement Reviews) for 50% of deaths during the year. Key themes of learning from SJRs have been presented as well as the learning from LeDeR reviews and StEIS reported deaths and Inquests.

- The trust has delivered /commenced the following training and improvement projects in 2022/2023

  - Delivered a regional Inquest Training Day in September 2022

- Commenced an Engineering Better Care Project to improve the management of complex investigations into a death.

- Undertaken a data validation project in respect of dataset submissions to TELSTRA.

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- The continued positive impact of the Medical Examiner Service is noted. The roll out of the ME programme to the wider community continues with the support of a Continuous Improvement Big Room project.

It is recommended that the Board of Directors note the content of the report for information and confirm it is assured of the robust arrangements in place relating to the management of patient deaths.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☐
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For The Future	☐

Previous consideration

End of Life Committee (June 2023)
Safety and Quality Committee (30 June 2023)

1. Introduction

The reporting period for TELSTRA Mortality data is January 2022 – December 2022 which is the most recent data set available.

The purpose of this report is to provide an update and assurance to the Board of Directors that the Trust has robust governance arrangements in place to monitor, review, report and learn from patient deaths. This report presents a range of mortality information and benchmarking data to provide assurance to the Board in the following areas;

- Mortality benchmarking – HSMR
- COVID-19 Mortality Data
- COVID-19 benchmarking
- Adult SJR Mortality Reviews & Learning
- Learning from Inquests
- LeDeR Deaths, Reviews & Learning
- StEIS Deaths & Learning
- Perinatal, Neonatal & Child Deaths
- Medical Examiner Service Activity
- Improvement projects and training associated with the investigation of deaths and TELSTRA mortality data validation.

2. Mortality Benchmarking - Hospital Standardised Mortality Ratio (HSMR)

Mortality benchmarking demonstrates that the Trust **HSMR** of **82.1** and Standardised Mortality Ratio (SMR) of **83.6** are significantly lower than expected for the 12 month period of January 2022 / December 2022.

The Trust had during the 12 month period one of the lowest HSMRs and SMRs in relation to regional acute peers as demonstrated in the funnel plots in Appendix 1 Figures 1 and 2 p 14.

The monthly trend data for HSMR is also provided in Appendix 1 Figure 3 p15 This demonstrates that the Trust position was “as expected” or” lower than expected” throughout the year.

The twelve-month rolling SMR for children is **90.6** and within the expected range. This shows a reduction on the previous year's figure of 124.3. There were 34 deaths during the twelve month period compared to an expected figure of 37.5.

The funnel plots highlighting this are at Appendix 1 Figures 5,5a,5b p.16/17.

The latest 12-month SMR for neonatal deaths (excluding still births) is **93.7** and within the expected range. The latest data reveals a stable relative risk, following a period where the trusts figures had significantly decreased from the concerning rising relative risk from September 2021 reported in last year's annual report. Please see the time-series analysis in figure 6a.p18 and Figures 8 ,8a ,8b p 20/21.

HSMR and SMR summary

HSMR and SMR across all age ranges are summarised in Table 1. below for ease of reference.

Table 1: HSMR & SMR Relative Risk for all Diagnoses January 2022- December 2022*

Measure	12 Months (January 2022 – December 22)
HMSR All Ages	82.1
HSMR Adult	81.8
SMR Relative Risk - All Diagnoses All Ages	83.6
SMR Relative Risk - All Diagnoses Adult	83.5
SMR Relative Risk - All Diagnoses Child (<1 day – 17 yrs.)	90.6
SMR Relative Risk - All Diagnoses Neonates (<1-28 Days)	93.7
SMR – neonatal deaths (excluding still births)	53.2

* This is the most current period available without signs and symptom (R codes) which affect the accuracy of the HSMR and alerts.

3. COVID-19 Mortality Data

3.1 COVID-19 Benchmarking with National and Regional Acute Peers

The Trust SMR for COVID-19 deaths is **93.0** and within the expected range compared with Trusts with a similar bed base and volume of COVID-19 admissions as demonstrated in the funnel plot in Figure 4 p15.

The HSMR does not include patients who presented with a primary diagnosis of COVID-19; these are mapped to the viral infections group and included in the SMR for all diagnoses however, any patients who present with one of the 56 diagnoses within the HSMR basket, who subsequently develop COVID-19, will be included in the HSMR. The Dr Foster statistical model, used to calculate the risk of mortality, has no historic data to accurately calculate patients expected risk of mortality for COVID-19 therefore, caution has to be taken when interpreting the current mortality data, and comparing the Trusts figures with other peers.

3.2 Nosocomial Covid-19 deaths

A total of **288** COVID-19 deaths occurred in the Trust between 01/04/2022 and 31/03/2023.

121 of these deaths were of patients who had definitely or probably acquired (nosocomial) COVID -19 in hospital. There were an additional 47 cases where it could not be determined whether the infection was hospital-acquired during that period.

The table below provides comparative data for the past 3 years. This shows a small increase in terms of total numbers of Covid-19 deaths and a significant increase in the numbers of hospital acquired Covid-19 deaths.

Of note the Cause of Death is not factored into this data and therefore patients may not have died from Covid-19, but it is likely that it would have been a contributing factor.

Additionally due to changes in testing over time both within the Trust and community comparative data should be interpreted with caution.

Table 2: Deaths Attributed to COVID-19 – BI Data – 01/04/22 – 31/3/23.

	HODHA	HOPHA	HOIHA	CO	TOTAL
No Deaths 2022/2023	67	54	47	120	288
No. Deaths 2021/2022	24	20	26	191	261
No Deaths 2020/2021	93	103	87	426	709

Key: **HODHA** = Hospital onset definite healthcare associated/**HOPHA** = Hospital onset probable healthcare associated
HOIHA = Hospital onset indeterminate healthcare associated/**CO** = Community onset

The Trust has continued to follow guidance from the Northwest Structured Judgement Review (SJR) Task and Finish Group (published on 31/03/21) with regard to combined IPC and SJR reviews of these cases.

4.0 Adult Mortality Structured Judgement Reviews (SJRs) & Learning

4.1 Primary Structured Judgement Reviews

The Trust overall reviewed 50% of cases, with the divisional performance presented in Table 3 below.

Although the aspiration is that all Trust deaths are reviewed, there is pragmatically a minimum target set of 20% in each directorate. There is work ongoing to support those specialties who have historically returned low review figures with improvement noted over the past twelve months across each of the specialities requiring support.

Table 3: Primary Structured Judgement Review Annual Performance

Division	April – June 2022			July - September 2022			October - December 2022			January – March 2023			Annual Totals		
	Deaths	Reviews	%	Deaths	Reviews	%	Deaths	Reviews	%	Deaths	Reviews	%	Deaths	Reviews	%
Medicine	338	122	36%	342	168	49%	398	175	44%	423	173	41%	1501	616	41%
Surgery	78	64	82%	79	67	85%	99	91	92%	85	60	71%	341	259	76%
DCS	41	27	66%	41	31	76%	49	33	67%	38	0	0%	169	83	58%
WAC	3	3	100%	0	0	N/A	1	1	100%	0	0	N/A	4	4	100%
Total	**460**	**216**	**47%**	**462**	**267**	**58%**	**547**	**300**	**55%**	**546**	**233**	**43%**	**2015**	**1016**	**50%**

The avoidability of death score at Primary SJR is used to determine cases which require escalation for a Secondary SJR, which are those cases with scores 1-3. Some cases may be directly referred for a Rapid

Incident/Serious Incident Review where there is already a concern that a clinical incident has occurred. Where relevant, those cases will be reported to StEIS. In which case the avoidability of death is only finally determined after an incident investigation has been completed or after a coroner's inquest where applicable.

Table 4: Avoidability Scores at Primary Review 2022/2023

Avoidability Scores	Medicine	Surgery	DCS	WAC	TOTAL
Score 1 Definitely avoidable	0	0	0	0	0
Score 2 Strong evidence of avoidability	1	1	0	0	2
Score 3 Probably avoidable (more than 50:50)	4	1	3	0	8
Score 4 Possibly avoidable but not very likely (less than 50:50)	28	9	6	0	43
Score 5 Slight evidence of avoidability	107	21	8	0	136
Score 6 Definitely not avoidable	437	230	74	4	745

4.2 Secondary Reviews 2022-2023

For the deaths which occurred during 2022-23, 53 were referred for a secondary review which is an increase from 22 cases in the last year's annual report. It should be noted that the increase in the number of referrals for a secondary review is not always due to the avoidability of death score or poor care. Some specialities trigger a secondary review if a second opinion /specialist opinion is required, or a need to highlight an issue to another speciality involved in patient's care.

Out of the 53 cases ten patients were given an avoidability of death score of 2 or 3 at the primary review. A secondary review has been completed for five of these cases, three cases have been referred for a level 3 investigation and two cases are still awaiting a secondary review. Please see the breakdown of all the outcomes in Table 5.

There were two Emergency Department (ED) deaths that were referred for a secondary review. The avoidability of death scores were not available for both of these reviews as the SJR form used for ED cases is different as it includes a question regarding cardiac arrest management – " *did the death occur on termination of resuscitation from an out of hospital cardiac arrest* " If the answer to this question is "yes" then an avoidability of death score is not required. Of the two patients involved, one patient had a Rapid Incident Review completed which concluded "No Harm" and the other patient was referred for a Level 3 investigation.

Table 5: Avoidability Scores at Secondary Review

Primary SJR Avoidability Scores	Cases escalated for Secondary SJR	Post Secondary Review Avoidability
Score 1 Definitely avoidable	0	
Score 2 Strong evidence of avoidability	2	1= Score 5 1= Score 6
Score 3 Probably avoidable (more than 50:50)	8	2= Score 3 1= Score 5 3= Level 3 investigation 2= Awaiting a review
Score 4 Possibly avoidable but not very likely (less than 50:50)*	14	3= Score 4 1= Score 5 2= Score 6
Score 5 Slight evidence of avoidability*	13	2= Score 5 4= Score 6
Score 6 Definitely not avoidable*	13	2= Score 5 7= Score 6

* Please note that cases scoring 4-6 do not require escalation for Secondary Review. A secondary review is also triggered by a poor care score.

4.3 Learning from Structured Judgement Reviews

During 2022-2023, the mortality review pro forma was updated to capture both positive and negative learning. Learning from deaths is regularly shared in the divisional Safety and Quality meetings and speciality governance meetings.

Key positive themes arising from the outcomes of SJR Mortality Reviews during 2022-23:

- Appropriate escalation of patients.
- Good Communication with the family and patient.
- Prompt investigations.
- Good documentation.
- Multi-disciplinary approach.
- Involvement of the Palliative Care Team.

Key negative themes arising from the outcomes of SJR Mortality Reviews during 2022-23:

- Missed diagnosis.
- Missed observations - nursing and clinical.
- DNACPR decision making and delays in initiating a DNACPR.
- Missed escalation of patients.

5. Learning Disabilities (LeDeR) Deaths, Reviews & Learning

There were 30 deaths of patients with Learning Disabilities in 2022-2023, all of these have had a Structured Judgement Review completed. None of the reviews were superseded by the Child Death Overview Panel Process, indicating that there have been no children who have died with a learning disability or autism.

Table 6: LeDeR Deaths Reviews 2022-2023

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	Totals
Deaths	3	3	3	1	5	2	3*	1	4	2	2*	1	30
Reviews	3	3	3	1	5	2	3	1	4	2	2	1	30
LeDeR reviews	3	2	4	0	0	0	0	0	0	0	0	0	9

*this includes patients who died in ED (3 in total)

Good care was reported in 27 cases and Adequate care in two patients, with scores not available for the other case (ED patient please see section 4.2 above).
In 24 cases death was 'Definitely not avoidable' and in four cases the death had a "slight evidence of avoidability'. One patient was referred for a Level 3 investigation.

In addition to the SJRs, cases are referred to the national LeDeR programme for review, the actions undertaken from learning are included in the LeDeR annual report. Nine of the cases have been reviewed by a LeDeR reviewer. Multi-agency learning has been shared through anonymised patient stories and generalised trends and themes have been noted.

Formal feedback to single agency is not yet provided by the LeDeR reviewer however this is being considered by the national LeDeR programme for 2023-2024 and NHS numbers are now provided which aids identification of learning linked to the Trust.

In January 2022 the national LeDeR process changed to include people with autism, the Trust has reviewed its process to ensure Business Intelligence and Structured Judgement Review's now capture autism. National Data opt out is also considered within the LeDeR process - no patients have 'opted out' for LeDeR information sharing.

The key findings from the national Annual LeDeR Report (2021 - 2022) which is the latest national report currently available has been reviewed for correlation with the Trust 2022 -2023 data with details provided at Appendix 2 p22.

The 2022-2023 national LeDeR report is expected to be available in 2023 and further comparative reporting will be provided to Mortality and End of Life Committee and Safety and Quality Committee in December 2023.

In addition, there has been local multi-agency learning (relevant to Acute General Hospitals) which has included: the assessment of pain, ensuring reasonable adjustments, the compliance of the Mental Capacity Act and Best interest decision making, advocacy, ensuring Learning Disability is not cited as a cause on DNACPR, Death certification or the Advance Care Plan documentation.

The Trust Learning Disabilities team continue to implement learning into actions and work closely with multi-agency partners and people with a lived experience. This includes -

- The Learning Disabilities Partnership Board and steering group 'Live Healthier, Live Longer'.
- The Autism Partnership Board and steering group 'Health and Social Care'.

Trust Continuous Improvement work to support both national learning (LeDeR Action from Learning report 2021-2022), and local LeDeR learning is detailed in Appendix 2 p22.

6. Deaths subject to StEIS Investigation

During the reporting period 19 Datix incidents with an outcome of death have been reported to StEIS and investigations commenced. As of 31st March 2023 five StEIS investigations have been concluded and are awaiting inquest outcome, ten are complete and four are ongoing.

Four StEIS cases representing 0.2% of the total patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

The learning from the four StEIS cases noted above (two Diagnostic incidents, one Medication incident and one Sub-optimal care of a deteriorating patient incident) where investigation has been completed includes:

- Closer review of prescribing practices within the Neurosurgery team including the review of clinical advice from other specialties when making decisions of medication prescribing.
- Improvement in clinical prioritisation tools and exploring potential for electronic alerts in patient record systems to identify patients on anticoagulants to enable prioritisation for their review.
- The need for a Task and Finish Group to address delays in clerking and medical reviews within the ED.
- Implement electronic discharge checklist in the ED and audit compliance through Always Safety First.
- Explore observation recording systems in the ED.
- Agreeing audit processes for Silver Trauma within the ED.
- Improve flow out of the ED to increase resuscitation capacity.
- Need to review triage system for Oesophago Gastro Duodenoscopy (OGD) requests with consideration for an algorithm to support triage.
- Review from the Orthopaedic Service into their handover paperwork to include discharge information and justifications on discharge paperwork when inpatient medication is not included.

The action plans from the completed StEIS investigations are all recorded and monitored through the Trust's Datix system and through the Trust's Safety and Learning Group.

7. Learning from Inquests

The safety learning from inquest cases is predominantly covered in the associated investigation reports. Any additional learning that emerges during an inquest is fed back to clinical teams and where appropriate new investigations / action plans are initiated. Inquests also provide an opportunity for the trust to learn from bereaved relatives' experiences and to share this with the clinical teams involved. Examples are provided below:

- Families being shocked by the death- reporting that clinical teams gave an over optimistic view of the condition and prognosis of the patient in the days leading to death.
- Difficulty getting to speak directly with senior medical staff in the days leading up to the death.
- Concerns raised by families were not listened to or documented.
- Misunderstanding of the family responsibilities regarding DNACPR.
- Confusion over the time of death which is formally recorded when the death is verified and not when it occurs.

8. Perinatal, Neonatal and Child Deaths

The report on perinatal, neonatal and child deaths and the learning from these deaths is presented in separate reports to Safety and Quality Committee meeting on a quarterly basis as per cycle of business. The annual summary charts for perinatal, neonatal and child deaths are included in Appendix 1.

9. Medical Examiner Service Activity

Table 7: Annual Medical Examiners Figures April 1st 2022- March 31ST 2023

The table below shows that 69.9% of in – patient and ED deaths were reviewed by a Medical Examiner. 100% of deaths were reviewed by the Medical Examiner Officer who is non – clinical.

	Number	Percentage
Inpatient & ED Deaths	2032	
ME Reviews of all Deaths	1422	69.9%
MEO Reviews of all Deaths	2032	100%
ME/MEO Conversations with Bereaved	1900	93.5
Referrals to Coroner	419	20.6

Summary of Activity for Medical Examiners

The introduction of the medical examiner system is designed to:

- Provide bereaved families with greater transparency and opportunities to raise concerns.
- Improve the quality/accuracy of medical certification of cause of death.
- Ensure referrals to coroners are appropriate.
- Provide the public with greater safeguards through improved and consistent scrutiny of all non-coronial deaths, and support healthcare providers to improve care through better learning.
- Align with related systems such as the Learning from Deaths Framework and Universal Mortality Reviews.

The certificate process remains electronic which means families do not need to re-attend the hospital to collect the Medical Certificate, this has reduced the waiting time for families receiving a registrar's appointment. Any

delay in the registration or release of a deceased patient's body – for example, due to documentation errors, can be distressing for the bereaved.

The medical examiner office will help address such delays by, for example, ensuring Medical Certificates of Cause of Death (MCCDs) are completed consistently and use correct wording; improving communications within hospitals and primary care; with external agencies such as coroner's offices and registrars; and engaging with and being an accessible expert resource for qualified attending practitioners.

The number of Coroner referrals due to medical examiner scrutiny is partly due to the Standard Operating Procedure agreed with the Coroner. This means cases are reviewed that would normally be referred directly to the Coroner such as deaths following falls, deaths in the post operative period, and where the cause of death may be unclear.

The service has established strong links with the Chaplaincy, Bereavement, and Mortuary teams alongside the Muslim Burial society and has significantly improved the medical certificate process for early burials for religious and cultural reasons – from the issuing of medical certificate to registration now takes on average one hour.

Furthermore, the service continues to identify themes, reduce inappropriate Coroner referrals, reduced the number of PALS complaints, and improve the quality of MCCDs issued.

The first half of the year was significantly affected by Medical Examiner sickness absence which has improved but with two MEs still affected by health issues. Recruitment is in place for further Medical Examiners to aid community roll out.

The service continues to be part of a continuous improvement programme "Big room" directed at community roll out with a pilot in place at a local GP practice and will imminently include a further GP practice pilot site and a site at St Catherine's hospice.

10. Improvement projects and Training

The Inquest and Mortality Team have delivered training and two major improvement projects in the past 12 months.
They address very different aspects of our work but are all equally important as we strive to improve our service to bereaved families and colleagues and provide assurance to our stakeholders.

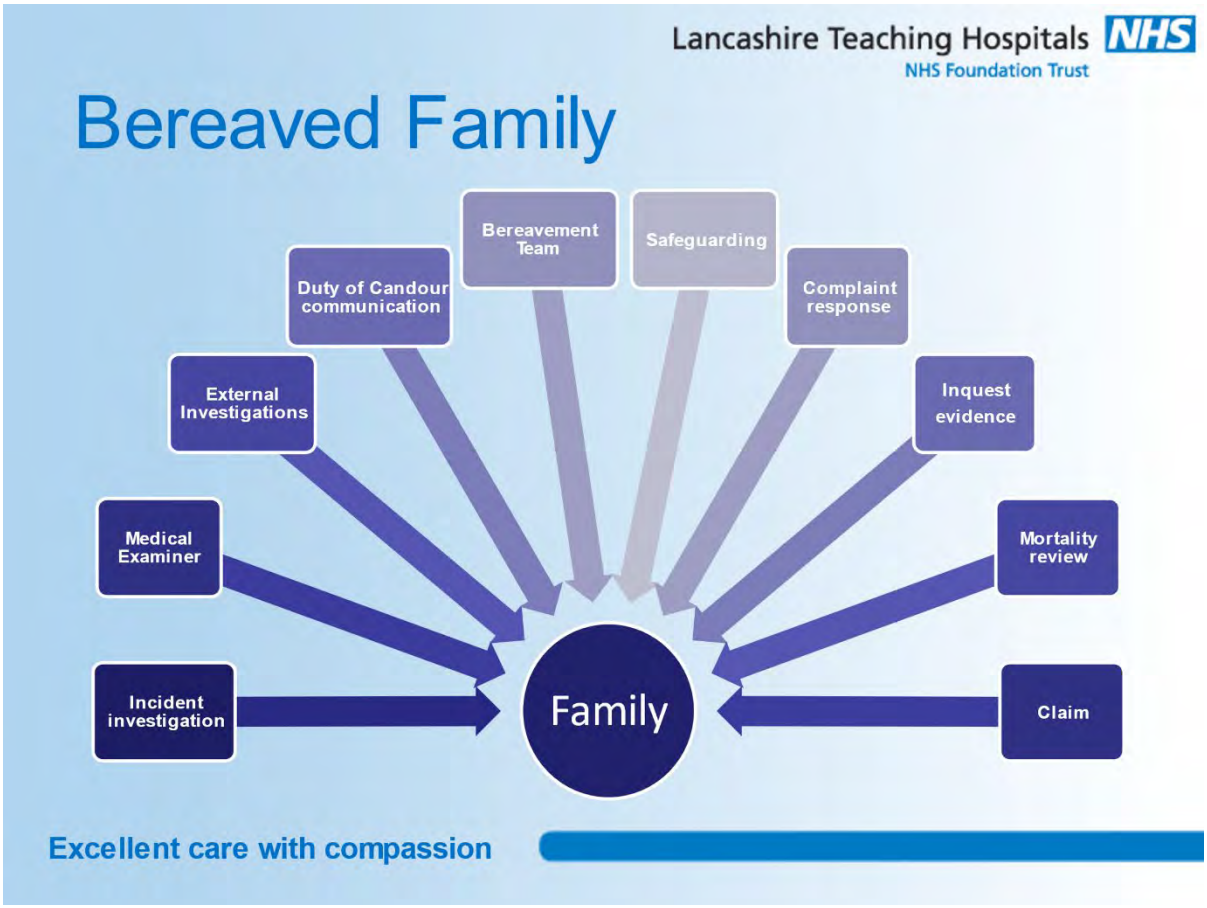
10.1 Inquest training day

In September 2022 the Trust delivered a regional Inquest training day which was well attended with much positive feedback. Speakers included the Senior Area Coroner, the Regional Medical Examiner, and the Trust Solicitors.

10.2 Engineering Better Care Project – Unexpected Death investigations

Figure 1. below demonstrates the need for this work – it shows the multiple investigations and contacts that a bereaved family are likely to have in cases where concerns have been raised regarding the care provided to a deceased loved one.

Figure 1



We know that this can be a confusing and frustrating place for our bereaved families to be – with possible delays to multiple investigations, multiple contact points and sometimes inconsistent views and information being given.

We also recognise that this is also a challenging and sometimes stressful situation for our colleagues who are either involved directly in the care/ incident or involved in leading any one of the multiple investigations that may follow.

In September 2022 we launched our Engineering Better Care Project supported by the Trust Continuous Improvement Team.
Our working group is well supported by representatives from all types of death investigations, divisional and corporate governance teams and the Coroner's Office.
We have held three workshops to date and are currently working on Phase 1 which is understanding the problem and collecting data. Seeking the views of bereaved families involved in unexpected death investigations is clearly a very important consideration.
We anticipate that the project will take one – two years to complete and look forward to providing further updates to the Safety and Quality Committee as work progresses.

10.3 TELSTRA data validation – Summary Mortality Indicators

Due to consistently low HSMR values reported and published for the trust by Dr Foster, a deep dive, data driven analysis was performed to understand if we could be assured these results were valid and correct.

The investigation included review of the trust data submission processes and the flow of data to TELSTRA as well as the methodology and factors included into TELSTRA's analysis. This work is presented in a separate paper to the Safety and Quality Committee.

A deep dive investigation into neonatal death/stillbirth data is ongoing and therefore the data provided by TELSTRA and presented in Appendix 1 should be interpreted with caution.

11. Summary

- This annual mortality report presents mortality benchmarking, demonstrating that the Trust **HSMR** of **82.1** and SMR of **83.6** are significantly lower than expected for the 12 month period of January 2022 / December 2022.

- The **SMR for children** is **90.6.** The latest 12-month SMR for neonatal deaths (excluding still births) is **53.2** and below the expected range. The latest data reveals a stable relative risk, following a period where the trusts figures had decreased. Please see the time-series analysis in figure 5a.

- The **SMR** for Covid-19 deaths has been within the expected range when compared to peers with a similar bed base, case mix and volume of Covid-19 admissions.

- The Trust completed SJRs (Structured Judgement Reviews) for 50% of deaths during the year. Key themes of learning from SJRs have been presented as well as the learning from LeDeR reviews and StEIS reported deaths and Inquests.

- The trust has delivered /commenced the following training and improvement projects in 2022/2023

  - Delivered a regional Inquest Training Day in September 2022

  - Commenced an Engineering Better Care Project to improve the management of complex investigations into a death.

  - Undertaken a data validation project in respect of summary dataset submissions to TELSTRA.
    .

- The continued positive impact of the Medical Examiner Service is noted. The roll out of the ME programme to the wider community continues with the support of a Continuous Improvement Big Room project.

12. Financial implications

None

13. Legal implications

Neonatal deaths may be subject to future litigation**.**

14. Risks

None identified.

15. Impact on stakeholders

None currently.

14. Recommendations

It is recommended that the Board of Directors note the content of the report for information and confirm it is assured of the robust arrangements in place relating to the management of patient deaths.

Appendix 1.

Mortality Benchmarking

Figure 1: HSMR Regional Acute Peers Benchmark, January 2022- December 2022

The HSMR for LTHTR is 82.1 and significantly 'lower than expected' for the most recent 12-month period.

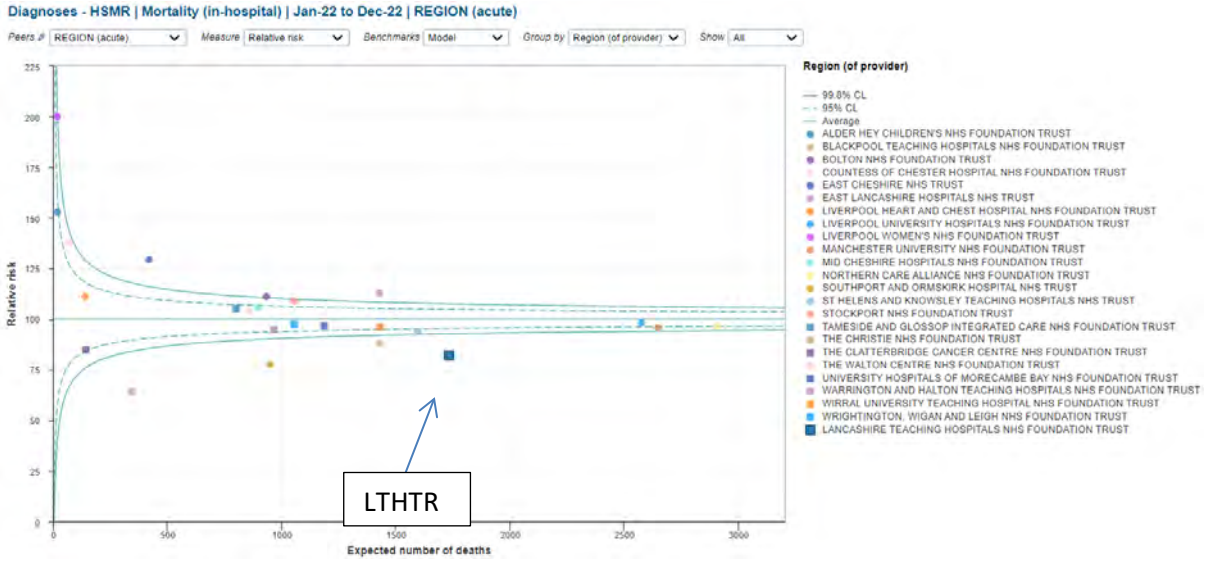
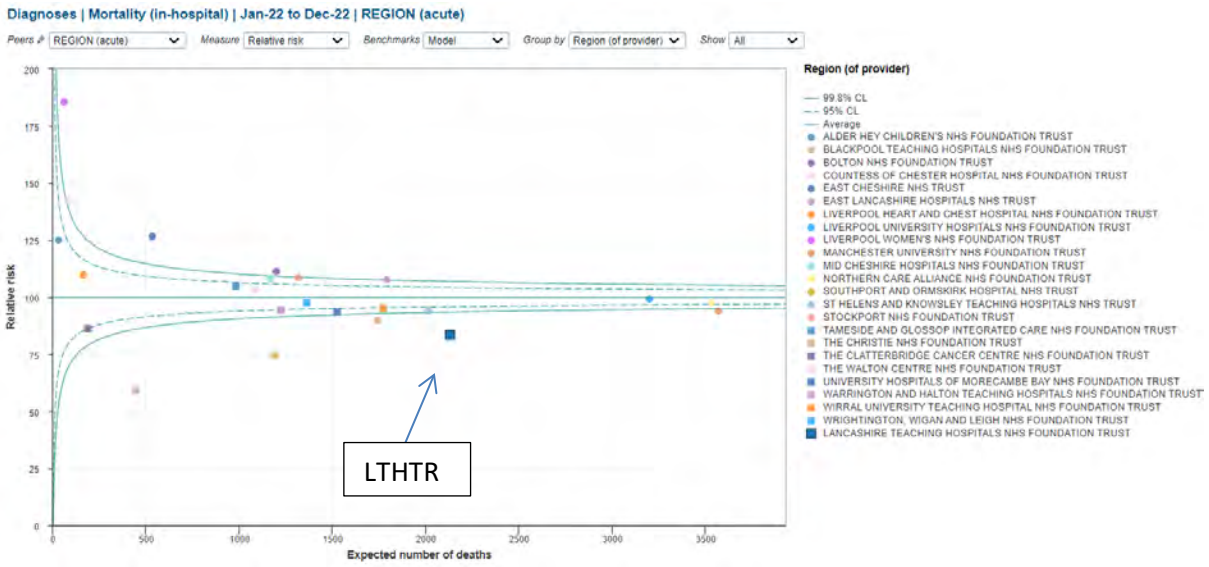


Figure 2: SMR Regional Acute Trust Benchmark, January 2022- December 2022

The SMR for LTHTR is 83.6 and significantly 'lower than expected' for the most recent 12-month period.



Trust HSMR Trend

Figure 3: HSMR by month trend Jan 2022-December 2022

This shows that the Trusts monthly HSMR was either ‘as expected’ (blue diamonds) or ‘lower than expected’ (green diamonds) for the period between January 2022 to December 2022.

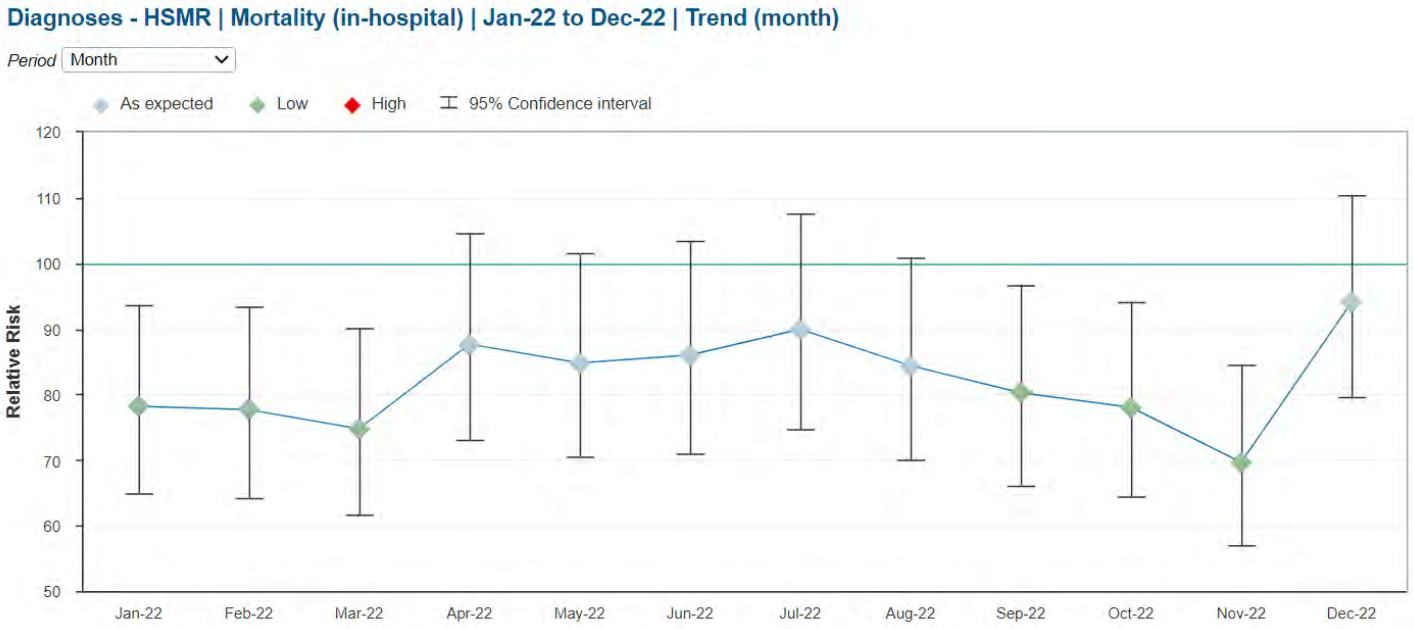
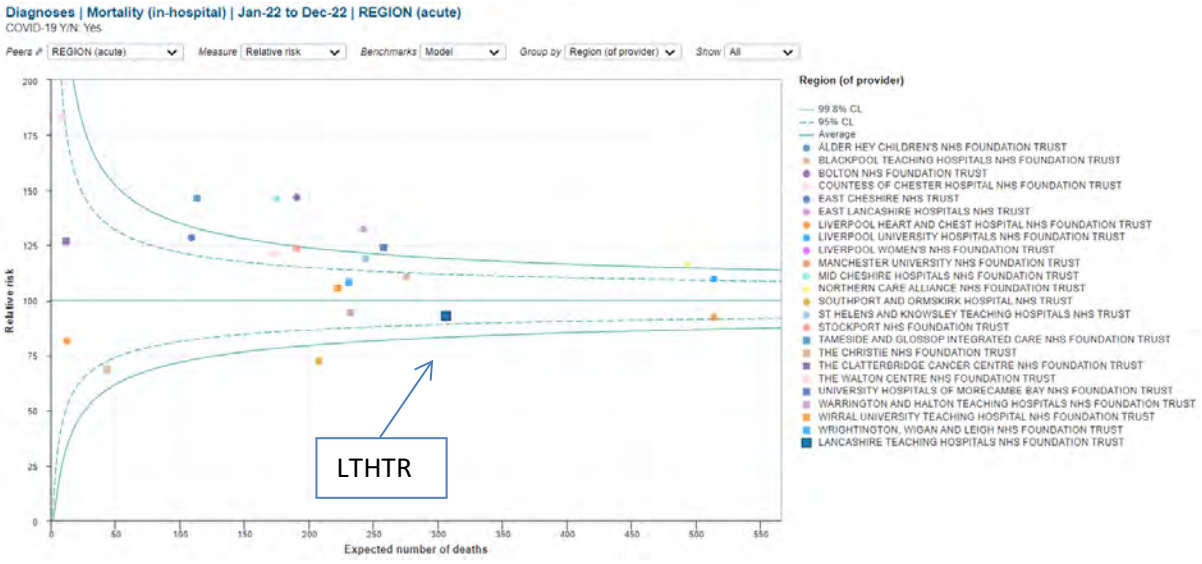


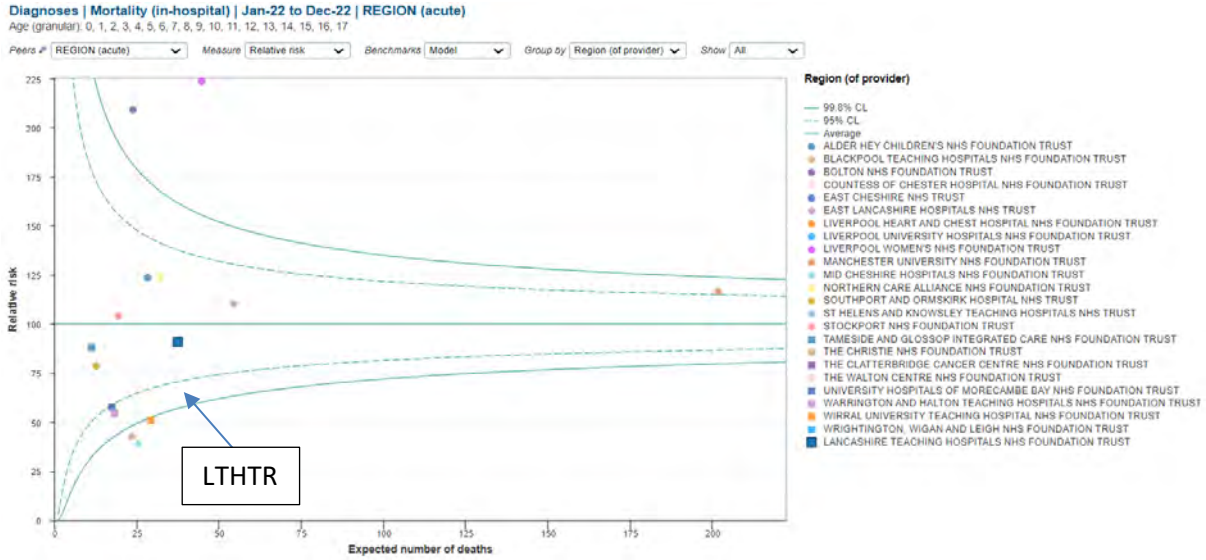
Figure 4: SMR COVID-19 - Trust with Similar Bed Base & admissions, January 2022- December 2022

The funnel plot provides a standardised mortality figure for Covid-19, which is 93.0 and within the expected range. This figure is lower than the previously reported figure of 93.8, for the period from December 21 to November 22. The peer group compares the Trust against similar providers, in terms of bed base, case-mix, and the volume of admissions with either a primary or secondary COVID-19 diagnosis, where U07.1 or U07.2 has been coded in any position.



The Hospital Standardised Mortality Ratio (HSMR) does not include patients who presented with a primary diagnosis of COVID-19, these are mapped to the viral infections group and included in the Standardised Mortality Ratio for all diagnoses. However, any patients who present with one of the 56 diagnoses within the HSMR basket, who subsequently develop COVID-19, will be included in the HSMR. The Telstra Health (formerly Dr Foster) statistical model, used to calculate the risk of mortality, has limited data to accurately calculate patients expected risk of mortality for COVID-19. Therefore, the Trust should use caution when interpreting the current mortality data and comparing the trusts figures with other providers.

Figure 5 - SMR Regional Acute Trust Benchmark Child mortality, January - December 2022



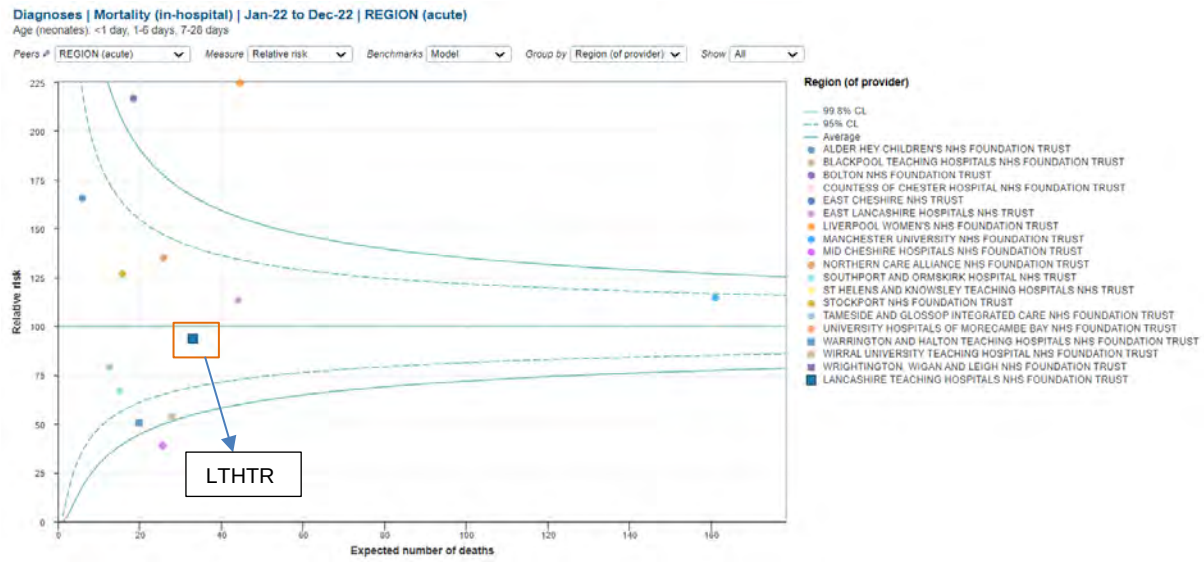
The twelve-month rolling SMR for children is 90.6 and within the expected range. There were 34 deaths during the twelve-month period, compared to an expected figure of 37.5. The trend analysis reveals that the previously decreasing relative risk, commencing from September 2021 to August 2022, has stabilised in the latest data point.

Figure 5a SMR child mortality – rolling twelve-month peer comparison

Figure 5b SMR child mortality – monthly observed mortality

Trend (month)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Expected rate (%)	Observed-expected	Relative risk	95% lower confidence limit	95% upper confidence limit
All	16153	100	16189	34	0.21	37.55	0.23	-3.55	90.55	62.7	126.54
Jan-22	1220	7.55	1223	4	0.33	2.59	0.21	1.41	154.34	41.52	395.15
Feb-22	1214	7.52	1218	4	0.33	3.53	0.29	0.47	113.44	30.52	290.42
Mar-22	1364	8.44	1364	4	0.29	2.50	0.18	1.50	160.14	43.08	409.99
Apr-22	1266	7.84	1267	3	0.24	3.33	0.26	-0.33	90.19	18.13	263.53
May-22	1393	8.62	1394	2	0.14	3.31	0.24	-1.31	60.50	6.79	218.44
Jun-22	1368	8.47	1373	2	0.15	3.35	0.24	-1.35	59.70	6.71	215.56
Jul-22	1419	8.78	1423	3	0.21	2.77	0.20	0.23	108.21	21.75	316.18
Aug-22	1186	7.34	1189	3	0.25	3.78	0.32	-0.78	79.34	15.95	231.83
Sep-22	1272	7.87	1275	1	0.08	2.64	0.21	-1.64	37.85	0.49	210.59
Oct-22	1338	8.28	1345	3	0.22	2.74	0.20	0.26	109.59	22.03	320.2
Nov-22	1575	9.75	1577	2	0.13	3.75	0.24	-1.75	53.37	5.99	192.69
Dec-22	1538	9.5214511	1541	3	0.20	3.27	0.21	-0.27	91.76	18.44	268.11

Figure 6: SMR Stillbirth and neonatal mortality data (<1 day – 28 Days), January 2022-December 2022



The latest 12-month SMR for neonates aged between zero and twenty-eight days is 93.7, which is within the expected range. The rolling twelve-month relative risk reveals a slight increase after a period of sustained decrease from September 2021 – August 2022. See figure 6a for further details.

Figure 6a SMR Stillbirth and neonatal mortality data (<1 day – 28 Days) -rolling twelve-month peer comparison.

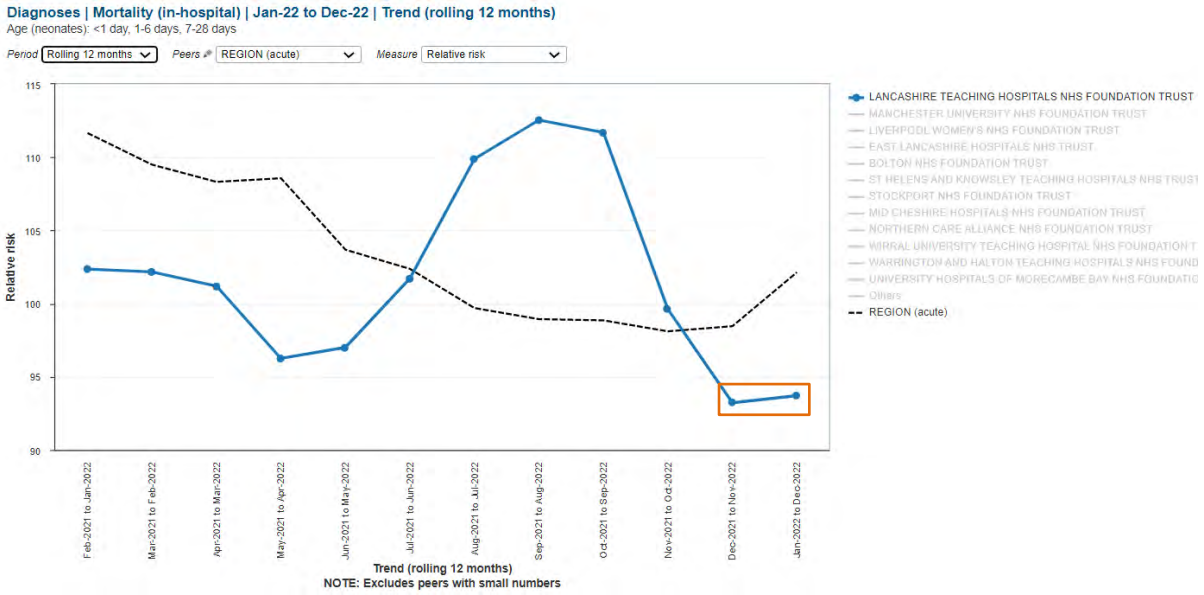


Figure 6b SMR Stillbirth and neonatal mortality data (<1 day – 28 Days) – monthly observed mortality for the period from January 2022- December 2022.

Trend (month)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Expected rate (%)	Observed-expected	Relative risk	95% lower confidence limit	95% upper confidence limit
All	4925	100	4932	31	0.63	33.08	0.67	-2.08	93.71	63.66	133.02
Jan-22	386	7.84	387	4	1.04	2.33	0.60	1.67	171.97	46.26	440.27
Feb-22	364	7.39	364	4	1.10	3.21	0.88	0.79	124.57	33.51	318.92
Mar-22	420	8.53	420	3	0.71	2.16	0.51	0.84	138.99	27.94	406.12
Apr-22	410	8.32	410	2	0.49	3.05	0.74	-1.05	65.54	7.36	236.62
May-22	378	7.68	378	1	0.26	3.01	0.80	-2.01	33.25	0.43	184.99
Jun-22	421	8.55	422	2	0.48	2.92	0.69	-0.92	68.53	7.7	247.44
Jul-22	446	9.06	447	3	0.67	2.41	0.54	0.59	124.59	25.04	364.04
Aug-22	415	8.43	416	3	0.72	3.52	0.85	-0.52	85.30	17.14	249.24
Sep-22	433	8.79	434	1	0.23	2.36	0.55	-1.36	42.29	0.55	235.3
Oct-22	414	8.41	415	3	0.72	2.36	0.57	0.64	126.91	25.51	370.8
Nov-22	431	8.75	432	2	0.46	3.22	0.75	-1.22	62.03	6.97	223.97
Dec-22	407	8.26	407	3	0.74	2.53	0.62	0.47	118.57	23.83	346.43

No months are considered statistically significant. The latest monthly data for December 22 reveals a slightly increased relative risk figure of 118.57, however this remains within the expected range.

Figure 7 Still birth mortality – January 2022- December 2022

The analysis provides a mortality trend, for neonates recorded under the ICD 3 code for fetal death of unspecified cause (ICD code P95). There were 14 still births reported to TELSTRA during the period from January 2022 to December 2022. The table of data in figure 6b, includes very low volumes of activity.

Trend (month)	Superspells	% of All	Spells	Observed	Crude rate (%)
All	15	100	15	14	93.3
Jan-22	2	13.3	2	2	100.0
Feb-22	0	0.0	0	0	-
Mar-22	0	0.0	0	0	-
Apr-22	0	0.0	0	0	-
May-22	0	0.0	0	0	-
Jun-22	2	13.3	2	1	50.0
Jul-22	2	13.3	2	2	100.0
Aug-22	3	20.0	3	3	100.0
Sep-22	0	0.0	0	0	-
Oct-22	3	20.0	3	3	100.0
Nov-22	1	6.7	1	1	100.0
Dec-22	2	13.3	2	2	100.0

Figure 7a still birth mortality – age analysis – January 2022- December 2022

The analysis highlights that a number of still births have been recorded as neonatal deaths as they have been recorded as being aged between one to five days old (see table below) The Trust has identified how the reporting error was made and has corrected the data on Harris Flex. This correction needs to be made in the commissioning data set so that TELSTRA can amend the records.

Length of stay	Trend (month)	Superspell	% of All	Spells	Observed	Crude rate (%)
1	Jun-22	1	11.1	1	1	100
1	Jul-22	1	11.1	1	1	100
1	Aug-22	1	11.1	1	1	100
2	Oct-22	1	11.1	1	1	100
3	Oct-22	1	11.1	1	1	100
4	Nov-22	1	11.1	1	1	100
5	Jan-22	1	11.1	1	1	100
5	Dec-22	1	11.1	1	1	100

Figure 8 SMR Neonatal mortality (<1 day – 28 Days) – excluding still births – January 2022-December 2022

The latest 12-month SMR for neonatal deaths (excluding still births) is 53.2 and below the expected range. This represents a decrease from 54.7, for the period from December 2021 to November 2022. The latest data reveals a stable relative risk, following a period where the trusts figures had decreased. This follows a similar overall trend to the NICU peer group of a gradual decrease. Please see the time-series analysis in figure 6a.

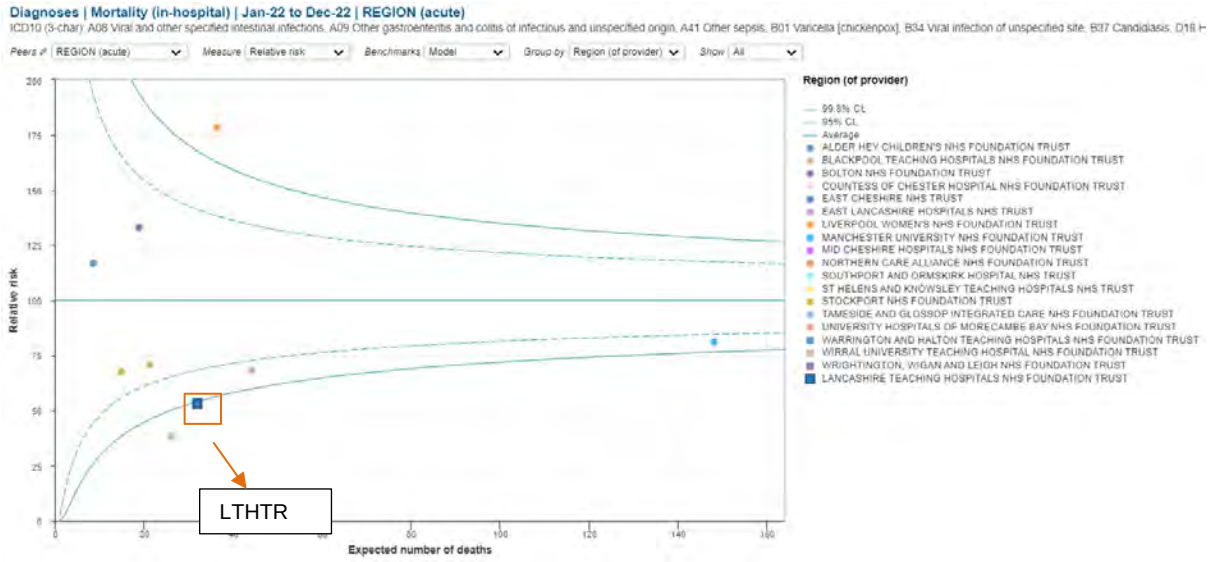
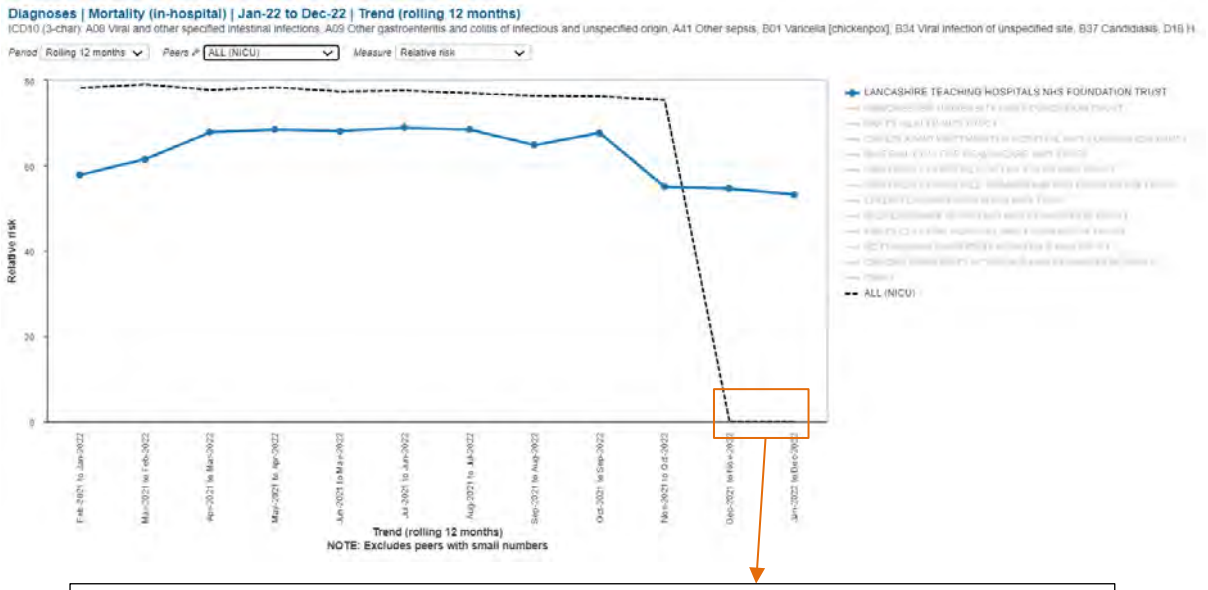


Figure 8a SMR Neonatal mortality data (<1 day – 28 Days) – excluding still births -rolling twelve-month peer comparison.



The rolling twelve-month relative risk shows a decrease across all NICU's from October 2021 to September 2022, the data has been suppressed due to small numbers in accordance with the NHS Digital HES Analysis Guide December 2019.

Figure 8b SMR Neonatal mortality data (<1 day – 28 Days) – Excluding still births - monthly observed mortality for the period from January 2022- December 2022

Trend (month)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Expected rate (%)	Observed-expected	Relative risk	95% lower confidence limit	95% upper confidence limit
All	4910	100	4917	17	0.35	31.93	0.65	-14.93	53.23	30.99	85.24
Jan-22	384	7.82	385	2	0.52	2.16	0.56	-0.16	92.78	10.42	334.98
Feb-22	364	7.41	364	4	1.10	3.21	0.88	0.79	124.57	33.51	318.92
Mar-22	420	8.55	420	3	0.71	2.16	0.51	0.84	138.99	27.94	406.12
Apr-22	410	8.35	410	2	0.49	3.05	0.74	-1.05	65.54	7.36	236.62
May-22	378	7.70	378	1	0.26	3.01	0.80	-2.01	33.25	0.43	184.99
Jun-22	419	8.53	420	1	0.24	2.77	0.66	-1.77	36.05	0.47	200.55
Jul-22	444	9.04	445	1	0.23	2.25	0.51	-1.25	44.52	0.58	247.69
Aug-22	412	8.39	413	0	0.00	3.31	0.80	-3.31	0.00	0	110.89
Sep-22	433	8.82	434	1	0.23	2.36	0.55	-1.36	42.29	0.55	235.3
Oct-22	411	8.37	412	0	0.00	2.16	0.53	-2.16	0.00	0	169.96
Nov-22	430	8.76	431	1	0.23	3.14	0.73	-2.14	31.84	0.42	177.16
Dec-22	405	8.25	405	1	0.25	2.36	0.58	-1.36	42.41	0.55	235.96

None of the months in the trend above are considered statistically higher than expected. The relative risk was at its highest during March 2022 at 138.99. The overall volume of deaths in the most recent twelve-month period is 17, compared to an expected figure of 31.93. The expected figure has increased since the last report. The last month's figures for December 2022, reveals a relative risk of 42.41 with one death reported.

Appendix 2.

Analysis of LeDeR deaths within the Trust for 2022-2023 against key findings from National LeDeR report 2021-2022.

LeDer report Key finding	National data	LTHTR data
Percentage of deaths by gender	56%	67 % male
Deaths in patients aged under 65	60%	52%
DNACPR in place	61%	93%
Leading cause of death	Covid 19 Circulatory disease Respiratory system Cancer Nervous system	Respiratory system Sepsis Cancer Cardiac
SJR rating of care good or excellent	58%	90% (rated as good)
Complete end of life care plans notes as a marker of positive practice	Not provided	2 of 27 patients had care preferences recorded. 3 patients who died in ED would be excluded from this criteria.
Learning disability recorded on Medical Cause of death certificate (against National guidance)	Not provided	In 3 cases Learning Disability or Down's Syndrome were recorded in part 2 of the death certificate (part 2 = contributory but not directly causative) The LTHTR Learning Disability Team and Medical Examiner now audit death certificates and DNACPR's.

Trust Continuous Improvement work to support both national learning (LeDeR Action from Learning report 2021-2022), and local LeDeR learning.

- Increased vulnerability to Covid-19 in people with a learning disability was noted with uptake encouraged. The Trust community hubs provided reasonable adjustments to support patients; pathways were developed alongside LTHTR Learning Disability team for patients to receive the vaccination if having general anaesthetic for other scheduled procedures. This project has ceased in 2023 as the vaccination hubs have relocated into primary care.
- The LTHTR Learning Disability team have worked closely with patients, families, carers, and specialist teams to provide social stories or easy read information to increase access to the vaccination hub and/or investigations, support admissions or elective procedures.
- Identifying and managing deteriorating health has been key given that many patients with a learning disability and/or autism cannot easily communicate they feel unwell. Hospital Passports are sought to enable staff to understand the patient's communication abilities and required adaptations, communication aids (for example pictorial aids) are provided on the Trust Intranet and highlighted in training and reasonable adjustments are identified to best support the patient through their journey.
- The Pain Management Team have ensured used of PAINAD tools for people with a learning disability and cognitive impairment. This tool is embedded within electronic patient records and policy.
- Reasonable Adjustments Needs are flagged on electronic patient records and the Trust is progressing with the ability to 'run' Reasonable Adjustments reports from electronic notes and whiteboards capturing

individual patient Reasonable Adjustments Needs, which will enable early identification and implementation (during inpatient stay and in advance of outpatient appointments).

- The LTHTR Learning Disability Team work closely with other acute hospital leads, providers, safeguarding teams, community Learning Disability services and LTHTR Specialist teams to share Hospital Passports, care plans (epilepsy or speech and language where appropriate) and consider constipation or mental capacity as highlighted in the Action from Learning report.
- The Palliative Care Team are currently leading on a project in improving advance care planning across all settings and are hoping to develop this for the ICB. This work is developed through the Flow Coach Academy Big Room with palliative and end of life care and with ICB representation. The Trust has been contacted by colleagues in other place-based areas expressing their desire to be involved. This compliments the local LeDeR Steering group plans to progress advance care planning.
- The Palliative Care Team are reviewing a tool called 'My Wishes', which is an online advance care planning platform, which can be localised to the Trust. This allows for the advance care plan completed by an individual to be shared to the Shared Care Record (LPRES). It has options for adding funeral wishes and doing things like digital legacy planning, which will reflect the desires of our patients when we have engaged in discussion.
- Advocacy information in relation to learning disability patients communicated on Trust Intranet.
- National learning in relation to DNACPRs has been highlighted within the Trust, communication from NHS England shared across the directorates (to highlight that Learning Disabilities should not be a reason for implementation), and an audit completed. The Medical Examiner reviews all deaths and is aware of the NHSE and LeDeR findings and will explore/escalate if required.
- A review of the Structured Judgement Review questions has been completed and further developed to reflect the needs of the LeDeR process (for example questions relating to mental health added which would indicate a need for a focused review).
- Planning into the Learning Disability and Autism Health Day event June 2023, which is aimed at reducing patient anxiety, introducing specialist teams, and reducing health inequalities (highlighting for example-cancer screening, oral health, audiology and the eye clinic).
- A new Learning Disability and Neurodiversity E-Learning Module has been developed by the Trust Neurodiversity Lead and Learning Disability Team which includes Oliver McGowen learning and LeDeR. The core module has been mandated from April 2023.
- Provided face to face training co-delivered by people with a learning disability and autism.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Maternity and Neonatal Services Update

Report to:	Board of Directors	**Date:**	5th October 2023
Report of:	Chief Nursing Officer Divisional Midwifery and Nursing Director	**Prepared by:**	Jo Lambert
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to provide the Trust Board with an update in relation to the safety and quality programmes of work within the maternity and neonatal services. NHS Resolution is operating in year 5 of the Maternity Incentive Scheme (MIS) and this report details progress against work relating to the ten safety actions of the Clinical Negligence Scheme for Trusts (CNST) and other high level service updates.

The service has remained on track with all the requirements set out in year 4 incentive scheme and is now working towards the additional actions required to ensure that the service is able to declare compliance with the Year 5 MIS. The service is currently 60% (6/10) compliant with the new CNST safety actions. Several standards have multiple new interventions which must be met to achieve full compliance. Focused work is ongoing to improve and maintain compliance with all standards, and workstreams are in place to track and monitor these closely. Standard 6 (SBLV3) and 8 (Maternity TNA) remain at risk due to the significant additional safety requirements needed to achieve these standards and monthly updates will be provided to the Safety and Quality Committee.

To demonstrate that there are robust processes and safe staffing in place and provide assurance to the Trust Board on maternity and neonatal safety and quality outcomes, the perinatal quality surveillance dashboard (Table 6) includes nationally mandated specified minimum data set requirements and additional local level indicators. The dashboard triangulates workforce information with safety, patient experience and clinical effectiveness indicators to provide assurance of a safe service.

The maternity service hosted NHS England National and Regional Maternity and Neonatal teams on the 13th September 2023. A service overview presentation and unit visit were undertaken, and high-level feedback confirmed a positive visit overall.

Recommendations

The Board is asked to:

i. Approve the Maternity Service Update
ii. Note the CNST update report and recommendations.
iii. Receive the associated action plans for information oversight and assurance.
iv. Note the National and Regional Maternity NHSE visit and the positive escalation and feedback

Appendix Catalogue

1. PMRT Cases
2. Overarching PMRT action plan
3. Avoiding term admissions into neonatal units and neonatal transitional care action plan outstanding actions from overarching plan.
4. Neonatal Medical Staffing
5. BirthRate + establishment
6. Workforce Action Plan
7. MNVP Provisional Work Plan.
8. HSIB Case overview
9. Red Flags

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place to Work	☒
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For the Future	☒

Previous consideration

None

1. INTRODUCTION

The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services specifically relating to the ten maternity safety actions included in year five of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. The Report also triangulates workforce information with safety, patient experience and clinical effectiveness indicators to provide assurance to the Board of a safe maternity service.

2. MATERNITY INCENTIVE SCHEME

A summary of progress to date regarding the attainment of all ten safety actions is detailed in the progress tracker below. (Table 1)

To date, work is ongoing with 4 of the safety actions rated as at risk and specific work streams are ongoing to track and monitor these closely.

Table 1: Progress Tracker

Safety Action	Progress Update	RAG Rating	Areas of concern/Update
Safety Action 1 - PMRT	On track		Compliant with requirements. Expected to deliver.
Safety Action 2 - MSDS	On track		Compliant with requirements. Expected to deliver.
Safety Action 3 - ATAIN	On track		Compliant with requirements. Expected to deliver.
Safety Action 4 – Clinical Workforce planning	On track		Medical workforce review audit is required to determine that the standards for locum employment is undertaken. Expected to deliver.
Safety Action 5 – Midwifery workforce staffing	At risk		BirthRate Plus additional staffing requirements shared with ICB. Awaiting outcome. Risk to delivery because of financial implications.
Safety Action 6 – SBLV2	At Risk		New requirements. Risk to delivery because of the 86 separate actions required for compliance.
Safety Action 7 – Maternity Neonatal Voices Partnership (MNVP)	At Risk		New Requirements New MNVP chair appointed. Several actions to ensure standard is achieved are required. Expected to deliver.
Safety Action 8 - Training	At Risk		Updating the Maternity Training Needs Analysis to meet Core competency Framework V2 Expected to deliver
Safety Action 9 – Board Assurance	On track		Compliant with requirements. Expected to deliver
Safety Action 10 – NHS Resolution	On track		Compliant with requirements. Expected to deliver

3. SAFETY ACTIONS UPDATE

A progress update is provided within this report on the key areas of focus within each safety action. Standard 6 (SBLV3) and 8 (Maternity TNA) remain at risk due to the significant additional safety requirements needed to achieve the standard and monthly updates will be provided to the Safety and Quality Committee and Trust Board confirming the updated position.

Standard 6 relates to the Saving Babies Lives Version 2 care bundle has 86 separate interventions which require documents to be uploaded to the NHS future platform for external review and validation of overall compliance to the standard.

Standard 8 details the Core Competency Framework V2 (CCFV2) requirements to address known variation in training and competency assessment and ensure that training addresses minimum core requirements for every maternity and neonatal service. The training syllabus for CCFV2 is more complex, with many of the 6 core elements now including additional sub speciality requirements. The Training Needs Analysis (TNA) must be updated to meet the new targets and includes both minimum datasets and stretch targets where possible which demonstrate a commitment to high quality training and ensure improved safety. It is anticipated that this standard will be met, but until the updated TNA is agreed, caution is applied.

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard? (• All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) • All stillbirths (from 24+0 weeks' gestation) • Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth).

To meet the requirements of standard 1, Trust Executive Boards must receive a report each quarter from 30 May 2023 that includes details of all deaths reviewed. Any themes identified and the consequent action plans should be included for oversight. The report should also evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) (Table 2) have been met.

As of the 16th of September 2023, there were seven eligible cases (Appendix1). All cases were notified to MBRRACE-UK within seven working days and surveillance completed within one calendar month of the death. The service is on track to meet the defined thresholds for multi-disciplinary reviews using the PMRT, where 95% are started within two months of the death, and a minimum of 60% of multi-disciplinary reviews are completed to the draft report stage within four months of the death and published within six months. Table 2 details the current position for all perinatal mortality reviews.

Table 2: Perinatal Mortality Tool progress tracker

Safety Action 1 (Standard A) *		**Compliance score**		**RAG**
i.	All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	**Notification**	**7/7**	
		Surveillance	**7/7**	
Safety Action 1 (Standard B) *				
i.	For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards. For standard b) for	**On track**	**7/7**	

	any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.			
Safety Action 1 (Standard C) *				
i.	For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months	**On track**	**Commenced with 2 months. 7/7** **Completed within 4 months: 7/7** **Completed within 6 months: 7/7**	
Safety Action 1 (Standard D) *				
i.	Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023 onwards that include details of all deaths reviewed, thematic learning and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	**April 2023** **July 2023** **September 2023**		
Neonatal Deaths				
I.	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death	**3/3 on track**		
II.	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information.	**3/3 on track**		

***Exclusions:** If the surveillance form needs to the assigned to another Trust for additional information, then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts, should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.

Appendix 1 details the progress against each review and the outstanding overarching action plan is included for oversight in Appendix 2. All deaths are reviewed individually, and any themes identified shared locally and regionally. From June to September 2023, it was identified that there were three PMRT cases associated with multiple pregnancy. Thematic analysis will be performed once the PMRT investigations have been completed.

The importance of hearing parents' perspectives during an investigation is central to the PMRT process. All parents must be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death, parents should also be told that a review will also be undertaken by the local CDOP (New requirement)

An updated letter for families has been agreed and will be used to ensure all families are partners in the review of the death of their baby and understand the PMRT or CDOP process. This process is supported by the bereavement midwife, and the level of engagement is guided by the parents. In addition, a separate

PMRT letter has been approved by the LMNS, which will be utilised in cases where joint review between providers is required.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Trust Boards are advised to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. (Published in October 2023).

The service confirms that it continues to be on track with 11 out of 11 CQIMs. The National Maternity Dashboard is now able to publish provisional data part way through the two-month data submission window and has advised Trusts to utilise this tool for 3 months to validate data before final submission.

The service contacted the MIS clinical lead to confirm whether utilising the NHS England Data Quality Submission Summary Tool function is mandatory, as the service confirms that a process for reviewing and resolving data error is in place and monitored by the IT midwife. The data is currently manually checked for error as a live process and means that when the tool is run an error code replaces the report. (As all data errors have already been resolved). The team confirmed via NHS England DQ who wrote the standard, that if the errors are resolved prior to submission that the tool will not be useful for Board assurance. Therefore, the Trust Board should be notified of this and agree that they are satisfied by the established process and data submissions relating to MSDS submissions. Final data for July 2023 will be published during October 2023. The Trust confirms that local analysis indicates that this standard has passed.

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal (ATAIN) units Programme?

Pathways of care into transitional care and ATAIN continue to be prioritised, jointly agreed, and monitored by the maternity and neonatal teams. The ATAIN and Transitional Care (TC) dashboards and associated action plans have previously been approved by the Maternity and Neonatal Clinical Directors and the updated action plan is scheduled to be presented and approved by the Safety Champions QUAD meeting in October 2023. The TC and ATAIN quarter 1 reports as well as the dashboards and joint action plan have been shared with the LMNS and ICB Quality Assurance Panel on the 13th September 2023 for oversight.

The service confirms that the current provision for keeping mothers and babies together is modelled on the principles of the family integrated care (FiCare). Lancashire Teaching Hospitals continues to have the lowest term admission rates of all 4 providers in the LMNS. The Working Better Together Group (WBT) convenes on a fortnightly basis to undertake multi-professional audit of all admission to the neonatal unit from 37 week+0 days gestation.

The division continues to track performance and monitor outcomes for babies requiring neonatal admission or transitional care. In addition, high level review of the primary reason for admission is included in the ATAIN quarterly performance report. Respiratory distress syndrome (RDS) remains the highest indicator for term admissions accounting for 77% which is an increase from 65% in the last quarter. A deep dive review is underway however the reported numbers mirror the national picture for term admission to NICU.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

a) Obstetric medical workforce

In order to demonstrate that safe processes are in place for short and long term obstetric locum employment, the service is required to confirm that doctors either currently work in their tier 2 or 3 rota, have worked in their unit in the last 5 years as a post graduate doctor in training, remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

In addition, Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board.

Trusts/organisations should use the monitoring/effectiveness tool contained within the 'RCOG guidance on the engagement of short and long-term locums in maternity' to audit their compliance with the recommendations for locum doctors and have a plan to address any shortfalls in compliance. The service is currently developing a process to monitor compliance and will confirm that this standard is on track in the November 2023 Board report. Ongoing compliance will be tracked via the Perinatal Surveillance Model. A standard operating procedure has been published detailing the process to be followed and assure the Board that the service complies with the standards set out by the RCOG.

To provide additional assurance and oversight, the acute obstetric unit medical staffing and consultant availability (daytime labour ward cover and out of hours/on call) is monitored monthly and reported on the Perinatal Surveillance dashboard. The data reflects the actual medical staffing compliance for the acute obstetric service, in relation to the planned staffing levels. In August 2023 100% of the rota was covered.

Finally, the service is required to demonstrate engagement with the Royal College of Obstetricians and Gynaecologists (RCOG) 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' document and action plans to review any non-attendance to the clinical situations listed in the document are detailed in the monthly audits. In August 2023 100% compliance was achieved.

b) Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant. A copy of the anaesthetic rota for all months during the reporting period is contained within the evidence folder and will continue to be monitored going forward. This will be used as evidence of compliance with this element. To date the service is compliant with this standard.

c) Neonatal medical workforce

Within the CNST reporting period a review of the neonatal medical workforce should be undertaken of any 6-month period between 30 May 2023 – 7 December 2023. In addition, and following this review,

the Trust is required to formally record in Trust Board minutes whether it meets the relevant British Association of Perinatal Medicine (BAPM) recommendations for the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.

A local workforce review of the neonatal medical staffing requirement to achieve BAPM standards has been undertaken by the Divisional Director and the Clinical Director for Neonatology. The review identified the Trust is not yet complaint with BAPM standards for neonatal medical workforce and has identified a gap of 1.7WTE Consultant and 1WTE Non medical Consultant.

The next phase of the review will be to present this to the Medical Director and seek approval of the recommendations. This will be completed as part of the Divisional Improvement Forum in November 2023. The funding for this is yet to be determined and will be sought through specialist commissioning, the action plan required to meet the CNST standards linked to neonatal medical workforce is contained within appendix 4.

d) Neonatal nursing workforce

The Trust is required to formally record in the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.

The Northwest Neonatal Network monitor staffing levels against BAPM standards using the Clinical Reference Group neonatal nurse calculator. Compliance with the standard is presented within the Activity Capacity Demand (ACD) report and for 2022/23 reporting period compliance was achieved based on the average activity for the previous 3 years. For the first time neonatal nurse staffing compliance is included in the Perinatal Surveillance dashboard as an average local calculation and a monthly calculation taken from the BadgerNet EPR system. This additional data allows the Board to have oversight of safe staffing levels for assurance. The service is compliant with the BAPM nursing standards.

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

Birth Rate Plus® is a recognised endorsed tool (NICE 2015) used to review midwifery staffing establishments. The tool uses case mix data and activity levels to determine the safe clinical midwifery establishment required for the service. Appendix 5 details the breakdown of the BirthRate + calculations to demonstrate how the establishment has been calculated. The BirthRate + calculation has been presented to Board as part of the bi-annual safe staffing report and whilst agreed in principle, the Trust Board has referred the funding of this to the ICB for consideration. Appendix 6 details the overarching workforce plan to support the delivery of safe maternity staffing.

A review of the Provider Workforce Return (PWR) data has been undertaken by the service and Local Maternity Neonatal Service (LMNS) to review the accuracy of the data published by NHS England. Inaccuracies of published data identified by the Trust, have been escalated to the regional and national maternity teams for review. Currently national dataset reports have included all midwives with a registration who work within the organisation, regardless of their role. This means that midwives who undertake specialist

positions in education or research and staff employed by Neonatal unit are included in the overall midwifery establishment. This has resulted in an overestimation of midwives working in maternity services being reported nationally.

On the 9th September 2023, NHS England confirmed that the way the service is submitting the PWR data is correct, and they have acknowledged that the national reporting is not pulling through the correct information. The national team plan to amend the report so that the number of midwives working in maternity services is correctly reflected.

The service continues to actively recruit to vacancies and is not currently up to establishment therefore the consequence of not funding Birthrate plus is not impacting clinical service delivery at this time.

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

The Saving Babies' Lives Care Bundle' (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality.

The new implementation tool is now being utilised by the service to track and evidence improvement and compliance with the requirements set out in Version 3. The requirement to achieve the standard is significant for providers and there are 86 separate interventions consisting of 29 guideline-based indicators, 34 data requirements and 23 audit actions.

To evidence adequate progress against this deliverable by the submission deadline in February 2024, providers are required to demonstrate implementation of 70% of safety interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.

As part of the three-year delivery plan for maternity, NHS Trusts are responsible for implementing SBLCBv3 by March 2024 and Integrated Care Boards (ICBs) for agreeing a local improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery. Several meetings have already taken place between the service and the LMNS/ICB to agree minimum standards and stretch targets and the first quarterly assurance visit is planned for the 25th September 2023. It is anticipated that an updated projected position will be shared with the Trust Board in November 2023 to include the updated tool and associated action plan.

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity and Neonatal Voices Partnership (MNVP) to coproduce local maternity services. Specifically, that the service listens to women, parents and families using maternity and neonatal services and co-produce services with users

In line with the single delivery plan and MNVP guidance the service must ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place**.** The MNVP lead and maternity service should also develop an action plan based on the CQC maternity survey, service user feedback and national agenda. Actions agreed should include response to feedback received in the free text of the survey report, prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation. Progress should be monitored regularly by safety champions and the LMNS Board.

Written confirmation is required from the service user chair that they and other service user members of the MVP committee can claim out of pocket expenses, including travel, parking, and childcare costs in a timely way. Funding is being provided by LMNS following the establishment of the Integrated Care Board (ICB) to the service and the MNVP chair is being hosted independently by Health Watch.

The service confirms that a new MNVP lead has been appointed and is awaiting a start date. An interim plan to confirm the 2023/24 work plan is in place, overseen by the East Lancashire MNVP lead. The service priorities will be re-confirmed once the new lead is in post. (Appendix 7).

The service continues to prioritise hearing the voice of service users through the ongoing work with the Muslim girl's school, as part of the National Bereavement Pathway peer review, using feedback from and following concerns and complaints and by including service user representation during key recruitments and in the co-design of the Gynaecology Assessment Unit (GAU) estate re-design.

Safety Action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

In collaboration with the national maternity and neonatal partner organisations, the Maternity Transformation Programme published an updated Core Competency Framework (CCFv2) in June 2023. This publication replaces the first version and sets clear expectations for both the minimum standard and the stretch target for excellence.

The CCFv2 requirements Training Needs Analysis (TNA) includes 6 modular elements with several sub speciality elements and the service is in the process of benchmarking and updating the training plan to include the new requirements. The service confirms that TNA standards have been aligned with version 2 of the Core Competency Framework and that once the programme is confirmed and approved by the Divisional Safety Champions QUAD that the service will remain fully compliant. It should be noted that the additional training requirements will increase the training burden on the service, and this has been included in the BirthRate + staffing paper with a requested uplift from 23% to 25%.

Using the "how to guide" published by NHS England, the training plan has been developed with support from the East Lancashire chair of the local maternity and neonatal voices partnership (MNVP) and will be agreed with the Safety Champion quadrumvirate before sign-off by the Trust Board and the LMNS. The training plan upholds the four key principles of CCFv2 with service user involvement in the development and delivery of training, with training based on learning from local findings from incidents, audit, service user feedback, and investigation reports reinforcing learning from care and learning from excellence in practice.

Overall compliance with fetal monitoring training and Practical Obstetric Multi-Professional Training (PROMPT) emergency skills is 94% and 86% respectively in September 2023. The decline in compliance with PROMPT (86%) is seen in the specialties of obstetrics and anaesthetic staffing associated with the new medical rotation. In addition, ongoing medical workforce industrial action has affected the availability of colleagues to attend PROMPT training. Specifically, this is because they have been required to prioritise clinical shifts over training attendance. Actions for improvement are ongoing with training dates booked to ensure compliance across all eligible staff groups returns to over 90%.

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

The expectation from the service and Board is that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; complaints triangulation: minimum staffing in maternity services and training compliance are continuing to take place at Board level monthly.

The Perinatal Quality Surveillance dashboard (Table 6) provides performance data in relation to key indicators of safety and quality to ensure that clinical quality is reviewed regularly and that the board-level perinatal safety champion and wider Board retains oversight of perinatal safety.

Reviewing trends and themes from complaints and claims provides the maternity service with the opportunity to learn and improve care and systems. Assurance is provided that actions have already been implemented by the maternity service to learn from the triangulated themes/trends identified within the new referrals to NHS resolution, the new letters of claim/ claims being considered, the claim score card, patient complaints and the concluded StEIS investigation reports. All StEIS investigations (including HSIB investigated incidents) are subject to detailed actions plans and compliance with associated actions monitored through the maternity Safety and Quality committee.

The Trust's claims score card continues to be reviewed quarterly alongside incident, complaint and patient experience data and a divisional report has outlined the detailed findings and targeted intervention for improvement. Analysis of the Q1 2023 report demonstrates that the themes identified within both the new referrals to NHS resolution, new claims, the claims score card, concluded StEIS investigations and the complaints within this quarter triangulated.

The detailed report was shared at Divisional Maternity and Neonatal Safety and Quality Committee and with the LMNS/ICB on the 19th September 2023.

Trust level safety intelligence, learning from excellence and incidents is shared via the Lancashire & South Cumbria Local Maternity and Neonatal System Serious Incident Review group. The Serious Incident (SI) meetings provide a system level approach to sharing high level themes, learning from incidents, and provide a forum for peer and system support and review.

The Maternity and Neonatal Board Safety Champions continue to support the perinatal quadrumvirate in their work focusing on positive cultures within the services. The Board Safety Champion(s) Perinatal 'Quad' leadership team meetings have now been established and the next meeting is scheduled for October 2023. The terms of reference include regular agenda items on the progress against the perinatal culture work stream and updates on the perinatal culture and leadership programme. In addition, the updated CCFV2 TNA and the pathways into transitional care and ATAIN continue to be prioritised, jointly agreed, and monitored by the maternity and neonatal safety quad at this time.

The Maternity and Neonatal Board Safety Champions undertook their planned walk around on the 12th September 2023 and re- visited the Emergency Department (ED) to review the arrangements for emergency neonatal resuscitation within in the ED department. The neonatal speciality was well represented at the safety walk around and the skills and experience of the team provided an opportunity to revisit this pathway.

The team were welcoming and friendly, however, the walkaround identified concerns relating to a lack of permanent and suitable location for storage of neonatal resuscitation equipment including the resuscitaire and accessibility to the equipment trolley and PANDA resuscitaire. During the visit it was identified that this equipment is not stored in a permanent location in the department which could result in a delay in care.

The outcome of the safety walk around was shared with the executive safety champions and escalated to the ED leadership team. Options for a more permanent solution are being evaluated.

The service confirms that it is working with the Trust to prepare for and implement the Patient Safety Incident Response Framework (PSIRF) with a launch date of the 6th November 2023.

Safety action 10: Have you 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?

In line with national reporting recommendations, details of all HSIB referrals are included in this report to enable the committee to triangulate incidents with safety outcome data and for oversight. Appendix 8 details the HSIB investigations referred by the Trust since the 6th of December 2022. The service confirms that it has reported all qualifying cases to HSIB reporting 100% compliance to the standard. It also confirms that it complies with Regulation 20 of the Health and Social Care Act 2008 in relation to appropriate and timely Duty of Candour (DOC).

4. THE PERINATAL QUALITY SURVIELLENCE DASHBOARD

To meet the requirements of the perinatal quality surveillance model, the service must inform the Board regarding safety intelligence, including the number of incidents reported as serious harm, themes identified serious issues, complaints and proactively gather ongoing learning and insight, to inform improvements in the delivery of perinatal services. Table 6 details the performance over time from September 2022- August 2023.

Table 6: Perinatal Quality Surveillance Model Safety Outcomes Table (Formally maternity specific safety and quality matrix check)

Metric	Red flag		Green flag		Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23	April 23	May 23	Jun 23	July 23	Aug 23
CNST 10 Key safety actions (Year 5 scheme updated in 31st May 2023)					**80%**	**80%**	**80%**	**80%**	**100%**	**100%**	**100%**	**100%**	**100%**	**40%**	**40%**	**60%**
Births					362	354	354	318	350	304	376	298	339	371	362	369
Total stillbirth rate (per 1,000 births)	>	4.9	≤	4.9	2.8	8.5	2.9	6.3	5.7	0.0	5.3	3.4	2.9	0.0	2.8	5.4
Stillbirth rate excluding termination for fetal abnormality					****	****	****	3.1	2.9	0.0	5.3	3.4	2.9	0.0	2.8	5.4
Examination of the newborn completed within 72 hours	<	95%	≥	95%	95.9%	97.7%	95.9%	96.5%	95.1%	95.7%	94.7%	95.6%	96.2%	95.7%	96.7%	96.5%
Breastfeeding initiation	<	70%	≥	70%	76.0%	60.1%	76.0%	75.9%	73.9%	76.3%	82.9%	79.8%	76.3%	77.6%	79.8%	77.9%
Booked by 9+6	<	50%	≥	50%	39.3%	49.4%	51.0%	45.8%	32.6%	38.7%	47.3%	42.2%	51.5%	51.3%+	47.4%	91.5%
Booked by 12+6	<	90%	≥	90%	87.1%	90.1%	93.1%	90.7%	88.0%	90.8%	88.9%	83.3%	92.7%	90.3%	48%	85.5%
Women giving birth in a midwife-led setting	<	25%	≥	30%	18.1%	19.2%	20.0%	18.0%	17.5%	16.6%	15.1%	16.6%	14.2%	15.8%	15.2%	14.2%
Home birth	<	1.7 %	≥	2.0%	2.2%	3.7%	2.0%	1.9%	2.3%	3.3%	2.1%	3.7%	3.2%	2.4%	2.5%	3.3%
Incidence of severe tears grade 3 and above	≥	2.4 %	<	2.4%	2.7%	4.5%	1.6%	4.2%	2.4%	2.1%	2.8%	2.3%	1.5%	2.7%	2.6%	1.8%
One-to-one care in labour in Delivery Suite	<	95%	=	100%	95.2%	98.2%	98.9%	97.7%	99.6%	98.4%	99.7%$	99.2%	97.6%	100%	100%	100%
One-to-one care in labour in Preston Birth Centre	<	95%	=	100%	97.2%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
One-to-one care in labour in Chorley Birth Centre	<	95%	=	100%	100%	100%	100%	92.9%	100%	100%	100%	100%	100%	100%	100%	100%

One-to-one care in labour overall	<	95%	=	100%	95.9%	98.5%	99.1%	97.7%	99.7%	98.6%	99.7%$	99.4%	97.9%	100%	100%	100%
HDU trained per shift	<	89%	=	90%									99.57%	99.57%	100%	100%
Supernumerary status of DS coordinator	<	95%	=	100%	100%**	100%**	100%	100%	100%	100% **	100%	100%	100%	100%	100%	100%
CTG update training	<	90%	≥	90%	95%	97%	95%	94%	92%	93%	94%	96%	99%	98%	99%	97%
Annual competency (K2 Training Package)	<	90%	≥	90%	97%	98%	99%	98%	99%	99%	99%	97%	97%	96%	95%	94%
GAP/GROW (Growth Assessment Protocol Training)	<	90%	≥	90%	84%	82%	87%	87%	82%	82%	87%	83%	80%	82%	83%	80%
Emergency skills Training (PROMPT – Practical Obstetric Multi-Professional Training)	<	90%	≥	90%	90%	97%	97%	98%	93%	93%	94%	93%	96%	94%	94%	86%
Incidents of moderate harm and above	--		--		2	0	4	3	1	2	2	0	0	3	0	3
HSIB referrals opened	--		--		2	0	0	2	0	2	1	0	0	0	0	0
Complaints	--		--		2	2	1	2	2	3	2	2	2	2	1	2
Prevention of future deaths regulation 28	--		--		0	0	0	0	0	0	0	0	0	0	0	0
CQC Enquiries (**New July 23)**															0	0
Maternal Death	> 1		<1		0	1	0	0	0	0	0	0	2	0	0	0
Number of Consultant hours on obstetric unit	<70 hrs		=/> 96.5hrs		76.5 hrs	76.5 hrs	76.5 hrs	76.5% hrs	76.6% hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs
RCOG obstetric benchmarking compliance	--		--		100%	100%	100%	100%	93%	95%	94%	100%	100%	100%	91%	100%
Compliance to RCOG Locum standards **New Sept 23**	--		--													NA
24-hour acute obstetric medical staffing fill rate	<95%		100%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Births per Funded Clinical Midwife WTE	>28		≤26		25	24	24	21	23	22	25	21	23	24	26	25
Neonatal Nurse Staffing compliance to BAPM (Badger Net report)	<95%		100%												90%	98%
Neonatal Nurse BAPM Compliance. (Local figure average New Aug 23)	<95%		100%													100%
Staff sickness rate	4%		4%		7.43%	7.2%	7.6%	11.5%	8.7%	8.6%	8.6%	7.9%	8.47%	8.6%	8.7%	8.8%
Fill rate RM Day	<85%		>85%		81%	82%	78%	73%	82%	81%	81%	82%	NA	93%	95%	91%
Fill rate MSW Day	<85%		>85%		67%	70%	77%	67%	77%	72%	71%	73%	NA	93%	90%	86%
Fill rate RM Night	<85%		>85%		82%	90%	88%	89%	95%	94%	90%	97%	92%	90%	84%	82%
Fill rate MSW Night	<85%		>85%		97%	98%	95%	89%	95%	94%	95%	100%	94%	89%	91%	100%
Registered Midwife shifts sent to agency per month. (New Jan 23)	--		--						122	143	152	107	110	110	127	127
Registered Midwife Agency hour fill rate percentage. New Jan 23.	--		--						58%	51%	51%	51%	46%	45%	39%	49%
Maternity Diverts	> 1		<1		0	1	0	0	0	0	0	0	0	0	1	0
Red flags					38	78	12	2	5	12	126	44	71	218	187	105
In- utero transfers declined to accept from other units (maternity)	--		--		2^	2	0	4	1	2^	2	0	2	5	4	5
In- utero transfers declined to accept from other units (NICU)	--		--		2	0	0	0	0	4	0	2	1	1	2	0
In- utero transfers from LTHTR to another Trust (Antenatal)	--		--		2	0	0	0	0	0	0	0	10	0	0	1**
NICU Closure	--		--		2	0	0	0	0	3	2	5	13	1	1	0
Percentage of women seen by a midwife within 15 minutes of	--		--						90%	89%	86%	94%	90%	91%	93%	89%

attendance in Maternity Triage															

* Amended rate following further case review from 92% to 94% after data validation. ** Data amended following publication of new guidance which clarified definition of supernumerary status (based upon deep dive results) *** Recording methodology changed and now reported as overall compliance following roll out of full day training. $ Adjusted 1:1 care rate following review of cases. ^ Rates adjusted in months where previously both maternity and neonatal declined IUT were recorded cumulatively. + Adjusted figure for month end extraction**One mother transferred to ELTH following the regional gold call, due to ongoing delays with induction of labour within the maternity service.

5. STILLBIRTH RATES

The stillbirth rate continues to be monitored monthly by maternity Safety and Quality Committee. In August 2023, there were two cases of antepartum still birth. Of the instances of stillbirth there were 2 cases of stillbirth between 24- and 26-weeks' gestation. The stillbirth rate was 5.4 per 1000 which is just above the national average of 4.9 per 1000 births. The Statistical Process Control analysis shows variation of the stillbirth rate that is within the expected range with no cause for concern identified. The maternity service continues to closely monitor the incidence of stillbirth and the MBRRACE real time monitoring tool is utilised to track cases.

6.1 BOOKING BY 9+6

Key performance related to booking by 9+6- and 12+6-weeks' gestation has been variable. Staffing pressures in July, August, and September 2023 because of increasing midwifery vacancies, long-term. sickness absence (WTE) and maternity leave have had a detrimental impact on the ability to achieve this target. Improvements are anticipated once the newly qualified midwives join the service in September and October 2023 and intermediate actions to mitigate the risk and rationalise the service have been implemented and have led to an improvement in performance.

6.2 GAP AND GROW

In June 2023 the saving babies lives care bundle version 3 was released. The care bundle was updated to reflect that staff who perform fundal height measurement should be competent in measuring, plotting (or recording), interpreting appropriately and referring when indicated. Only staff who perform fundal height measurement need to undergo training in fundal height measurement.

In response to the standards relating to GAP/GROW training, the maternity service is currently reviewing the staff groups that require the training in accordance with the SBLv3 standard and the training performance data will be updated accordingly.

It is anticipated that there will be an improvement in training compliance observed when the data is aligned with the SBLv3 standards. However, an improvement plan is in place to reach the 90% stretch target. The Clinical Director for Obstetrics has also been asked to support with prioritising obstetric medical compliance.

6.3 CONTINUITY OF CARER (MCOC)

The Trust is required to confirm that Board level discussions related to the ability of the maternity workforce to maintain current and future rollout of MCoC have taken place. The service confirms that the current level of MCoC can continue to be delivered safely without impacting on the safety of the service. However, until staffing has stabilised, there will be no further expansion of MCoC.

Although there are no plans to expand the MCoC at the current time, work to consider the geographical population demographic within Preston, Chorley and South Ribble has been undertaken so that priority can be given to those most likely to experience poorer outcomes first, including women from Black, Asian and mixed ethnicity backgrounds and those living in areas with the lowest decile of deprivation, in line with national guidance. A meeting has been scheduled to enable planning of service progression for the enhanced MCoC teams with the national team on the 13th November 2023.

6.4 SAFE STAFFING

The service currently has 3.19 WTE midwifery vacancies and 15.24 WTE midwives on maternity leave. This leads to an 18.43 WTE impact upon the service. We anticipate that by the 1st November 2023, the cumulative vacancy and maternity gap for midwives in the service will have reduced to 10.11 WTE in total. The current vacancy is leading to higher use of bank and agency within the service. It should be noted several measures have been taken to deploy clinicians from a variety of settings to mitigate the current staffing shortfall. This is maintaining safety within the service. Midwifery red flags highlight potential areas of staffing concern within the service and are highly valuable intelligence for service leaders.

6.5 RED FLAGS

The incidence of maternity red flags continues to be monitored by the maternity service. All instances of delayed BSOTS reviews by either the midwife or the obstetric team have been reviewed and there were no incidents associated with a harm outcome. The maternity service is also closely monitoring delays in the induction of labour process. In August 2023 there was one incidence of a mother being transferred to another local Trust due to delays in induction of labour, the patient was transferred following the request for mutual aid being made at the daily regional gold call. There was no harm attributed to the transfer of this woman's care. The breakdown of red flags by category is detailed in Appendix 9.

6.6 GOVERNANCE REVIEW

The maternity governance review by the LMNS is ongoing as part of the recommendations made by the regional chief midwife following the CQC inspection. The team have attended several meetings including the weekly Datix assurance review, patient experience and complaints triangulation meetings and the Quality Lead and the Associate Director of Maternity and Neonatal for the ICB have attended a PMRT and Rapid Incident Review (RIR).

The feedback has so far been positive and included: "*Good representation of team members in attendance at meetings, appropriate level of challenge and exploration of incidents, appropriate review of grading and categorisation, clear audit trail and knowledge of the discussions and cases, demonstrated learning from audit and thematic analysis being utilised".*

6.7 NATIONAL MATERNITY VISIT

The maternity service hosted NHS England National and Regional Maternity and Neonatal teams on the 13th September 2023. A service overview presentation and unit visit were undertaken, and high-level feedback confirmed that they were extremely impressed with everything they had seen and heard. The Deputy Chief Midwife for England commented that the passion from the team and all the staff was

palpable, and the National Service User Voices representative informed the regional team that the bereavement provision was the best that he had ever seen.

6. CONCLUSION

This report provides an update in relation to the safety and quality programmes of work within the maternity and neonatal services. The report confirms progress against the ten new workstreams set out by the CNST NHS Resolution for year 5 of the maternity incentive scheme with 60% compliance to date.

The perinatal quality surveillance dashboard is indicating a stable service despite current midwifery staffing challenges.

7. RECOMMENDATIONS

The Board of Directors are asked to:

i. Approve the Maternity Service Update
ii. Note the CNST update report and recommendations.
iii. Receive the associated action plans for information oversight and assurance.
iv. Note the National and Regional Maternity NHSE visit and the positive escalation and feedback.

Appendix 1 – PMRT cases

ID (Datix/PMRT)	Gestation	Stillbirth/ Neonatal death	Narrative	PMRT upload date	PMRT ref	Parents informed	Report drafted within 4 months	Actions ongoing
125023	33+1	Neonatal death	IUT from BVH. Antenatally diagnosed fetal anomaly.	Yes	88023	Yes	Yes	PMRT has been completed, care graded as B, B, C. Ongoing work with the LMNS advocate to develop a SOP for when PMRT review is shared between organisations.
125969	24+5	Neonatal death	Multiple pregnancy – Significant antenatal haemorrhage, emergency caesarean section performed.	Yes	88146	Yes	Yes	Second twin survived.
127505	33+1	Antepartum stillbirth	Multiple pregnancy – fetal heart seen to slow during routine USS. Transferred for emergency caesarean section from scan but unsuccessful resuscitation.	Yes	88277	Yes	Yes	Second twin survived.
130650	26+6	Antepartum stillbirth	Multiple pregnancy – twin one	Yes	88804	Yes	Yes	Emergency caesarean section performed for the health of the second twin.
131848	26+6	Neonatal death	Multiple pregnancy – twin two	Yes	88804	Yes	Yes	
133056	24+1	Antepartum stillbirth	Early onset fetal growth restriction. Antenatally Trisomy 18 suspected.	Yes	89093	Yes	Yes	
135345	28+4	Antepartum stillbirth	Early onset fetal growth restriction -declined delivery at earlier gestation.	Yes	89276	Yes	Yes	

Appendix 2 PMRT overarching action plan.

Action Plan – PMRT overarching action plan.

Version	Date
V1	18.09.2023

Organisation:	Lancashire Teaching Hospital NHS Foundation Trust
Lead Officer:	Emma Holden
Position:	Safety and Quality matron
Tel:	01772 524307
Email:	Emma.gornall@lthtr.nhs.uk
Address:	Royal Preston Hospital

Status Key	
1	Not complete / not expected to meet timescales me
2	Actions on track to achieve deadlines
3	All actions complete.
4	All actions completed and evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
TF 106111 StEIS 2023/365 PMRT 85133						
1	Ockenden safety action – maternity services must ensure women and their families have their voice heard.	Debrief meeting to be organised to feedback the investigation findings to the family.	Matron for safety and quality	30.06.2023	Specialist midwife for bereavement to organise family meeting once investigation is finalised. 16.05.2023 ACTION COMPLETED.	
		PMRT review to be completed and provided to the family.	Matron for safety and quality	30.05.2023	16.05.2023 – PMRT review held for the case, care graded as D and C. Family feedback meeting held on 23.05.2023 and PMRT report provided.	
2	Ockenden safety action – incident investigations must be meaningful for families and staff,	To share the case at the next stillbirth special interest group for wider system level learning	Divisional midwifery clinical governance and risk	30.05.2023	16.05.2023 Presented at May 2023 regional stillbirth special interest group.	

	and lessons must be learned and implemented in practice in a timely manner.		management midwife			
		Regional meeting to be organised regarding the NWAS current position regarding the presentation of neonates to the emergency department in resuscitation situation.	Matron for safety and quality	30.01.2023	Meeting held on 20.01.23. Action completed.	
		To present the case for discussion at the LMNS quality assurance panel for wider system level learning	Divisional midwifery clinical governance and risk management midwife	30.06.2023	Action completed presented at LMNS serious incident overview panel.	
		Learning template to be generated and shared with all staff relating to threatened preterm labour, template to include discharge advise.	Matron for safety and quality	30.06.2023	Learning template generated and action completed.	
3	Clinical guidelines should be up to date and evidence based.	Clinical guideline EBG00140 telephone triage – maternity, should be updated to include the BSOTS processes which have been adopted by the department, including the triage algorithms which are in use.	Matron for safety and quality	30.06.2023	30.05.23 Guideline has been reviewed and is currently in the ratification process. Action completed.	
		Task and finish group to be established to review the	Deputy divisional	30.04.2023	Guideline reviewed, ratified and published March 2023. Action completed.	

		Trust SOP for babies born in the emergency department.	midwifery and nursing director			
4	Point of care testing for assessment of preterm labour risk should be available.	Until a reliable supply of fFN can be assured, MAS should continue to stock Actim Partus as an alternative to fFN.	Maternity assessment suite manager	30.05.2023	30.05.2023 Stock of Hologic fFN received May 2023 however, only 75 units can be guaranteed therefore MAS will continue to stock Actim partus as an alternative. ACTION COMPLETED.	
5	Ockenden safety action – bereavement care. Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	Bereavement support to be provided to the family for as long as required.	Specialist midwife for bereavement.	30.05.2023	30.05.2023 the specialist midwife for bereavement continues to support the family. Action completed.	
		Referral to the reproductive trauma service to be offered to the family.	Matron for safety and quality	30.06.2023	30.5.2023 – updated from the bereavement midwife – the mother is already being supported by RTS.	
RD 101722 StEIS 2022/24747 PMRT 84476						
1	Ockenden safety action – maternity services must ensure women and their families have their voice heard.	Arrange family meeting to feedback the investigation findings to the family.	Divisional Midwifery Clinical Governance and Risk Manager	30/05/2023	Action completed; family meeting organised by the specialist midwife for bereavement.	
2	Ockenden safety action – incident investigations must be meaningful for families and staff, and lessons must be learned and	Review and update the pre-eclampsia and hypertension in pregnancy guidelines to include a plan for increased pre-eclampsia surveillance for mothers with uterine artery notching.	Consultant obstetric lead for Delivery Suite	30/10/2023	18.09.2023 EH – action ongoing.	

	implemented in practice in a timely manner.	Share learning with the midwifery team regarding the significance of uterine artery doppler notching.	Divisional Midwifery Clinical Governance and Risk Manager	30/04/2023	Learning template generated and shared. Action completed.	
		NWAS consultant midwife to review the prehospital care.	NWAS Consultant Midwife	31/12/2022	NWAS consultant midwife contributed to the investigation process. NWAS records obtained for the investigation. Action completed.	
		Use the mother's atypical presentation in pre-eclampsia/ eclampsia skills drills taught on the multi-disciplinary PROMPT study day.	Midwifery practice educator	30/08/2023	18.09.2023 EH – case included in the TNA for PROMPT 2024. Eclampsia to be included in the drills on PROMPT in 2024. Atypical presentation to be used as part of the drill.	
3	Ockenden safety action – complex antenatal care. Trusts must follow national guidance for managing women with hypertension in pregnancy.	Clinical guideline EGB00176 Nausea and vomiting in pregnancy and hyperemesis gravidarum should be reviewed to include a section relating to management of onset of vomiting in the second and third trimesters of pregnancy.	MAS lead midwife	30/10/2023	18.09.2023 EH – action ongoing.	
		Establish a failsafe process to ensure that attendance in antenatal clinic, for ultrasound scan review, can be monitored and non-attendance identified and actioned.	Matron for Complex Midwifery Care	30/12/2023	18.09.2023 EH – a working party has been convened and development of a SOP is ongoing.	
		Make a CleverMed change request for the Aspirin compliance question to be added to the midwifery led	Digital lead midwife	31/10/2023	18.09.2023 Change request to be made to Clevermed.	

		antenatal appointment templates and the obstetric specialist review antenatal appointment templates on the BadgerNet system.				
		Review the current arrangement of offering universal uterine artery doppler scanning at the anomaly ultrasound scan and advise if this practice, outside RCOG (2014) recommendations, should continue.	Fetal medicine consultant obstetrician	31/12/2023	31.07.2023 Awaiting specialist consultant to commence in post with the Trust. Recruitment has been successfully completed. 18.09.2023 EH – consultant now in post. Process to be reviewed.	
		Until the universal offer for uterine artery doppler scanning has been reviewed, all women that have uterine artery doppler notching identified at the anomaly ultrasound scan, should have their blood pressure measured and recorded at 20 weeks gestation (at the scan review) and an additional antenatal appointment for measurement of blood pressure and urinalysis at 25 weeks gestation. Update schedule of antenatal appointments guideline.	Matron for safety and quality	30/10/2023	31.10.2023 EH – action is ongoing.	
4	Ockenden safety action – bereavement care.	Bereavement support to be provided to the family.	Specialist Midwife for Bereavement	20/11/2022	20.11.2022 The specialist midwife for bereavement continues to support the family. Action completed.	

	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	PMRT investigation	Divisional Midwifery Clinical Governance and Risk Manager	30/04/2023	02.08.2023 PMRT review held, and report provided to the family along with the StEIS investigation report. Action completed.	
5	HSIB national learning investigation report – Telephone triage services should support 24-hour access to a systematic structured risk assessment of pregnant people's needs. Telephone triage services should be operated by appropriately trained and competent clinicians who are skilled in the specific needs required for effective telephone triage.	Clinical guideline EBG00140 telephone triage – maternity, should be updated to include the BSOTS processes which have been adopted by the department, including the telephone triage algorithms which are in use.	Safety and quality maternity matron	30/04/2023	11.04.2023 Guideline updated and ratified action completed.	
		The MAS phone should be relocated to an area away from the MAS environment. The investigation team recommends that the completion of this action be prioritised to remove the risk of unconscious bias affecting decision making when performing telephone triage assessments.	Deputy Divisional Midwifery and Nursing Director (DMND)	30/01/2024	30.05.2023 – action is ongoing as part of the antenatal services development plan. Deadline extended to reflect the size and scope of the action.	
		The investigation team recommends that the maternity service works towards full implementation of the BSOTS system in accordance with the actions detailed on the risk register.	MAS lead midwife/ matron for complex midwifery care.	30/01/2024	30.05.2023 – action is ongoing as part of the antenatal services development plan. Deadline extended to reflect the size and scope of the action.	

HF 105125 HSIB MI-019756 StEIS 2022/27283 PMRT 85135						
1	**Ockenden safety action –** incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner.	Refer to HSIB	Clinical governance and risk management midwife	31.12.2022	HSIB investigation completed, and final report received. Action completed.	
		StEIS report	Clinical governance and risk management midwife	15.12.2022	StEIS number obtained when 72-hour report submitted. Action completed.	
		Formal duty of candour	Clinical governance and risk management midwife	15.12.2022	Verbal and formal DOC provided to the parents prior to discharge from hospital. Action compelted.	
		Perinatal Mortality Review Tool (PMRT) review	Clinical governance and risk management midwife	13.04.2022	PMRT reported on 23/12/2022 review completed on 27.07.23 following receipt of final HSIB report. Graded as C and B. HSIB involved in the PMRT review and agree with the grading. Action completed.	
2	**HSIB safety recommendation:** The Trust to ensure that staff are supported to complete a comprehensive risk assessment for each mother at the beginning of, and at least hourly throughout her		Deputy divisional nursing and midwifery director	Action completed	Hourly holistic reviews and hourly CTG peer reviews implemented into practice. Action completed.	

	labour to ensure place of birth is in line with national guidance.					
3	**HSIB safety recommendation:** The trust to ensure all members of the clinical team undergo training in Human Factors, including the risks of normalisation and expectation.	Implementation of Human Factors within the mandatory PROMPT and Fetal Monitoring Training.	Practice Education Midwife/Fetal Monitoring Lead Midwife	Action Completed	Human Factors training included in PROMPT and Fetal Monitoring training. Action completed.	
4	**Trust Action:** Transferring Midwife to reflect on the documentation of the neonatal resuscitation with the matron for midwifery led services		Matron for Midwifery led services	30.01.2023	Action has been completed.	
HH 117009 PMRT 86858						
1	**Ockenden safety action –** incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner	Ability for the mother to add communication notes to the Badger record to be removed as this is an unmonitored function.	Digital lead midwife	30.11.2023	18.09.2023 EH – action ongoing by the maternity digital team.	

MC125023 PMRT 88023						
1	**Ockenden safety action – bereavement care.** Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	To work with the LMNS advocate and BVH to agree the roles and responsibilities of each Trust when PMRT investigations are shared across organisations.	Maternity matron for safety and quality	30.11.2023	18.09.2023 EH – action ongoing meeting planned for 20.09.2023.	
		Review the PMRT card for LTHTR to align with the recently published tools on the MBRRACE website.	Maternity matron for safety and quality	30.11.2023	18.09.2023 EH – action ongoing meeting planned for 20.09.2023.	
		Review the PMRT letter for neonatal deaths to include information on the CDOP process.	Maternity matron for safety and quality	30.11.2023	18.09.2023 EH – action ongoing meeting planned for 20.09.2023.	
		Develop a PMRT letter for use when care is shared between two organisations. The letter should give information regarding the named family liaison person for the family at both organisations.	Maternity matron for safety and quality	30.11.2023	18.09.2023 EH – action ongoing meeting planned for 20.09.2023.	

Appendix 3 – Avoiding term admissions into neonatal units and Neonatal Transitional Care Action Plan Outstanding actions from overarching plan.

Action Plan – Joint Transitional Care and ATTAIN.

Organisation:	Lancashire Teaching Hospitals Womens and Children's Division
Lead Officer:	Maria Esslinger-Raven/Neonatal Outreach Manager
Position:	Safety & Quality Audit Midwife/Neonatal Outreach Manager

Status Key	
1	**Action outstanding**
2	**Action on track but not yet delivered**
3	**Action delivered**
4	**Action delivered and assurance evidence collated**

Ref	Standard	Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	ATAIN Collect data for future reporting to meet requirements of CNST 4 safety action 3(e)	1.1 Revise current ATAIN spreadsheet	Continuous Improvement Midwife	31.09.2021	30.09.21 New data requirements added to current ATAIN spreadsheet (located on t drive-Womens Health RPH-ATAIN)	
		1.2 Work with data analyst to create graphs to display data for future quarterly reports	Continuous Improvement Midwife	30.11. 2021	09.05.22 Q4 ATAIN report produced incorporating data display charts and all subsequent reports will include these data display charts.	
2	ATAIN	2.0 Develop ATAIN Dashboard to demonstrate performance and actions to be undertaken	Continuous Improvement Midwife Business Intelligence Analyst	31.03.2021	11.01.2 Q4 dashboard complete	
		2.1 Set up new data collection process to enable capture and validation of future data	Continuous Improvement Midwife	31.03.2022	01.10.21 ongoing weekly meetings commenced with transitional care lead and safety and quality midwife to support the required manual data collection	
3	ATAIN Quarterly review of the reasons for full term babies being admitted to neonatal unit	3.0 Complete a high-level review of the primary reasons for all admissions to neonatal unit should be completed	Safety and Quality Audit Midwife	31.01.2022	11.01.23 Q4 report completed. 09.08.2023 Q1 report completed.	
		3.1 Focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed.	Safety and Quality Audit Midwife	31.01.2022	11.01.23 Included in Q4 report 09.08.2023 Q1 report completed.	

4	ATAIN Quarterly review of the reasons for full term babies being admitted to neonatal unit	4.0 Twice Monthly ATAIN reviews ongoing with actions and lessons learnt.	Continuous Improvement Midwife Safety and Quality Audit Midwife	31.03.2022	11.01.23 WBTG continue to meet every 2 weeks. 09.08.2023 WBTG continue to meet every 2 weeks. Action complete.	
5	TC Ensure relevant staff aware of: Importance of keeping mother and baby together both by avoiding admission to NNU and by stepping baby down as soon as possible Criteria for admission to TC particularly that term babies can meet criteria for TC and that babies do not necessarily need admission to NNU for NGT feeding alone.	5.0 Review and update the Transitional care guideline to ensure that it is benchmarked against and details operating processes for admission and timely stepdown from NNU care.	Neonatal unit Matron Neonatal Outreach Manager	~~28.02.2022~~ 31.07.2026	22.4.22 amendments to appendix for TC guideline being undertaken following actions from operational group. Awaiting update on heritage. 20.6.23 - original action complete however BAPM released a new framework for late preterm in January 2023 so this has been incorporated into the TC guideline. This has been reviewed by NICU senior team and is due to be reviewed by maternity guideline group by end of June 2023 and can then be ratified as it is up for renewal in July 2023. Completed, Version 3 validated 11.07.2023, review date, 31.07.2026.	
		5.1 Add information to Transitional Care newsletter and circulate to relevant staff	Neonatal Outreach Manager	31.12.2021	16.12.2021 Newsletter circulated and updated regularly as required to all specialities. 15.08.2023 – updated as required and circulated. Action complete.	
		5.2 Share information at neonatal ops meeting system wide	Neonatal Outreach Manager Postnatal ward manager	30.11.2021	01.04.22 TC Divisional Board report produced and shared at S&Q. 15.08.2023 – TC updated and operational issues are discussed at the neonatal MDT weekly communication meeting. Action complete.	

		5.3 Share information at neonatal band 7 coordinators meeting	Neonatal Outreach Manager	30.11.2021	01.04.22 TC divisional board report produced and shared with band 7 co-ordinators. Action complete.	
		5.4 Share information at neonatal consultants meeting	Neonatal Outreach Manager	30.11.2021	01.04.22 TC divisional board report produced and shared with consultants at grand ward round. Action complete.	
6	TC Ensure babies step down from NNU as soon as criteria for TC are met	6.0 Implement process to include discussion on each neonatal ward round whether baby now meets criteria for stepping down to TC	Neonatal consultant	31.11.2021	14.10.2021 Discussion now included in each ward round and process discussed at team meetings. Action complete.	
7	TC Ensure full and transparent understanding of TC staffing	7.0 Ensure staff aware to accurately and consistently complete neonatal bed state to reflect the appropriate work load detailing when the coordinator is unable to provide TC.	Neonatal unit Matron	30.11.2021	12.11.2021 Information shared at Friday communications meeting Evidence meeting minutes. Action complete.	
		7.1 Staff to complete Datix if TC nurse not available	Neonatal Outreach Manager	30.11.2021	12.11.2021 Information shared at Friday communications meeting. 8.2.22 Datix that are linked to staffing TC will be reviewed at the weekly governance meeting. Action complete.	
8	TC Ensure clarity regarding role of the TC nurse	8.0 Remit of the transitional care roles and responsibilities agreed by Matron and service leads	Neonatal unit Matron	31.12.2021	Dec 2021 Meeting held with JS/JC/HA/PD, agreement made to revise the role of the TC (TC nurse to take over care of babies on the septic pathway as well as preterm). 8.2.22 Day in the life of the TC nurse Circulated. Action complete.	

9	TC Maintain oversight of operations of TC service	9.0 Reinstate the TC Operational Group Meetings	Deputy Divisional Nursing & Midwifery Director	31.01.2022	11.01.2022 TC Operational group meetings recommenced and scheduled for next 12 months. Action complete.	
10	TC Ensure TC nurses receive training on Maternity Badgernet system	10.0 Digital Midwife to deliver training to TC nurses	Neonatal Outreach Manager	31.01.2022	22.4.22 documentation review ongoing to confirm process is embedded. 5/7/22 All NTC documentation now on BN Action complete.	
11	TC Review of the Transitional care booklet to ensure that this can be translated into the electronic record	11.0 Digital Midwife to discuss requirements at clever med IT change board and confirm that changes can be made to an electronic form	Neonatal Outreach Manager	28 02.2022	January 2022 Transitional care booklet shared with digital team for discussion and transfer to electronic maternity record. 15/3/2022- All staff trained. Pathway testing ongoing with EA Consultant midwife and JS/KN. Action complete.	
12	TC Quarterly review of the findings from the transitional care data collection and audit of the pathway	12.0 Review of the transitional care dashboard and pathway of care findings to inform the transitional care action plan	Neonatal Outreach Manager		09.05.22 Q4 ATAIN report incorporating joint ATAIN/TC action plan produced. Monthly review of the progress actions to be undertaken for assurance. Action complete.	
13	TC Obtain data in order to establish if administration of antenatal corticosteroids is a viable project.	13.0 Audit Midwife to obtain data for percentage of **all** CS births with an admission to NNU for RDS and the percentage of **all** inductions	Safety and Quality Audit Midwife	30.4.2022	11.5.2022 Data collection completed and presented to the WBTG. Action complete.	

		of labour which have an admission to NNU for RDS				
	Respiratory Distress Syndrome (RDS) identified as most frequent reason for admission	13.1 Deep dive review of data relating to RDS ongoing	Safety and Quality Audit Midwife Obstetric consultant C.L	31.03.2024	5.7.22 Improving outcomes for high-risk baby's special interest group commenced to optimise theatre as a birth environment. Running alongside the MatneoSIP optimisation 05.10.22 3rd Improving outcomes for high-risk babies meeting to take place in October 2022. 11.01.23 Improving Outcomes sub-group unable to meet in Q4 due to clinical pressure but workstreams identified in previous groups continue to be implemented into practice. 20.06.2023 Improving Outcomes sub-group unable to meet due to clinical pressures but Working Better Together meetings undertaken regularly and CNST TC reviews continue to be utilised to investigate practice. 15.08.2023 Improving Outcomes sub-group unable to meet due to clinical and staffing pressures but Working Better Together meetings continued regularly to include review of primary reason for admission to NICU.	
14	Procure Digital EPR for TC to align end to end maternity and neonatal systems	Neonatal Team to work with Trust IT team to consider use of end to end BadgerNet system pan specialty	Neonatal unit Matron	30/09/2023	22.4.22 Awaiting outcome from IT. 21.4.22 IT scoping undertaken, and funding confirmed by Deputy CIO. Awaiting allocation of project lead. 20.6.23 - funding for a 12-month secondment or fixed term neonatal digital nurse post agreed. Interviewing on 27th June 2023. Implementation of neonatal Badgernet	

					EPR system project can begin once digital nurse in post (Clevermed requirement). 15.08.2023 Neonatal digital nurse post has been recruited and expected to be in post by end September 2023. Neonatal data entry clerk vacancy has now been filled.	
15	A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded.	Ability to undertake analysis and review of NTC activity	Neonatal unit Matron	30/10/2023	5.7.22 Escalated to DMND and DND lack of capacity to complete deep dive review. 20.6.23 - TC Lead Nurse has been extracting data from maternity and neonatal Badgernet to capture TC data for the dashboard and quarterly reports. Anticipated long term absence for TC Lead Nurse so neonatal team will need to identify an alternative person for reviewing and analysing the TC data. 15.08.2023 Dedicated time allocated to member of neonatal nursing team to review and monitor data in the anticipated absence of the TC lead nurse. Action Complete.	
16	Sub-Group 'Improving Outcomes for High-Risk Babies' to identify workstreams required aiming to reduce the numbers of Term Admissions for RDS.	15.0 Improving Outcomes for High-Risk Babies group to continue to meet and progress actions identified.	Safety and Quality Audit Midwife	~~11.01.23~~ 31.03.2023	8.6.22 Improving Outcomes for High-Risk Babies meetings commenced, and workstreams/actions identified. October 2022. 11.01.23 Improving Outcomes sub-group unable to meet in Q4 due to clinical pressure but workstreams identified in previous groups continue to be implemented into practice. 20.06.2023 Improving Outcomes sub-group unable to meet due to clinical pressures but Working Better Together meetings undertaken regularly and CNST TC reviews continue to be utilised to investigate practice.	

					15.08.2023 Improving Outcomes sub-group unable to meet due to clinical and staffing pressures however primary reasons for admission continues to be discussed at the Working Better Together meetings.	
17	Deeper level review of babies admitted for hypoglycaemia to mothers with diabetes.	16.0 Via continuous collection of data for term admissions for hypoglycaemia, obtain further detail of maternal blood sugars during labour.	Safety and Quality Audit Midwife	Completed	05.10.22 Reviews of mothers with diabetes now routinely include detail of maternal blood sugars during intrapartum care. Action complete.	
18	18.A. ATAIN: Avoiding separation by treating NAS babies requiring oramorph on the postnatal ward with mother.	New guideline/policy for babies receiving oramorph for NAS treatment to remain on TC with mother to avoid separation, exemptions allowed i.e. social issues.	Neonatal consultant	31.05.2023 Completed	31.05.2023 Policy and guideline introduced and utilised by maternity and neonatal team. Action complete.	
	18.B. ATAIN: Ensure all staff are aware of the new guideline and management of NAS.	Share communication with all staff within maternity and neonatal teams to ensure knowledge of new guideline.	Neonatal consultant Safety and Quality Audit Midwife	30.06.2023 Completed	15.08.2023 Communication shared within maternity and neonatal teams and staff aware of updated policy. Communication continues to ensure all staff are aware.	
19	TC:	Identify funding for substantive recruitment of neonatal digital nurse.	Neonatal matron	29.02.2024	15.08.2023 escalated to DND to try and identify funding source.	

	Ensure the neonatal digital nurse post funding is recurrent.					
20	ATAIN: TTN proforma	Review of management of TTN proforma	Neonatal consultant Advanced neonatal nurse practitioner	30.11.2023	09.08.2023 Neonatal consultant planning to hand this action over to Advanced neonatal nurse practitioner. Action is ongoing and continued.	
21	ATAIN: Share communication with all staff within maternity and neonatal teams	Share communication with all staff within maternity and neonatal teams regarding management, guidelines and treatment of:	Advanced neonatal nurse practitioner	01.12.2023	15.08.2023 Awaiting confirmation that changes in policy have been shared with all staff providing Transitional Care	
		21 A Jaundice policy and interpretation of TSB and TCB results	Neonatal consultant	30/04/2023 Completed	15.08.2023 Communication has been shared with staff but if required can be completed again as action is ongoing and continued when and as required.	
		21B/18B NAS – see action 18. B.	Neonatal consultant	Completed	15.08.2023 Communication has been shared with staff but if required can be completed again as action is ongoing and continued when and as required.	
		21 C Post resuscitation admission to NICU	Neonatal consultant	30/04/2023 Completed	15.08.2023 Communication has been shared with staff but if required can be completed again as action is ongoing and continued when and as required.	
		21 D	Neonatal consultant	30.10.2023	15.08.2023 Communication currently being shared with staff and communication ongoing at present.	

		Neonatal hypoglycaemia – Management, treatment with glucose gel and importance of minimising delay of treatment.	Safety and Quality Audit Midwife			
		21 E Neonatal hypothermia – normothermia and risk that hypothermia has for increasing RDS and separation.	Safety and Quality Audit Midwife	~~30.08.2023~~ 1.11.2023	15.08.2023 Neonatal normothermia poster being produced to share importance of normothermia in neonates.	
		22 A Confirmation of actions from avoidable admission	Safety and Quality Audit Midwife	~~30.08.2023~~ 1.11.2023	15.08.2023 To discuss the avoidable admission at Working Better Together meeting and confirm an action plan with the MDT.	
		22 C To review midwives training of administration of glucose gel to neonates to ensure correct administration.	Postnatal Ward Manager Safety and Quality Audit Midwife	30.10.2023	15.08.2023 To discuss at Working Better Together meeting MDT regarding glucose gel and current midwifery practice relating to administration. Possibly for a poster to be produced to share communication regarding administration of glucose gel.	
		22 D Storage of glucose gel: Review of trust policy and medicine management/storage to identify if storage of glucose gel can be located in another	Postnatal ward manager	19/07/2023	19/07/2023 Medicine management following gold standard and as per policy behind two locked doors. Measures in place to reduce delay in gathering medication (Key box in cupboard if no key available). Action complete.	

		area/space that is easier for staff to access (Not behind a locked door in a locked cupboard).				

Appendix 4 Medical Staffing

1	*12.09.2023*

Action Plan – Medical Staffing Neonatal services 2023

Organisation:	Lancashire Teaching Hospitals NHS Foundation Trust
Lead Officer:	Dr Aubrey Makhalira
Position:	Clinical Director Neonatal services
Tel:	01772 524554
Email:	Aubrey.makhalira@lthtr.nhs.uk
Address:	NICU, Royal Preston Hospital

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
1	Neonatal Medical workforce review	Local review of neonatal medical workforce to benchmark current establishment against BAPM standard.	Clinical Director for Neonatal/ Divisional Director	30/10/2023	07/09/2023 Workforce review of WTE medical neonatal workforce per tier groups undertaken to identify further funded establishment required to meet 1:8 ratios for safe neonatal staffing based on BAPM recommendations	
				30/11/23	12/09/2023 Staffing review to be presented to Medical Director for approval at DIF in November 2023.	
2	Tier 1 (ST1-3) does not currently meet BAPM standards of 1 in 8 rota requirements. Currently achieving 1:7	2 ANNP's in training. Planned to integrate into tier 1 rota by July 2023	Clinical Director for Neonatal services	~~05/02/2023~~ 05/02/2024	**Action carried over from year 4.** 8/09/23: ANNP completed training and now integrated into the Tier 1 rota. There are plans to review current staffing to transition to 1 in 8 rota.	
3	Funding: Tier 2 (ST4-8) does not currently meet BAPM standards, 1 in 8 rota requirements. Currently achieving 1:7	ANNP's to be integrated into medical rota to support Tier 2 rota as non-medical Consultants	Clinical Director for Neonatal services	~~05/2/2023~~ 01/12/2023	15/11/22 Paper planned for Divisional Board in December 22 to move ANNP's with appropriate competencies onto middle grade rota.- completed 08/09/23 ANNP transitioned to Tier 2 rota on 3rd April 2023. Currently rota does not meet BAPM compliance	

					until further recruitment of 2 posts to Tier 2. 1 post out to recruitment Via ORDER program.	
4	Recruitment Maternity leave back fill	To recruit 2 senior clinical fellows to replace specialty doctors (on maternity leave)	Clinical Director for Neonatal services	01/09/2022	23/2/22 Recruited 1 senior clinical fellows and 1 Medical Training Initiative MTI to replace specialty doctors who are on maternity leave. Action complete.	
5	Expansion of workforce Consultant's rota does not currently meet BAPM standards 1 in 8 requirements (Based on the birth-rate and admission to NICU) Currently achieving 1:7	To present the BAPM medical staff gap to prepare business case for 2 additional consultants to support Tier 2 and Tier 3 rota and enable expansion of Tier 2 and Tier 3 cover to achieve (1 in 7 rota)	Clinical Director for Neonatal services	June 2020	Business case for 2 additional resident consultants approved July 2020. Action complete.	
		Recruited to 2 WTE consultant posts as above following approval of business case	Clinical Director for Neonatal services	01/09/2024	1/5/22 All post now recruited. (This facilitated a move from 1 in 6 to 1 in 7)	
6	Expansion of workforce Consultant's rota does not currently meet BAPM standards 1 in 8 requirements (Based on the birth-rate and admission to NICU)	To present 2023 medical staffing review to specialist commissioning to seek funding to achieve BAPM compliance.	Clinical Director Neonatal services/ Divisional Director	31/12/2024	September 2023 - Speciality staffing review completed November 2023 – present to medical Director at DIF December 2023 – Present approved gap analysis to specialist commissioning.	

Appendix 5 BirthRate + Calculation.

Detailed Birth Rate + (BR+) staffing summary (2022) Presented to the Board of Directors August 2023

Background

The Three-Year Delivery Plan for maternity and neonatal services (March 2023) states that:
It is the responsibility of Trusts to:

- Undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. Where Trusts do not yet meet the staffing establishment levels set by Birth Rate Plus (BR+) or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28.
- Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and clinicians who wish to return to practice.
- Provide administrative support to free up pressured clinical time.

It is the responsibility of ICBs to:

- Commission and fund safe staffing across their system.
- Agree staffing levels with Trusts, following NHS England workforce planning principles, for those healthcare staff where an evidence-based planning tool does not yet exist. National guidance should be considered when determining staffing levels (for example, guidelines for the provision of anaesthesia services for an obstetric population and implementing the recommendations of the neonatal critical care transformation review).

It is likely that CNST Year 5 will state that Trusts have to have a funded establishment based upon BR+ calculations or an agreed plan which includes the timescale for achieving an appropriate uplift in funded establishment, which includes mitigation to cover any shortfalls.

BR+ is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour.

The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives and have been endorsed by the Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG). The RCM strongly recommends using BR+ to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels.

Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour. It takes into account changes in government policies on maternity services and clinical practices, and local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. BR+ is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide care.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. Adjustment of clinical staffing between midwives and competent & qualified support staff to provide elements of postnatal care is included. Other support staff roles are based upon professional judgement of safe staffing levels. The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local 23% uplift for annual, sick & study leave allowance and for travel in community.

Factors which influence the BR+ assessment include transitional care which is provided on the ward rather than in neonatal units, and safeguarding needs which require significant input putting higher demand on the workload. Shorter postnatal stays before transfer home requires sufficient midwifery input to ensure that the mothers are prepared for coping at home. It is well known that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided. Community based care is expanding with the emphasis being placed on care being provided in community venues by midwives and midwifery support roles. Women and babies are often seen more in a clinic environment with less contacts at home. However, reduced antenatal admissions and shorter postnatal stays result in an increase in community care.

Midwives undertake the Newborn and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home. Cross border activity can have an impact on community resources in two ways. Some women may receive antenatal and/or postnatal care from community staff in the local area but give birth in another Trust. Equally, there are women who birth in a particular hospital but from out of area so are 'exported' to their local community service. Adjustments are made to midwifery establishments to accommodate these community flows. The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks' gestation, consequently more women are meeting their midwife earlier than previously happened. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal.

<u>The assessment</u>

The maternity service last undertook a BR+ assessment in 2019. A new assessment was commissioned in 2022 and the report was made available in draft form. The service has now reviewed this for accuracy and agreed the contents of this report as of May 2023.

The results of the most recent BR+ assessment are based on three months case mix data obtained for the months of December – February 2021/22. Annual activity is based on the Financial Year 2021/2022 and total births of 4219. The Trust agreed uplift of 23% for annual, sick and study leave is included, however it is acknowledged that the Local Maternity and Neonatal System (LMNS) recommend a 25% uplift for midwifery staff to accommodate the increased levels of training that are now required following the publication of the recent national reports therefore a 25% uplift figure has also been included in the report for consideration. 15% community travel is included in the staffing figures and time to lead is included for Band 7 Coordinators, Ward and Department Managers, and Team Leaders to cover the day-to-day management and coordination of all areas.

The number of births is similar to the last assessment carried out in 2019, however there have been changes in the following areas, which account for the recommendation to uplift staffing:

- A significant change in the case mix, with an increase of 10/11% in Category IV and Vs (the most complex care categories)

- An increase in both emergency and elective caesarean section rates from 13.2% to 22.3% (Emergency) and 11.9% to 19.6% (Elective).
- An increase in the number of Outpatient Clinics
- Staffing requirements for Triage to meet the nationally recommended BSOTS model.
- Additional safeguarding built into the community.
- Staffing requirements for the Homebirth team to cover 24/7 on call.

The development of the maternal medicine centre is likely to further increase the complexity of cases, and this must be considered.

Table 1 shows the recommended BR+ staffing levels for clinical midwives and Maternity Support Workers (providing postnatal care) in each clinical area including 23% uplift.

Table 1 – BR+ recommended establishment

Birthrate Plus® Staffing: inclusive of 23% uplift

Clinical WTE required	
Delivery Suite: • Births • A/N cases • Postnatal Readmissions • Non-viable pregnancies • Induction of labour	45.90wte RMs
Triage - BSOTS Model	14.69wte RMs
Preston Birth Centre • Births & postnatal care • Births only • Transfers to Delivery Suite	21.36wte RMs
Antenatal Ward • A/N Admissions • Inductions of Labour Postnatal Ward • Postnatal women • NIPE • Extra Care Babies • Postnatal readmissions • Postnatal ward attenders	11.02wte RMs *min staffing 2 RMs per shift)* *38.38wte* *(Includes B3 MSWs for postnatal care)*
Outpatients Services • midwife led clinics • Obstetric/Specialist clinics • Fetal medicine • CDH clinics • Maternity Day Care Unit	11.43wte RMs 1.84wte MWs
Community Services: • Home births • Community cases • Attrition • Additional safeguarding	37.44wte RMs and B3 MSWs *(Includes 6.00wte for Homebirth Team, and MSWs -postnatal care)*
Chorley Birth Centre • Births/Triage cases	8.04wte RMs
Total Clinical WTE	**190.10wte RMs & PN MSWs**

Table 2 shows a breakdown of current clinical midwifery establishment in each clinical area.

Table 2 – current midwifery establishment

Area	Current Midwifery Establishment (WTE) not including Band 3 PN MSW
Delivery Suite	35.46
Maternity Triage	11.56
Preston Birth Centre (PBC)	41.38
Community Services	
Antenatal Ward	8.71
Postnatal Ward	25.69
Outpatient Services	7.17
Continuity teams (Includes Homebirth team and CBC team, Tulip team works across antenatal clinic, Delivery Suite and community)	25.42
Contribution from Specialist Midwives	5.54
Total	**160.93**

Table 3 compares the current establishment with the BR+ recommended establishment for each area. It is evident that all areas have a midwifery staffing deficit. Within the table there is the addition of the continuity teams. BR+ does not have the ability to calculate staffing requirements based upon continuity team models, however the national ask is that whilst migration towards continuity models is paused until all the building blocks are in place to do this safely, services should continue to plan towards migration. The service currently has 3 teams one covering women with diabetes in pregnancy (Tulip Team), one covering homebirths (Ivy Team) and one covering Chorley Birth Centre (CBC Team). The funding for these teams is shown in the continuity cost centre and these midwives work across different areas of the service therefore this has been added/subtracted from the totals at the bottom of the table.

Table 3 – Comparison of current midwifery establishment and BR+ recommended establishment

Area	Current Midwifery Establishment (WTE)	BR+ recommended Establishment (WTE)	Number of WTE midwives required
Delivery Suite	35.46	**45.90**	10.44
Maternity Triage	11.56	**14.69**	3.13
Preston Birth Centre (PBC)	41.38 (this includes staffing for PBC and community services and not CBC which is counted in continuity teams)	21.36 (PBC)	16.09
Chorley Birth centre (CBC)		8.04 (CBC)	
Community Services		37.44 includes PN MSW so with these removed (9.37) = 28.07 community **(Total of PBC+ CBC+ Community = 57.47)**	
Antenatal Ward	8.71	**11.02**	2.31
Postnatal Ward	25.69	38.38 includes PN MSW so with these removed (9.64) = **28.74** midwives	3.05

Outpatient Services	7.17	11.43 +1.84 = **13.27**	6.10
Subtotal	128.97	171.09	41.12
Continuity teams (work across all areas of the service)	25.42 (this includes 8.04WTE at CBC)		-25.42 from total
Contribution from Specialist Midwives	5.54		-5.54
Total	160.93	171.09	**=10.16**

Specialist midwives

The total clinical establishment as produced from BR+ with 23% uplift of 190.10wte excludes the non-clinical midwifery roles needed to provide maternity services the RCM Staffing Guidance support 9-11% and BR+ is NICE endorsed hence being applied in maternity services. 10% of the workforce would give 19.01WTE specialist midwifery posts, however this can be increased by the service depending upon specialist midwifery need requirements. Currently the service has funded 12.90WTE band 7 Specialist Midwives and 3.80WTE funded band 6 midwives working to support the specialist midwifery teams (16.70 WTE in total) this leaves a deficit of 2.31WTE specialist midwife posts. The plan would be to fund a 1.0WTE Band 8a Advanced Midwifery Practitioner to support the obstetric team in maternity triage and the maternity ward. This would reduce the current pressure and risk currently being experienced in these areas. In addition, the service requires a 1.0WTE Band 7 Specialist Midwife for Multiple Pregnancy which is a national recommendation from NICE, MBRRACE and Ockenden. The remaining 0.31WTE hours would be for Bereavement Midwifery hours to contribute to the provision of a 7 day per week bereavement service which is an Ockenden recommendation.

Support staff

The total clinical establishment contains the contribution from Band 3 Maternity Support Workers (MSWs) in hospital and community postnatal services. It is recommended that maternity units work with a minimum of 90/10% skill mix split of the clinical total whole-time equivalents (WTE). The current skill mix is based on 87% of RMs, and 13% Band 3 Midwifery support workers on the Postnatal Ward/Community. In addition, there is a need to have support staff usually at Band 2 working on delivery suite, maternity wards and in outpatient clinics. These roles are essential to the service but are not included in the midwifery ratio. To calculate the requirement for these support staff, professional judgement of the numbers per shift is used rather than a clinical dependency method.

There is a significant shortfall of Band 2s on the ward and a staffing deficit for Band 2 and Band 3 workers in other areas of the service. The requirement is to have at least one Band 2 per shift on the wards and Delivery Suite to carry out the housekeeping duties and assist in general care. The MSWs focus on other tasks that would otherwise be completed by the midwives. The lack of support staff hinders the midwives' ability to focus on clinical care because they are picking up tasks usually performed by health care assistants or clerical staff. Recruiting to these posts in the short term will see significant benefit whilst recruitment to midwifery posts, which is challenging across the UK at present, is ongoing.

Table 4 shows the current and recommended establishments for Band 2 and band 3 workers within the service. The total uplift required equates to 5.53WTE Band 2 HCA and 5.93WTE band 3 MSW (this includes the recommended 1.42WTE uplift for PN work)

Table 4

Area	Band 2 (Current WTE)	Band 2 (Recommended WTE)	Difference WTE Band 2	Band 3 (Current WTE)	Band 3 (Recommended WTE)	Difference WTE Band 3
Delivery Suite	5.90 (includes 0.6WTE housekeeper)	5.51 (1 per shift includes housekeeper responsibilities)	-0.39	0	0	0
Maternity Triage	1.0	Not required	-1.0	1.0	5.51	4.51
Preston Birth Centre (PBC)	0	0	0	12.80	5.51 (1 per shift to support PN work)	2.08
Chorley Birth centre (CBC)		0	0		5.51 (1 per shift to support birth)	
Community Services		0	0		3.86 (for PN work in community)	
Antenatal Ward	3.50 (includes 1.0WTE housekeeper)	5.51 (1 per shift includes housekeeper responsibilities)	2.01	0	0	0
Postnatal Ward	0	5.51 (1 per shift)	5.51	10.30	9.64 (2 long shifts and 1 short shift during day and 1 at night)	-0.66
Outpatient Services	0.6	Not required	-0.6	4.02	4.02	0
Total required			**5.53**			**5.93**

Staffing uplift required

Based on 2021/22 activity, a 23% uplift the clinical total recommended for Lancashire Hospitals NHS Trust is 190.10wte. To align the workforce to a 90/10 skill mix split for postnatal and community work 171.09WTE should be Registered Midwives and 19.01WTE MSW to provide postnatal care. The clinical deficit would then be 10.16WTE midwives, and 1.42WTE MSWs for the postnatal and community areas. Based upon professional judgement as recommended in the BR+ paper the total uplift of Band 2 and 3 workers required by the service is 5.53WTE Band 2 HCA and 5.93WTE band 3 MSW (this includes the recommended 1.42WTE uplift for PN work)

The current calculations are based upon a 23% uplift for the midwifery staff; however, it is recognised that this does not accommodate the increased training requirements that have been applied since the publication of the recent national safety reports. The Local Maternity and Neonatal System (LMNS) undertook a piece of work to collate all the training required and calculate the number of hours this would take. As a result, their recommendation is that midwifery services should have a 25% uplift. Without this uplift the service will continue

to rely on bank and agency shifts to support completion of essential training. Calculations based on 25% uplift would require an additional 4.2WTE midwives.

Table 5 and 6 are the financial breakdown of this staffing uplift.

Table 5 – Financial implications

Staff group (Working 24/7 shifts unless stated otherwise)	WTE required	Costs
Midwives (Band 6)	10.16	£596,167
Staffing uplift of 25% for midwives (Band 6)	4.20	£245,647
MSW (Band 3)	5.93	£218,844
HCA (Band 2)	5.53	£195,769
Specialist Midwives (Mon-Fri 9-5)	2.31	£136,418
Total	29.73	£1,392,845

Table 6 – Financial breakdown

Required input Department / Ward Staff Group	Pay Band (Select)	Scale Position (Select)	Shift Req't (Select)	Hours per Week	WTE per Week	Req'd Hours	Req'd WTE	Salary Cost	Enh't Cost	Net Cost	N.I. Class 1 13.8 Nov 22 rate	N.I. Class 1 Upper Earning	Super 14.38% 2223 rate	Annual Cost £
Staff group (Working 24/7 shifts unless stated otherwise)														
Midwives (Band 6)	Band 6	Mid Point	Rotational	37.50	1.00	37.50	10.16	379,838	86,327	466,165	62,967	0	67,035	**596,167**
Staffing uplift of 25% for midwives (Band 6)	Band 6	Mid Point	Rotational	37.50	1.00	37.50	4.20	157,020	35,686	192,706	25,230	0	27,711	**245,647**
MSW (Band 3)	Band 3	Mid Point	Rotational	37.50	1.00	37.50	5.93	134,982	36,813	171,795	22,344	0	24,704	**218,844**
HCA (Band 2)	Band 2	Mid Point	Rotational	37.50	1.00	37.50	5.53	116,147	37,647	153,793	19,860	0	22,115	**195,769**
Specialist Midwives (Band 7) (Mon-Fri 9-5)	Band 7	Mid Point	Days (Only)	37.50	1.00	37.50	1.31	59,012	0	59,012	6,780	0	8,486	**74,279**
Specialist Midwives (Band 8a) (Mon-Fri 9-5)	Band 8a	Mid Point	Days (Only)	37.50	1.00	37.50	1.00	49,542	0	49,542	5,473	0	7,124	**62,139**
Department Total							28.13							1,392,845

Appendix 6 Workforce action plan

RAG	Key
Action outstanding	
Action on track but not yet delivered	
Action delivered	
Action delivered and assurance evidence collated	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
1	**Review temporary staffing solutions.**	Introduce Thursday 11am weekly operational planning meeting between the ward managers and matrons. Sickness absence should also be discussed during the meetings.	Matrons	~~01.05.2023~~ ~~01.06.2023~~ ~~01.08.2023~~ 1.12.2023	24.04.2023 To commence week beginning 15.05.2023. 15.05.2023 First meeting planned. 03.07.2023 First meeting held. Template to be revised and the regular meetings to be set up. 18.09.2023 Action ongoing.	
		Develop a midwifery staffing team's channel.	Matron for complex midwifery care	01.05.2023	24.04.2023 JG to provide MR with a list of people to be added to the team's channel. 15.05.23 List collated and teams' channel open. 18.09.2023 Action completed.	
		Develop a weekly staffing meeting template to record meetings and actions.	Matron for complex midwifery care	~~01.05.2023~~ ~~07.07.23~~ ~~01.08.2023~~ 1.12.2023	24.04.2023 Draft template to be updated by MR 03.07.2023 Template trialled and to be revised. 18.09.2023 Action ongoing.	
		Consideration of an on-call system for the unit.	Matrons	~~30.06.2023~~ 01.09.2023	24.04.2023 Offer on-call shifts as a volunteer temporary arrangement to staff. Draft an expression of interest for staff.	

					Considered and excluded	
		Consult summer leavers to understand if they will consider deferring end date.	Matron for midwifery led services	30.06.2023	24.04.2023 Staff have been consulted and majority are going to new positions. Action closed.	
		Request 10WTE agency midwives block booking for 6-month period.	Chief Nursing Officer	06.07.23	03.07.23 - Request made through temporary staffing and agency recruitment for block booking ongoing based on unfilled shifts through top October 2023. 18.09.2023 Options reviewed and agency booked when possible. Agency fill rates included in the perinatal Surveillance table. Action Closed	
		Explore use of registered Nurses from critical care within maternity services.	Chief Nursing Officer	31.07.23	03.07.23 -Request made of critical care team for nursing staff to support when appropriate and in line with “Safe practice principles for adult nurses working as part of multidisciplinary teams (MDT) in Maternity Services” published by NHS England on 25th May 2023. Options for other nurse roles within maternity services to be explored. 18/09/2023 continuous review of alternative bookings via nursing and critical care. Action closed	
		Publicise bank shifts within and external to the unit	Recruitment team	06.07.23	03.07.23 -Request made of recruitment. 18/09/2023 Action completed	
		Additional shifts created for band 2 and 3 shifts to provide support on reduced fill rate shifts.	Deputy Midwifery and Nursing Director	ongoing	03.07.23 - In place. 18/09/2023 Action completed	
		Bank midwifery advert agreed with Chief Nursing Officer	Chief Nursing Officer	ongoing	3.07.2023 Advert for bank midwives published.	

2	**Utilisation next 3 months**	Review Newly Qualified Midwife (NQM) preceptorship clinical rotation plan to identify any possible rotations which could be better utilised within the service.	Team leaders	~~30.04.2023~~ 31.05.2023	24.04.2023 Shifts have potentially been identified in ANC – assessment to be completed to identify prioritisation of the clinical areas to receive the additional staffing. 15.05.2023 Scoping of hours undertaken. Unable to progress at this time as movement of NQM from ANC will potentially impact on essential planned work re-organisation. Action closed.	
		Review of the birth centre staffing models because of the current birth rates within midwifery led services.	Matron for midwifery led services	30.06.2023	24.04.2023 review is ongoing. Potential for the third person to be a "floating midwife". 15.05.2023- Matron for MLS reviewed percentage of births in co-located birth centre. Plan to reduce staffing to 2 per shift from 3 per shift from the 10th of June 2023. Action closed.	
		Identify and consider potential withdrawal of non-essential services.	Divisional midwifery and nursing director.	30.05.2023	24.04.2023 identify the non-essential services. 15.05.2023 Unable to identify any non-essential services at present. Non-viable option. Action closed.	
		Identify areas of the service that could be distributed to other staff groups.	Public Health Midwife	~~30.06.2023~~ ~~31.07.23.~~ 1.11.2023	15.05.2023 To explore vaccination services. Potential for a nurse to administer vaccines. Public health midwife liaising with LMNS to consider wider system options.18/09/2023 Action ongoing.	
		Telephone consultation/ virtual services for differed visits.	Matron for midwifery led services	30.05.2023	24.04.2023 Scoped whether there is appetite for a leaver to stay and complete hybrid virtual working. Non-viable option. Action closed.	
		Determine which specialist midwives can be utilised to work clinical shifts during anticipated summer pressures.	Senior management team	~~30.04.2023~~ 30.05.2023	24.04.2023 Specialist midwives identified: screening midwives, midwifery practice educator, preceptorship and retention lead, public health midwife, infant feeding and potentially service development midwife.	

					15.05.2023 8 specialists will contribute 1 day a week to ANC, Maternity A, B and DS from the 10.06.2023 Action Closed.	
		Consult specialist midwives regarding the preferrable pattern of clinical working (i.e.) 2 days per week or one block week.	Matrons	30.05.2023	24.04.2023 to be discussed at the band 7 meeting 25.04.2023. 15.05.2023 Matrons have emailed individuals affected and arranged a meeting regarding booking into vacant shifts. Action closed	
		All managers to have time to lead reduced to days per week during anticipated summer pressures.	Matrons	30.05.2023	24.04.2023 to be discussed at the band 7 meeting. 15.05.2023. All managers and team leaders to increase clinical shifts from 1 day per week to 2 days per week from 10.06.2023.	
		Consult team leaders and ward managers regarding the preferrable pattern of clinical working.	Matrons	30.06.2023	15.05.2023 Matrons have emailed individuals affected and arranged a meeting regarding booking into vacant shifts. Action closed	
		Consider rationalisation of meeting schedule.	Deputy DMND	~~30.06.2023~~ ~~01.08.2023~~ 1.12.2023	15.05.2023 Review speciality meetings to consider rationalisation and defined attendance over months of June, July, August and September 23.18/09/2023 Action ongoing.	
3	**Birth rate plus data utilisation**	Review the latest birth rate plus data and complete a paper for board.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 Paper to be shared with chief nurse and then presented to board for review. 15.05.2023 Paper to be presented as part of bi-annual staffing review in May 2023 26.05.23 Biannual staffing report presented to S&Q. Action closed	
		Trust Board to share findings of BR+ assessment with ICB	Chief Nursing Officer	1.12.2023	18.09.2023 Br+ Paper approved for sharing and consideration with the ICB and LMNS. Action ongoing	

		PWR data review to be undertaken to ensure accurate midwifery staffing establishment reported to NHSE.	Divisional midwifery and nursing director	1.11.2023	25.08.2023 PWR Data review meeting arranged and discrepancies noted with national data published. Escalated to national team via Regional Associate lead Midwife. Awaiting update.	
		Complete the training for the ward acuity tool.	Matron for complex midwifery care	~~30.06.2023~~ 31.11.23	24.04.2023 date agreed for training with the external providers. Staff to attend currently being agreed. 15.05.2023 Ward managers assigned to attend, and additional staff released if possible. Session will be recorded for use later. App not working at this time action paused	
		Launch the acuity tool across the ward areas.	Matron for complex midwifery care	~~30.06.2023~~ 31.11.2023	24.04.2023 to be launched in June 2023 following completion of training. Action paused as above.	
4	**Roster management**	Meet with the health roster term to specify supernumerary tiles which will not be included in the unfilled rate.	Matron for complex midwifery care	30.06.2023	24.04.2023 MR has met with health roster team. Health roster team to review request and feedback. 15.05.2023 Email request for speciality meeting. 30.06.2023 Supernumerary tiles now in place. Action closed	
		Matron review of roster templates to ensure that templates reflect the establishment for each area.	Matrons	01.07.2023	15.05.23 Meeting to be arranged with e-roster team to confirm templates reflect staffing requirements. Awaiting update that all areas reviewed. Action completed.	
		Meet with team leaders/ ward managers regarding summer annual leave planning. Reiteration that maximum allowance is 17%.	Matron for complex midwifery care	30.04.2023	24.04.2023 MR has pulled the roster reports and confirmed that the annual leave is booked and does not exceed the maximum requirement. Action closed	
		Creating a new cost centre for preceptees or team midwives	Finance BP	~~31.07.23~~ 1.12.2023	15.05.2023 Finance BP to create new cost centre. Update awaited. 18/09/2023 Action ongoing.	

		Unused roster hours to be reviewed by the matrons at sign off.	Matrons	30.04.2023	24.04.2023 Healthroster to be reviewed as part of monthly sign off with each area to utilise un-filled shifts. Action closed	
		Maternity ward B roster to be reviewed for balance. Review MSW staffing ratios across day and night.	Matron for complex midwifery care	30.05.2023	24.04.2023 MR to discuss with HA. 15.05.2023 Staffing gaps have been reviewed to reflect the service requirement. Action closed	
		Consider options for assessing and balancing staff numbers across whole service and develop plan for June-October 2023.	Matrons	30.05.2023	15.05.2023 Matrons to meet to review establishments and confirm plan for distribution of staff across the areas with highest establishment gaps. 03.07.23 – This is now done on a weekly basis. Action closed	
5	**Recruitment**	Continuation of the preceptorship lead midwife post for further 11 months.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 awaiting confirmation from finance. JG has completed the workforce form for the extension. Action closed	
		Recruit up to 16 international recruits.	Preceptorship and retention leader midwife	~~30.07.2023~~ 31.12.2023	24.04.2023 – 3 currently in post, 2 coming to the testing centre in May 2023. Awaiting further information. Recruitment ongoing. 15.05.2023 Deadline date extended to reflect ongoing recruitment plan. 01.07.23 – 4 RM in post. Action ongoing. 18.09.2023 Local recruitment for international recruitment in house commenced.	
		Vacancy and maternity leave tracker to be overseen workforce committee.	Matrons	~~30.05.2023~~ 30.06.23	24.04.2023 – two external recruits successfully made week commencing 17.04.2023. 15.05.2023 Deadline date extended to reflect ongoing and continuous monitoring of vacancies.	

					30.06.2023 Item to be added to workforce committee in July 2023. Workforce action tracker in place. Action closed.	
		Recruitment to delivery suite core team.	Matron for complex midwifery care	30.05.2023	24.04.2023 – shortlisting has been completed awaiting date for interview. 15.05.2023 Core team recruited. Action closed	
		Recruitment to the birth centre core team.	Matron for midwifery led services.	30.05.2023	24.04.2023 – successfully completed	
		Recruitment to the Mat A/B ward core team.	Matron for midwifery led services.	31.08.23	01.07.23 - Advert out currently. Action closed	
		Recruitment to the caesarean section team as core (1.6 WTE).	Matron for complex midwifery care	~~30.05.2023~~ 30.06.2023	24.04.2023 – advert for the team has been completed and approved by EA. Advert to go to vacancy control this week. 15.05.2023 Shortlisting outcome awaited. Deadline extended. 01.7.23 – recruited to successfully.	
		Associate leader positions to be considered.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 – stand down as non-viable at present time.	
		Band 5 advertisement to be released.	Matron for midwifery led services	~~30.04.2023~~ ~~30.06.2023~~ 01.09.2023	24.04.2023 – advert has been approved by EA and RC. Currently with vacancy control anticipated release 28.04.2023. 15.05.2023 Shortlisting in progress. Deadline extended. 01.07.23 – continuous adverts out. Action closed	
		Recruitment open day for band 5 midwives.	Matrons	~~30.05.2023~~ ~~31.07.2023~~ 1.12.2023	24.04.2023 – to be organised once the vacancy is released. 15.05.2023 Consider whether open day or engagement of new starters required.	

					01.07.23 – ongoing next recruitment event to be confirmed.18.09.2023 events ongoing.	
		Consider recruitment to the band 4 practice development post once the funding becomes available.	Divisional midwifery and nursing director	~~30.05.2023~~ ~~01.09.2023~~ 1.12.2023	24.04.2023 – awaiting outcome of funding. 15.05.2023 Update awaited. 01.07.23 – paper to LMNS submitted and awaiting final approval to recruit. 18.09.2023 funding awaited	
		Band 3 allocation to be reviewed across the service.	Divisional midwifery and nursing director	~~30.05.2023~~ ~~01.09.2023~~ 1.12.2023	24.04.2023 – needs finance review. Long term funding of the roles needs to be reviewed. 01.07.23 – Birth rate plus report taken to Board May 2023. 18.9.2023 Additonal band 3 recruitment undertaken for MAS. Awaiting outcome of funding overall.	
		Increase consultant obstetricians by 3 WTE to support demand and capacity and increase in complexity	Divisional Director and Deputy Medical Director	01.01.2024	03.07.23 Demand and capacity assessment has taken place and business case has been created to discuss with finance. Business case will support 98 hours obstetric cover, antenatal clinics, caesarean section list, induction of labour and maternity triage. 18.9.2023 action ongoing	
6	**Retention** **Flexible working**	Line manager to have conversations with all staff about flexible working opportunities. Flexible Working Toolkit available	All Managers	1.11.2023	30.06.2023 Flexible working conversations to be included in appraisals and as part of team meetings. Action completed	
7	**Retention Seeking Feedback**	To seek feedback from staff via TED surveys, listening events, team meetings	All Managers	31.09.2023	30.06.2023 All areas to undertake a TED survey and develop local ways to seek feedback from teams. 18.09.2023 Awaiting confirmation that all areas have signed up to TED	
8	**Retention Retain, Reward and Recognise – Staff Satisfaction**	Utilise resources from Review and Celebrate Success tools to help enhance feeling valued and recognised.	Preceptorship and retention Lead Midwife	31.03.2023	30.06.2023 Monthly thank you awards nominated by the band 5 team for a team member who offering supportive mentorship and professional support.	

		Utilise resources from Review and Celebrate Success tools to help enhance feeling valued and recognised.	Preceptorship and retention Lead Midwife	31.10.2023	17.04.2023 Shining Star award. A monthly award for outstanding kindness and team work continues	
		Engage in Microsystems Coaching Programme via CI team.	Divisional midwifery and nursing director	31.10.2023	17.04.2023 Divisional Engagement with flow and micro coaching programmes. 18.9.2023 Staff identified to complete flow coaching. Action ongoing.	
		Opportunities for development and career progression available via CPD funding work streams	Divisional midwifery and nursing director	31.10.2023	30.03.2023 CPD requests submitted. HDU courses, NIPE, PMA, Fetal monitoring speciality training, maternal medicine. ANNB ARC. Action complete	
9	**Retention Engagement**	Alternate month mobile coffee catch up with leadership team visiting clinical areas scheduled for 12 months.	Leadership Team	31.03.2024	30.06.2023 Mobile coffee catch up sessions ongoing.	
10	**Retention of Students**	Link with the LMNS 2-day course to be facilitated by university to link with colleges for perspective midwives.	Divisional midwifery and nursing director	~~30.06.2023~~ 01.01.2024	24.04.2023 – awaiting further information. 15.05.2023 Action ongoing. 18.09.2023 Actions continue.	
		Explore continuation of funding for midwifery clinical placement facilitator.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 – awaiting further information to meet. 15.05.2023 Meeting arranged for 19.05.23 to discuss PEF funding. 03.07.23 – Meeting held and funding continued for PEF with other funding streams being explored therefore action closed	
11	**Retention Health and wellbeing**	Maternity conference to be organised for 15/06/2023 for current midwives and maternity support workers.	Matron for midwifery led care	30.06.2023	24.04.2023 – progressing well. Agenda in development. 15.05.2023 Planning on track 15.06.2023 – Maternity conference delivered as planned	

		Establish and agree the PMA offer.	Divisional midwifery and nursing director	~~30.05.2023~~ ~~01.09.2023~~ 1.12.2023	24.04.2023 – date to meet with PMA's to be arranged. 15.05.2023- Meeting with DMND to be confirmed. 01.07.23 – Trust structure agreed for PNA/PMAs. 5 PMA trained. Staffing limiting activity. To remain on workplan and meeting to be arranged with PMAs to agree development of this service. 1.09.2023 Additional £11,00 funding agreed via a bid for backfill for establishing PMA's Action ongoing.	
		International day of the midwife – cups and biscuits for the clinical areas/ teams.	Deputy divisional nursing and midwifery director.	30.05.2023	24.04.2023 – Cup designs have been developed and order placed. 15.05.2023 Mugs and biscuits distributed to all areas. Celebrated IDM 2023. Action closed	
		Expansion of the unit coordinator role to include ward and area managers.	Matrons	~~30.05.2023~~ 30.06.2023	24.04.2023 – to discuss with ward managers. Action deadline extended. No further progress. Action stood down	
		Introduce de-brief tool to support hot de-briefing.	S&Q matron	~~30.05.2023~~ ~~31.08.2023~~ 1.12.2023	24.04.2023 – EH to explore hot debrief tool and feedback at the next meeting. 15.05.2023- Options for debrief ongoing. Deadline extended.18.09.2023 Action ongoing	
		OD department to develop division wide action plan with ideas for action which are specific to each area	OD leads	~~01.09.2023~~ 1.12.2023	03.07.23 – Meeting held with OD lead for division and area action plans to be developed. 18.09.2023 Draft action plan in place and awaiting confirmation. Action ongoing	
12	**Correlation between staffing and safety intelligence**	Monitor safety data daily, including red flags, BR plus acuity, coordinator feedback at safety huddles, PALS, service	Divisional midwifery and nursing director	Ongoing	Systems in place. Daily monitoring	

		user feedback, governance systems.				
		Monthly oversight of safety and quality metrics through the maternity safety dashboard to safety and Quality group in division and Board.	Divisional midwifery and nursing director	Ongoing	Systems in place	
13	**Well Led**	Trust development programme based on ward manager and matron handbook to develop leadership capability and capacity.	Chief Nursing Officer	~~30.09.23~~ 1.12.2023	Chief Nurse leading.18.09.2023 awaiting update of plan.	
		To undertake a training needs analysis of the leaders and managers within the Division, understanding who has completed which development programme, where additional tailored support can be provided and who may need performance management intervention.	OD and Divisional Board to commit & enable attendance	~~1.11.2023~~ 1.12.2023	30.06.2023 Scoping work to understanding of level of capability and confidence in department. What development support is needed, how expectations are communicated and reinforced to improve management effectiveness across the Division. 18.09.23 Action ongoing.	
		To set up a Band 7 Action Learning set where leaders come together monthly to have the headspace, facilitated support, consultancy support to identify how to make improvements in team engagement and staff satisfaction, enabling them to develop actions plans which improve colleague experience	OD and Divisional Board to commit & enable attendance	31.10.2023	30.06.2023 Action Learning groups to be set up from October 2023 after new recruits in post. 18.09.2023 Action ongoing.	
		Based on the findings of the training needs analysis consider the delivery of a	OD and Divisional Board to commit & enable attendance	30.09.2023	30.06.2023 Agree bespoke series of meetings following review of leadership TNA and from listening to feedback from the team. 18.09.2023 Action ongoing.	

		series of bespoke leadership 'away days.				
		To improve the quality of appraisal conversations/paperwork, objective and development planning in appraisal. This will be achieved by all appraisers attending the Appraisal Masterclass.	OD and Divisional Board to commit & enable attendance	31.03.2024	30.06.2023 Improved appraisal quality audit rating. Increased use of 360 feedback in appraisal. Increased number of appraisals with objectives and personal development plan completed. Increased scores benchmarked against the 2022 National Staff Survey for questions relating to having a quality appraisal.18.09.2023 Action ongoing.	
		Increased capacity within senior midwifery team through creation of: - Deputy Divisional midwifery and Nursing Director - Creation of Safety and Quality matrons - Creation of the Specialist Midwife for maternal medicine - Creation of the Planned work, capacity, and flow co-ordinator - Enhanced antenatal and newborn screening leadership capacity	Chief Nursing Officer	~~31.04.23~~ 01.09.23	03.07.23 – All posts recruited.	

Appendix 7 – MNVP provisional work plan

MNVP/LTHTR Co-production action plan – 2023

Organisation:	Maternity Voices Partnership
Lead Officer:	Jo Lambert
Position:	Deputy Divisional Midwifery and Nursing Director
Tel:	01772 528327
Email:	Joanne.lambert@lthr.nhs.uk

Status Key	
1	Not complete
2	Actions partly achieved or on track to meet delivery timescale.
3	All actions complete , evidence outstanding
4	All actions completed and supporting evidence provided

Version	Date
1.0	1.5.2023
2.0	20.6.2023
3.0	1.7.2023
4.0	18.09.2023

The Lancashire Teaching Hospitals Maternity and Neonatal Voice Partnership (MNVP) work plan is based on the principles included in the 3-year single delivery plan, the Ockenden, Kirkup reports and Clinical Negligence Scheme for Trust. Its aim is the co-produce and design a safer caring and personalised maternity service that is equitable to service users, modern and personal to women and families. The actions included in the plan are written in response to national external recommendations, complaints, and patient experience feedback. It is expected that once the new MNVP lead is appointed that actions will be adjusted to ensure that the plan is co-produced and meaningful to the local population of Preston and South Ribble for both maternity and neonatal services.

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
1	**Listening to women and families with compassion which promotes safer care**	Engaging with local communities to seek feedback and to hear the voice of families using maternity services.	MNVP Lead	~~1.9.2023~~ 1.12.2023	1.5.2023 Arrange quarterly engagement events chaired by the MNVP lead which are both virtual and in community locations. Whilst MVP chair is absent, alternative engagement events will be used to collect feedback.	
					January 2023 Final Latent labour Infographic co-produced with service users and distributed via BadgerNet.	
					6/7.01.2023 January 2023 Partial MVP 15 steps undertaken.	
					April 2023- Leaflet for balloon induction shared with service user and awaiting feedback. 18.09.2023 Action ongoing.	

					June 2023 – Leyland Fair – completed.	
					March to June 2023 Gynaecology Improvement plan service user individual meetings held to seek views of women using the early pregnancy service.	
		15 Steps Assessment	Matron for midwifery Led Care	1.02.2023	06/07.01.2023 January 2023 Partial MVP 15 steps undertaken. Did not fulfil the criteria for quoracy of representation but walk round undertaken and actions agreed.	
		15 steps action plan	Matron for Safety and Quality	1.8.2023	1.03.2023 Develop a system level action plan for co-design and improvement.	
		Collate a 15 Steps Response paper	Matron for Safety and Quality	1.08.2023	30.06.2023 Response paper and associated action plan written. Paper shared on maternity Safety and Quality Meeting	
		Undertake a repeat baseline 15 steps walk round when new MNVP chair appointed	MNVP Lead/ Matron for Midwifery Led Care.	1.9.2023	1.5.2023. Arrange a co-produced 15 steps to seek views of local service users so that service can be co-designed. Action complete.	
		Recruitment and appointment of MNVP chair	Divisional Director of Midwifery and Nursing	1.12.2023	18.09.2023 New MNVP chair appointed and awaiting start date.	
2	**Ensuring pregnant women and new mothers have access to pelvic health services.**	Develop accessible pelvic health services.	Divisional Director of Midwifery and Nursing	~~1.9.2023~~ 1.11.2023	1.5.2023 Employ a specialist lead midwife for pelvic health. Funding approved	
					20.06.2023 Recruit to band 7 Pelvic Health Midwife. 23.6.2023 Post awaiting approval at Vacancy Control Panel. 18.09.2023 Interview planned 20/09/2023.Interview 20/09/2023.	

1	**Rolling out perinatal mental health services**	Ensure that women have equitable access to mental health services during the perinatal period	Divisional Director of Midwifery and Nursing	~~1.9.2023~~ 1.12.2023	01.05 2023 Review current service offer with new MNVP Lead. 18.09.2023 Action ongoing.	
					01.05.2023 Specialist lead midwife and ANC in place.	
					23/06/2023 Liaise with the reproductive trauma service quarterly to seek anonymised thematic feedback. Meet date to be confirmed. 18.09.2023 Action ongoing.	
3	**Choice and personalisation** Enhance the antenatal experiences and choices of mothers and their families	To make care safer, more personalised, and more equitable.	Deputy Divisional Midwifery Director/ MNVP Lead	~~1.9.2023~~ 1.12.2023	1.5.2023 Personalised care plans are utilised for all women and birthing people so that they can make informed decisions about where to have their baby. Need to collate evidence via BadgerNet.18.09.2023 Action ongoing.	
					1.5.2023 Choice and personalisation conversations with a midwife at 34 weeks supports birth choices.	
					A birth options clinic is available for women who need additional information to support them with informed choice.	
4	**Bereavement Services**	Improve availability of bereavement services across 7 days a week by the end of 2023/24.	Divisional Director of Midwifery and Nursing	~~30.06.2023~~ 1.12.2023	20.6.23 Completed the LMNS funding work plan detailing work plan for additional bereavement funding.	
					1.7.2023 Funding agreed. Bid to be approved at ICB Quality Assurance Panel 7.7.23.(Not yet received outcome) 18.09.2023 Action ongoing.	

5	**Rainbow Service antenatal education and peer support**	Review current provision for specialised antenatal education and peer support offer for families experiencing a rainbow pregnancy	Lead Midwife for Bereavement and service user.	~~1.09.2023~~ 1.12.2023	30.6.2023 Lead midwife for bereavement working with service users to develop an antenatal and peer support offer for rainbow families. 18.09.2023 ion ongoing.	
6	**Bereavement Services Review bereavement service offer (including miscarriage and stillbirth**	Plan services that are responsive to women's needs and to feedback provided by service users.	Director of Patient experience/ Matron for Safety and Quality.	1.09.2023	1.5.2023 Learn from concerns and complaints and review complaints quarterly to ensure that thematic concerns are identified and used to co-design services. Themes reviewed and used to inform gynaecology experience improvement plan 2023/24 and maternity experience improvement plan 2023/24. 18.09.2023 Action ongoing SI learning used to design Maternity and Neonatal TNA. Action complete.	
		Gynaecology experience Improvement Plan	Deputy Divisional Midwifery Director/ MNVP Lead Matron for Gynaecology	1.12.2023	1.5.2023 Agree key priorities for early pregnancy service based on experience data, service user feedback, concerns, and complaints. Action completed	
					20.6.23 Improvement actions confirmed, and journey posters developed.	
					01.05.2023 Charitable bid submitted for lead nurse for bereavement for early pregnancy (2 year) 18.09.2023 Action ongoing interview 25/09/2023 with service user panel member.	

					01.06.2023 Awaiting final costing agreement for environmental improvement to waiting areas, ambulatory care and the scan room in GAU. To co-produce environment once build completed. 18.09.2023 Action ongoing.	
		Undertake National Bereavement Pathway external review	National Bereavement Pathway	30.06.2023	1.5.23 External review of maternity, neonatal and gynaecology by National Bereavement team commissioned to benchmark service against standards. (13th 14th July 2023)	
		National Bereavement Pathway to seek Feedback from service users who have experienced pregnancy loss, termination of pregnancy	National Bereavement Pathway	15.07.2023	1.06.2023 National Bereavement review to include meetings with service users who have experienced pregnancy loss, termination and stillbirth. Action complete.	
7	**Integrated care systems (ICSs) will publish equity and equality plan and take action to reduce inequalities in experience and outcomes.**	Promote cultural diversity and ethnicity engagement in maternity care.	Deputy Divisional Midwifery Director/ MNVP Lead	~~1.09.2023~~ 1.12.2023	1.06.2023 Co-produce and implement local plans to reduce inequalities in experience and outcomes for women and babies, including neonatal and maternal mortality based on LMNS equity plan. Require MNVP chair to complete this. Healthwatch due to recruit during July 23. 18.09.2023 ion ongoing.	
8	**Improve Health inequalities**	Services listen to and work with women from all backgrounds to reduce inequality and improve access, plan, and deliver personalised care.	Divisional Midwifery and Nursing Director NMVP Lead	~~1.09.2023~~ 1.12.2023	1.5.2023 Seek opportunity through MNVP and other public sector. organisations and such as community leaders, schools to hear the local population voices.18.09.2023 Action ongoing.	

		Deputy Divisional Midwifery Director/ MNVP Lead	Chief Nursing Officer	~~1.8.2023~~ 1.12.2023	1.7.2023 Chief Nursing Officer to link with local Muslim girls' school to arrange a visit to seek views of young women who are future service users.18.09.2023 Action ongoing.	
9	**Update Web pages** Refresh Trust internet page using feedback provided in MVP LTHTR gap analysis	Refresh and review in collaboration with MNVP to reflect changes required to improve accessibility	MVP Chair Deputy Divisional Midwifery and Nursing Director	~~31/09/23~~ 1.12.2023	1.5.2023 Review gap analysis document and update website with new MNVP Lead. Action carried over from 2022. 18.09.2023 Action ongoing. EPAU page now live but work continues to update maternity webpages.	
10	**Strategic Engagement and collaboration**	In collaboration with the service ensure that any joint communication is agreed by all stakeholders. Attend any local, regional, or national events.	MNVP Lead	28.04.2023	28.04.2023 Insight visit undertaken by MVP Chair (Pennine LSC). Feedback received for action. *Co-production-acknowledge the MVP Chair vacant but as a Trust you are clearly committed and have continued to undertake various pieces of work with services users.*	
				31.03.2024	1.5.2023 Ongoing action as required.	
11	**Involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.**	As per updated October 2022 standards the MNVP should: Evidence that the MVP Chair is invited to attend maternity governance meetings. Create Maternity experience improvement plan.	MNVP Lead Lead midwife for Governance	~~31/03/2023~~ 1.11.2023	01.07.2023 Invite East Lancs MNVP to Maternity Safety and Quality in the absence of MNVP Lead. Awaiting appointment. Email sent.	
			MNVP chair and Divisional Midwifery and Nursing Director	30.8.2023	23.06.23 Improvement plan/roadmap created following thematic review of experience feedback. 18.09.2023 Action ongoing.	

			MNVP chair and Divisional Midwifery and Nursing Director	~~01.09.2023~~ 1.12.2023	23.06.2023 Maternity experience roadmap to be reviewed with new MNVP chair. 18.09.2023 Action ongoing	
		Review maternity TNA to ensure the service user voice is included in TNA plan.	Matron for Safety and Quality	01.11.2023	18.09.2023 Action ongoing and full Lesson plan review to include local learning and service user stories.	
12	**Forward planning for 2023**	The MNVP and Service to following appointment to confirm and updated work plan to include maternity and neonatal services workplan for 2023/24	MNVP Divisional Midwifery and Nursing Director/Neonates CYP	~~5/02/2023~~ 1.11.2023	28/11/22 Meeting to be arranged in January 2023 to schedule co-production work plan for 2023 and sign off plan with LMNS. 1.7.2023 Awaiting appointment of new MNVP lead to confirm requirements of local work plan.18.09.2023 Action ongoing awaiting MNVP chair for East Lancs to provide provisional feedback for work plan.	
		The new MNVP chair will review the co-production plan and confirm this is appropriate for 202324.	MNVP chair and Divisional Midwifery and neonatal Director	~~31.8.2023~~ 1.12.2023	Meeting to be scheduled once appointed.18.09.2023 Action ongoing.	

Appendix 8 Summary of HSIB cases

MI number	Case Summary	Early Notification applicable	Early notification completed	Status of HSIB investigation	Final HSIB report sent to legal team.	Duty of Candour
019756	Spontaneous onset of labour, admitted to birth centre. Progressed to normal birth, baby born in poor condition. Resuscitated and transferred to the neonatal unit for therapeutic cooling. Post cooling MRI showed severe HIE. Decision made for compassionate withdrawal of care.	Yes	Yes	Completed – final report received.	Yes. Early notification investigation proceeding.	Yes
020352	Induction of labour. Transferred to delivery suite once labour established. Progressed to normal birth, baby born in poor condition. Resuscitated and transferred to the neonatal unit for therapeutic cooling. At 24 hours cooling stopped by the neonatal team as baby clinically very well. MRI performed and did not show evidence of HIE.	Not applicable – confirmed by legal department. Cooling not completed, no HIE on MRI and HSIB declined to investigate.	Not applicable – confirmed by the Trust legal department.	HSIB declined to investigate as referral criteria not met – based on MRI and the parents had no concerns with care.	Not applicable	Yes
021966	Severe shoulder dystocia (22 minutes) following instrumental birth. Therapeutic cooling treatment initiated. Post cooling MRI showed moderate HIE.	Yes	Yes	Completed – final report received.	Yes. Early notification investigation proceeding.	Yes
022696	Induction of labour. Fetal bradycardia on the antenatal ward. Category one caesarean section. Therapeutic cooling treatment initiated. Post cooling MRI showed severe HIE.	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes
024639	Induction of labour. Abnormal fetal heart rate auscultated; Therapeutic cooling treatment initiated. Post cooling MRI showed mild HIE.	Yes	Yes	Draft report received and factual accuracy checking completed by the Trust. Final report awaited.	Investigation ongoing.	Yes
032957	Spontaneous onset of labour, admitted to birth centre. Progressed to normal birth, baby born in poor condition. Resuscitated and transferred to the neonatal unit for therapeutic cooling. Post cooling MRI showed moderate to severe HIE	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes

Appendix 9 – Maternity red flag data

Red flag Reporting Metrics	Jun -22	Jul -22	Aug -22	Sept -22	Oct -22	Nov -22	Dec -22	Jan -23	Feb -23	Mar -23	Apr-23	May 23	Jun 23	Jul 23	Aug 23
Delay in time critical activity	1	1	25	11	16	2	1	2	13	54	22	17	17	50	43
Missed or delayed care> 60 mins in washing or suturing	0	0	1	0	2	0	0	0	0	1	0	0	1	2	0
Failure for women to receive the medication required	0	1	6	2	3	2	0	0	0	1	0	0	0	0	0
>30-minute wait for pain relief.	1	0	0	2	1	0	0	0	0	1	0	0	0	3	2
Lack of full examination when woman presents in labour.	0	0	0	0	1	0	0	0	0	1	0	0	0	0	1
>2-hour delay in induction?	3	2	27	15	19	3	1	1	0	10	1	6	4	30	10
Delay in recognition of and action of abnormal signs.	0	0	0	1	1	0	0	0	0	2	2	0	0	0	2
Inability to provide one to one care in labour?	1	2	5	4	5	0	0	0	0	2	0	0	0	7*	0
>30-minute delay for assessment by a midwife when presenting in labour. Replaced by BSOTS	0	0	0	1											
>15 minute delay following presentation for BSOTS midwife assessment. (New parameter August 2023)															5
>30-minute wait for obstetric triage.	0	1	2	2	1	1	0	1	1	40	15	15	15	29	29
Was there a delay in transfer of a BSOTS red case from MAS? (New parameter Oct 22)					1	0	0	0	0	0	0	0	0	1	0
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation? (New parameter Oct 22)					13	3	0	1	0	7	3	5	3	24	5
Was there a delay in transfer once labour was established? (New parameter Oct 22)					3	0	0	0	0	1	0	0	1	3	1

Was there a delay in transfer to delivery suite within 30 minutes where the MEWS was 6 or more or scoring a 3 on a single parameter? (New parameter Oct 22)					1	0	0	0	0	0	0	0	0	0	1
Was there a delay of more than 30 minutes to initiate the sepsis care bundle? (New parameter Oct 22)					1	1	0	0	0	0	0	1	0	0	1
Has there been a deferred date of planned induction of labour? (New parameter Oct 22)					9	0	0	0	0	2	0	1	0	7	1
Has there been any cancelled or delayed community work? (New parameter Oct 22)					1	0	0	0	1	4	1	27	177	31	4
Total numbers of red flags	**5**	**7**	**66**	**38**	**78**	**12**	**2**	**5**	**15**	**126**	**44**	**72**	**218**	**187**	**105**

*7 incidents reported on Datix however, when reviewed as part of the monthly assurance process, it was assessed that one-to-one care in established labour was provided on all occasions.

Board Report

NHSE notification: Verdict in the trial of LL			
Report to:	Board of Directors	**Date:**	5th October 2023
Report of:	Chief Nursing Officer	**Prepared by:**	S Cullen
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to provide assurance to the Board of Directors following the case of Lucy Letby and the learning that may be drawn from the case at this time whilst the statuary public enquiry takes place.

The neonatal nurse murdered seven and attempted to murder six other infants in her care between June 2015 and June 2016. Suspicions arose after an outbreak of unexpected collapses and infant deaths between June 2015 and June 2016 at the Countess of Chester Hospital, starting around the same time Letby qualified to work with children in the intensive care unit. Concerns were raised that Letby was always on duty during the incidents.

A Board Workshop was held on the 5th September 2023 which provided an opportunity to discuss and reflect upon the case alongside a letter received from NHS England to all ICB and NHS Trusts. It is important to acknowledge the full details are not yet known and conclusions are in part influenced by the press coverage of the case and the communications from NHS England. The Board will continue to have the opportunity to reflect on the findings of the case as they become formalised.

The paper sets out the arrangements for leadership, oversight and engagement and identifies a number of varied mechanisms to look and listen to patient and staff feedback, speak up arrangements and patient and staff outcomes. It is critical the Board continues to remain vigilant and adopts an enquiring approach to the data we do and do not receive.

The Boards discussion of this topic at the Board workshop on 5th September identified good levels of assurance in a number of areas and functions and has also identified several areas that the organisation will now focus on strengthening to ensure learning is implemented from the case. Progress against this will be reflected within the Freedom to Speak Up reports to Board.

Recommendation

The Board is asked to note the contents of the report, confirm it is assured of the measures in place and planned developments.

Appendix 1 – NHS England Letter.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims	Ambitions

To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☐
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

1. Introduction

The purpose of this report is to provide assurance to the Board of Directors following the case of Lucy Letby and the learning that may be drawn from the case at this time whilst the statuary public enquiry takes place.

The neonatal nurse murdered seven and attempted to murder six other infants in her care between June 2015 and June 2016. Suspicions arose after an outbreak of unexpected collapses and infant deaths between June 2015 and June 2016 at the Countess of Chester Hospital, starting around the same time Letby qualified to work with children in the intensive care unit. Concerns were raised that Letby was always on duty during the incidents.

A Board Workshop was held on the 5th September 2023 which provided an opportunity to discuss and reflect upon the case alongside a letter received from NHS England to all ICB and NHS Trusts. The case has underscored the significance of good governance and providing healthcare professionals with a safe and secure environment to raise concerns about patient safety, clinical practice, and organisational issues. The Board discussed the importance of fostering a culture of Freedom to Speak Up with robust feedback mechanisms in order to help prevent and detect similar situations occurring.

2. Importance of Freedom to Speak Up

Freedom to Speak Up promotes a culture in which staff feel empowered to report concerns without fear of repercussions. This culture not only protects patients but also supports staff well-being, as it encourages learning, improvement, and accountability. Last year NHS England rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest. NHS leaders and Boards must ensure proper implementation and oversight of speak up arrangements specifically, Boards must urgently ensure:

a. All staff have easy access to information on how to speak up.

b. Relevant departments, such as Workforce, Organisational Development, Equality, Diversity and Inclusion and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.

c. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

d. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.

e. Boards are regularly reporting, reviewing and acting upon available data.

3. Systems in place to detect and prevent harm occurring

There are a number of arrangements in place within the organisation and system that provide staff and patients with the opportunity to raise concerns and for leaders to interrogate data that may indicate an emerging issue of concern. These are organised within the categories of Leadership, Oversight and Engagement. The list is not exhaustive however provides the core areas that aim to underpin safe services to patients.

Leadership Infrastructure

- Board of Directors
- Board designated safety and speak up guardians
- Senior Independent Director
- Freedom to Speak Up Guardian
- Robust Leadership Triumvirate arrangements
- Clinical Divisions with specific dedicated leadership for women and children services
- Responsible officer arrangements for professions
- Person In Position of Trust (PIPOT)

Oversight

- Our Big Plan
- Committees of Board
- Raising concerns group (Triangulation of incidents, complaints, feedback, surveys)
- Safety and Learning Group
- Incident reporting analysis
- Medical examiner function
- Perinatal Mortality Review Tool (PMRT) reporting
- National peer comparison data
- LEDER reviews
- National audits
- Getting it right first time (GIRFT)
- Coroner
- Current patient safety incident framework
- STEIS investigation process, soon to be replaced with patient safety incident response framework (PSIRF)
- Complaints
- Patient Advice and Liaison Service (PALS)
- Friends and Family
- Safety Triangulation Accreditation Review (STAR) quality assurance
- Biannual safe staffing reporting
- Quarterly serious case report
- Mortality reports
- Freedom to speak up reports
- Professional survey response and peer benchmark
- Health and Safety Investigation Branch (HSIB) review
- Safety and quality dashboard
- Person in position of trust (PIPOT) report
- Safeguarding – managing allegations process
- External Regulator- raising concern arrangements
- Local authority safeguarding concern arrangements
- Staff and patient survey results
- Suspension report

Engagement

- Council of Governors
- Board Safety and Experience visits
- Strategic Operations Group debrief
- Freedom to speak up
- Executive question and answer
- Nursing, Midwifery, Governance, Allied Health Profession and Consultant Forums
- Exit interview analysis

- Educational feedback
- Ambassador forums
- Junior Doctors forum
- NHS Resolution discussion
- Claims thematic review
- Part II risk register
- Maternity Voices Partnership Chair
- Patients as partners
- Emergency Department (ED) safety Forum

4. Fit and proper person

The Board has been asked to adopt the NHSE framework for the Fit and Proper Persons (FPP) Test post Kark review at its meeting on 5 October. In compliance with this framework an annual review of FFP has been factored into the annual cycle of business, with the review being undertaken in February/March each year to coincide with the director appraisals and align with each new financial year. As part of the implementation of the new framework from 1 October 2023 a review of all current files has been undertaken and all new directors (including interim appointments and secondments) being offered or taking up post on or around 1 October onwards will be subject to the FPP procedure under the new framework.

5. Communications

On the release of the verdict several actions have been taken by the organisation.

- Communications to the whole organisation
- Communication to the parents on the unit
- Communication to the neonatal team
- Discussion held with leaders on the importance of listening and speaking up in all areas of the organisation
- Discussion held with specific focus on neonatal impact
- Visit to the neonatal area by the Chief Medical and Nursing Officers

Speak up communications will continue to feature within our communications program.

6. Future Actions

To strengthen our systems, process and culture with regards to providing healthcare professionals with a safe and secure environment to raise concerns about patient safety, clinical practice, and organisational issues, the following actions are to be implemented:

6.1 Understanding of Risks

- Expand the Confidential Culture Risk Process and focus of the part 2 element of Divisional Improvement Forums, Workforce Committee and Board to share decision making around high-risk employee relations casework/individuals and suspensions.
- Through the implementation of the Patient Safety Incident Review Framework (PSIRF), review, strengthen and implement analysis of incidents and concerns through the lens of the individuals involved to determine if patterns exist, whilst still ensuring a just culture approach is taken to ensure system wide learning is understood and blame is not unfairly attributed.
- For areas where a confidential culture risk is identified, to review all patient safety Datix reports via an organisational development and human factors lens, to understand if themes which may indicate a weak safety culture and normalisation of low expectations or apathy.
- To explore Audit Committee's role in reviewing and exploring external reports relating to cultural

investigations, employee relations issues, in response to CQC or other external whistleblowing cases.

6.2 Development and Awareness

- To include high profile national cases as part of all leadership and management development training and culture masterclasses, to raise awareness of leaders in their role in escalating concerns, creating psychological safety in their teams, providing opportunities for team members to come forward and share their views.
- To utilise Freedom to Speak Up Month during October 2023 to focus on breaking down barriers to raising concerns. This will include awareness communications and facilitated sessions which outline types of barriers and all colleagues role in how they can be addressed.

6.3 Raising Concerns Group

- To review and improve the meeting terms of reference, membership and cycle of business to ensure there is a clear focus, remit and outcomes from the meeting which lead to onward action and measurement of improvement.
- To develop a data triangulation pack to be utilised in the meeting as a method in which to enable intelligence to be obtained, allowing the Group to move from being reactive to proactively understanding themes and trends, as well as determining where a concern needs to be escalated and remedial actions put in place.
- To develop communications which demonstrate a restorative, just and learning culture, where we seek to share the actions we have taken forward via FTSU concerns, the learning we have taken at individual, team, organisational and system levels.

6.4 FTSU Case Management Processes

- Developing a more detailed FTSU Case Management Framework that provides clarity on how cases will be managed, this will include describing the processes for recording, communication, escalation, and triangulation of information, as well as when it will be considered appropriate for cases to be closed.
- Through consultation with Divisional Management Teams provide greater oversight and assurance as to how concerns raised within their divisions are being progressed.
- A review of the use of DATIX to manage FTSU cases to ensure this provides adequate support in delivering on the above, whilst also adhering to the recording criteria set by the National Guardian's Office.
- Ensuring the FTSU Guardian/s deliver the requirements of the role within the scope set out by the National Guardian's Office, specifically maintaining objectivity, being non-judgemental and seeking to act as an independent source of support for all those involved in the concern.

6.5 FTSU Communication and Reporting of Concerns

- Development monthly FTSU Divisional Reporting to support the Divisional Management Team (DMT's) to have the understanding and awareness of the concerns raised in their division.
- Ensuring the information provided to DMT's also includes a descriptive narrative, highlighting areas for concern such as repeated themes, reference to individuals/teams/services or lack of progress with regard to specific cases.
- Encouraging the DMT to provide information back to FTSU regarding action taken to support case progression.
- Develop a more consistent approach to triangulation of FTSU data alongside other sources of data, such as Workforce, Organisaitonal Development and Patient Safety, to support a proactive approach to managing these concerns organisationally. Examples may include prevalence of grievances, low scores in Staff Survey, Confidential Culture Risks, suspensions, Team Engagement Tool (TED) tool findings, General Medical Council (GMC) trainee survey feedback and patient safety incidents.

6.6 Engagement with Stakeholders regarding FTSU

- Engaging with the FTSU Champions Network – providing regular supervision, support, and opportunities to explore the speaking up culture in their places of work. Actively recruiting more champions, with a targeted approach to services where we feel there is a need.

- Providing support to our colleagues (such as Union and Workforce Advice) on FTSU and how this can be used appropriately to support colleagues when they have a concern they want to raise.

- Improving the organisational awareness and understanding of the FTSU service offer, how colleagues can access it and what to expect when a concern is raised. Specifically targeting lower banded colleagues, and colleagues with protected characteristics who may experience additional barriers to speaking up.

- Re-introduce twice yearly reporting to Board, and regular communications to all colleagues on the value of FTSU, what colleagues have spoken up about, lessons learned, and action taken to respond to these.

7. Conclusion

The Lucy Letby case highlights the critical role of leadership, good governance, speak up arrangements and the importance of creating and maintaining positive cultures within NHS organisations. There are a number of mechanisms on place to protect patients and staff, however, there is no room for complacency and as a Board it is critical we continue to be vigilant, adopt an enquiring mindset and seek assurances on patient and staff outcomes including speak up arrangements.

The Boards discussion of this topic at the Board workshop on 5th September identified good levels of assurance in a number of areas and functions and has also identified several areas that the organisation will now focus on strengthening to ensure learning is implemented from the case. Progress against this will be reflected within the Freedom to Speak Up reports to Board.

8. Recommendation

The Board is asked to note the contents of the report, confirm it is assured of the measures in place and planned developments.

Classification: Official

NHS England

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

a. All staff have easy access to information on how to speak up.
b. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
c. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking

up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

d. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.

e. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

Chair's Report

Committee:	Education, Training and Research Committee
Chairperson and role:	Professor Paul O'Neill, Non-Executive Director
Date(s) of Committee meeting(s):	8 August 2023
Purpose of report:	To update the Board on the business discussed by the Education, Training and Research Committee. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and for escalation to the Board

Committee Chair's narrative

The Committee conducted a comprehensive review of the scheduled items on the agenda, approved the minutes of the June meeting and noted the status of the action log.

The Committee received presentations from the four divisions of Medicine, DCS, Surgery and Women's & Children's Services, which highlighted the key challenges, strengths, and areas for development in relation to education and the delivery of divisional education contracts within each division.

The Committee was presented with the Education Quality Surveillance report, which provided an update on information presented to the Committee in June 2023 in relation to the Health Education England (HEE) quality intervention visit on 5 and 7 July 2023. It also presented the results for the 2023 GMC National Training Survey which had recently been shared by HEE.

The Committee scrutinised the core skills training report, which provided a summary of compliance status at Trust and Divisional level. Key points to note included Trust appraisal compliance was 88.78% (target 90%), Trust medical device compliance was 84.44% (target 90%), 6 mandatory training metrics were currently below compliance target and 3 pieces of training had been added to the mandatory group in April 2023.

The Committee considered and agreed the strategic risk rating should remain at 20 but careful consideration would be given at the next meeting whether some of the discussion today had mitigated the risk for it to be reduced.

The Committee noted positive and negative escalations from the ETR feeder groups - Apprenticeships Strategy & Assurance Committee, Training Compliance and Assurance Sub-committee and Research and Innovation Sub-committee.

Items for the Board's attention

Positive escalation

None.

Negative escalation
None.
Committee to Committee escalation
None.
Items recommended to the Board for approval
None.
Committee Chairs reports received
a) Apprenticeships Strategy & Assurance Committee b) Training Compliance and Assurance Sub-committee c) Research and Innovation Sub-committee
Items where assurance was provided and/or for information
a) Education Quality Surveillance report b) Core skills training report
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 10 October 2023 using Microsoft Teams.

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Education, Training and Research Committee agenda (8 August 2023)

Education, Training and Research Committee

8 August 2023 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	1.00pm	Verbal	Information	P O'Neill
2.	Apologies for absence	1.01pm	Verbal	Information	P O'Neill
3.	Declaration of interests	1.02pm	Verbal	Information	P O'Neill
4.	Minutes of the previous meeting held on 13 June 2023	1.03pm	✓	Decision	P O'Neill
5.	Matters arising and action log	1.05pm	✓	Decision	P O'Neill
6	Strategic risk register review	1.10pm	Verbal	Assurance	P O'Neill
7	CPO portfolio: implications for ETR Committee	1.15pm	Verbal	Information	J Foote
8.	PERFORMANCE				
8.1	Education contracts review: Medicine	1.20pm	Pres	Decision	Mark Brady, Michael Brown, Rachel Sansbury
8.2	Education contracts review: DCS	1.40pm	Pres	Decision	Parag Desai
8.3	Education contracts review: Surgery	2.00pm	Pres	Decision	Aprajay Golash Lisa Elliott, Kate Hudson
8.4	Education contracts review: Women's & Children's Services	2.20pm	Pres	Decision	Emma Ashton, Joanne Connolly, Nick Wood
8.5	Education Quality Surveillance report	2.40pm	✓	Assurance	A Sykes
8.6	Core skills training report	2.50pm	✓	Assurance	L O'Brien
9.	GOVERNANCE & COMPLIANCE				
9.1	Strategic risk review and update	2.55pm	✓	Assurance / Decision	P O'Neill
10.	ITEMS FOR INFORMATION				

№	Item	Time	Encl.	Purpose	Presenter
10.1	Feeder group Chair's reports negative/positive escalations: a) Apprenticeships Strategy & Assurance Committee b) Training Compliance and Assurance Sub-committee c) Research and Innovation Sub-committee	2.57pm	✓	Information	L O'Brien / P Brown
10.2	Items for referral to the board or items to/from other committees	2.58pm	Verbal	Information	P O'Neill
10.3	Reflections on the meeting and adherence to the Board Construct	2.59pm	✓	Assurance	P O'Neill
10.4	Date, time, and venue of next meeting: 10 October 2023, 1pm via MS Teams	3.00pm	Verbal	Information	P O'Neill

Chair's Report

Committee:	Workforce Committee
Chairperson and role:	Jim Whitaker, Non-Executive Director
Date(s) of Committee meeting(s):	12 September 2023
Purpose of report:	To update the Board on the business discussed by the Workforce Committee. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The Committee conducted a comprehensive review of the scheduled items on the agenda and approved the minutes of the meeting on 11 July 2023 and noted the status of the action log.

The Committee scrutinised the Workforce and Organisational Development integrated performance report review, noted the key metrics, improvements made and continued areas of challenge.

The Committee received the recruitment strategy report, which detailed actions being taken to reduce vacancies and increase candidates plus a summary of the key priorities for the team for 2023-24.

The Committee was provided with an ICB central services update.

The Committee reviewed the violence and aggression report, noted the increased number of incidents reported and how issues continued to be addressed through several workstreams outlined in the 3-year violence prevention and reduction strategy.

The Committee received the appraisal, revalidation and medical governance annual report, which provided assurance that appraisal systems were robust, supported revalidation and were operating effectively, whilst acknowledging further improvements were to be made.

The Committee was presented with the annual onboarding and retention strategy report, which outlined progress against the retention element of the 'to engage, retain, reward and recognise' strand of the newly launched Our People Plan 2023-2026.

The Committee welcomed Stephanie Finch, Ward Manager, Ward 5 and Samantha Kenny, Head of Programmes, Organisational Development who highlighted the achievements made on Ward 5.

The Committee reviewed the strategic risk register and agreed the risk rating should remain at 16.

Items for the Board's attention
Positive escalation
None.
Negative escalation
None.
Committee to Committee escalation
None.
Items recommended to the Board for approval
Appraisal, Revalidation and Medical Governance annual report
Committee Chairs reports received
Temporary staffing group. Equality, diversity & inclusion group
Items where assurance was provided and/or for information
Workforce and organisational development integrated performance report review Recruitment strategy report Violence and aggression report Annual onboarding and retention strategy report Exception report from the DIFs
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 14 November 2023 using Microsoft Teams

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Workforce Committee agenda (12 September 2023)

Workforce Committee

12 September 2023 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	a) Chair and quorum b) Temporary recording of meeting	1.00pm	Verbal	Information	J Whitaker
2.	Apologies for absence	1.01pm	Verbal	Information	J Whitaker
3.	Declaration of interests	1.02pm	Verbal	Information	J Whitaker
4.	Minutes of the previous meeting held on 11 July 2023	1.03pm	✓	Decision	J Whitaker
5.	Matters arising and action log	1.05pm	✓	Assurance	J Whitaker
6.	Strategic risk register review	1.10pm	Verbal	Assurance	J Whitaker
7. PERFORMANCE					
7.1	Workforce and organisational development integrated performance report review	1.15pm	✓	Information	K Downey
8. STRATEGY DELIVERY					
8.1	Recruitment strategy report	1.25pm	✓	Assurance	K Downey
8.2	ICB central services update	1.35pm	Verbal	Information	L Graham
9. TO BE INCLUSIVE AND SUPPORTIVE					
9.1	Violence and aggression report	1.45pm	✓	Assurance	R O'Brien
10. TO BE INCLUSIVE AND SUPPORTIVE					
10.1	Appraisal, Revalidation and Medical Governance annual report	1.55pm	✓	Assurance	A Gale
11. TO ENGAGE, RETAIN, REWARD AND RECOGNISE					
11.1	Annual onboarding and retention strategy report	2.05pm	✓	Assurance	L Graham
11.2	Staff story	2.15pm	Pres	Information	L Graham
12. GOVERNANCE AND COMPLIANCE					
12.1	Strategic risk register review	2.35pm	✓	Decision	J Whitaker

№	Item	Time	Encl.	Purpose	Presenter
12.2	Reflections on the meeting and adherence to the Board construct	2.40pm	✓	Information	J Whitaker
12.3	Items for escalation to the Board or items to/from other committees	2.42pm	Verbal	Information	J Whitaker
13. ITEMS FOR INFORMATION					
13.1	Exception report from the DIFs	2.45pm	✓	Information	N Latham
13.2	Feeder group Chair's reports: a) Temporary staffing group b) Equality, diversity & inclusion group	2.47pm	✓	Information	R O'Brien / K Downey / L Graham
13.3	Action 2: Representation of our workforce protected characteristics	2.48pm	✓	Information	L Graham
13.4	Date, time, and venue of next meeting: *14 November 2023, 1.00pm via Microsoft Teams*	2.50pm	Verbal	Information	J Whitaker

PLEASE NOTE FOLLOWING THIS MEETING A RESTRICTED ITEM WILL BE DISCUSSED (A SEPARATE AGENDA HAS BEEN ISSUED)

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Appraisal & Revalidation & Medical Governance Report			
Report to:	Board of Directors	**Date:**	5 October 2023
Report of:	Chief Medical Officer	**Prepared by:**	R Haslam
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary:

This report covers the period of the 1 April 2022 to the 31 March 2023.

The template format of the report has been provided by the NHS England Revalidation Team. All Trusts have been requested to use the template and submit the full report which includes the Compliance Statement to NHS England before 31 October 2023.

The purpose of this report is to provide assurance that appraisal systems are robust, support revalidation and are operating effectively, whilst acknowledging that there are further improvements to be made. The report forms part of the Chief Medical Officer's duties as Responsible Officer.

On the 31 March 2023 there were a total of 712 doctors who had a prescribed connection to Lancashire Teaching Hospitals NHS Foundation Trust.

Of the 712 doctors connected to the Trust, 606 were due an appraisal in 2022/23 appraisal cycle. A total of 590 doctors completed an appraisal between 1 April 2022 and 31 March 2023. There were 15 approved missed appraisal which were due to Sickness during the cycle, Career Break or Maternity Leave. One appraisal was categorised as an unapproved missed appraisal.

A total of 121 revalidation recommendations were made between 1 April 2022 and 31 March 2023. The number is above the normal due to the number of revalidation date changes made by the GMC during the pandemic in 2020/21 period.

The report was scrutinised by the Workforce Committee at the meeting on 12 September 2023 and recommended to the Board for approval.

The Board of Directors is asked to:

a) Confirm that the report provides assurance regarding medical appraisal and revalidation within the Trust.
b) Approve the report for the Chair to sign the Statement of Compliance (section 9) prior to submission of the return to NHS England by the deadline of 31 October 2023.

Trust Strategic Aims and Ambitions supported by this Paper:			
Aims		**Ambitions**	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☐
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For The Future	☐
Previous consideration			
Workforce Committee (12 September 2023)			

NHS England North West
Medical Directorate
Professional Standards Team

2022-2023 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

Contents

Introduction:

The Annual Organisational Audit (AOA) has been stood down for the 2022/23 year. A refreshed approach is in development. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for assurance visits to Designated Bodies.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted electronically to NHS England North West by **31st October 2023** and should be sent to england.nw.hlro@nhs.net

Section 1: General

2022-2023 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Lancashire Teaching Hospitals NHS Trust
What type of services does your organisation provide?	Acute

	Name	Contact Information
Responsible Officer (RO)	Dr G Skailes	drgeraldine.skailes@lthtr.nhs.uk
Chief Medical Officer (CMO)	Dr G Skailes	as above
Medical Appraisal Lead (MAL)	Dr A Gale	alison.gale@lthtr.nhs.uk
Appraisal and Revalidation Manager (RAM)	Rhona Butters	rhona.butters@lthtr.nhs.uk
Head of Medical Workforce	Lisa Eccles	lisa.eccles@lthtr.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes

If yes, who is this with?

Organisation: St Catherine's Hospice Please describe arrangements for Responsible Officer to report to the Board: Date of last RO report to the Board: August 2022 Action for next year: Continue with process for presentation of report to Board

Section 2a: Appraisal Data

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2023?	712
Total number of appraisers as of 31 March 2023?	166
Total number of agreed exceptions granted between 1 April 2022 and 31 March 2023?	15
Total number of missed appraisals* between 1 April 2022 and 31 March 2023?	1

*A missed appraisal is an appraisal that is not completed, and no exception has been granted in that appraisal year (1 April 2022-31 March 2023).

Section 2b: Revalidation Data

Timely recommendations are made to the General Medical Council (GMC) about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Total number of recommendations made to the GMC between 1 April 2022 and 31 March 2023?	121
Total number of positive recommendations submitted between 1 April 2022 and 31 March 2023?	87
Total number of recommendations for deferral submitted between 1 April 2022 and 31 March 2023?	34
Total number of recommendations for non-engagement submitted between 1 April 2022 and 31 March 2023?	0
Total number of recommendations submitted after due date between 1 April 2022 and 31 March 2023?	2 (Admin issue, submitted on time but not received)

Appendix 1 GMC Data 01/04/2022 to 31/03/2023

Section 3: Medical Governance

Concerns data

How many doctors have been through the Maintaining High Professional Standards (MHPS) or equivalent process between 1 April 2022 and 31 March 2023?	2
How many doctors have been referred to the GMC between 1 April 2022 and 31 March 2023?	1 (self-referral)

How many doctors have been referred to the Practitioner Performance Advice Service (PPA) between 1 April 2022 and 31 March 2023?	**5**
How many doctors have been excluded from practice between 1 April 2022 and 31 March 2023?	1

Organisational Policies

List your policies to support medical appraisal and revalidation	Implementation date	Review date
Medical Appraisal Policy	May 2021	May 2024

List your policies to support MHPS and managing concerns	Implementation date	Review date
Handling Concerns about doctors & Dentists Conduct & Capability	03/04/2018	31/10/2024

Other relevant policies	Implementation date	Review date
Early resolution Policy	22/04/2021	31/07/2024
Raising concerns at Work policy & procedure – freedom to speak up	13/06/2022	31/07/2025

How do you socialise your policies?

The policies are published on Heritage, which is available to all staff via the LTHTR Intranet. Updated guidelines are brought to the attention of staff by a Trust wide email.

Section 4: General Information

The board / executive management team can confirm that:

4.1 An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes, this is held by the Chief Medical Officer who is the Responsible Officer
Action for next year (1 April 2023 – 31 March 2024). None

4.2 The designated body provides sufficient funds, capacity, and other resources for the responsible officer to carry out the responsibilities of the role.

Yes
If No, please provide more detail:

4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained?

Yes
If yes, how is this maintained? The revalidation & appraisal manager monitors new starters, leavers, and ad hoc connections in line with set processes.
If no, what are you plans to implement a record keeping process? (Action for next year (1 April 2023 – 31 March 2024). Not applicable

4.4 Do you have a peer review process arranged with another organisation?

If yes, when was the last review? The Trust is part of a regional group for peer review including the acute trusts within the Lancashire and South Cumbria Integrated Care System, the last full review was undertaken in 2017. The 2023 peer review is in progress, the Trust was visited on 4th July 2023, the report has recently been received and is included in the appendices. Appendix 2 Peer Review Report Action for 2023/24

The appraisal team will review the Trust peer review report for actions and any process changes recommended. The appraisal team will also review good practice highlighted in the peer review final meeting. Any actions will be provided in the next board report with process changes.

4.5 Is there a process in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation?

Yes

4.6 How do you ensure they are supported in their continuing professional development, appraisal, revalidation, and governance? The trust has an established medical bank. Doctors engaged through the bank work ad-hoc hours, some more than others. Some bank doctors require the trust to act as their designated body when they undertake most of their work at Lancashire Teaching Hospitals whereas others may be employed elsewhere, and this employer acts as the designated body. For those with a prescribed connection to LTH as their designated body, the doctors will undertake an annual appraisal and be supported through revalidation by the Trust. For those doctors without a prescribed connection, we offer any support required for revalidation, this varies on a case-to-case basis (i.e. completed exit report). All new doctors including bank doctors who have a prescribed connection are invited to meet the RAM for training on appraisals and content.

Section 5: Appraisal Information

5.1 Have you adopted the Appraisal 2022 model?

Yes

5.2 Do you use MAG 4.2?

No

5.3 Please describe any areas of good practice or improvements made in relation to appraisal and revalidation in the last year (1 April 2022 to 31 March 2023).

New Appraisal Lead appointed April 2022. Re-established medical appraiser training sessions.

Feedback to new appraisers by the Appraisal Lead.

Re-commenced Quality Assurance of appraisal summaries

Audit trail for postponement appraisals.

Action plan for revalidation deferrals developed and in use.

5.4 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

Review of medical appraiser training to be undertaken.

Review of existing processes and Standard Operating Procedures (SOPs).

5.5 How do you train your appraisers?

In-house training sessions approx. 3 per annum. Content of training to be reviewed in the 23-24 cycle to improve quality.

Currently the training is 1 day, with the morning session delivered by Organisational Development and the afternoon session focussing the appraiser functions on the appraisal system. The sessions have been delivered by MS Teams.

Following completion of appraiser training, new appraisers are only allocated 3 appraisees over the first 12 months. The documentation of these appraisals is reviewed by the Appraisal lead and detailed feedback provided.

5.6 How do you Quality Assure your appraisers?

Each year the Revalidation & Appraisal team provide annual update sessions to facilitate attendance for all appraisers, attendance at such events is monitored. Appraisers who are unable to attend any of the sessions are provided with the material content.

The Quality Assurance of appraisal summaries is undertaken each year. The appraisal lead reviews the outputs completed by new appraisers and provides individual feedback. The RAM undertakes a review of a 20% sample of completed appraisal summaries using the template (Appendix 3) and provides this feedback to the appraisers.

Post appraisal Questionnaire (PAQ) summary reports are being provided from the L2P system for those appraisers who have received 3 or more completed feedback questionnaires from appraisees.

The RAM collates all feedback obtained through the annual quality assurance process and themes identified from this feedback are incorporated into the annual update sessions.

Appendix 3 Template of QA for 22-23 cycle

Appendix 4 PAQ overall feedback

5.7 How are your Quality Assurance findings reported to the board?

The result of the Quality Assurance (QA) findings are included in the annual report. Due to the pandemic and the number of appraisal templates the review of summaries was paused in 2021-22.

QA was resumed in the 2022 -23 appraisal cycle. A 20% random selection have been reviewed and the findings added to the table of results.

Appendix 5 – QA Summary Findings

Action for 2023/24

Ensure that all appraisers receive feedback either via the PAQs or a summary from the RAM. Report summary of QA findings to the board in the 2024 annual report.

5.8 What was the most common reason for deferral of revalidation?

The most common reason for deferral (88%) was due to incomplete 360 feedback. The process was changed in 2021 when a new 360 feedback system was procured. Doctors were added in the 4th & 5th year of their cycle at that time. Because of the high deferral rate, we have amended the process to allocate doctors at the mid- point of their revalidation cycle. However, there is still a transition and delay in the number of doctors commencing the process once allocated to the system. The commencement of the process by several doctors has been late and therefore the Multi Source Feedback (MSF) has not been completed before the revalidation submission date, despite reminders from the RAM.

Action for 2023/24

Communication to doctors highlighting the need to commence their 360 promptly. Review progress 6 months prior to revalidation date to ensure completed and highlight actions required.

5.9 How do you manage doctors that are difficult to engage in appraisal and revalidation?

The Trust has a process of reminders and the RAM and the MAL meet regularly to review doctors who are not engaging in appraisal and revalidation. A deferral plan and SOP has been developed. The MAL will meet with doctors who are not engaging to agree an action plan.

Action for 2023/24

Review SOP for management of late appraisal and embed the new process.

Section 6: Medical Governance

6.1 What systems and processes are in place for monitoring the conduct and performance of all doctors?

To provide assurance that Lancashire Teaching Hospitals provides a suitable environment delivering effective clinical governance for doctors, an assessment against the GMC Clinical Governance Handbook has been undertaken with Information Governance leads, the Medical Workforce Manager and Revalidation and Appraisal Manager. The review of the GMC Clinical Governance Toolkit was undertaken in 2021. The Completed Self-Assessment Toolkit was completed at that time and potential areas for improvement have been identified, progress in some of these areas has been made.
A Non-Executive Director has been identified for Maintaining High Professional Standards (MHPS) and will support revalidation issues.
Actions for 2023/24
Repeat the GMC 'Effective Clinical governance for Medical Profession' self-assessment and complete a full benchmarking exercise to inform future improvements.

6.2 How is this information collated, analysed and shared with the board? (Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors).

This information is presented to the Workforce Committee annually in the 'Concerns about Doctors Annual Report'. The 2023 report is due to be presented by the Head of Workforce Advice according to the Committee Cycle of Business.
Actions for 2023/24
Annual report to be presented to Workforce Committee.

6.3 How do you ensure that any concerns are managed with compassion?

We aim to uphold the principles of Restorative Just and Learning Culture throughout our processes for managing concerns. We continue to support an environment where colleagues feel enabled to speak up through appropriate channels, such as their line manager/supervisor, Freedom to Speak Up, DATIX or staff forums, and that their concerns will be taken seriously and acted upon. We act with compassion throughout this process, supporting colleagues to remain in their place of work throughout any investigation where it is safe and appropriate for them to do so and receive appropriate Health and Wellbeing support if required. We seek to understand the circumstances surrounding any concerns, not just focussing on the individual or placing undue amounts of blame on them personally. We encourage supportive debrief activities to take place

so that individuals and teams can process and reflect on these situations. This allows us to acknowledge the emotional impact this may have had or continue to have, what support might be needed to address this, and any learning that can be taken to reduce the likelihood of this happening again in the future.

Organisationally, we continue to place great emphasis on every colleague taking personal responsibility for upholding our values through their own conduct and performance. Our Best Version of Us cultural campaign supports all colleagues taking a zero-tolerance approach towards negative behaviour from others. Through this, we are enabling our colleagues to take positive action to challenge the behaviour of others which is having a negative impact on them. The approach here is one of curiosity and compassion, helping each other to understand the impact of our behaviours, and the standards we should be upholding in the delivery of our day-to-day roles.

6.4 How do you Quality Assure your system for responding to concerns?

The Trust 'Handling Concerns about doctors & Dentists Conduct & Capability' Policy details how concerns are responded to.
All ongoing Conduct and Performance concerns are reviewed monthly by the Chief Medical Officer, Deputy Chief Medical Officer, Chief People Officer, Head of Workforce Advice and the Revalidation and Appraisal Manager.

Regular meetings are also held with the NHS Resolution Practitioner Performance Advice (PPA) and the GMC ELA (Employer Liaison Advisor) to review active cases. As well as these planned meetings, urgent cases are discussed by a decision-making group (membership as above) and referred where necessary for PPA/GMC ELA advice.

6.5 How if this Quality Assurance information reported to the board?

This information is presented to the Workforce Committee annually in the 'Concerns about Doctors Annual Report'.

6.6 What is the process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)?

A RO-to-RO transfer of information form is completed and sent to a new organisation as requested.
For a doctor with concerns, the transfer of information document is prepared by the RO or DRO and provided to the new organisation and doctor.

In some cases, the RO will communicate directly with the new RO to discuss any concerns. Appendix 6 Transfer of Information Request Template

6.7 What safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination?

Trust policies followed for example MHPS, Early resolution policy, Freedom to Speak up policy. Policies are quality impact assessed and are completed in consultation with staff side and in various forums.

6.8 Please describe any areas of good practice or improvements made in relation to medical governance in the last year (1 April 2022 to 31 March 2023)?

All ongoing Conduct and Performance concerns are reviewed monthly by the Chief Medical Officer, Deputy Chief Medical Officer, Chief People Officer, Head of Workforce Advice and the Revalidation and Appraisal Manager.

Regular meetings are also held with the NHS Resolution Practitioner Performance Advice (PPA) and the GMC ELA (Employer Liaison Advisor) to review active cases. As well as these planned meetings, urgent cases are discussed by a decision-making group (membership as above) and referred where necessary for PPA/GMC ELA advice.

6.9 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

Roll out of Compassionate Conversations training as part of the NHS Resolution Pilot

Section 7: Employment Checks

What is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties?

All doctors recruited to the Trust (whether substantive, fixed term or bank) are subject to the same pre-employment checks as defined by NHS Employment Check Standards

Each check when completed is recorded on the Trust recruitment system (TRAC). All documents are seen and verified in person and are scanned for evidence.

Do you collate EDI data around recruitment and /or concerns information?

Yes
If yes, how do you use this information?' Information used for WRES national report which the Trust Board receive a copy.

Section 8: Summary of comments and overall conclusion

Please use the table below to detail any additional information that you wish to share.

Section 9: Statement of Compliance:

The Board – of Lancashire Teaching Hospitals NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

Official name of designated body: Lancashire Teaching Hospitals NHS Foundation Trust

Name: Peter White

Role: Chairman

Date: ……..

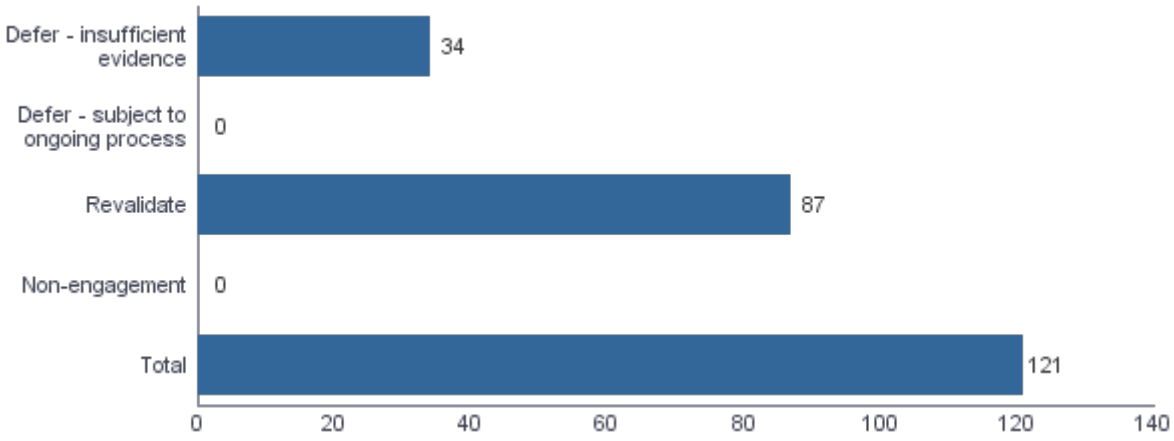
Appendices – Appraisal, Revalidation and Medical Governance Report

Appendix 1

GMC Data 01/04/2022 to 31/03/2023

Recommendations by type

	GP	Specialist	GP & Specialist	Other	**Total**
Defer - insufficient evidence	0	26	0	8	**34**
Defer - subject to ongoing process	0	0	0	0	**0**
Revalidate	0	63	0	24	**87**
Non-engagement	0	0	0	0	**0**
Total	**0**	**89**	**0**	**32**	**121**



Late Recommendations (i.e., after revalidation submission date)

	Number
Defer - insufficient evidence	0
Defer - subject to ongoing process	0
Revalidate	2
Non-engagement	0
Total	2

Deferral Periods

	number
Average Deferral Period (days)	207
# Doctors with chain deferrals	6

Appendix 2 (page 7)– Peer Review Report July 2023

Medical Appraisal and Revalidation Peer Review of

Lancashire Teaching Hospitals NHS Foundation Trust

Date of visit – Tuesday 4th July 2023

1.0 Introduction

The peer review process has been implemented across the Northwest region with the aim of supporting designated bodies and reducing inconsistencies in medical appraisal and revalidation processes.

Each designated body will undergo a peer review at least once in the revalidation cycle.

The process of peer review involves a review and sharing of good practice and making recommendations to the reviewee and the wider regional revalidation team on areas for improvement/opportunities for consistency.

This report follows UHMB's visit to LTHTR on 4th July 2023 to review their process for appraisal, revalidation and responding to concerns.

2.0 Documents provided to the review team prior to the peer review visit

The following documents were provided by LTHTR prior to the visit:

- Letter of Good Standing template
- LTHTR Trust Board Report 2020/2021
- LTHTR Trust Board Report 2021/2022
- Medical and Dental Staff Appraisal Policy
- Medical/Dental Temporary Staffing Policy
- MIAA Review Working Paper
- Private Practice Guidelines
- Peer review of LTHTR by Blackpool Teaching Hospitals NHS Trust - 2017
- Peer Review Paper prepared for this Peer Review

3.0 Attendance at the review

Trust	Name and title
Lancashire Teaching Hospitals NHS Trust	Dr Alison Gale, Medical Appraisal Lead (MAL), Deputy Chief Medical Officer for Professional Standards.
	Mrs Rhona Butters, Revalidation and Appraisal Manager (RAM)
University Hospitals of Morecambe Bay NHS Foundation Trust	Mr Peter Dyer Associate Medical Director of Appraisal & Revalidation / Fitness to Practise
	Mr Karnad Krishnaprasad Deputy Medical Director for Professional Standards
	Mrs Johanne Herman Medical Appraisal & Revalidation Co-ordinator
	Miss Sally Totton Medical Appraisal & Revalidation Administrator

3.0 Summary of discussion

The following areas were discussed during the visit:

Topic	Comments
Introduction and background	• Dr Gale and Rhona gave a detailed presentation of the Appraisal and Revalidation team's role at their Trust, including the recent history of not having had a Medical Appraisal Lead for two years until Dr Gale was appointed. • There are no Deputy Medical Appraisal Leads. • Appraisal sits within the Workforce function but, although the RAM reports to the Medical Workforce Manager, the A&R function is kept separate from Workforce to avoid conflict. • The appraisal window is between April to November. This has increased from a six-month window. • The Trust has switched to the L2P appraisal software in November 2019, just before the Covid pandemic hit. • They moved to the "Edgecumbe 360" for their Patient Feedback in May 2021 as they found it more useful for their specific patient feedback programme. This has been particularly useful for Anaesthetics and Radiology which are two areas which normally struggle with feedback.
Provision of governance reports for all doctors, including private practice.	• L2P contains an email template in the "Resources" section for doctors to request their own reports from "Datix" and the Complaints team, who email back with any relevant information. The doctor can then upload the email to their appraisal for reflection as necessary. • It is the doctor's own responsibility to source governance information for any private practice, including volunteering roles. There is a "good standing" template on L2P Resource for the doctor to use. • The Appraisers must ensure that all scope of work is declared, and that the correct documents are uploaded to the appraisal.
Appraisers : *Numbers and training	• The Trust currently has around 710 doctors with a GMC Connection and 167 Appraisers. The appraisers are trained in-house by the

*Allocations *Quality assurance	Organisational Development Team, outside of the Appraisal and Revalidation function. The training is in line with the GMC framework. • Appraisers are allocated within the same Division, and usually within the same speciality. The MAL feels that cross-specialty appraisals are good, but there is currently resistance from Divisions. • The Divisions pay towards the cost of the L2P software. • L2P is set to automatically reallocate the same Appraiser for the maximum of 3 years. • Appraisees do not choose their own Appraisers. • The RAM reviews the L2P reports for doctors without Appraisers and allocates. • Appraisers receive a SPA allocation of 0.025 per appraisal within their job plan for a minimum of 4 and a maximum of 10 per year. This does not include time for update events. The Team is looking into this. • Newly trained Appraisers do a maximum of 3 appraisals in their first year. • QAs are done using the modified "Galloway" form. The RAM undertakes a sample of 20% of completed appraisals for the quality assurance audit. Due to Covid and the lack of a MAL for the 2 years, no QAs were done from 2020 until it was revived for the 2022/23 revalidation cycle. • Locum doctors employed for 12 months or more will be provided with an appraisal. • Those employed for less than 6 months are not offered an appraisal but receive an "exit report" to take with them to their next employer.
Maintaining an accurate list of prescribed connections	• The RAM is based in the Medical Workforce team and has access to TRAC. She receives notifications when a new starter is generated. • The RAM has access to the medical locum bank also. • The RAM gets contract change details. • The RAM sends a welcome email to new doctors with details of their appraisal month and allocates a named Appraiser.
Multi-Source Feedback – training and giving feedback	• This is done in-house by the Organisational Development team who train 360 Facilitators. This sits outside of the Appraisal function. • Doctors who are not Appraisers may be encouraged to be 360 Facilitators.

	• Doctors can choose to download a Patient Feedback form from Edgecumbe, use electronic feedback, or use a QR code. All responses go back to the doctor's account and are reviewed by a 360 Facilitator for feedback. The doctor can then upload it to their L2P account for reflection. • The RAM gets an email when the report is ready to review it for revalidation purposes.
Process for Non-Engagers	• There is a good process in place with the L2P reminders followed by two letters to participate with the process. Doctors must then meet with the MAL to discuss the situation. • The RAM documents each stage and pulls a final report for the Medical Director / Responsible Officer for any incomplete appraisals.
Areas of Concern	• The Appraisal and Revalidation Team is very small for so many doctors and it is a credit to them how well the appraisal process is managed at LTH. • The MAL role was vacant for 2 years, putting the new MAL under pressure without a Deputy and the RAM feeling isolated and pressured. • The RAM is a lone worker and has indicated she will be retiring in March 2024. There is no clear succession plan for such a specialised and important role which is of concern. • Due to the number of doctors and appraisal window, there are always high appraisal numbers to be reviewed. • How does the MAL ensure the quality of Appraisers if the training is done by the Organisational Development team? • The time allocated for Appraisers is very short at 0.025PA. Our Clinical Appraisal Lead raises some concern that this is not enough for the task, considering the time also taken to prepare for each appraisal meeting, and asks if the Trust might review this. • Although locum doctors with LTH as their designated body do not have appraisals if they are employed less than 6 months, and receive an "exit" report, our CAL questions if they still receive support from the A&R team to ensure they meet the requirements of revalidation. • Having at least one Deputy MAL would give the team more opportunity for training and developing their roles to enhance the dedicated

	support to their doctors, which also aids the reputation of the department. • The MAL and RAM have indicated they look forward to the Peer Group follow up meeting to look at other areas of good practice

Summary

The UHMB team are grateful to LTH for the opportunity to meet and assess their service as part of our Peer Review process. It is clear from the Review that the small team at LTH are dedicated, follow their processes, and work hard to ensure doctors respect the revalidation process with appropriate support given as needed. The team from UHMB are satisfied that the appraisal and revalidation function at LTH is fit for purpose.

Appendix 3 (page 9) Quality Assurance Template

Quality Assurance for Medical Appraisal ID: (Appraiser Initials – No of Appraisal+ Date of sign-off):
Appraiser: Appraisal End Date
Appraisal Template: Appraisal 2020/Standard
Scoring: 1- Poor, 2 – Satisfactory, 3- Good, 4 Very Good.

Quality Indicators	Score	If a score of 2 or below, please provide comments on areas for improvement and detail where evidence is lacking/improvement needed.
Section Specific Feedback		
Scope of Work Reference made to scope of work, evidence provided in support of external work undertaken i.e. private work (letter of good standing or similar		
PDP Review Contained evidence that last year's PDP had been reviewed and outcomes discussed.		
Well-Being Comment on impact of Covid-19 on health & Wellbeing/professional work life (please note not included in scoring)		
CPD Keeping Up To Date* Provides an overview of the activity completed by the appraisee and how CPD activity has supported their scope of work. If appropriate provides constructive feedback to help the appraisee consider future CPD opportunities.		
Quality Improvement - Review of Practice * Summary of quality improvement activity provided and comments reflect discussions in how outcomes have helped to change practice.		
Significant Events An overview provided of Significant Events declared and further actions required.		
Colleague & Patient Feedback * Summary provided of 360 degree feedback (if appropriate), demonstrating that a conversation has taken place around identified strengths and development needs.		
Complaints & Compliments** An overview of Complaints/compliments declared and evidenced and any further actions required		
PDP Agreed/ Proposals Appraiser has provided assurance that PDP is appropriate, supports identified development needs or service developments		
Achievements - Areas for Discussion Summary contains evidence of the appraisee's achievements, challenges and aspirations. Where appropriate the appraiser may have provided support, suggestions or encouragement.		
Summary of Appraisal discussion – GMC Domains *** Appraiser provides a summary of the evidence they have reviewed to supports the GMC domains. Where appropriate comments made about future development needs.		
Overall Feedback		
The feedback provided in the Appraisal Summary was detailed and showed evidence of the discussions which had taken place.		

The feedback provided in the Appraisal Summary reflected the information provided by the appraisee (for example from the portfolio or within the appraisal document).		
The feedback was well written, balanced and constructive (highlighting areas of strength and potential ways to develop).		
Total:		

If the total score is 29 or less please refer to appraisal lead as this will indicate that a score of 2 – Satisfactory or 1 – Poor has been allocated and may indicate a quality or training need. Total marks available are 52.

A score of 52 – 43 indicates that the appraisal is of a good to very good level of quality, with no gaps and high quality evidence provided.

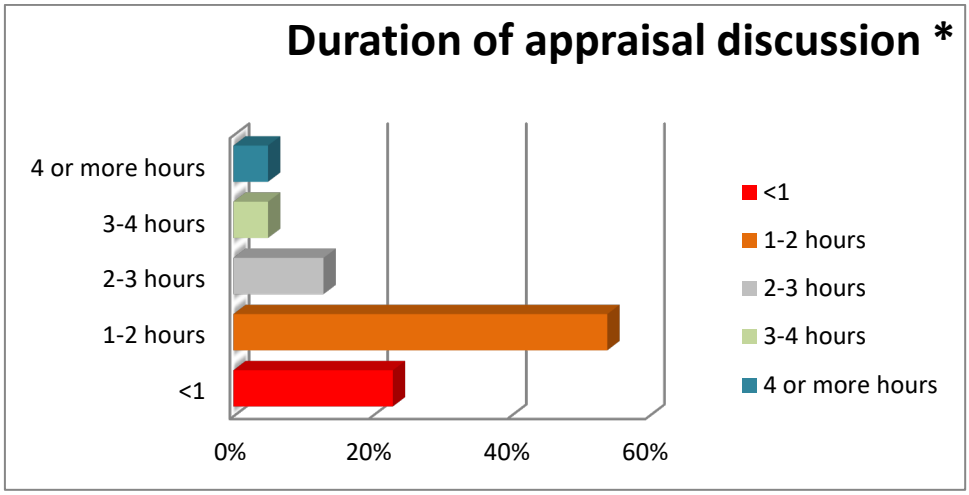
A score of 42 – 30 indicates that there are some good areas however there may be some gaps identified.

A score of 29 – 16 indicates that there are gaps identified or evidence is lacking in the report submitted.

Score of 15 and below indicates that the appraiser has failed to meet quality standards and remedial measures are needed.

- CPD/QI & Feedback is a combined section on Appraisal 2020 template
- ** Complaints section not included in Appraisal 2020 template (auto score of 3)
- *** GMC domains not included in Appraisal 2020 template (auto score of 3)

Appendix 4 (page 9) – PAQ Overall Feedback (L2P system report)



Appraisal Reflections

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Average
There was sufficient protected time for the appraisal discussion *	1%	1%	5%	44%	49%	4.38
The venue was private and professional *	1%	0%	2%	38%	59%	4.52

Appendix 5 (page 10) QA summary findings

Appraisal Cycle	Below 15 Indicates the appraiser has failed to meet quality standards	16 – 29 Indicates that there are gaps identified or evidence is lacking	30-42 Indicates that there are some good areas however there may be some gaps	43-55 Indicates the appraisal summary is of a very good level of quality, with no gaps and high quality evidence	Number with Full Marks! Excellent quality appraisal summary
2014/2015	4.50%	62%	28%	4.50%	0
2016/2017	5%	28%	24%	43%	5
2017/2018	0	11.2%	46.6%	42%	4
2018/2019	0.9%	7.00%	50%	42%	0
2019/2020	0	8%	51%	41%	1
2020/2021*	0	0	91%	8.82%	0
2021/2022**	Not undertaken due to differing templates available				
2022-2023 ***	0	4.30%	87%	8.70%	0

* Note: Due to the number of appraisals cancelled due to the pandemic, there has been a reduced number of appraisal summaries reviewed.. A random selection of 20% appraisals have been reviewed.

** Note None undertaken due to differing templates and confirmed by the Chief Medical Officer

*** Note Appraisal templates for this year were a total of 2 with one combining elements and therefore a shorter appraisal. A random selection of 20 % have been reviewed.

Appendix 6 (page 11) – Transfer of Information Request RO-RO

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Revalidation Reference

Doctor's Name:
GMC Number:
Position Applied for:

Please read the following questions and respond accordingly. If you answer YES to any of the following questions, please supply full details.

Professional Conduct and Performance

Is the above named doctor currently the subject of any investigation by you into their professional conduct or performance?	YES/NO
Has the above named doctor ever been the subject of any investigation by you into their professional conduct or performance?	YES/NO
As far as you are aware, has the above named doctor ever been the subject of an investigation by any licensing, regulatory or other body where the findings were adverse?	YES/NO
What is the current Practice Status of the above named doctor (please delete as appropriate)	A) No known restrictions B) Local restrictions are in place C) Doctor excluded from clinical practice
If you have answered B or C to the above question, please give further details:	

Appraisal and Revalidation

Please give the date revalidation is due for the above named doctor.	
Please give the last revalidation date for the above named doctor (where applicable)	
Please confirm the dates of completed appraisals for the above-named doctor	1. 2. 3. 4. 5.

Were any concerns regarding the above-named doctor's performance identified at the last appraisal?	YES/NO
If yes, please give further details:	
Has the above named doctor regularly engaged in the appraisal process?	YES/NO
If no, please give further details:	
Please give the date of the end of the prescribed connection to your organisation.	

Records of Patient and Colleague Feedback

Information	Year Undertaken	Exception and Reason
Patient Survey Feedback		
Colleague Survey Feedback		

Additional Information

Please detail below any further information deemed appropriate to disclose to the new Responsible Officer:

Responsible Officer Details:

Responsible Officer Name	
Responsible Officer GMC Number	
Responsible Officer Email Address	
Responsible Officer Contact Details	
Organisation details (including Address)	

Name of person completing this reference
(If not Responsible Officer): _____

Designation:_____

Organisation:_____

Telephone Number: _____

Email Address: _____

The above information has been provided without prejudice and is correct to the best of my knowledge and belief.

Signed: _____ Date: D D / M M / Y Y Y Y

You are reminded that references are given in good faith and that under the Data Protection Act 1998 candidates can ask the organisation receiving the reference for a copy of it.

By completing this form you agree to the disclosure of this reference to the named candidate if any concerns are raised by them.

Please return completed form to:

Revalidation and Appraisal Manager, Lancashire Teaching Hospitals NHS Foundation Trust, Medical Workforce Team, 2nd Floor, Preston Business Centre, Preston PE2 8DY.

Or via e-mail: revalidation@lthtr.nhs.uk

Chair's Report

Committee:	Finance and Performance Committee
Chairperson and role:	Tricia Whiteside, Non-Executive Director
Date(s) of Committee meeting(s):	25 July 2023
Purpose of report:	To update the Board on the business discussed by the Finance and Performance Committee on 25 July 2023. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The committee conducted a comprehensive review of the agenda's scheduled items, approved the meeting's minutes on 23rd May 2023 and reviewed updates on associated committee actions. Specific reports were received and scrutinised on the following standing agenda items:

- **Strategic Risk Review** - The Committee resolved to refresh the controls on assurance statements in line with the new system and regional controls and to continue working with colleagues on their implementation. The need to ensure that statutory obligations were maintained during the transition period was emphasised.
- **Financial Performance** - The M3 Finance Report for 2023/24 was discussed, including the International Recruitment Strategy and its impact on the budget. The effects of industrial action on income in day cases were also reviewed and plans for mitigating these challenges were outlined.
- **Operational Performance**
  - i) **Performance Assurance Progress** - Updates on emergency care, cancer care, and outpatient services were provided. While there were positive developments in reducing wait times and cancer backlogs, concerns remained about the impact of industrial action on income and productivity.
  - ii) **Contract Performance** - The Committee noted the need to strengthen the controls linked to the urgent and emergency care programme of work, and the current contractual income position and shortfalls in underlying activity levels.
- **Strategy and Planning**
  - **i) Planning Framework -** There were concerns about managing changes from various external and internal programmes, highlighting the need for effective change management controls. Clarity was sought on the roles of the Trust Board, PCB, and ICB in terms of making decisions about new clinical models of care, specifically in cases like urology and cardiology and the role of the Board in taking such decisions.
  - ii) **Continuous Improvement & Transformation** - The Committee noted that further work was planned to strengthen the PMO function to track the programmes of work and some assurance was received during the discussion. Further work would be required to improve the assurance provided within the report along with a focus on benefits realisation.
  - iii) **Financial Improvement Plan (inc. Simon Barber Action Plan)** - The executive team was expected to take time to reset and re-evaluate the Financial Improvement Plan, addressing the need for a comprehensive and actionable strategy. Concerns were expressed about the existing gaps and the necessity to fill them for effective progress. The Committee noted progress in the

Financial Improvement Plan and discussed strategies to bridge the financial gap, given the challenging operating environment.

In addition, the Committee received reports for consideration/discussion for:

- **Lancashire Procurement Collaborative update** - The Committee received an update on the Lancashire Procurement Collaborative's activities, including cost-saving initiatives and workforce well-being programmes.
- **Financial Strategy 'Knowing the Business' Refresh update** - Concerns were raised about the need for clarity in implementing the recommendations.
- **Northwest Sub-National Secure Data Environment -** The capital funding approach for the initiative was presented, and discussions revolved around governance and sustainability.

The Committee also updated and approved its **Cycle of Business.**

Items for the Board's attention

Positive escalation

- Progress on trajectories despite challenging operating environment and pressures
- 65-week cohort
- Cancer passed the diagnostic performance, over target for March 2024
- Movement on further evolution of the planning framework.
- Endorsed the decision to create a Shared Data Environment, subject to further clarity on governance and risk.
- Significant improvement on NWAS and reduction in ambulance handovers.

Negative escalation

- Continued challenge position on our financial and deficit gap (trajectories for winter pressure seeking early assurance).
- Seeking greater clarity on new system controls focused on cost containment and further assurances on governance arrangements as they operationalise into practice from a system and region perspective.
- Operational challenges around ongoing industrial action.
- Growing trend of mental health delays in ED; was not successful in the first UEC round of monies in securing capital funding to co-locate the LSCFT MHUAC next to the Preston ED and so work to explore an alternative was in place with LSCFT.

Committee to Committee escalation

None

Items recommended to the Board for approval

None

Committee Chairs reports received

(a) EPRR Committee (b) New Hospitals' Programme full report (c) SIRO/IAO Working Group (d) ICS, ICP, PCB system update
Items where assurance was provided and/or for information
ELFS Shared Services Report Exception Reports from Divisional Improvement Forums
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its Cycle of Business. The next meeting of the Committee will take place on 22 August 2023 using Microsoft Teams

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Finance and Performance Committee agenda (*25 July 2023*)

Chair's Report

Committee:	Finance and Performance Committee
Chairperson and role:	Tricia Whiteside, Non-Executive Director
Date(s) of Committee meeting(s):	22 August 2023
Purpose of report:	To update the Board on the business discussed by the Finance and Performance Committee on 22 August 2023. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The committee conducted a comprehensive review of the agenda's scheduled items, approved the meeting's minutes on 25th July 2023 and reviewed updates on associated committee actions. Specific reports were received and scrutinised on the following standing agenda items:

- **Strategic Risk Review** – There was a shared understanding that risks were becoming more tangible and required careful monitoring and control. The Committee felt it was important to not only address the current year's challenges but also stressed the importance of having a comprehensive plan for sustained financial recovery over the medium term.
- **Financial Performance** - The report and discussion emphasised the steep financial challenges faced by the Trust and the need for proactive internal measures and collective cooperation with system partners to improve the financial situation.
- **Operational Performance**
  - i) **Performance Assurance Progress –** The Committee was assured by the measures being taken to improve performance and recognised the difficult balance of decision required against the quadruple aims.
  - ii) **Contract Performance** - The Committee resolved that an improved action plan that provided greater assurance around achieving desired goals was necessary.
- **Strategy and Planning**
  - i) **Planning Framework -** The Committee addressed issues related to decision criteria, risk, finance, alignment, and governance structure.
  - ii) **Continuous Improvement & Transformation** - The Committee discussed the need to connect actions to tangible outcomes with greater transparency and measures of success; having aligned programme governance; and the importance of unified reporting. There was recognition of progress and a commitment to furthering these efforts.

iii) **Financial Improvement Plan –** Recognition was given to the continuing work with system colleagues and partners to identify high value/high impacting changes to close the remaining gap. The Committee welcomed the planned development of an Executive level action plan.

In addition, the Committee received reports for consideration/discussion for:

- **Digital Strategy 6 Month Update** - The committee was assured by the progress in various digital initiatives, recognising the importance of digital transformation and measuring its successes against Trust goals.
- **EPRR Core Standards Annual Assurance 2023-24 -** The report indicated substantial assurance in meeting the standard, with improvements noted since the last review.

Items for the Board's attention

Positive escalation

- Recognition of the significant work delivered in terms of identified improvements, including ambulance handovers, ED wait times and cancer backlogs.
- Achievement of faster diagnostic standards in cancer letting people know faster whether they have or have not got cancer.
- Progress against the Digital Strategy, acknowledging several good programmes of work.
- Endorsement of the EPRR strategy, given contingent on corresponding from independent review.

Negative escalation

- Worsening of financial position and continued pressures within the operating environments.
- Increasing risk of cash availability arising from the in-balance of planned income and expenditure.
- Risks to the delivery of the financial plan and the heightened risk of detrimental impacts on the Strategic Oversight Framework (SOF) ratings.

Committee to Committee escalation

None

Items recommended to the Board for approval

None

Committee Chairs reports received

(a) Capital Planning Forum (inc. TOR)
(b) New Hospitals' Programme flash report
(c) ICS, ICP, PCB system update

Items where assurance was provided and/or for information

Exception Reports from Divisional Improvement Forums

Progress against the Committee's cycle of business

The Committee continues to cover its business work in line with its Cycle of Business. The next meeting of the Committee will take place on 25 September 2023 using Microsoft Teams

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 2 – Finance and Performance Committee agenda (*22 August 2023*)

Finance and Performance Committee

25 July 2023 | 2.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	2.00pm	Verbal	Information	T Whiteside
2.	Apologies for absence	2.01pm	Verbal	Information	T Whiteside
3.	Declaration of interests	2.02pm	Verbal	Information	T Whiteside
4.	Minutes of the previous meeting held on 23 May 2023	2.03pm	✓	Decision	T Whiteside
5.	Matters arising and action log	2.04pm	✓	Decision	T Whiteside
6.	Strategic Risk Review	2.10pm	✓	Assurance	J Wood
7.	FINANCIAL PERFORMANCE				
7.1	M3 Finance report	2.20pm	✓	Assurance	C McGourty
7.2	Lancashire Procurement Collaborative update	2.40pm	✓	Assurance	S Robson
8.	OPERATIONAL PERFORMANCE				
8.1	Performance assurance progress report (inc. Speciality Based Recovery Plans)	2.50pm	✓	Assurance	F Button
8.2	Contract Performance	3.10pm	✓	Assurance	C McGourty
9.	STRATEGY AND PLANNING				
9.1	Planning Framework Update	3.20pm	✓	Assurance	G Doherty
9.2	Continuous Improvement and Transformation Update (benefit profile)	3.40pm	✓	Information	A Brotherton
9.3	Financial Improvement Plan – (inc. Simon Barber Action Plan)	3.55pm	✓	Assurance	C McGourty
9.4	Northwest Sub-National Secure Data Environment (SNSDE) Programme	4.05pm	✓	Decision	S Dobson
10.	GOVERNANCE AND COMPLIANCE				
10.1	Cycle of Business	4.20pm	✓	Assurance	All

№	Item	Time	Encl.	Purpose	Presenter
10.2	Items for referral to the Board or to/from other Committees.	4.30pm	Verbal	Information	T Whiteside
10.3	Reflections on the meeting and adherence to the Board compact	4.40pm	✓	Information	T Whiteside
11.	ITEMS FOR INFORMATION				
11.1	ELFS Shared Services Report		✓		
11.2	Exception report from Divisional Improvement Forums		✓		
11.3	**Chairs' reports**: (a) Capital Planning Forum (no report) (b) EPRR Committee (c) New Hospitals Programme full report (d) SIRO/IAO Working Group (e) ICS, ICP, PCB system update		✓		
11.4	Date, time, and venue of next meeting: 22 August 2023, 2.00pm, Microsoft Teams	4.45pm	Verbal	Information	T Whiteside

Finance and Performance Committee

22 August 2023 | 2.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	2.00pm	Verbal	Information	T Whiteside
2.	Apologies for absence	2.01pm	Verbal	Information	T Whiteside
3.	Declaration of interests	2.02pm	Verbal	Information	T Whiteside
4.	Minutes of the previous meeting held on 25 July 2023	2.03pm	✓	Decision	T Whiteside
5.	Matters arising and action log	2.04pm	✓	Decision	T Whiteside
6.	Strategic Risk Review	2.10pm	✓	Assurance	J Wood
7.	FINANCIAL PERFORMANCE				
7.1	M4 Finance report	2.20pm	✓	Assurance	A Mulholland-Wells
8.	OPERATIONAL PERFORMANCE				
8.1	Performance assurance progress report (inc. Speciality Based Recovery Plans and Cancer)	2.35pm	✓	Assurance	F Button
8.2	Contract Performance	2.50pm	✓	Assurance	A Mulholland-Wells
9.	STRATEGY AND PLANNING				
9.1	Financial Improvement Plan	3.05pm	✓	Assurance	A Mulholland-Wells
9.2	Planning Framework Update	3.20pm	✓	Assurance	G Doherty
9.3	Continuous Improvement and Transformation Update (benefit profile)	3.35pm	✓	Information	G Doherty
9.4	Digital Strategy Six Month Update	3.50pm	✓	Information	S Dobson
10.	GOVERNANCE AND COMPLIANCE				
10.1	EPRR Core Standards Annual Assurance 2023-24	4.10pm	✓	Decision	F Button

№	Item	Time	Encl.	Purpose	Presenter
10.2	Items for referral to the Board or to/from other Committees.	4.25pm	Verbal	Information	T Whiteside
10.3	Reflections on the meeting and adherence to the Board compact	4.35pm	✓	Information	T Whiteside
11.	ITEMS FOR INFORMATION				
11.1	Exception report from Divisional Improvement Forums		✓		
11.2	**Chairs' reports**: (a) Capital Planning Forum (inc. TOR) (b) New Hospitals Programme flash report (c) ICS, ICP, PCB system update		✓		
	Date, time, and venue of next meeting: 26 September 2023, 2.00pm, Microsoft Teams	4.45pm	Verbal	Information	T Whiteside

Board of Directors Report

Integrated Performance Report			
Report to:	Board of Directors	**Date:**	5th October 2023
Report of:	Executive Team	**Prepared by:**	Executive Directors
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to provide the Board with an update on the Trust's performance as at the end of August 2023, unless otherwise stated.

- **The report reflects the revised 2023/24 Big Plan measures agreed by each sub-committee.**

Consistently Deliver Excellent Care

Operational Performance

Emergency care performance headlines:

- In August, 181 patients waited between 30-60 minutes: a slight decrease of 19 from last month. 79 patients waited over 60 minutes to be handed over from NWAS to the Trust in August, an increase of 17 from last month, however this is within normal variation and still a significant improvement trend overall for handover delays and best in the ICS. Ambulance handover delays remain a high priority and a local improvement collaborative is in place.

- 4 Hour ED performance is showing a deterioration in performance to 72.5% compared to 74.3% in July, just below the national average position of 73% and 7th out of the acute trusts in the North-West. This will be a focus to achieve the 76% target for March 24.

- Performance relating to the number of patients waiting over 12 hours (admitted and non-admitted) in ED for August has seen improvement maintained with 7.7% from 10.1% in October 2022.

- The occupancy metric has been updated to reflect the new requirement to reduce adult general and acute (G&A) bed occupancy to 92% or below, with Trust occupancy for August at 93% and July at 94%; a reduction from 97% in June.

- The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMCTR) has increased to 80 patients this month. There has been good utilisation of available capacity in the Home First service, and the Community Healthcare Hub at Finney House.

Unfunded capacity and operational changes:

There have been a number of changes to processes and services, including Finney House, Virtual Ward, reprofiling of space in the Emergency Department to create an Acute Assessment Unit and an update to the organisational response to demand related escalation. This has enabled the following changes to be put in place:

Ward/Area	Impact	Delivery Date	Status
Closure of Avondale	Reduction of 28 G&A beds	Mar-23	Completed
Closure of Cath Lab & RAU	Reduction of 14 G&A beds	May-23	Completed – require COO/CMO approval to open
Closure of acute ward	Reduction of 17 G&A beds	Jul-23	Completed
Establishment of Acute Assessment Unit	Reduced ED footprint, reducing long waits in ED	Apr-23	Completed
No overnight escalation into Same Day Emergency Care	Reduced need for additional staffing, protects SDEC function	May-23	Completed
No ED escalation into CT wait area in hours	Reduced need for additional staffing, protects CT function	Jun-23	Completed
Co-location of Mental Health Urgent Access Centre (MHUAC)	Reduced cubicle space in ED, improved environment for patients awaiting MH assessment/treatment	Nov-23	Capital bid unsuccessful – alternatives being explored
MAU/SAU Development	Right-sizing MAU and SAU to improve UEC pathways and increase direct access	2024/25	Capital bid successful – planning underway

The Trust continues to work with health and social care organisations across the Central Lancashire system to support improvement and in addition to system plans, the Trust has its own internal programme of improvement being delivered through the Urgent Care Transformation Board. Details of progress with the work streams is provided in the transformation update.

Winter planning has commenced, and the Trust is working alongside the Urgent Care Transformation Board and the senior operational groups of partner organisations. A regional winter event was held on 6th September and a national winter event took place on 18th September. The events focused on five key areas:

- Increasing capacity
- Increase workforce capacity and flexibility
- Improving discharge
- Expanding care outside hospital
- Making it easier to access the right care

There is a joint focus ahead of winter, led jointly by the Deputy Chief Operating Officer at the Trust and the Director of Operations for Central and West Lancashire from Lancashire and South Cumbria Foundation Trust (LSCFT) to establish an integrated team to support demand management, admission avoidance and supporting people to stay safe and well at home. The team will be a single point for all professionals to access services, with co-location of teams to accept referrals for time-limited, physical health and care to enable people to remain safe and well at home with a level of support appropriate to meet their needs in the least intrusive way - including for those people where an admission to hospital can be avoided or a discharge facilitated. The initial phase with co-location of 2 Hour Urgent Crisis Response; Virtual Ward, Same Day Emergency Care and NWAS starts in September.

Elective performance headlines:

- Patients continue to wait for a significant amount of time to receive non-urgent surgery. Progress against the plan to reduce all waits to no longer than 65 weeks by March is reviewed weekly and is

ahead of target. A small number of 78 week waits remain in the system, reflecting the impact of the industrial action, a plan is in place to treat these patients alongside the continued reduction in the number of patients waiting 65 weeks.

- Diagnostics performance beyond 6 weeks was 46.03% for August. Urgent and cancer patients are seen within 2 weeks.

- Endoscopy remains pressured, Changeology continue their work with the Trust, to review waiting lists and booking processes. Agreed capital bids will provide additional capacity on the Preston site in 20203/24.

- Elective and outpatient activity has been significantly affected by periods of industrial action. The recent junior Doctors and Consultants action during August, resulted in the cancellation of 116 (IP/DC) and 746 (OP/D). In addition, the current strike action during September has resulted in the cancellation of 126 (IP/DC) and 862(OP/D).

Cancer recovery:

The table below shows how the Trust compares with England averages by tumour group for 62 day performance at week ending 27th August.

Suspected Tumour Type	Total waiting list	Number past day 62	Number past day 62 - DTT	% of waiting list past day 62	Change in number past day 62 (4 weeks)	Change in number past day 62 (12 weeks)	England % of waiting list past day 62	Distance from England average (>62 days)
Urological	188	40	6	21.3%	-21	-40	15.9%	10
Breast	134	10	8	7.5%	0	2	3.5%	5
Gynaecological	161	18	6	11.2%	-19	-9	9.0%	4
Head & Neck	142	15	6	10.6%	-8	-1	8.0%	4
Haematological	5	3	0	60.0%	-3	-3	16.3%	2
Lung	59	11	4	18.6%	-5	8	14.7%	2
Upper Gastrointestinal	107	11	1	10.3%	0	1	8.2%	2
Children's	5	0	0	0.0%	0	0	3.5%	0
Brain/Central Nervous System	77	1	0	1.3%	1	1	2.9%	-1
Other	16	0	0	0.0%	-2	0	4.7%	-1
Sarcoma	34	3	2	8.8%	-6	-3	13.5%	-2
Skin	854	32	23	3.7%	-5	12	5.0%	-11
Lower Gastrointestinal	714	40	10	5.6%	-4	-7	9.6%	-29
All Suspected Cancers	2,496	184	66	7.4%	-72	-39	8.3%	-15

2023/24 Cancer targets:

Performance against the tumour group specific trajectories for the Cancer 62 day recovery plan, to March 24 is below:

Speciality		Recovery period	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep-23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral at the end of the reporting period	Brain	Trajectory	2	2	2	2	2	2	2	2	2	2	2	1
		Actual	8	0	0	1	1							
	Breast	Trajectory	8	7	7	7	7	6	6	6	6	6	6	6
		Actual	4	6	2	8	13							
	Colorectal	Trajectory	53	52	50	48	46	44	42	41	42	44	40	38
		Actual	42	39	51	41	42							
	Gynaecology	Trajectory	28	27	26	25	24	24	23	22	22	24	21	20
		Actual	34	27	29	34	23							
	Haematology	Trajectory	10	9	9	9	9	8	8	8	8	8	8	7
		Actual	4	7	7	5	3							
	Head & Neck	Trajectory	25	24	23	22	21	21	20	19	20	21	19	18
		Actual	13	15	22	22	20							
	Lung	Trajectory	13	13	12	12	12	11	11	10	11	11	10	10
		Actual	12	10	6	13	11							
	Sarcoma	Trajectory	4	4	4	4	4	4	4	3	4	4	3	3
		Actual	3	9	8	9	3							
	Skin	Trajectory	25	24	23	22	21	20	20	19	20	20	19	18
		Actual	22	23	37	47	26							
	Upper GI	Trajectory	8	8	7	7	7	7	6	6	6	7	6	6
		Actual	8	12	19	15	8							
	Urology	Trajectory	74	72	71	68	65	63	60	58	59	63	56	53
		Actual	71	87	76	50	42							
	Total	Trajectory	250	242	234	226	218	210	202	194	200	210	190	180
		Actual	221	235	257	245	192							

The performance reflects an overachievement against the trajectory for the end of August. The target for 2023/24 is 180 and is therefore achievable over the next year with support from the Cancer Alliance, agreed tumour group specific trajectories for FDS and 62 day are detailed in the report.

- 62-day performance - the number of patients over 62 days reduced in August to 192 from a July position of 245. The position for the end of August is well within the trajectory of 218. The Trust has tumour site specific actions plans that are monitored weekly.

- **Cancer FDS actual position against trajectory to August 23:**

	Apr-23			May-23			Jun-23			Jul-23			Aug-23		
Tumour Group	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var
Brain	40.8%	41.5%	0.7%	46.3%	64.1%	17.8%	52.6%	56.2%	3.5%	62.1%	57.1%	-5.0%	70.5%	40.4%	-30.1%
Breast	93.0%	98.2%	5.2%	93.0%	96.6%	3.6%	93.0%	95.0%	2.1%	93.0%	98.1%	5.2%	93.0%	96.5%	3.5%
Breast Symptomatic	94.3%	94.6%	0.2%	94.3%	96.6%	2.3%	94.3%	98.9%	4.6%	94.3%	100.0%	5.7%	94.3%	95.1%	0.7%
Colorectal	50.0%	50.2%	0.2%	55.6%	44.2%	-11.4%	61.1%	58.7%	-2.4%	66.7%	52.3%	-14.3%	72.2%	22.5%	-49.7%
Gynaecology	49.5%	45.8%	-3.7%	52.2%	55.9%	3.7%	54.9%	67.1%	12.1%	60.4%	63.7%	3.3%	65.9%	48.0%	-17.9%
Haematology	0.0%	20.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	50.0%
Head and Neck	70.9%	77.4%	6.5%	71.8%	74.2%	2.4%	72.7%	76.0%	3.3%	73.6%	83.3%	9.6%	74.5%	77.3%	2.8%
Lung	65.2%	67.4%	2.2%	68.1%	73.2%	5.1%	71.0%	74.0%	3.0%	73.9%	91.1%	17.2%	73.9%	75.0%	1.1%
NSS	75.0%	80.0%	5.0%	75.0%	80.0%	5.0%	75.0%	85.7%	10.7%	75.0%	25.0%	-50.0%	75.0%	77.8%	2.8%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Paediatric	75.0%	100.0%	25.0%	75.0%	100.0%	25.0%	75.0%	100.0%	25.0%	75.0%	100.0%	25.0%	75.0%	100.0%	25.0%
Sarcoma	59.5%	66.7%	7.1%	61.9%	50.0%	-11.9%	64.3%	61.5%	-2.7%	66.7%	52.6%	-14.0%	69.0%	61.5%	-7.5%
Skin	90.0%	93.4%	3.4%	90.0%	95.5%	5.5%	90.0%	95.0%	5.0%	90.0%	92.0%	2.0%	90.0%	89.3%	-0.7%
Upper GI	75.4%	69.6%	-5.8%	75.4%	71.8%	-3.6%	75.4%	66.1%	-9.3%	75.4%	73.2%	-2.2%	75.4%	70.1%	-5.3%
Urology	45.8%	44.9%	-0.9%	51.9%	38.7%	-13.2%	55.7%	46.2%	-9.5%	61.1%	25.0%	-36.1%	67.2%	36.4%	-30.8%
Grand Total	**70.1%**	**72.7%**	2.6%	**72.4%**	**73.4%**	1.0%	**74.4%**	**77.7%**	3.3%	**75.0%**	**75.8%**	0.8%	**75.0%**	**66.7%**	-8.4%

A Cancer Transformation Plan is in place to support delivery in 2023/24.

Cancer pathway re-design for Lower GI, Skin and Prostate:

In relation to the specific asks of Tier 1 Trusts for Lower GI, Skin and Urology pathways:

- **Lower GI: Full Implementation of FIT in the 2ww pathway**

  This is in place at the Trust with clinical review of all existing patients awaiting OPD for double fit negative results / no other red flags and removal from 62-day PTL.
  Performance detailed below against indicators relating to the proportion of double negative FIT Test colorectal cancer referrals that underwent a Colonoscopy:

  1) All Patients referred on a Colorectal Cancer Pathway with Double Negative FIT Test, of these the number that underwent a Colonoscopy:

Referral Month	Double Negative	Colonscopy Flag	% Colonoscopy
Apr-22	58	39	67.24%
May-22	70	46	65.71%
Jun-22	71	55	77.46%
Jul-22	77	43	55.84%
Aug-22	83	42	50.60%
Sep-22	87	23	26.44%
Oct-22	70	25	35.71%
Nov-22	79	28	35.44%
Dec-22	58	10	17.24%
Jan-23	63	10	15.87%
Feb-23	70	21	30.00%
Mar-23	91	33	36.26%
Apr-23	69	23	33.33%
May-23	79	42	53.16%
Jun-23	107	42	39.25%
Jul-23	74	23	31.08%
Aug-23	58	19	32.76%
Total	**1264**	**524**	**41.46%**

- **Skin: Full implementation of Teledermatology in the suspected skin cancer pathway**

  Implementation is co-ordinated across the ICS and Teledermatology started on 7th November, undertaken in the main by medical illustration departments in secondary care.

  Performance detailed below against an indicator relating to the proportion of 2-Week Rule Dermatology Attendances undertaken in the Teledermatology Clinic, this has improved further in August with performance at 83% compared to 81% in July 23.

	Aug-23
Total 2WR Attendances (incl Tele-Derm)	595
Attendances at Tele-Derm Clinic	491
Proportion attending Tele-Derm Clinic	83%

- **Full implementation of the Best Practice Timed Pathway for prostate cancer**

  The BPT pathway has been agreed and was due to be fully implemented in 22/23, this has been impacted by capacity issues and full implementation will be completed by the end of Q3 - consumable supplies for biopsies (now resolved) and capacity for multiparametric MRI (MpMRI) slots.

NHS England requirements:

The NHS England letter of 4 August 2023 to NHS Trust and Foundation Trust chief executives and chairs set out the following expectation for Trusts to expand and protect elective capacity:

Expectation	Current Status	Update
Validation		
The Trust has agreed actions in place to improve current validation rates against pre-covid position, utilising available data quality (DQ) reports to target validation, with progress reported at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.	In place	• The ChatBot validation process is well established within the Trust with weekly internal and ICS touchpoint meetings in place. • Chatbot returns validation summary is reported on a fortnightly basis to Performance Recovery Group (PRG) • LUNA Data Quality checks have been used to identify improvements in documentation of specialty and referral source. • LUNA data quality compliance is summarised in Board Data Quality Report • Trust internal validation database in place • Trusts QlikView data quality reports and The Trust has a dedicated RTT Validation and Assurance Team that work to improve RTT data quality using over 20 separate validation reports. The Trust also maintains an internal validation database used by both the validation team and divisional teams to highlight data quality issues.
The Trust has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified.	In place	• The Trust is using ChatBot to support pathway validation as per previous practice when circa 92% of patients were validated within 12 weeks of last validated status. The Trust has implemented a ChatBot validation process – rolling programme with agreed exclusions and contact cohorts. • Weekly ICB touch point chatbot meeting in place
The Trust ensures that the RTT rules and guidance and local access policies are applied, and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. A clear plan should be in place for communication with patients.	In place	• The Trust follows Referral To Treatment (RTT) guidelines as per national policy. Recent changes have been managed across the Integrated Care System (ICS) relating to managing patient choice, active monitoring, and patient complexity. The Trust Patient Access policy has been reviewed and updated to reflect national guidance.
The Trust has produced a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	On track – not yet completed	All service areas have sight of all RTT and non RTT related pathways and waiting lists. Supporting documentation details the content and use of each list. • RTT admit • RTT non admit • RTT & non RTT diagnostics • NEW OP Waiting List • FU Waiting List • Endoscopy Waiting List The RTT PTL is also risk stratified for potential clinical risk, both admit and non admit patients using • intended procedure • age adjusted Charleson co-morbidity score • history of co-morbidities • IMD Decile Long waiter pathways are then clinically reviewed for potential harm using the additional clinical information. The Trust is in the process of reviewing whether this process can be extended to non RTT patients
First Appointments		
The Trust has a signed off plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.	In place	• The Trust has submitted a signed off activity and operational performance trajectory plan for 2023/24. This was presented at Finance & Performance Committee and Board as part of the planning round. • The Trust plan is to eliminate >65 week waits by March 24. The Trust has agreed cohort and snapshot 65 week trajectories in place at specialty level, monitored via Performance Recovery Group and externally via weekly Tier 1 meetings. • The Trust has started an impact assessment review along with other partner providers with an additional assessment of waiting list growth and has identified a number of services at risk of non delivery. The growth is likely to be in the >52 week waits as services will target all capacity for clinically urgent, cancer and long waits. As at 30th August 2023, there were 12,987 pathways at risk of breaching >65 week waits if not treated. Of this cohort 1,652 do not have a 1st OPA booked and 1,271 that will need to be brought forward because dated > 31/10/2023. All specialty leads have target lists of patients in the 65 week cohort, by risk category. All risks are reviewed at Performance Recovery Group.

The Trust has a signed off plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers.		• The Trust participates across the ICS and region in both accessing and offering mutual aid. • There is an ICS wide Independent Sector programme in place. • There is a weekly ICS mutual aid meeting with both ICS and regional capacity reviews to support mutual aid (including Digital Mutual Aid System – DMAS). • Updates regarding the use of insourcing and outsourcing to mitigate capacity risks report through to Finance and Performance committee and Board.
Outpatients		
The Trust report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and produced an options analysis on going further and agreed an improvement plan.	In place	The Trust has established an Out-Patient Transformation Board with delivery plans in place. The overall aim of the programme is to deliver services that patients can access and interact with in a way that better suits their lives. This means ensuring equality of access, giving patients and their carers more control and greater choice over how and when they access care. Four workstreams have been identified as the main areas of focus in 23/24: • Referral optimisation – including Triage, referral demand, A&G • Personalised OP Patient Care -including PIFU, PIFU Sprint, PEP, pre-op • Productivity & efficiency – including N2R rates, DNA/DNA Sprint FU Reduction with performance dashboard in place • GIRFT best practice – working with clinical leads to identify opportunities Progress reports through the transformation update to Finance and Performance committee. Performance against the OP Improvement Plans is monitored via the Divisional Improvement Forums Grant Thornton have recently completed an external review of outpatient recording and coding to ensure accuracy and further opportunities for improving coverage. To be reviewed at OP Transformation Board Divisional specialty plans and schemes to reduce outpatient follow up activity by 25% have been developed and from September 2023 will be presented to the outpatient transformation board and subsequently to the divisional DIF's for accountability. Divisional teams will present performance against plan, outlining any variance to plan and agreeing any required recovery actions. Schemes have currently been identified to achieve a 15% reduction in follow-ups.
The Trust has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty.	In place	The Trust has established an Out-Patient Transformation Board with delivery plans in place. The overall aim of the programme is to deliver services that patients can access and interact with in a way that better suits their lives. This means ensuring equality of access, giving patients and their carers more control and greater choice over how and when they access care. Four workstreams have been identified as the main areas of focus in 23/24: • Referral optimisation – including Trage, referral demand, A&G • Personalised OP Patient Care -including PIFU, PIFU Sprint, PEP, pre-op • Productivity & efficiency – including N2R rates, DNA/DNA Sprint FU Reduction with performance dashboard in place • GIRFT best practice – working with clinical leads to identify opportunities • Progress reports through the transformation update to Finance and Performance committee. The NHS national Patient Initiated Follow Up (PIFU) sprint has been completed and local sub-groups are being initiated to complete a gap analysis and establish plans to ensure at least 5% of patients are aligned to a PIFU pathway by March 2024. The Trusts current PIFU performance is currently at 1.2%. The outline business case for In Touch (digital check in) presented to OP transformation board, further work in progress to identify financial impact and benefits realisation which will be presented back to the outpatient board in

		October 2023.
The Trust has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments.	In place	The Trust has established an Out-Patient Transformation Board with delivery plans in place. The overall aim of the programme is to deliver services that patients can access and interact with in a way that better suits their lives. This means ensuring equality of access, giving patients and their carers more control and greater choice over how and when they access care. Four workstreams have been identified as the main areas of focus in 23/24: • Referral optimisation – including Trage, referral demand, A&G • Personalised OP Patient Care -including PIFU, PIFU Sprint, PEP, pre-op • Productivity & efficiency – including N2R rates, DNA/DNA Sprint FU Reduction with performance dashboard in place • GIRFT best practice – working with clinical leads to identify opportunities Progress reports through the transformation update to committee and Board. The Patient Engagement Portal (PEP) digital integration project plan and timeframes have been developed, with initial specialities; immunology and pain management going live from December 2023.
The Trust has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking data (via the Model Health System and data packs) to identify further areas for opportunity.	In place	The Trust has established an Out-Patient Transformation Board with delivery plans in place. The overall aim of the programme is to deliver services that patients can access and interact with in a way that better suits their lives. This means ensuring equality of access, giving patients and their carers more control and greater choice over how and when they access care. Four workstreams have been identified as the main areas of focus in 23/24: • Referral optimisation – including Trage, referral demand, A&G • Personalised OP Patient Care -including PIFU, PIFU Sprint, PEP, pre-op • Productivity & efficiency – including N2R rates, DNA/DNA Sprint FU Reduction with performance dashboard in place • GIRFT best practice – working with clinical leads to identify opportunities Progress reports through the transformation update to Finance and Performance committee. The Unwarranted Variation Transformation Programme utilises GIRFT, PLICS and Model Hospital information to identify and triangulate opportunities, with action plans in place.
The Trust has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	In place	The Trust has established an Out-Patient Transformation Board with delivery plans in place. The overall aim of the programme is to deliver services that patients can access and interact with in a way that better suits their lives. This means ensuring equality of access, giving patients and their carers more control and greater choice over how and when they access care. Four workstreams have been identified as the main areas of focus in 23/24: • Referral optimisation – including Trage, referral demand, A&G • Personalised OP Patient Care -including PIFU, PIFU Sprint, PEP, pre-op • Productivity & efficiency – including N2R rates, DNA/DNA Sprint FU Reduction with performance dashboard in place • GIRFT best practice – working with clinical leads to identify opportunities Progress reports through the transformation update to Finance and Performance committee with over 60 key milestones for delivery covering: • Divisional FU reduction plans • Referral optimisation covering Referral Assessment Service (RAS), Clinical Assessment Service (CAS),Referral Quality Improvement Service (RQIS)

		• PIFU Sprint and PFIFU Pathway development • Activity and Income opportunities • DNA Sprint • DNA Subgroup development • OP Digitisation incl. Digital check-in, PEP+, Pre Op,
Support required		
The Trust board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	In place	• Areas for support were initially identified during the Trust's Tier 1 self-certification process for assurance. Support requirements continue to be discussed and agreed as part of the Tier 1 process. Additional support reports through to the Finance and Performance committee and to Board.

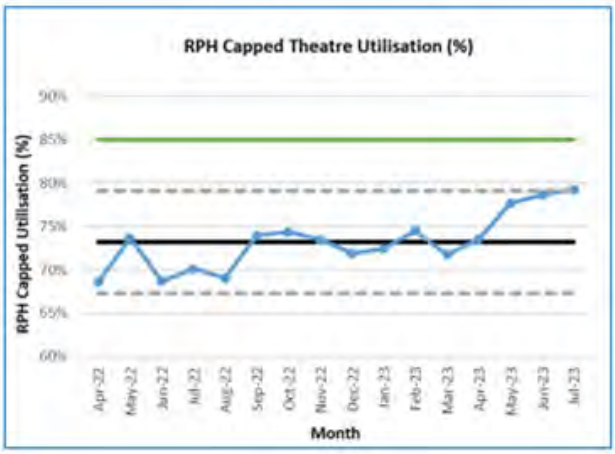
Elective restoration 78 and 65 weeks:

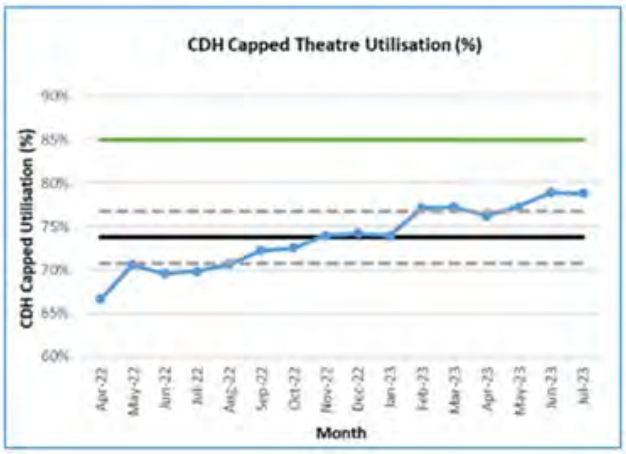
Clearing the 78 and 65-week waits is a priority for the divisional teams with performance under constant review. Additional capacity continues to be required both in-house and through utilisation of Independent Sector and mutual aid capacity, to clear the backlog of long waits. In-sourcing arrangements have been agreed and one provider has started. These arrangements will provide longer term support and resilience in the most pressured areas (Urology and Gynae) whilst industrial action continues, and plans have been stressed tested, with the expectation that industrial action continues into Qtr3.

A small residual number of 78 week waits remained in August due to the impact of the ongoing industrial action. A day zero PTL approach will be applied to these over the next two months.

The 65-week trajectories factor in the impact of improved theatre productivity, utilisation of the independent sector and waiting list initiatives. A Theatre Efficiency Programme reports progress through the Elective Care Transformation Board.

The current capped theatre utilisation rates by site are shown below indicating an improving and consistent capped performance over the last 10 months:





The current 65-week specialty cohort month end trajectories to March 2024 are detailed below with actual end of August position:

		30/04/2023			31/05/2023			30/06/2023			31/07/2023			31/08/2023		
Division	**Specialty**	**Plan**	**Actual**	**Var**	**Plan**	**Actual**	**Var**	**Plan**	**Actual**	**Var**	**Plan**	**Actual**	**Var**	**Plan**	**Actual**	**Var**
DCS	C Immunology	846	787	-59	762	718	-44	670	628	-42	582	540	-42	490	468	-22
DCS	Pain Management	766	664	-102	690	576	-114	606	473	-133	526	410	-116	442	337	-105
Medicine	Cardiology	1185	1036	-149	1068	820	-248	938	612	-326	815	464	-351	685	335	-350
Medicine	Diabetes	74	59	-15	67	51	-16	59	39	-20	51	25	-26	43	20	-23
Medicine	Elderly Care	48	37	-11	43	23	-20	38	12	-26	33	8	-25	28	6	-22
Medicine	Endocrinology	588	572	-16	530	485	-45	466	371	-95	405	321	-84	341	235	-106
Medicine	Gastroenterology	1059	964	-95	954	791	-163	839	590	-249	729	422	-307	614	275	-339
Medicine	General Medical	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1
Medicine	General Medicine	1787	1752	-35	1610	1556	-54	1415	1338	-77	1229	1133	-96	1034	861	-173
Medicine	Neurology	4891	4613	-278	4407	3762	-645	3874	3086	-788	3365	2536	-829	2335	1968	-367
Medicine	Rehabilitation	24	17	-7	22	10	-12	19	6	-13	17	6	-11	14	2	-12
Medicine	Renal	213	113	-100	192	76	-116	169	55	-114	147	33	-114	124	8	-116
Surgery	Clinical Oncology	206	189	-17	186	164	-22	164	134	-30	143	133	-10	121	116	-5
Surgery	Colorectal Surgery	1560	1455	-105	1406	1220	-186	1236	991	-245	1074	803	-271	904	677	-227
Surgery	Dermatology	490	426	-64	442	359	-83	389	189	-200	338	104	-234	285	69	-216
Surgery	ENT	1235	1064	-171	1113	850	-263	978	583	-395	850	480	-370	715	373	-342
Surgery	General Surgery	924	795	-129	833	701	-132	732	554	-178	636	276	-360	535	388	-147
Surgery	Maxillo-Facial	426	411	-15	384	316	-68	338	264	-74	293	197	-96	247	164	-83
Surgery	Medical Oncology	35	25	-10	32	25	-7	28	20	-8	24	19	-5	20	15	-5
Surgery	Neurosurgery	2842	2637	-205	2561	2163	-398	2252	1724	-528	1956	1336	-620	1180	1094	-86
Surgery	Ophthalmology	1940	1780	-160	1748	1442	-306	1536	1090	-446	1334	874	-460	700	634	-66
Surgery	Oral Surgery	341	295	-46	307	216	-91	270	175	-95	234	143	-91	197	108	-89
Surgery	Orthodontics	241	250	9	217	240	23	191	234	43	166	220	54	140	214	74
Surgery	Orthopaedics	1432	1277	-155	1290	1015	-275	1134	811	-323	985	647	-338	829	525	-304
Surgery	Plastic Surgery	1581	1492	-89	1424	1241	-183	1252	1069	-183	1087	938	-149	915	857	-58
Surgery	Surgical Dentistry	1481	1445	-36	1334	1253	-81	1173	1137	-36	1019	989	-30	858	887	29
Surgery	UGI	473	457	-16	426	379	-47	374	313	-61	325	243	-82	273	196	-77
Surgery	Urology	1799	1734	-65	1621	1460	-161	1425	1227	-198	1237	1071	-166	930	863	-67
Surgery	Vascular Surgery	1677	1640	-37	1511	1404	-107	1329	1133	-196	1155	1138	-17	973	825	-148
WCS	Breast Surgery	57	56	-1	51	53	2	45	45	0	39	36	-3	33	31	-2
WCS	Gynaecology	619	550	-69	558	451	-107	490	363	-127	426	309	-117	358	214	-144
WCS	Neonatology	1	1	0	1	0	-1	1	0	-1	1	0	-1	1	0	-1
WCS	Paed. Cardiology	72	59	-13	65	40	-25	57	18	-39	50	12	-38	42	10	-32
WCS	Paediatrics	805	737	-68	725	591	-134	637	411	-226	553	268	-285	350	212	-138
Total	**Total**	**31719**	**29389**	**-2330**	**28581**	**24451**	**-4130**	**25125**	**19695**	**-5430**	**21825**	**16134**	**-5691**	**16757**	**12987**	**-3770**
	Monthly reduction	-2826			-3138			-3456			-3300			-5068		

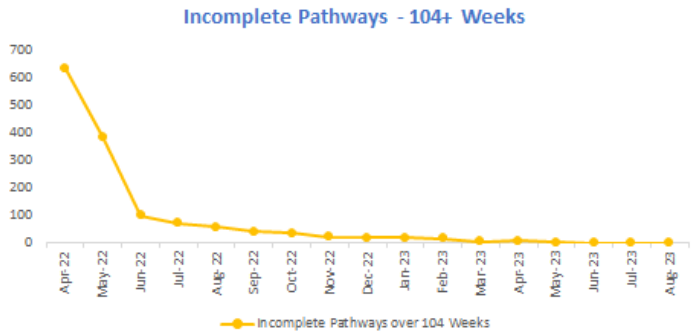
Those specialties at small numbers now are expected to achieve and maintain 65 weeks in the next few months.

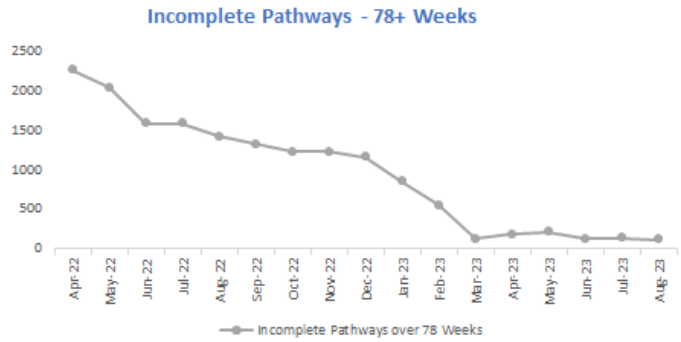
- The 65-week snapshot position on 18th September was 1,354, with a cohort (end March 2024) position of 11,142 – 3,388 admitted and 7,754 non-admitted cases. This remains a key focus operationally.

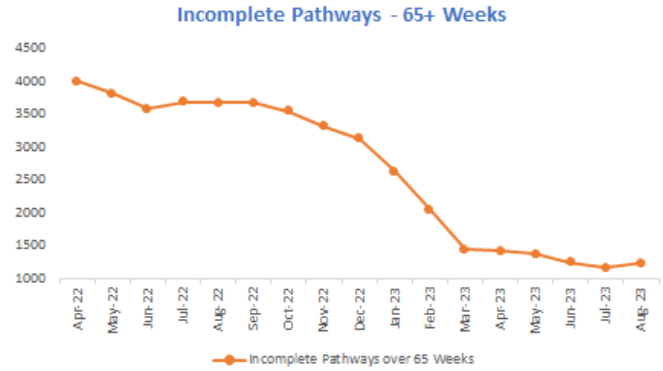
There are a number of risks to delivery of the required reduction in the number of patients waiting in excess of 65 weeks, these include:

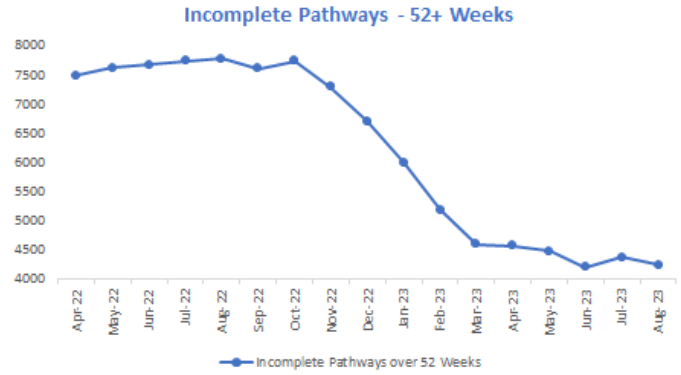
- Further junior doctor and Consultant industrial action impacting on activity.
- Workforce - sickness and vacancies
- Anaesthetist capacity
- Urgent care pressures – COVID, Flu, NMC2R and poor patient flow
- Number of complex cases and particular pressures in Urology and Gynaecology.

Significant progress has been made with reducing the number of long waiting patients, despite the volume of activity lost during periods of industrial action:



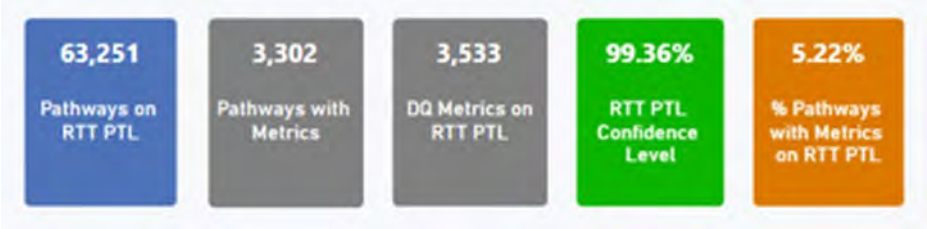






RTT PTL Validation

Data quality assurance is reported through the bi-annual Data Quality Assurance Report to Board. This details data quality compliance via the national LUNA data quality solution. Current information indicates a very high data quality confidence level.



The Trust has been utilising the Chatbot patient contact solution to meet the national requirement to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023.

The Trust has sent over 51,000 messages to patients via the Chatbot rolling programme since August 2022, current responses in relation to the current active PTL are summarised below.

CHATBOT SUMMARY

Specialty	Exclusions	Language Barrier	Leave	Leave - Division State to Remain	No Contact	Other	Remain	Review	Total
Breast Surgery	-	-	-	-	3	-	16	2	**21**
Cardiology	-	-	28	-	172	9	535	4	**748**
Clinical Immunology	1	-	3	-	222	13	464	-	**703**
Colorectal Surgery	1	-	40	-	112	8	290	34	**485**
Dermatology	1	-	14	-	71	8	179	-	**273**
Diabetes	-	-	1	-	9	1	21	-	**32**
Elderly Care	-	-	1	-	-	-	3	-	**4**
Endocrinology	-	-	12	-	107	5	277	-	**401**
ENT	1	-	2	-	61	1	174	12	**251**
Gastroenterology	-	-	31	-	154	4	395	1	**585**
General Medicine	4	-	49	-	326	21	726	2	**1128**
General Surgery	-	-	8	-	27	3	89	12	**139**
Gynaecology	1	-	10	-	71	4	147	38	**271**
Maxillo-Facial Surgery	1	-	12	-	49	2	110	1	**175**
Neurology	1	-	26	13	842	68	2084	23	**3057**
Neurosurgery	-	2	68	-	352	29	1189	22	**1662**
Ophthalmology	-	-	28	-	167	16	485	15	**711**
Oral Surgery	-	-	5	-	19	1	52	2	**79**
Orthodontics	-	-	1	-	30	4	52	-	**87**
Orthopaedics	-	-	6	-	79	9	276	190	**560**
Pain Management	-	-	4	-	92	7	311	166	**580**
Plastic Surgery	1	-	54	-	215	12	549	74	**905**
Surgical Dentistry	-	-	2	-	25	1	42	3	**73**
Upper Gastrointestinal Surgery	1	-	15	-	27	5	77	22	**147**
Urology	2	-	37	-	143	10	391	63	**646**
Vascular Surgery	-	-	68	-	320	30	878	24	**1320**
Total	**15**	**2**	**525**	**13**	**3695**	**271**	**9812**	**710**	**15043**

Safety and Quality

Pressure Ulcers
Pressure ulcer incidence is within common cause variation, there are some early indications that a positive shift may be occurring however, this remains an area of risk. The improvement work continues as part of the Always Safety First Improvement Programme of work.

Falls
Falls improvement work continues through the Always Safety First programme of work. The improvement target for the big plan is now identified within the SPC chart. There have now been three positive consecutive months of special cause variation.

HSMR
Mortality metrics remain stable and within expected parameters.

STAR
STAR Quality assurance accreditation awards of silver and above is consistently higher than we would expect within normal variation.

INFECTION PREVENTION AND CONTROL

Clostridium *difficile*
The data is demonstrating continued raised levels of C. *difficile.* Weekly executive oversight meetings are in place to focus on cleaning, movement of patients, training and education and developing greater understanding of further actions that may improve the C.*difficile* rate. The work to reduce the consumption of antibiotics that are more prevalent in C.*difficile* presentations has resulted in the reduction anticipated, this is positive and aims to contribute to a reduction in future.

Registered Nurse and Midwifery Fill Rates
The fill rates continue to reflect positive staffing levels overall, with fluctuations day to day depending on sickness. Staffing is closely monitored on a three times daily basis with mechanisms to escalate and request support when required.

Always Safety First
The annual target for basic and intermediate safety training was met in 2022/23. The new target audience for intermediate safety training has not yet been set and therefore compliance with this metric is not a true reflection and will be updated in next month's Board.

A Great Place to Work

Both short-term and long-term sickness absence increased during July and August 2023. The Workforce Team is supporting the divisional teams to manage high priority cases, however, due to gaps in the team and an increase in other activity, the support available is currently limited. This is affecting the timely management of absence cases and the delivery of proactive absence management strategies in areas of concern. We are, however, continuing to make good progress in reducing the average duration of mental health-related absence episodes, and outreach calling from the psychological wellbeing helpline is proving to be effective. It is important we try to mitigate the impact of seasonal viruses which normally start to increase from Quarter 3, thus our flu and COVID vaccination campaigns for colleagues launch on 18 September 2023.

Violence and aggression incidents continue to rise, with a particular peak experienced during July and August 2023. We have recently agreed for additional panic buttons to be installed in two areas where incidents are frequent. A 'Big Room' is also being established in September, enabling us to take a continuous improvement approach to addressing violence and aggression.

Our overall Trust vacancy rate continues to fall. At an overall level we appear to have 0% vacancies for our registered nurse population. However, we continue to have areas of over- and under-establishment masking a true vacancy position of 108.98 FTE as of August 2023 for our inpatient areas. Clinical colleagues continue to coordinate redeployment, particularly of our competent international nurses. All our planned international nurses for 2023/24 have arrived. We continue to focus on international midwifery recruitment due to ongoing vacancy pressures in the area, with four already arrived in the UK and a total of 16 planned by December 2023.

The Workforce Team is currently reviewing the content of the NHS workforce plan with a view to assessing actions required against our current workforce and organisational development strategy and workforce plan.

In addition to our internal vacancy control processes, additional ICB vacancy controls have been introduced for roles that are band 5 and above and are impacted by Central Services as well as band 8b roles and above otherwise. Controls are also proposed in respect of agency over-cap rates and long-term medical agency bookings. We await further detail on what is required in respect of agency reporting and control.

We continue to regularly monitor and review ward-based agency escalations with clinical colleagues to ensure necessity and to control nursing demand pushed to agency. Our next ICS nurse agency rate card price drop is scheduled for September 2023; rates will be reduced by a further 50p.

Whilst the decision of the One LSC host employer has been confirmed, the target operating model design is having a direct impact on several workforce operational teams that support the delivery of this work for the Trust. A target operating model and workforce structure, including costs, is being developed in preparation for the move to a centralised One LSC temporary staffing team. This work continues to place resourcing pressure on an already overstretched senior team. Time required is currently 1.5 days a week. This work has not been supported with funding or resource for local teams.

Delivering Value for Money

Income and Expenditure

The Trust reports a YTD Month 5 deficit position for 2023/24 of £28.6m against a £18.7m deficit plan, this gives a YTD Variance on Plan of £9.9m. This can be explained mainly by the £4.1m System Support Gap (£18.5m for the year), £3.8m under-delivery of CIP, £2.8m of double running nursing costs, £1.2m for the cost of strikes, £1.0m activity impact of strikes, £0.9m shortfall in pay awards and £1.5m of net restoration adverse impact offset by £5.4m of operational underspends.

Capital Position

Capital expenditure in the year to date is behind plan. This is management of projects in the early part of the year to create capacity to deal with emergency requirements as they arise during the year. Projects are planned for the latter part of the year to deliver the plan in full by the year-end. No issues are anticipated with achieving the plan for the year.

Cash Position

The Trust has drawn down cash support amounting to £13.4m in the year to date with a further amount of £2.6m requested for September. This has fully exhausted the cash available to the Trust as deficit support. An application for further support in Q3 has been submitted and this will in the form of working capital support if it is approved by NHSE.

Cost Improvement Programme

The Trusts core 2023/24 Financial Improvement Plan (FIP) target is £48.5m or 6.2% of total OPEX, of which £5.9m is carry forward of undelivered recurrent FIP from 2022/23. The total FIP target is £67m which includes the system gap of £18.5m.

As at Month 5 (August 2023), YTD delivery of FIP is £9.8m against a plan of £17.7m, an adverse variance of £7.9m. The variance has increased since M4 £4.6m (YTD) due to the profiling of the FIP plan in M4; £2m reflecting 9/12ths the system gap of (£18.5m) and £1.2m increased plan for the generic FIP (£48.5m). The Forecast outturn delivery of FIP is £39m against the £67m full year target; £36m of FIP and assumed £3m system gap will be identified before the year end. There is enhanced focus on the delivery of FIP in the Trust and as a system to minimise the current system deficit of £37m (as at month 4). The Trusts executive agreed with the Trust Board to review the challenging decisions and agree on key decisions to support the delivery of the 2023/24 full year FIP.

Use of Resources

The Trust is in Segment 3.

Segment 3 is where there are significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence.

Segment 3 means the Trust will receive mandated support that is led and co-ordinated by NHS England and NHS Improvement regional teams with input from the national intensive support team where requested.

The Agency spend in 2023/24 in YTD Month 5 was £10.3m against an Agency Ceiling of £7.5m. This is an overspend of £2.8m mainly due to a slower than expected benefits from international recruitment the Trust, cost of industrial action cover and significant costs of agency spend associated with some service developments such as CDCs, Finney House as well as some legacy issues.

Fit for the Future

These qualitative indicators will be reported separately to board within the normal cycle of board business.

It is recommended that:
I. The Board note the contents of the report and the action being taken to improve performance.

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching, and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Finance and Performance Committee, Workforce Committee, Safety and Quality Committee

Excellent care with compassion

Always Safety First

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Board of Directors

Performance to August 2023

Together

INTRODUCTION

Performance to 31st August 2023

Our Big Plan

Mission

To provide excellent care with compassion

Strategic Aim

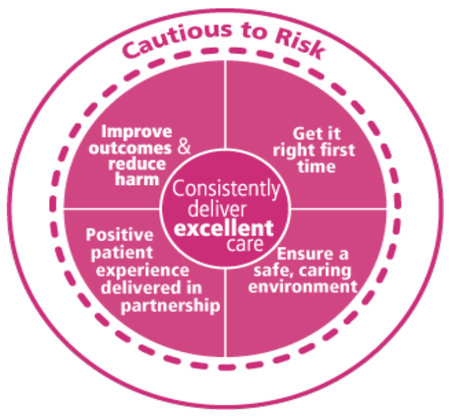
To provide excellent healthcare to our local communities

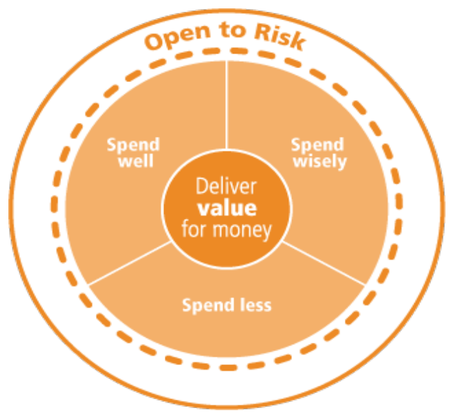
Strategic Aim

To offer a range of high quality specialist services to patients in Lancashire and South Cumbria

Strategic Aim

To drive innovation through world class education, training and research*






Seeking to Involve


Being Caring and Compassionate


Recognising Individuality


Taking Personal Responsibility


Building Team Spirit

In order to ensure that the we are continually monitoring delivering against our Big Plan, the metrics within the Integrated performance report for the Board of Directors are aligned to the Big Plan 2021/24 outcomes and provide details of performance against the agreed KPIs. Each of the ambitions upon which our Big Plan is founded is aligned to a board sub committee which will undertake more detailed scrutiny of progress in achieving the identified outcome, understand risk and seek assurance against delivery.

Kevin McGee
Chief Executive

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Metric Description			Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment One – Improve outcomes and prevent harm										
CQC	Big Plan	To achieve a rating of good with one outstanding service	M | T-D-S | TB-SQ | ALL	Yes	Progress towards CQC rating of good is ongoing					
	Sub Metric	Percentage of Must and Should do's completed			-	-	-	100%	100%	-
Pressure Ulcers	**Key Metric**	**Reduce the number of people developing pressure ulcers by 5% Includes device related pressure ulcers (Rate per 1000 beddays)**	M | T-D-S | TB-SQ | SC	No	F			1.68	3.23	3.69
	Big Plan	Reduce the number of device related pressure ulcers by 5% (Rate per 1000 beddays)		No				0.21	0.74	0.75
Maternity safety	Big Plan	Maintain compliance with the 10 safety actions for maternity services		No	-	-	-	100.0%	60.0%	-
	Big Plan	Deliver year 1 of the national maternity & neonatal improvement plan		UNDER DEVELOPMENT						
Children and Young People safety	Big Plan	Develop 10 safety actions for children and young people and achieve compliance		10 safety actions created for children and Young people, reported through the Divisional Improvement Forum						
Contribute to PLACE Adult and Children CORE20 PLUS 5 strategy	Big Plan	Develop a plan to respond to CORE20 PLUS 5 – Adults and maternity. Deliver year 1 actions		Delivery Plan in place						
	Big Plan	Develop a plan to respond to CORE20 PLUS 5 – CYP. Deliver year 1 actions		Delivery Plan in place						
Segment Two – Get it right first time										
Mortality	**Key Metric**	**Continue to achieve a mortality HSMR figure of <100 (Hospital Standardised Mortality Ratio (56 Basket – Adult)**	M | T-D-S | SQ | GS	No	Lower Than Expected				75.4	-
Access Standards	**Key Metric**	**Achieve the Emergency Department within 4 hours target**	M | T-D | FPC | FB	No				76%	72.5%	74.2%
	Key Metric	**Reduction in patients waiting +12 hours in Emergency Department**	M | T-D | FPC | FB	No	F			2%	7.7%	9.2%
	Key Metric	**Reduction in ambulance turnaround times - seen within 15 minutes**	M | T-D | FPC | FB	No	F			65%	57.3%	52.2%
	Key Metric	**Reduction in ambulance turnaround times - seen within 30 minutes**	M | T-D | FPC | FB	No	F			95%	89.0%	74.2%
	Key Metric	**Reduction in ambulance turnaround times - 60 minutes**	M | T-D | FPC | FB	No	F			98%	96.7%	89.4%
	Key Metric	**Achieve agreed trajectory for reducing 52 week waiters**	M | T-D-S | FPC | FB	No				4751	4242	5375
	Key Metric	**Eliminate waits over 65 weeks for elective care by March 2024**	M | T-D-S | FPC | FB	No	F			822	1242	1295
	Key Metric	**Eliminate waits over 78 week waiters**	M | T-D-S | FPC | FB	No	F			0	121	697
	Key Metric	**Achieve Cancer - 28 day FDS**	M | T-D-S | FPC | FB		F			79%	66.9%	68.7%
	Key Metric	**Number of patients waiting over 62 days**	M | T-D-S | FPC | FB	No				218	211	238
	Key Metric	**Moving or discharging 5% of outpatient attendances to a PIFU pathway**	M | T-D-S | FPC | FB	UNDER DEVELOPMENT						
	Key Metric	**Reduce outpatient follow ups by a minimum of 25% against 2019/20 activity levels**	M | T-D-S | FPC | FB	UNDER DEVELOPMENT						
	Key Metric	**Reduce adult general and acute (G&A) bed occupancy to 92% or below**	M | T-D-S | FPC | FB	No				92%	93%	96%
	Key Metric	**Achieve 5% of patients in hospital who no longer meet the criteria to reside**	M | T-D-S | FPC | FB-SC	No				87	80	106
	Key Metric	**Reduce length of stay to next best quartile**	M | T-D-S | FPC | FB	UNDER DEVELOPMENT						
SDEC	Big Plan	Divert 10 ambulances a day from ED (to SDEC or the appropriate service; SAU, MAU AAU, 2hr UEC response) (Target of 1924 ambulance arrivals per month based on a reduction of 10 amulance arrivals per day on 2022/23 actuals)	M | T-D-S | FPC | FB	No	F			1924	2369	2228
Pre-procedure elective bed days	Big Plan	To reduce the number of days patients spend in hospital prior to planned surgery	M | T-D-S | FPC | FB	No				0.15	0.20	0.33
Pre-procedure non-elective bed days	Big Plan	To reduce the number of days patients spend in hospital prior to unplanned surgery	M | T-D-S | FPC | FB	No				0.50	0.24	0.66
Elective Inpatient Average length of stay (Spell)	Big Plan	To reduce the average length of stay for patients undergoing planned surgery	M | T-D-S | FPC | FB	No				3.3	2.9	3.1
Cancer	Big Plan	Implement pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result)	M | T-D-S | FPC | FB	No	F			80%	32.76%	28.79%
	Big Plan	Full implementation of Teledermatology in the suspected skin cancer pathway	M | T-D-S | FPC | FB	No				80%	82.52%	54.15%
	Big Plan	Full implementation of the Best Practice Timed Pathway for prostate cancer	M | T-D-S | FPC | FB	No	No Patients Currently on this Pathway					

Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive	
A = Annual	T = Trust	TB = Trust Board	All = All Exec Team	GS = Gerry Skailes
B = Bi-annual	D = Division	W = Workforce Committee	JW = Jonathan Wood	GD = Gary Doherty
Q = Quarterly	S = Specialty	ETR = Education, Training & Research Committee	FB = Faith Button	SD = Stephen Dobson
M = Monthly	C = Cost Centre	FPC = Finance & Performance Committee	SC = Sarah Cullen	AB = Ailsa Brotherton
		SQ = Safety & Quality Committee		

Variation Icon \ Assurance Icon	F – Will consistently fail target within expected variation	– Could both pass or fail target within expected variation	P – Will consistently pass target within expected variation
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
Normal variation – no recent change	Failing target and no change happening. Process review needed. May need exception report	Close to Target and no change. Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and no change happening
Recent positive pattern in the data	Failing the target but getting better May need exception report	Close to Target and getting better Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and getting better

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Metric Description			Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment Three – Ensure a safe, caring environment										
Falls	Big Plan	Reduce the number of falls by a further 5% - per 1000 bed days	M | T-D-S | SQ | SC	No	F	+	⚑	3.72	4.41	5.84
Infection	**Key Metric**	**Achieve less than the annual tolerance for C.difficile**	M | T-D-S | SQ | SC-GS	Yes	F	−	⚑	10	19	16
	Big Plan	Achieve zero MRSA bacteraemia	M | T-D-S | SQ | SC-GS	No	-	-	-	0	0	-
Safety	Big Plan	Maintain 90% staff trained in level 1 safety training	M | T-D-S | ETR | NL	No	P	+	-	90%	97.5%	96.1%
	Big Plan	Achieve 90% executive and senior leaders safety training	M | T-D-S | ETR | NL	No	P	+	-	90%	93.2%	92.3%
Segment Four – Work in partnership to deliver a positive patient experience										
Complaints	Big Plan	Reduce the number of complaints relating to communication.	M | T-D-S | SQ | SC	No	~	−	-	22	24	13
Patient involvement	**Key Metric**	**Achieve a minimum of 90% of patients reporting their experience of good or very good (including neither good/bad)**	B | T-D-S | SQ | SC	No	~	~	-	90%	91%	91%
Candour	Big Plan	Maintain >90% compliance with duty of candour for all moderate and above harm incidents.	M | T-D-S | SQ | SC-GS	No	~	~	-	90%	94%	96%
Safe Staffing	Big Plan	Maintain Registered Nurse and Midwife fill rates of > 90%	M | T-D-S | SQ | SC-GS	No	F	+	-	95%	94%	89%

Reporting Requirements Key

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		SQ = Safety & Quality Committee	NL = Nicki Latham	

Variation Icon \ Assurance Icon	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
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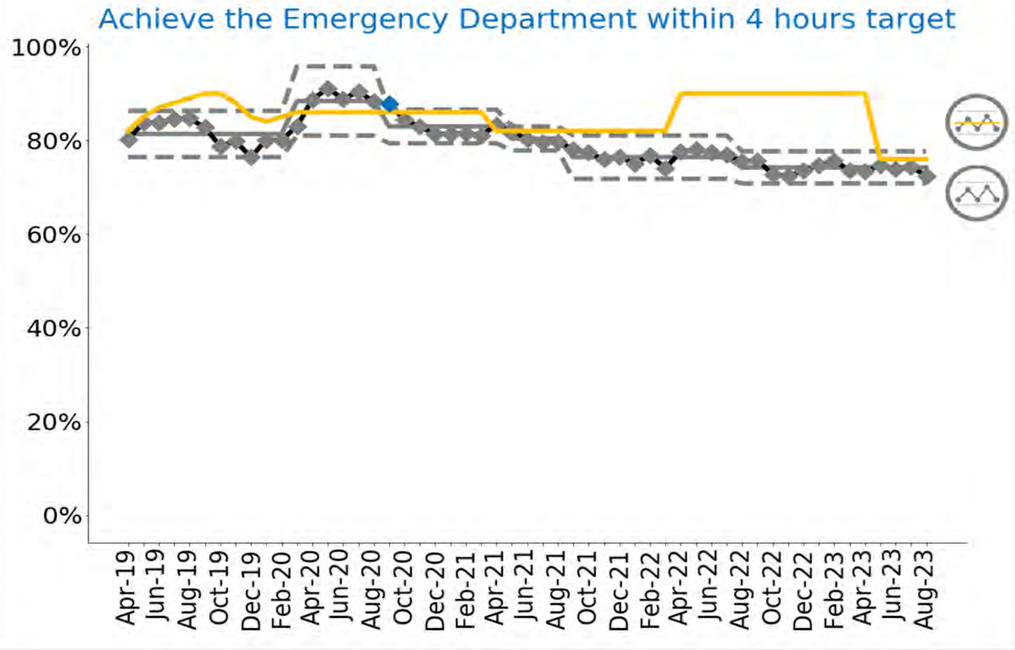
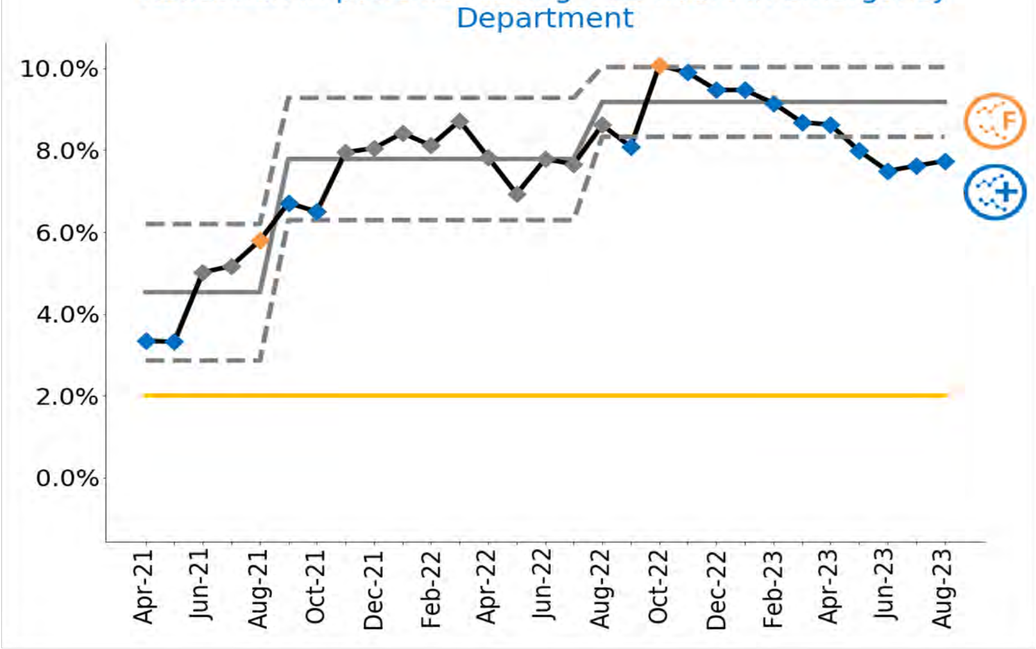
Recent positive pattern in the data	Failing the target but getting better May need exception report	Close to Target and getting better Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and getting better

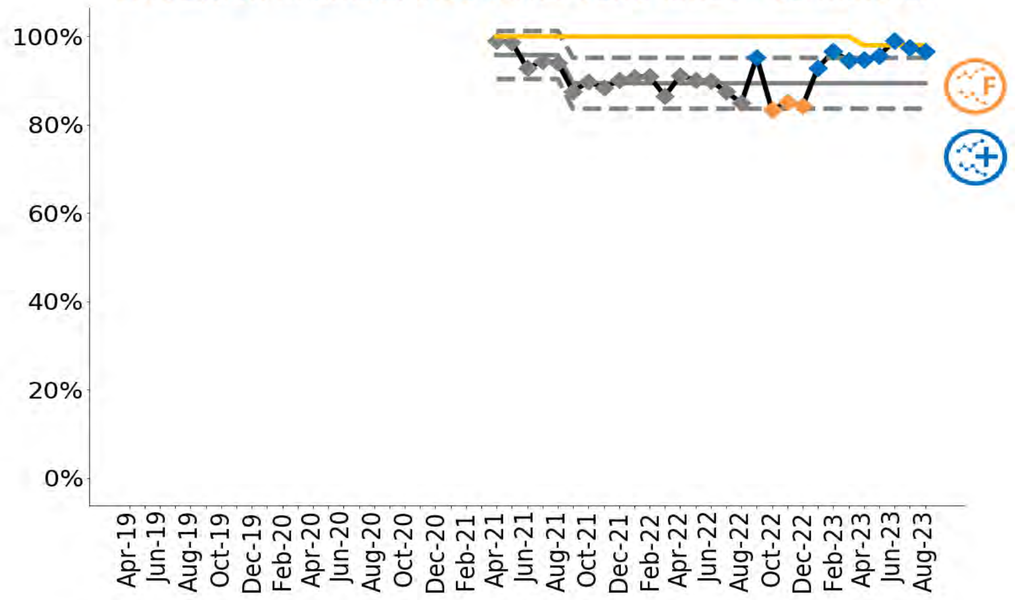
Achieve the Emergency Department within 4 hours target



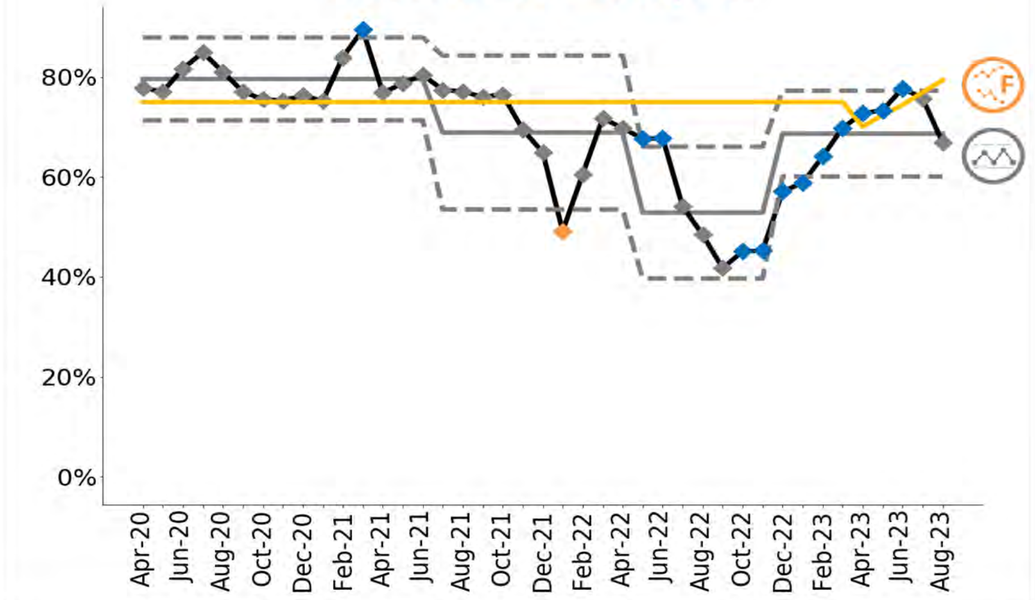
Reduction in patients waiting +12 hours in Emergency Department



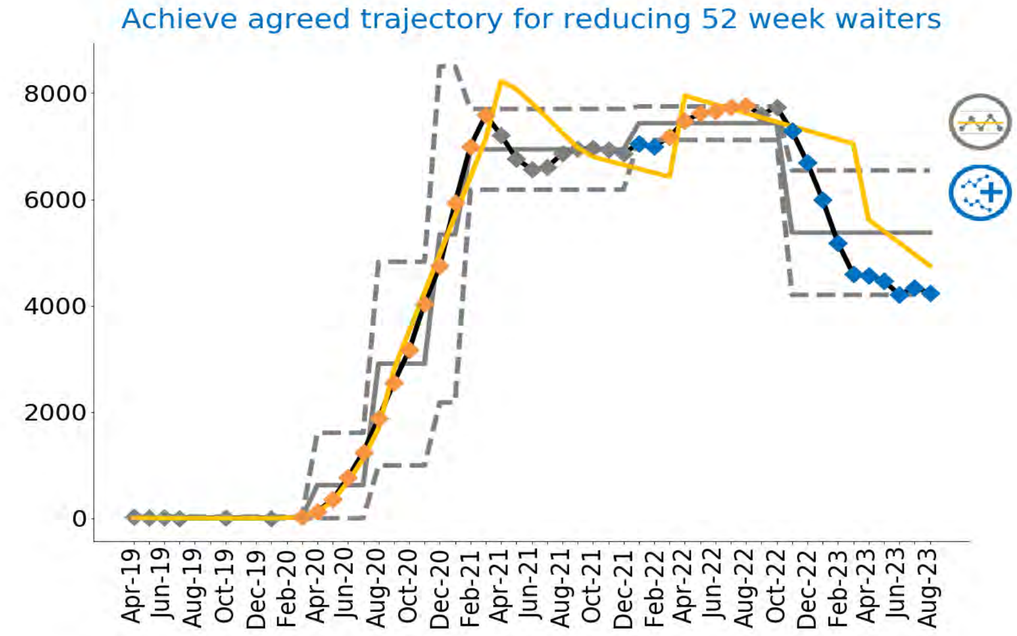
Reduction in ambulance turnaround times - 60 minutes



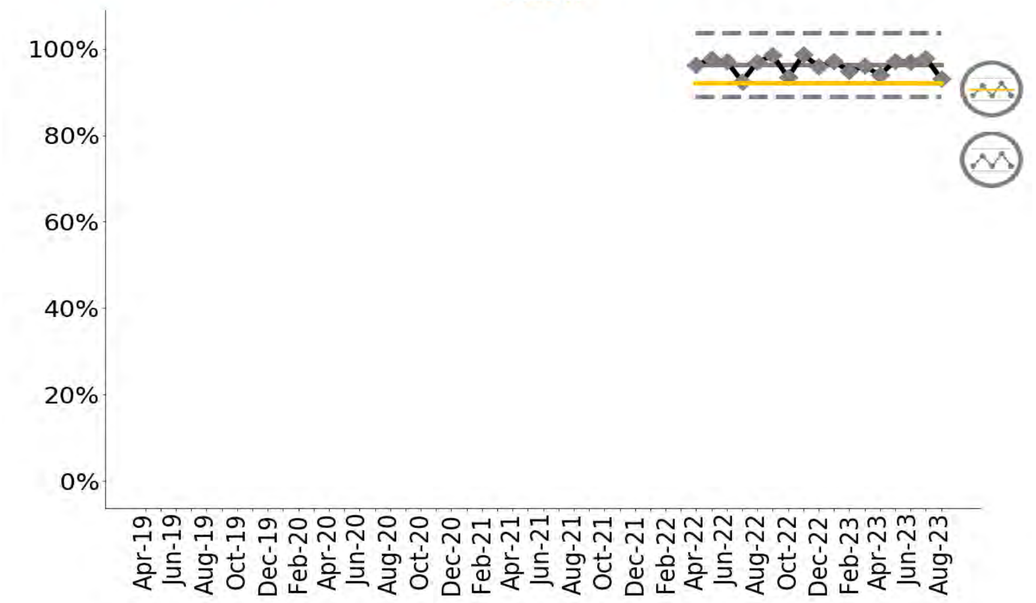
Achieve Cancer - 28 day FDS

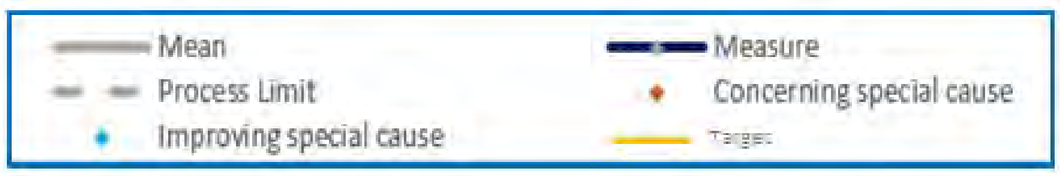


Achieve agreed trajectory for reducing 52 week waiters



Reduce adult general and acute (G&A) bed occupancy to 92% or below





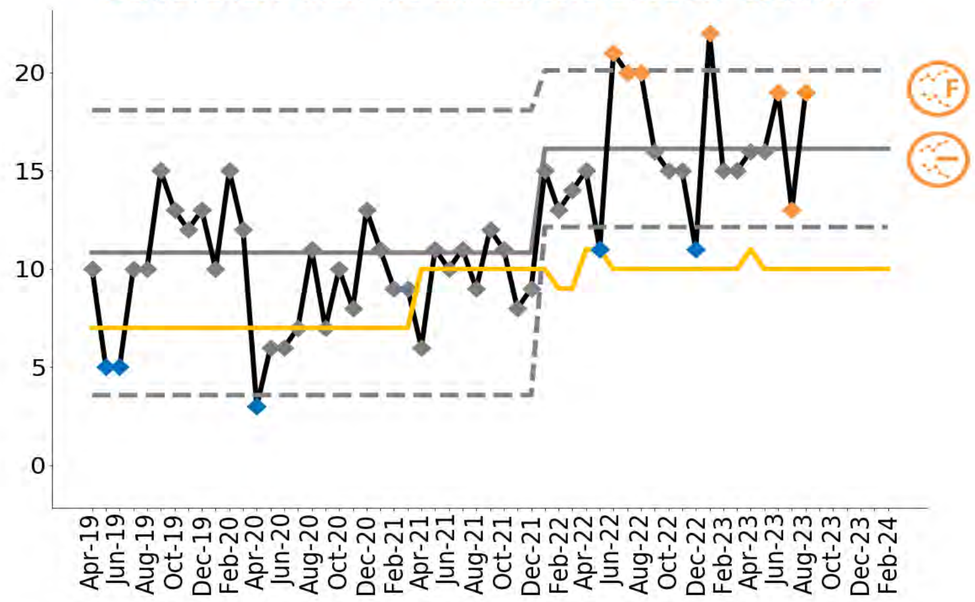
Assurance Icons – How likely are we to hit the set target in future?

It's possible the target could be either passed or failed within the expected month to month variation of the measure	*The target will be consistently failed within expected variation unless the process is changed*	*The target will be consistently passed within expected variation unless the process is changed*

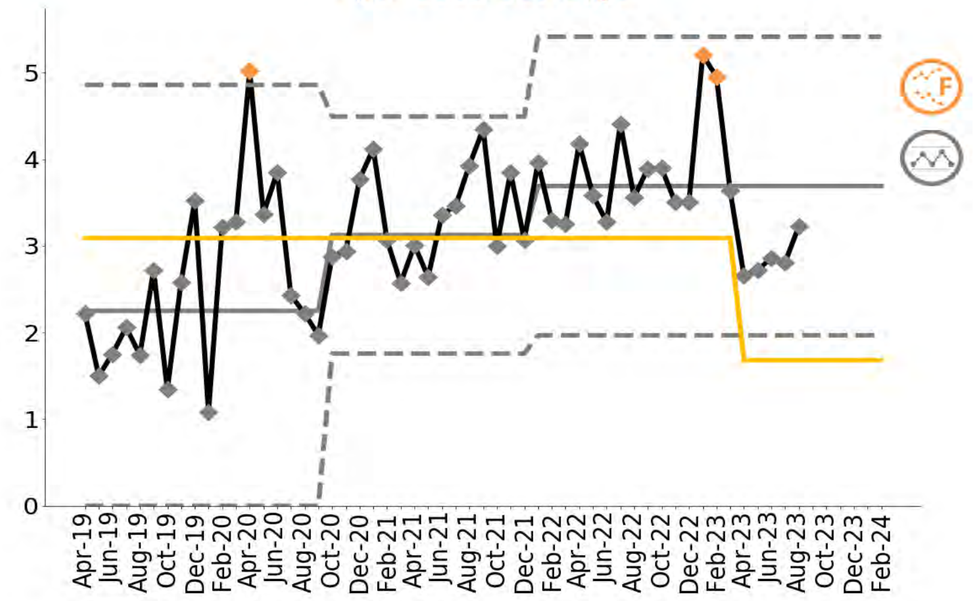
Variation Icons – Is the measure showing signs of change over time?

No signs of change over time evident in recent data	*An example of concerning change is evident in the recent data*	*An example of positive change is evident in the recent data*

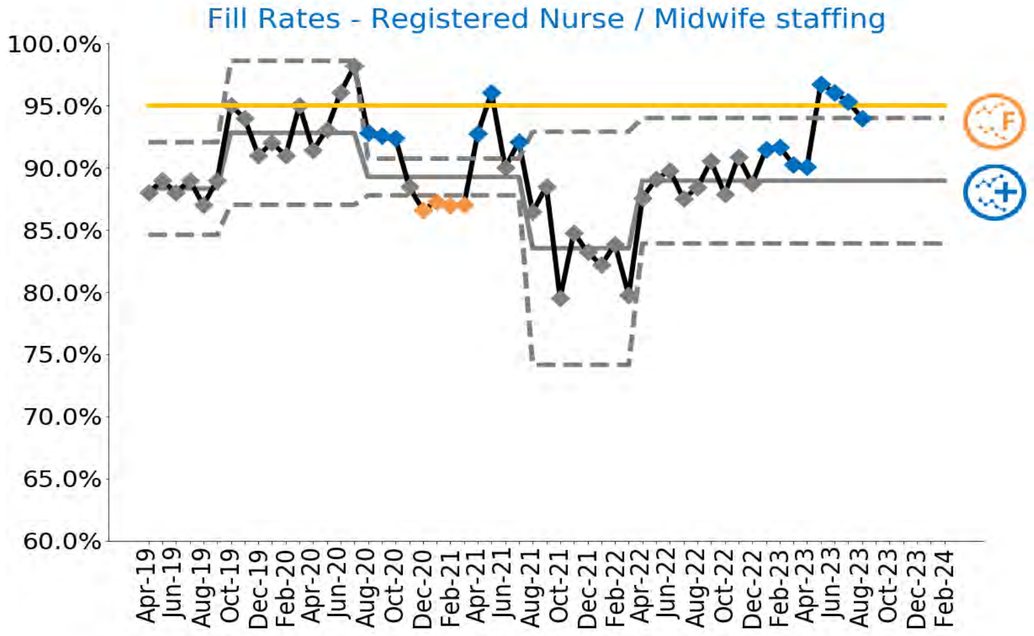
Achieve less than the annual tolerance for C.difficile



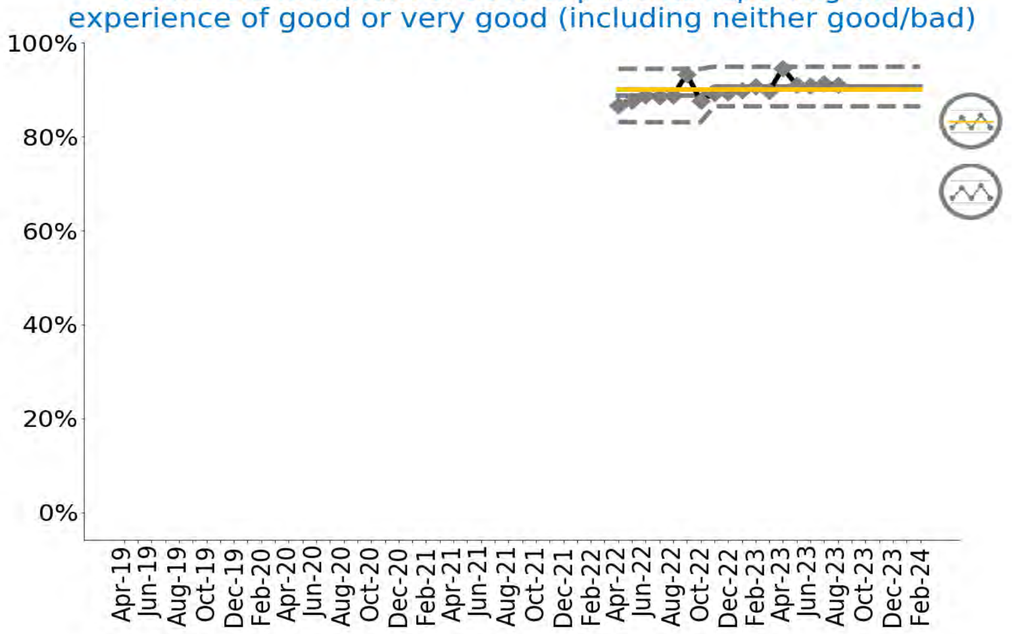
Reduce the number of people developing pressure ulcers by 10% - per 1000 bed days



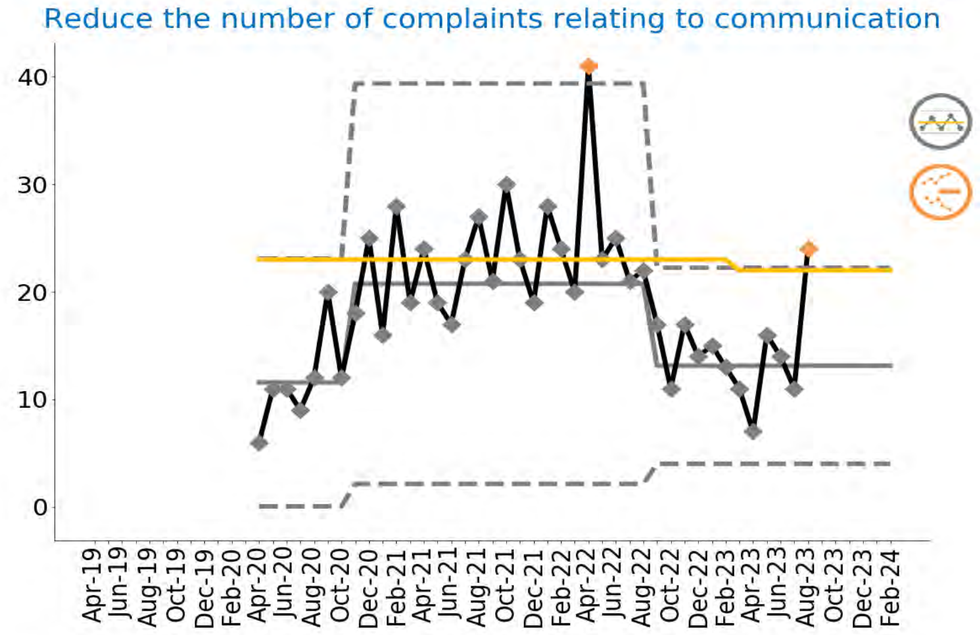
Fill Rates - Registered Nurse / Midwife staffing



Achieve a minimum of 90% of patients reporting their experience of good or very good (including neither good/bad)



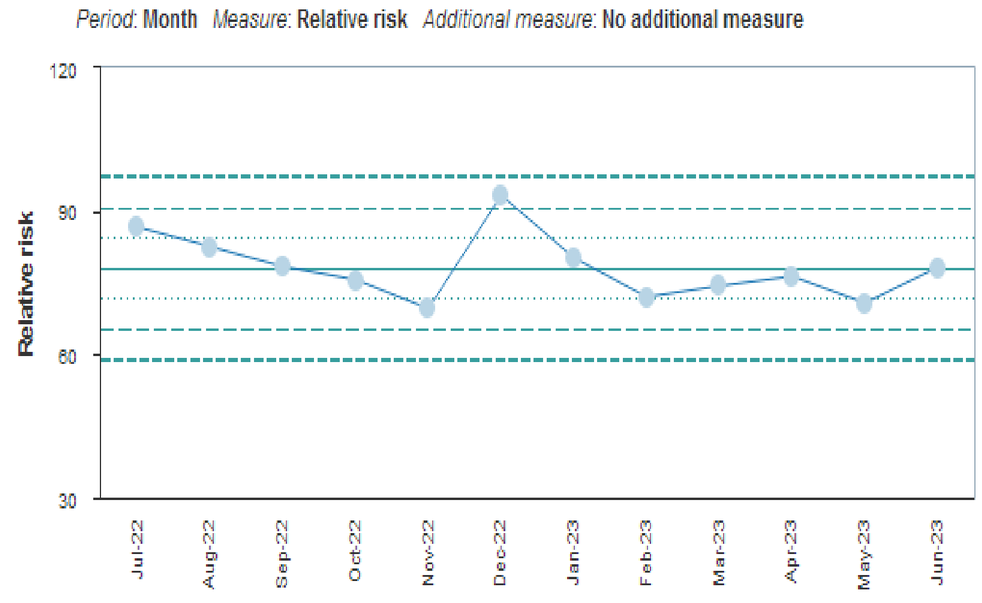
Reduce the number of complaints relating to communication

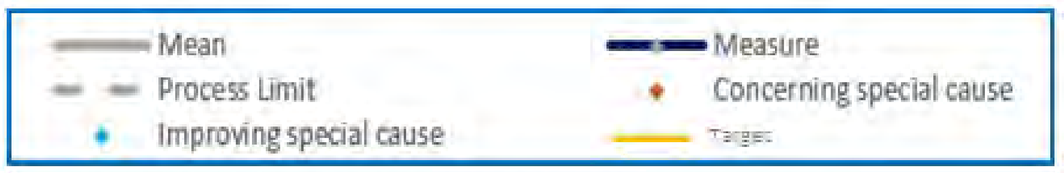


Diagnoses - HSMR | Mortality (in-hospital) | Jul-22 to Jun-23 | Trend (month)

Age (adult/child): 'Adult'

Period: **Month** *Measure:* **Relative risk** *Additional measure:* **No additional measure**





Assurance Icons – How likely are we to hit the set target in future?

It's possible the target could be either passed or failed within the expected month to month variation of the measure	*The target will be consistently failed within expected variation unless the process is changed*	*The target will be consistently passed within expected variation unless the process is changed*

Variation Icons – Is the measure showing signs of change over time?

No signs of change over time evident in recent data	*An example of concerning change is evident in the recent data*	*An example of positive change is evident in the recent data*

A GREAT PLACE TO WORK
Reviewed monthly / quarterly

Together

	Metric Description	Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Promote Health and Wellbeing									
Sickness Absence	Reduce overall sickness absence to 5.00% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 5%	5.59 %	6.14 %
	Reduce short-term sickness absence to 1.75% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 1.75%	1.94 %	1.99 %
	Reduce long-term sickness absence to 3.25% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 3.25%	3.65 %	4.16 %
Health & Wellbeing	Reduce average duration of psychological health related absences by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 33.11	36.30	37.07
	Reduce average duration of MSK-related absences by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 20.11	13.74	22.54
	Drive forward zero tolerance of violence and aggression toward staff by reducing the number of incidents by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 73	80	59.00
Develop People									
Turnover	Maintain annual staff turnover between 8% and 11% FTE (annual assessment; ESR in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 0.83%	0.62 %	0.76 %
Vacancies	Reduce the number of vacancies by a further 5% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 6%	5.70 %	9.05 %
Appraisals	Maintain 90% HC compliance rate for appraisals	M | T-D-S-C | W | KS	-				≥ 90%	88.85 %	
Mandatory Training	Maintain 90% HC compliance against all core skills training requirements (module compliance reported)	M | T-D-S-C | ETR | KS	-				≥ 90%	95.02 %	
Medical Devices	Achieve 90% HC compliance with medical device training	M | T-D-S-C | ETR | KS	-				≥ 90%	84.44 %	
Inform, Listen and Involve									
Staff Engagement & TED	Increase the number of teams that have undertaken TED by 15% (annual assessment; in-month reported)	M | T-D | W | KS	-			-	≥ 17	17	7.92
	Ensure 60% of our staff would recommend us as a place to work	Q | T-D | W | KS	-			-	≥ 60%	52.45 %	61.79 %

Assurance Icon / Variation Icon	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
Normal variation – no recent change	Failing target and no change happening. Process review needed. May need exception report	Close to Target and no change. Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and no change happening
Recent positive pattern in the data	Failing the target but getting better May need exception report	Close to Target and getting better Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and getting better

Reporting Requirements Key

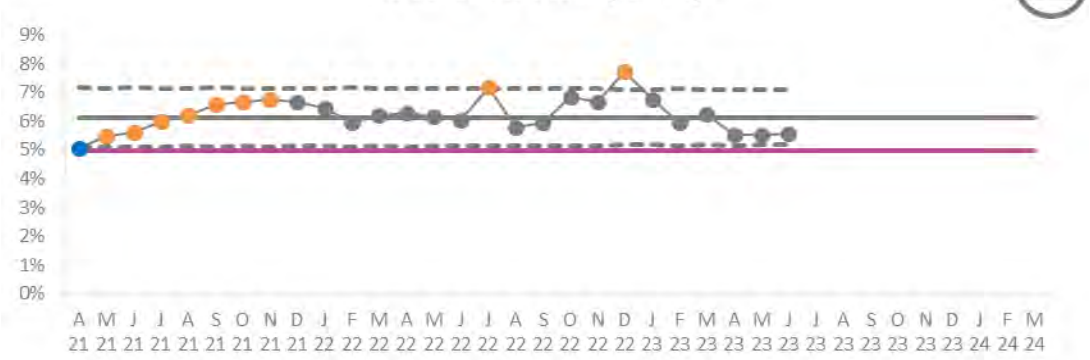
Frequency	Level	Sub-Committee	Responsible Executive
A = Annual	T = Trust	W = Workforce Committee	KS = Karen Swindley
B = Bi-annua	D = Division	ETR = Education, Training & Research Commit	JW = Jonathan Wood
M = Monthly	S = Specialty		All = All Exec Team
Q = Quarterly	C = Cost Centre		

A GREAT PLACE TO WORK
Reviewed via committee cycles of business

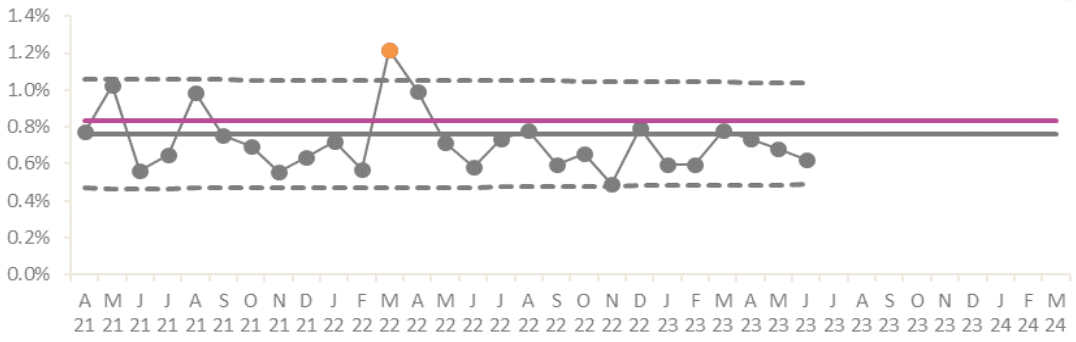
Together

	Metric Description	Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Promote Health and Wellbeing									
Enivronment	Upgrade a further five local staff rest areas	B | T | W | JW							
	Create five agile activity based workspaces	B | T | W | JW							
	Create outdoor recreational space on both the Chorley and Preston sites	B | T | W | JW							
Health & Wellbeing	Increase staff perception that the organisation takes positive action on health and wellbeing to 40%	A | T-D-S-C | W | KS							
	Support staff to stay well by ensuring adequate rest and recuperation in line with working time regulations	B | T-D-S-C | W | KS							
Develop People									
Appraisals	Improve staff perception of the quality of appraisals by 5%	A | T-D | W | KS							
Inform, Listen and Involve									
Just Culture	Reduce further the number of grievances that are managed through formal processes to monitor the move to a just culture	B | T | W | All							
	Reduce the gap between the scores achieved in the annual culture survey between staff perception of the current and desired culture	A | T-D-S | W | All							
Freedom to Speak Up	Ensure all staff accessing the Freedom to Speak Up team are satisfied with how their concerns were managed	A | T | W | KS							
Staff Engagement & TED	Increase the staff engagement score, as measured by the annual staff survey, to 7 out of 10	A | T-D | W | KS							
	Ensure 50% of our staff complete the annual staff survey	A | T-D | W | KS							
Value Each Other									
Race Equality	Reduce the number of staff from BAME backgrounds that have personally experienced discrimination at work to be in line with that of their white colleagues	A | T | W | All							
	Increase the number of colleagues from a BAME background in senior roles (AfC Band 8a and above)	A | T | W | All							
Disability Equality	Reduce the number of disabled staff that experience harassment, bullying and abuse from managers to be in line with the experience of non-disabled colleagues	A | T | W | All							
Corporate Social Responsibility	Engage with our local communities through a range of workforce and education programmes	A | T | W | KS							

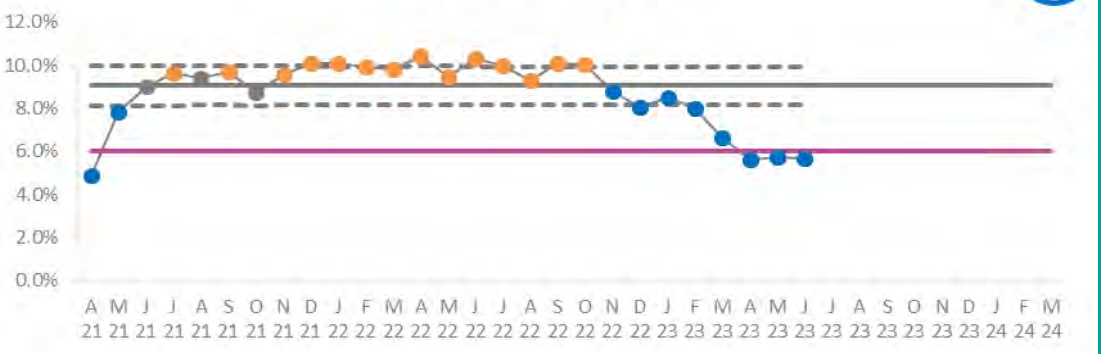
Overall Sickness (% FTE)



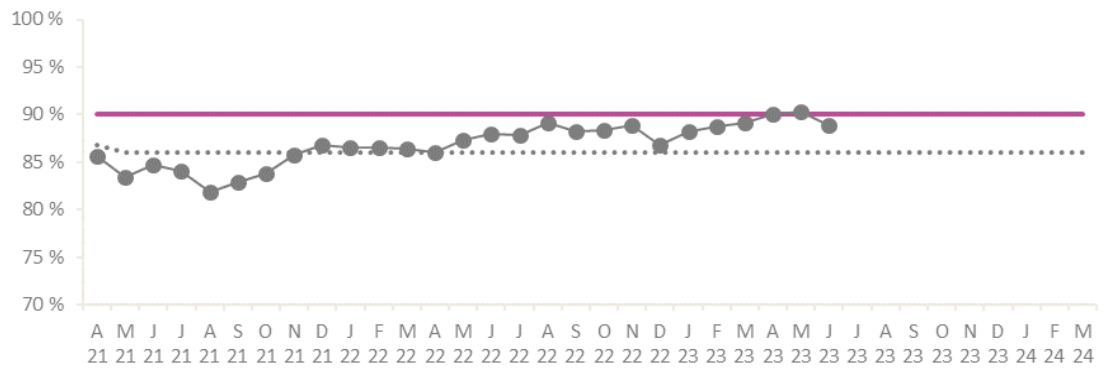
ESR Turnover (% FTE)



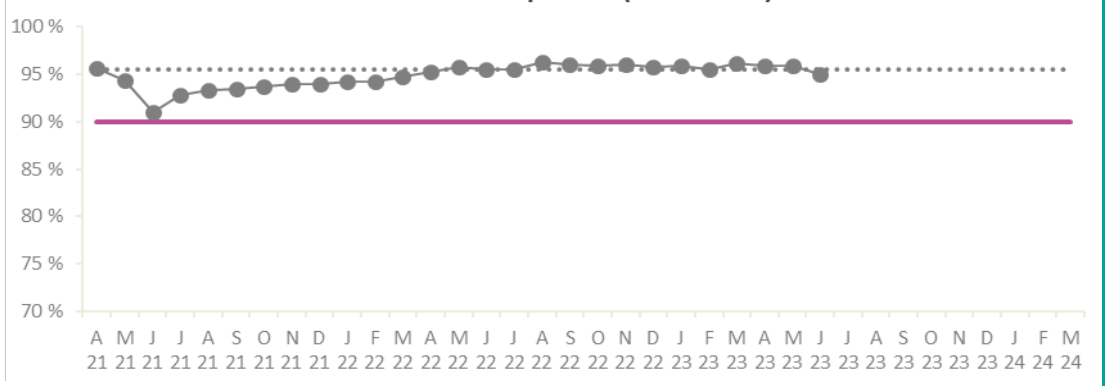
GL Vacancy Rate (% FTE)



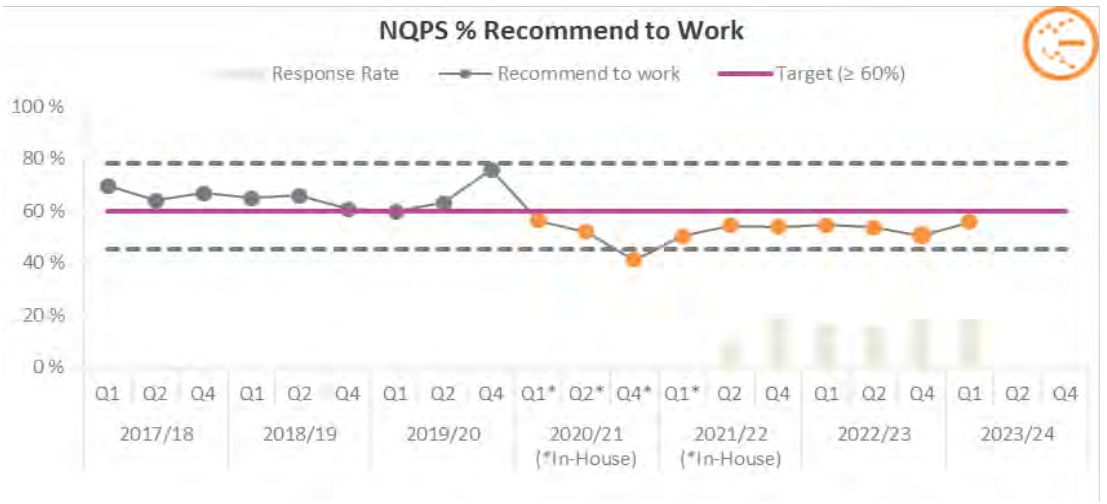
Appraisal Compliance (% HC)



CSTF Compliance (% modules)



NQPS % Recommend to Work



NSS % Recommend to Work

Deliver Value for Money

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment One - Spend Less (Economy)												
Agree revenue and capital financial plan with ICB	**Key Metric**		Deliver 100% of the agreed targeted reduction in our underlying financial deficit	A | T | TB - FPC | JW	This indicator is reported separately agreed at Trust level at budget setting							
Deliver agreed cost improvement delivery target	**Key Metric**		To deliver 100% of agreed cost improvement target	M | T-D-S | FPC | JW	No	-	-	-	3595	2325	-
Segment Two - Spend Well (Efficiency)												
Bed Occupancy Rate (Including Escalations)	Big Plan		Achieve a bed occupancy rate of no higher than 90%	M | T-D-S | FPC | FB	No	F			90%	93.7%	94.3%
Theatre Efficiency	Big Plan		RPH - Theatre capped utilisation rates are no lower than 80%	M | T-D-S | FPC | FB	No	-	-	-	80%	77.3%	-
	Big Plan		CDH - Theatre capped utilisation rates are no lower than 85%	M | T-D-S | FPC | FB	No	-	-	-	85%	74.9%	-
GIRFT (Model Hospital)	Big Plan		Achieve 85% day case basket using GIRFT	M | T-D-S | FPC | FB	UNDER DEVELOPMENT						
OP Follow Ups	Big Plan		Reduce OP follow ups by 25%	M | T-D-S | FPC | FB	UNDER DEVELOPMENT						
Supplier payments (BPPC)	Big Plan		To ensure all suppliers are paid in line with national guidance	M | T | FPC | JW	No			-	95%	95.3%	-
Segment Three - Spend wisely (Effectiveness)												
Agency costs	Big Plan		Reduce agency costs to 3.7% of the total pay bill	M | T-D-S | W | SC-GS	No	-	-		3.7%	4.65%	-
Delivery of Activity and Revenue Plan	**Key Metric**		To ensure 100% delivery of the Trust's activity and revenue programme	M | T | FPC | JW	No	-	-	-	-18681	-28613	-
Capital	**Key Metric**		To ensure 100% delivery of the Trust's Capital programme	M | T | FPC | JW	No	-	-	-	8350	7010	-

Reporting Requirements Key

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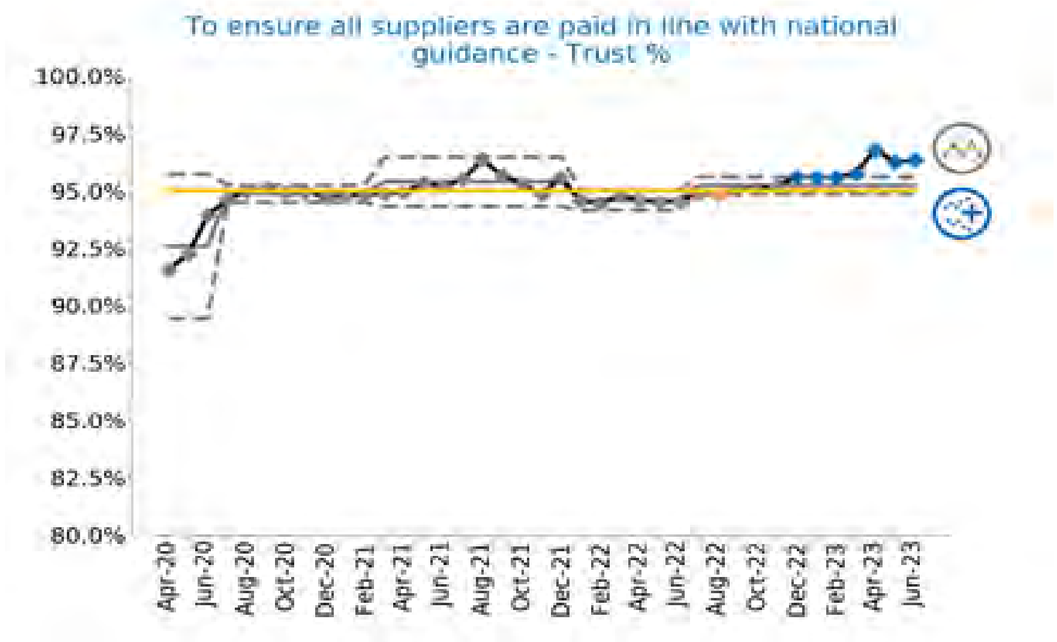

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Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Target	Current Rating	Position @ Q1	Position @ Q2	Position @ Q3	Position @ Q4	Comment
Segment One – Strategy and Transformation												
Clinical Services Strategy	Big Plan	FFTF-1	To deliver the 23/24 actions in the LTH clinical services strategy, including addressing the challenges and opportunities of multi-site working:	B | T-D | TB | GS							
			To provide outstanding, sustainable healthcare to our local communities and in our tertiary services								
			To drive health innovation through world class education, teaching and research								
			System working in a new NHS landscape								
Outpatients Transformation	**Key Metric**	**FFTF-2**	**Deliver the 23/24 actions and outcomes from the agreed Transformation Plan including:**	M | T | FPC | GS							
			Deliver Personalised Outpatient Care (Patient Initiated Follow up & Patient Stratified Follow Up)								
			Referral optimisation and demand management								
			Deliver our follow up reduction target to drive the outpatient element of our Financial Improvement Plan								
Elective Care Transformation	**Key Metric**	**FFTF-3**	**Deliver the 23/24 actions and outcomes from the agreed Transformation Plan**	M | T | FPC | FB							
			Deliver agreed national waiting list improvement targets and productivity benchmarks								
			Develop our elective strategy to include repatriation of activity from the independent sector and other regions, and the maximisation of our surgical hub capacity								
			Deliver our planned care financial targets in support of the Financial Improvement Plan								
Urgent and Emergency Care Transformation	**Key Metric**	**FFTF-4**	**Deliver the 23/24 actions and outcomes from the agreed Transformation Plan including:**	M | T | FPC | AB							
			Focus on pre hospital pathway/front door to include integrated mental/physical health services and a 40% reduction in ambulance conveyances								
			Reduce Lengths of stay by 10% reduction in LoS on 10 pilot wards and reduce Not Meeting Criteria to Reside reduced to 5% (system aim)								
			Deliver agreed financial benefits to support Financial Improvement Plan								
Unwarranted Variation	Big Plan	FFTF-5	Deliver the 23/24 actions and outcomes from the agreed Transformation Plan including:	M | T | FPC | GD							
			Fully establish and embed the programme governance			▲	▲	▲			Programe fully established
			Undertake deep dive reviews into the 9 identified priority specialities, agreeing and deliver the consequent improvement plans			▲	▲	▲			Reviews undertaken and actions underway- however, financial benefits are below target
			Deliver agreed financial benefits to support Financial Improvement Plan								

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Target	Current Rating	Position @ Q1	Position @ Q2	Position @ Q3	Position @ Q4	Comment
Financial Improvement Plan	Big Plan	FFTF-6	Deliver the 23/24 actions and outcomes from the agreed Improvement Plan:	M | T | FPC | JW							
			Fully embed FIP governance & reporting								
			Fully embed FIP delivery framework								
			Develop and agree 3 year FIP								
Segment Two – Place Based Partnership											
Collaboration and Integration at Place	**Key Metric**	**FFTF-7**	**Fully establish the required governance structure and processes for Place based working, agree and deliver the 23/24 agreed Place strategies, actions and outcomes**	Q | T | TB | GD							
			Agree a comprehensive set of priorities & programmes								
			Deliver the Core20PLUS5 action plan and outcomes								
			Deliver the Frailty improvement action Plan & Outcomes								
Social Value	Big Plan	FFTF-8	Building on our Social Value Framework, work with partners to develop a Social Value Strategy driving a place based focus on equality, wider determinants of health, poverty and social capital:	B | T | TB | GD							
			Review and refresh Green Plan and deliver agreed actions/metrics								
			Prepare for Level 2 Social Value Quality Mark accreditation application in 2024/25								
			Deliver the Core20PLUS5 action plan and outcomes								

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Target	Current Rating	Position @ Q1	Position @ Q2	Position @ Q3	Position @ Q4	Comment
Segment Three – System Working												
ICB Joint Forward Plan	**Key Metric**	**FFTF-9**	**Deliver the 23/24 actions and outcomes from the agreed JFP. Work with ICB to:**	Q | T | TB | GD		▭	▭	▭			
			Finalise the JFP			▲	▲	▲			JFP signed off by the ICB Board
			Align strategies and plans with the JFP priorities			▭	▭	▭			
			Develop detailed delivery plans			▭	▭	▭			
Clinical Collaboration	Big Plan	FFTF-10	Deliver the 23/24 actions and outcomes from the agreed Clinical Collaboration work plan including:	M | T | FPC | GS		▭	▭	▭			
			Develop & deliver implementation plans for new models of care in Vascular, Head & Neck, Urology, Stroke and Elective Hubs			▭	▭	▭			
			Agree next set of specialties for the implementation of new models of care and develop implementation plans			▭	▭	▭			
			Undertake challenged services review of fragile and financially challenged services, and deliver agreed action plans			▭	▭	▭			
Central Services Collaboration	Big Plan	FFTF-11	Deliver the 23/24 actions and outcomes from the agreed Central Services Collaboration work plan including:	M | T | FPC | JW		▭	▭	▭			
			Target Operating model agreed and mobilised			▭	▭	▭			
			Phase 1 transactional services (Payroll and General Ledger provision) underway			▲	▲	▲			
			Bank and Agency Collaborative proposal sign off/implementation			▲	▲	▲			
Digital Northern Star / EPR Convergence	Big Plan	FFTF-12	Deliver the 23/24 actions and outcomes from the agreed Digital/EPR work plan	M | T | FPC | SD-GD		▭	▭	▭			
			EPR tenders evaluated, and preferred supplier awarded			▲	▲	▲			Scripts and videos scored, awaiting final moderation and on track for a preferred supplier status in quarter 2. OBC progressing.
			Digital Convergence programme governance reviewed and revised			▲	▲	▲			Governance in place.
			Implement Secure data Environment			▭	▭	▭			14M allocated through treasury. FBC progressing through North West Approval process.
Elective Recovery	Big Plan	FFTF-13	Deliver the 23/24 actions and outcomes from the agreed ECRG work plan – maximise system working to deliver:	M | T | FPC | GD		▭	▭	▭			
			National waiting times targets			▭	▭	▭			
			National productivity targets			▭	▭	▭			
			Surgical Hub Strategy			▲	▲	▲			
New Hospitals Programme	Big Plan	FFTF-14	Milestones and metrics to be finalised following further discussions with national teams	M | T | FPC | JW							

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Green Delivering actions and outcomes

Amber On track to recover actions & outcomes

Red Significantly off track with actions & outcomes

Chair's Report

Lancashire Teaching Hospitals NHS Foundation Trust

Committee:	Audit Committee
Chairperson and role:	Tim Watkinson, Non-Executive Director
Date(s) of Committee meeting(s):	21st September 2023
Purpose of report:	To update the Board on the business discussed by the Audit Committee on 21st September 2023. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The Committee received and scrutinised a number of reports which were standing items on the cycle of business, including:

- Minutes and actions from the previous meeting
- Mersey Internal Audit Agency (MIAA) Audit Progress Report
- Combined Internal Audit and Anti-Fraud Follow-Up Summary Report
- Counter-Fraud Progress Updates (including previous investigations)
- External Audit (KPMG) technical update highlighting the main issues currently affecting the health sector.

The Committee also discussed and received assurance from the following reports:

- RTT Patient Access Audit
- Theatre List Management
- Cyber Security
- WHO Audit
- Single Tender Waivers
- Losses and Special Payments
- Clinical Audit Programme Update

The Committee also reviewed the Committee Risk Reviews: Providing a Range of the Highest Specialised Services Report and decided that further updates were needed to reflect the changes in commissioning arrangements and the complexity of service delivery.

The Committee received the Risk Management Strategy and Risk Management Policy review and agreed to endorse the strategy with the caveat that development work would continue and an update be provided in 3 months' time. Updates to the Risk Management Policy were approved. The Committee noted the commencement of the new Risk Management Group and received and approved the updates to the action plan.

Items for the Board's attention

Positive escalation

(a) Positive assurance from the Data Security Tool Kit
(b) Number of substantial internal audit reviews received – on track with delivery and implementation of recommendations.
(c) Positive Cyber Security paper with a lot of assurance.
(d) Positive Clinical Audit update
(e) Endorsement of the Risk Strategy
(f) Collaborative discussions with other Trusts' Audit Chairs

Negative escalation

(a) Current financial position
(b) Theatre List Management Audit – more action was required on recommendations, further update sought in January.
(c) Increasingly high number of Single Tender Waivers
(d) Further assurance was needed on overseas debt.

Committee to Committee escalation

Single Tender Waivers: Request for the Director of Procurement to provide specific updates regarding improvements in forward forecasting for contractual renewals to the Finance and Performance Committee.

Items recommended to the Board for approval

Risk Management Strategy
Updates to the Risk Management Policy

Committee Chairs reports received

None

Items where assurance was provided and/or for information

- Strategic Risk Report
- Civil Claims Annual Report
- MIAA Final Audit Reports
  (a) Equality, Diversity & Inclusion Review
  (b) Safeguarding Supervision PiPoT Review
  (c) Radiology IT Infrastructure Management Final Report
  (d) Data Security & Protection Toolkit Report
- RTT Data Quality Report

Progress against the Committee's cycle of business

The Committee continues to cover its business work in line with its cycle of business.
The next meeting of the Committee will take place on 18th January 2024 on Microsoft Teams

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Audit Committee agenda (*21st September 2023*)

Audit Committee

21 September 2023 | 10.30am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	10.30am	Verbal	Information	T Watkinson
2.	Apologies for absence	10.31am	Verbal	Information	T Watkinson
3.	Declaration of interests	10.32am	Verbal	Information	T Watkinson
4.	Minutes of the previous meeting held on 23 June 2023	10.33am	✓	Decision	T Watkinson
5.	Matters arising and action log	10.34am	✓	Decision	T Watkinson
6.	LSC Audit Chair's Meeting	10.35am	Verbal	Information	T Watkinson
7. INTERNAL AUDIT					
7.1	Internal Audit Progress Report	10.40am	✓	Assurance	MIAA
7.2	Combined Internal Audit and Anti-Fraud Follow-Up Summary Report	10.50am	✓	Assurance	MIAA
7.3	Counter-Fraud Progress Update (including previous investigations)	11.00am	✓	Assurance	MIAA
8. RISK AND ASSURANCE					
8.1	RTT Patient Access Audit	11.10am	✓	Assurance	E Ince
8.2	Theatre List Management	11.20am	✓	Assurance	G Skailes/S Dobson
8.3	Cyber Security	11.30am	✓	Assurance	S Dobson
8.4	WHO Audit	11.40am	✓	Assurance	F Button/G Skailes
8.5	Committee Risk Reviews Providing a Range of the Highest Standard of Specialised Services	11.50am	✓	Decision	G Skailes
8.6	Risk Management Strategy and Risk Management Policy Review	12.00pm	✓	Decision	S Regan
8.7	Single Tender Waiver Report	12.10pm	✓	Assurance	B Patel K Fletcher
8.8	Losses and Special Payments Report	12.20pm	✓	Decision	B Patel

№	Item	Time	Encl.	Purpose	Presenter
8.9	Clinical Audit Programme Update	12.30pm	✓	Assurance	S Regan
9. EXTERNAL AUDIT					
9.1	Technical Update	12.40pm	✓	Information	KPMG
10. OTHER MATTERS					
10.1	Items for escalation to the Board or referral to/from other Committees	12.45pm	Verbal	Information	T Watkinson
10.2	Reflections on the meeting and adherence to the Board Compact	12.50pm	✓	Information	T Watkinson
11. ITEMS FOR INFORMATION					
11.1	Strategic Risk Report		✓		
11.2	Civil Claims Annual Report		✓		
11.3	MIAA Final Audit Reports a) Equality, Diversity & Inclusion Review b) Safeguarding Supervision PiPoT Review c) Radiology IT Infrastructure Management Final Report d) Data Security & Protection Toolkit Report e) RTT Data Quality Report		✓ ✓ ✓ ✓ ✓		
11.4	Date, time and venue of next meeting: *18 January 2024, 10.30am, Microsoft Teams*	12.50pm	Verbal	Information	T Watkinson

Chair's Report

Committee:	Charitable Funds Committee
Chairperson and role:	Ms K Smyth, Non-Executive Director
Date(s) of Committee meeting(s):	19 September 2023.
Purpose of report:	To update the Board on the business discussed by the Charitable Funds Committee on 19 September 2022. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The Committee conducted a comprehensive review of the agenda's scheduled items, approved the meeting's minutes on 20 December 2022, and reviewed updates on associated Committee actions. Specific reports were received and scrutinised on the following standing agenda items:

- Financial performance, review of spending plans and balances
- Hospitals' Charity update including Baby Beat Appeal
- Rosemere Charity Update

The 2022/23 Annual Report and Accounts for both the Lancashire Hospitals and Rosemere Cancer Foundation charities were approved as presented for submission to the Charity Commission.

The Committee also received an update on inactive charitable funds and was assured that management of inactive funds was appropriate.

In addition, updates were given on the following:

Investment Policy and the Green Agenda: The Committee considered the Charity's investments and how much exposure these had to companies involved in fossil fuels or anti-environmental technologies. The Committee was comfortable with the current level of exposure; the ethical dilemma of investments in these sectors was acknowledged, but the balanced approach adopted was endorsed.

Financial Improvement Plan & Requests for Funding: The Committee undertook a focused discussion around what could and could not be funded from a legal, regulatory and ethical perspective. The Company Secretary refreshed the Committee on the general requirements of charity law in respect of use of charitable funds.

The Committee approved a funding request for an Early Pregnancy Bereavement Specialist Nurse on a 2-year fixed term contract, subject to annual review.

Items for the Board's attention

Positive escalation
• Ethical debate around the acceptable use of Charitable Funds • Decision to approve the charitable funding of a 2-year fixed term Early Pregnancy Bereavement Nurse • Green agenda debate and assurance
Negative escalation
None
Committee to Committee escalation
None
Items recommended to the Board for approval
2023/24 Annual Reports and Accounts
Committee Chair's reports received
(a) Rosemere Management Committee (b) Notes from the Chair's Briefing June 2023
Items where assurance was provided and/or for information
• Lancashire Teaching Hospital's Charity update including Baby Beat Appeal - The purpose of the report was to provide the committee with an update on the activities and fundraising plans of Lancashire Teaching Hospitals Charity (including Baby Beat and Children's Appeal). • Rosemere Cancer Foundation Charity Report - The purpose of the report was to provide the committee with an update on the activities and fundraising commitments of the Rosemere Cancer Foundation (RCF).
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 19 December 2023 using Microsoft Teams

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Charitable Funds Committee agenda (19 September 2023)

Charitable Funds Committee

19 September 2023 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chairman and quorum	1.00pm	Verbal	Information	K Smyth
2.	Apologies for absence	1.01pm	Verbal	Information	K Smyth
3.	Declaration of interests	1.02pm	Verbal	Information	K Smyth
4.	Minutes of the previous meetings held on 20 December 2023 (a) Written Resolution 01.23	1.03pm	✓ ✓	Decision Information	K Smyth
5.	Matters arising and action log	1.04pm	✓	Decision	K Smyth
6.	Financial Improvement Plan: Requests for Funding	1.05pm	Verbal	Discussion	S Cullen/D Hill/J Foote
7.	Funding request: Early Pregnancy Bereavement Specialist Nurse	1.20pm	✓	Decision	S Cullen
8.	Investment Policy and the Green Agenda	1.30pm	Verbal	Discussion	D Hill/B Patel
9.	REPORT CARRIED FORWARD FROM JUNE AGENDA				
9.1	Update on inactive funds	1.40pm	✓	Assurance	B Patel
10.	STRATEGY AND PLANNING				
10.1	Hospitals' Charity update including Baby Beat	1.50pm	✓	Decision	D Hill
10.2	Rosemere Charity update	2.00pm	✓	Decision	D Hill
11.	FINANCE AND PERFORMANCE				
11.1	Finance update including review of spending plan and balances	2.10pm	✓	Assurance	B Patel
12.	GOVERNANCE AND COMPLIANCE				
12.1	Charities annual report and accounts	2.20pm	✓	Decision	B Patel/D Hill
12.2	Items for referral to the Board or from/to other committees	2.25pm	Verbal	Information	K Smyth
12.3	Reflections on the meeting and adherence to the Board Compact	2.28pm	✓	Information	K Smyth
13.	ITEMS FOR INFORMATION				
13.1	Rosemere Management Committee Chair's report		✓		
13.2	Notes from Chair's Briefing June 2023		✓		

№	Item	Time	Encl.	Purpose	Presenter
13.3	Date, time and venue of next meeting: *19 December 2023, 10.30pm, MS Teams*	2.30pm	Verbal	Information	K Smyth

Board of Directors Report

Risk Management Strategy (2023-2026) & Risk Management Policy

Report to:	Board of Directors	**Date:**	5th October 2023
Report of:	Chief Nursing Officer	**Prepared by:**	S. Regan

Purpose of Report

For assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary:

The purpose of this paper is to:

- Present the new Risk Management Strategy (2023-2026) and the updated Risk Management Policy for formal ratification.
- Give details in relation to the implementation of a new Risk Management Group.

The development of the Risk Management Strategy and updates made to the policy, specifically support the achievement of two actions developed in response to recommendations from an externally commissioned Risk & Assurance review which concluded in November 2022, and was presented to the Board of Directors in February 2023.

Risk Management Strategy

A key recommendation from the Risk & Assurance review was Recommendation 6: ***"The trust should develop a strategy for risk management in a separate document, setting out its objectives in relation to improving and embedding risk management over the coming years, and including an action plan with clear deadlines. This could be derived from the existing risk maturity plan."***

A new Risk Management Strategy (2023-26) has now been developed in a separate document to the Risk Management Policy and a copy can be found in Appendix 1.

The strategy is framed upon the consistent principles adopted within the Trust's Always Safety-First Strategy, and the Patient Experience & Involvement Strategy:

i. Insight
ii. Involvement
iii. Improvement

It sets out the approach to further enhancing Risk Management at Lancashire Teaching Hospitals over the next 3 years.

The strategy has been developed after consultation with members of the Senior Leadership Team (SLT), the Board of Directors and wider groups.

The strategy was approved at Audit Committee in September 2023 with a recommendation that the strategy should be formally ratified by the Board of Directors. Going forward, the strategy will be overseen by the Risk Management Group and progress will be presented annually to the Audit Committee.

Risk Management Policy

The Risk Management Policy has also been updated in line with the introduction of the Risk Management Strategy and its annual review cycle. The updated policy can be found in Appendix 3 and a summary of key changes can be found in the addendum section on page 1 and 2 of the policy.

The Risk Management Policy was approved at Audit Committee in September 2023 with a recommendation that the strategy should be formally ratified by the Board of Directors.

Risk Management Group

The second key recommendation from the Risk and Assurance review was Recommendation 7: ***"The trust should establish a Risk Management Group, chaired by an executive director and with senior membership, to perform the functions currently exercised by the Senior Leadership Team in respect of risk management."***

A new Risk Management Group will be introduced from November 2023 as outlined in the Risk Management Strategy and Risk Management Policy. The group will be chaired by the Chief Nursing Officer, and this will run alongside the Senior Leadership Team meeting. The Risk Management Group will report into committees of the Board. An overview of the governance and escalation arrangements are included within the main body of the report.

It is recommended that the Board of Directors:

I. Receive and ratify the Risk Management Strategy.
II. Receive and ratify the updates to the Risk Management Policy.
III. Note the commencement of a new Risk Management Group.

Appendix 1 – Draft Risk Management Strategy 2023-26
Appendix 2 – Risk Management Policy

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Audit Committee – September 2023

1. Background

1.1 The purpose of this paper is to:

- Present the new Risk Management Strategy (2023-2026) and the updated Risk Management Policy for formal ratification.
- Give details in relation to the implementation of a new Risk Management Group.

1.2 The development of the Risk Management Strategy and updates made to the policy, specifically support the achievement of two actions developed in response to recommendations an externally commissioned Risk & Assurance review which concluded in November 2022, and was presented to the Board of Directors in February 2023. These are:

- Recommendation 6 - The trust should develop a strategy for risk management in a separate document, setting out its objectives in relation to improving and embedding risk management over the coming years, and including an action plan with clear deadlines. This could be derived from the existing risk maturity plan.
- Recommendation 7 - The trust should establish a Risk Management Group, chaired by an executive director and with senior membership, to perform the functions currently exercised by the SLT in respect of risk management.

1.3 An action plan was developed in response to the Risk and Assurance review, which accepted both of the recommendations and the action plan was adopted by the Board of Directors in February 2023, with a commitment to develop a Risk Management Strategy and introduce a group specifically to focus on Risk Management within the organisation to further enhance the Trust's risk maturity.

1.4 For background and context, the Trust previously had a Risk Management Strategy in place but early feedback from the Risk & Assurance review indicated that whilst this was described as a strategy, it was more in line with a policy and described the processes and requirements for managing risk within the organisation. A full review of the document was therefore undertaken, and the revised document was approved by the Board of Directors as a Risk Management Policy in August 2022.

2. Discussion

Risk Management Strategy (2023-26)

2.1 In pursuit of excellence in its Risk Management arrangements, the Trust have developed a Risk Management Strategy (2023-26) which is attached at Appendix 1 for formal ratification.

2.2 The strategy is framed upon the consistent principles adopted within the Trust's Always Safety-First Strategy, and the Patient Experience & Involvement Strategy:

i. Insight
ii. Involvement
iii. Improvement

2.3 It sets out the approach to further enhancing Risk Management at Lancashire Teaching Hospitals over the next three years after consultation with members of the Senior Leadership Team (SLT), the Board of Directors and wider groups.

2.4 The strategy was approved at Audit Committee in September 2023 with a recommendation that the strategy should be formally ratified by the Board of Directors.

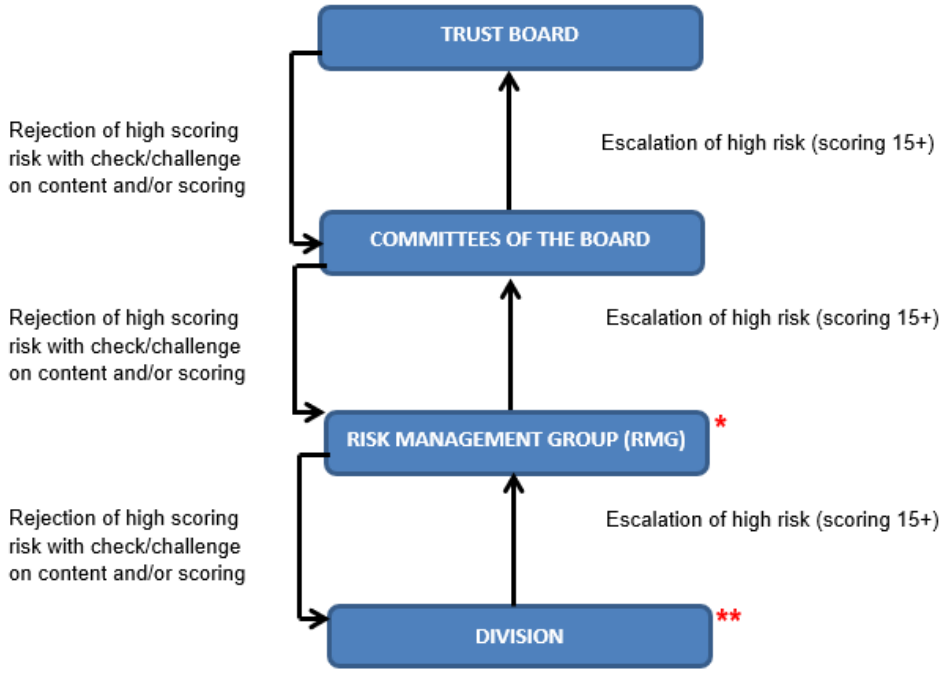
2.5 The strategy will be overseen by the Risk Management Group, with progress presented annually to the Audit Committee.

Risk Management Policy

2.6 A full review of the Risk Management Policy has been undertaken to take account of the development of the new Risk Management Strategy and is attached as Appendix 2 for formal ratification.

2.7 A summary of key changes can be found in the addendum section on page 1 and 2 of the policy.

2.8 The main change to note is the introduction of a new Risk Management Group from November 2023 which will be chaired by the Chief Nursing Officer, and this will run alongside the Senior Leadership Team (SLT) meeting. An overview of the governance and escalation arrangements are shown below:



* In the absence of the Risk Management Group meeting, urgent risk escalations can be made via the Senior Leadership Team (SLT) meeting to Committees of the Board.

** This could include escalation from Divisional Board, Divisional Safety and Quality Committee, Divisional Finance and Performance Committee or Divisional Workforce Committee

2.9 Other minor changes include changes to job titles, updated infographics to align with Our Big Plan, changes to the portfolios of the Executive Team and other general updates identified during the review.

3. Financial implications

3.1 There are no identified financial implications to introducing the strategy or amending the policy.

4. Legal implications

4.1 There are no identified legal implications to introducing the strategy or amending the policy.

5. Risks

5.1 The paper is risk focussed and introduces the new Risk Management Strategy, the updated Risk Management Policy and the new Risk Management Group with the intention to further improve governance and risk management within the organisation.

6. Impact on stakeholders

6.1 The Risk Management Group will change the meeting requirements for stakeholders and any impact of this will be monitored and minimised as far as is reasonably practicable.

6.2 The Risk Management Strategy, Risk Management Policy and Risk Management Group have been created and updated following consultation with key stakeholders.

7. Recommendations

7.1 It is recommended that the Board of Directors:

I. Receive and ratify the Risk Management Strategy.
II. Receive and ratify the updates to the Risk Management Policy.
III. Note the commencement of a new Risk Management Group.

Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Risk Management Strategy
2023–2026

Excellent care with compassion

Always Safety First

@LancsHospitals

Contents

Foreword

At Lancashire Teaching Hospitals NHS Foundation Trust we believe in establishing an organisational culture that ensures risk management is an integral part of corporate objectives, business plans and management systems.

As a large and complex organisation delivering a range of services, in a challenging operational and financial environment, we recognise that risks are an inherent part of the day-to-day life in the delivery of healthcare. However, the Board are fully committed to ensuring that risks are identified and managed, so that they are reduced to an acceptable level, or eliminated as far as reasonably practicable.

As a Board, we place particular emphasis on having robust and effective controls in place to mitigate clinical and non-clinical risks. We have an effective framework in place that supports the identification and mitigation of risks as they may present themselves over time, but that also enables us to be agile when emerging risks present themselves through the course of the Trusts' day-to-day activities. Assurance is provided to the Board through the Board Assurance Framework (BAF). The BAF provides a structure and process to enable us to identify those strategic and operational risks that may compromise the achievement of our high level strategic objectives.

In developing this strategy our teams have reviewed the Trust's Risk Management Policy alongside recommendations and learning from external reviews conducted by the Care Quality Commission (CQC), NHS England/Improvement (NHSE/I), the Good Governance Institute (GGI) and Mersey Internal Audit Agency (MIAA).

Through this strategy and implementation plan, in conjunction with the Trust's Risk Management Policy, we will aim to ensure Risk Management processes are embedded at every level of the organisation. This is important to ensure there is a culture that supports active and consistent management of risks, where staff feel confident to speak up and raise concerns about issues that affect safety and quality outcomes, finance and performance, and staff and patient experience.

We believe that whilst compliance with legislative requirements is important, we see this as a minimum standard only. Through implementation of this strategy, we will strive for excellence and innovation in risk management to empower and enable our teams with the right education, framework and platform to resolve complex issues, and deliver 'Excellent Care with Compassion' for our patients.

Strategy overview

Our three year strategy (2023-2026) is designed to further improve and refine our approach to risk management across the organisation, with the aim of fostering a proactive and responsive culture in mitigating threats that may affect safety, quality, performance and finance to the detriment of patients and their families, staff, services and the sustainability and future viability of the organisation. In doing so, this strategy supports us in working towards the achievement of the strategic Aims and Ambitions within Our Big Plan.

Developing the strategy

Previous iterations of the Risk Management Strategy have also incorporated elements of the Risk Management Policy and this strategy marks a shift in approach. The Risk Management Strategy sets out our organisational plans over the next 3 years and should be read in conjunction with our Risk Management Policy, which sets out our policy requirements and processes in detail.

In developing this strategy, we looked at previous external reviews related to governance and risk, at different levels of the organisation including by:

- The Care Quality Commission (CQC).
- NHS England/Improvement (NHSE/I).
- The Good Governance Institute (GGI).
- Mersey Internal Audit Agency (MIAA).

We also looked at:

- Risk management approaches both in the NHS and in other sectors.
- The Health and Social Care Act 2012.
- CQC Guidance for Providers, encompassing the Essential Standards of Quality and Safety.
- NHS Foundation Trust Code of Governance.
- The NHS Oversight Framework.
- National Guidance from the National Quality Board on Quality Risk Response and Escalation in Integrated Care Systems.

We asked Executive Directors, Non-Executive Directors, Divisional and Departmental Leads and Governance Professionals to contribute to building the strategy and will continue to work in partnership with stakeholders to review progress and constantly look for ways to enhance and develop organisational Risk Management and Board Assurance processes.

We have developed this 3 year plan to build on the solid foundations in place and drive Risk Maturity forward within the organisation.

Defining our approach to Risk Management

In undertaking Risk Management activity there are two key approaches that the Trust takes: the top down and the bottom-up approach.

Top Down **(Identifying Strategic Risks)**	The Trust undertakes Strategic Risk Management through Executive Management and Committee structures that enables the identification, assessment and recording of strategic risks which threaten the achievement of the Trust's Strategic Objectives. The management of Strategic Risks also consider the implementation and monitoring of controls and mitigating actions. (Strategic Risks may also be identified through the monitoring and reporting of operational risks).
Bottom Up **(Identifying Operational Risks)**	The Trust undertakes Operational Risk Management activity through staff working in adherence to the Trust's Risk Management Policy. Operational Risks are those that sit on the divisional and corporate risk registers and may affect and relate to the day to day running of the organisation. Operational Risks may present themselves via incidents, complaints, claims, patient feedback, safety inspections, external review and ad hoc assessments etc., which may impact on the Trust's ability to meet its objectives and targets.

Risk Management Activity – Top down and Bottom up approach

The Board Assurance Framework

The Board Assurance Framework (BAF) provides a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives and is made up of two parts the Strategic Risk Register and the Operational Risk Register.

- Strategic Risks are those risks that threaten the delivery of the strategic objectives and are not likely to change over time.
- Operational Risks are those that sit on the divisional and corporate risk registers and may affect and relate to the day to day running of the organisation. They mainly affect internal functioning and service delivery and are managed at the appropriate level within the organisation.

The BAF records organisation wide strategic risks that include risks identified in relation to the business objectives, corporate objectives and the Care Quality Commission Standards. The BAF enables the Board to demonstrate how it has identified and met its assurance needs. Every strategic risk on the BAF is assigned to an Executive Director who is responsible for reporting on progress to the Board of Directors via Committees of the Board. The BAF is presented to the Board of Directors meeting on a bi-monthly basis.

Risk Scoring

Risks are scored utilising a matrix which was derived from the National Patient Safety Agency Risk Matrix and compares likelihood and consequence.

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

The overall score determines the level of risk and monitoring within the Trust.

Risk Monitoring and Escalation

As a 'Clinically Led Organisation' we believe that operational risks are best managed by clinical staff and those that are closest to the risk and can affect it positively. However, we recognise that support and guidance can often be required, along with appropriate oversight from Departmental, Divisional and Corporate Management teams, and the Board of Directors..

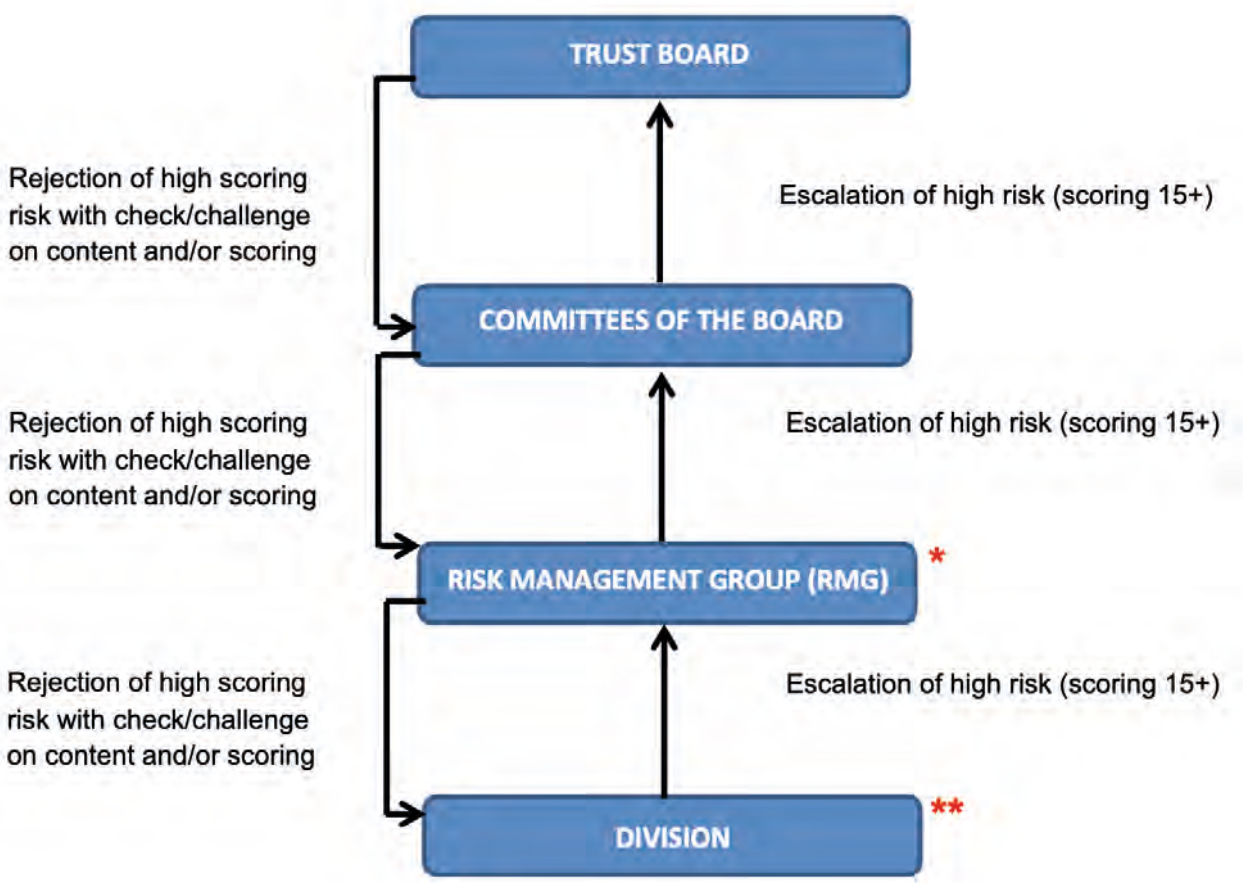
The frequency at which a Risk should be reviewed is determined by the risk score with higher scoring risks requiring more frequent review.

- Risks rated as 'High' (15-25) must be reviewed monthly
- Risks rated as 'Significant' (risk score 8-12) or 'Moderate' (score of 4-6) must be reviewed on at least a quarterly basis
- Risks rated as 'Low'(risk score 1-3) must be reviewed at least annually.

The monitoring and escalation processes will ensure that risks are not managed by staff without sufficient authority, experience and knowledge to mitigate the risk and that significant and serious risks are identified and escalated as quickly as possible.

The high risks to the organisation are overseen by Senior Leaders, Committees of the Board and Trust Board using the following escalation process:

Route of escalation for high risks



* In the absence of the Risk Management Group meeting, urgent risk escalations can be made via the Senior Leadership Team (SLT) meeting to Committees of the Board.

** This could include escalation from Divisional Board, Divisional Safety and Quality Committee, Divisional Finance and Performance Committee or Divisional Workforce Committee

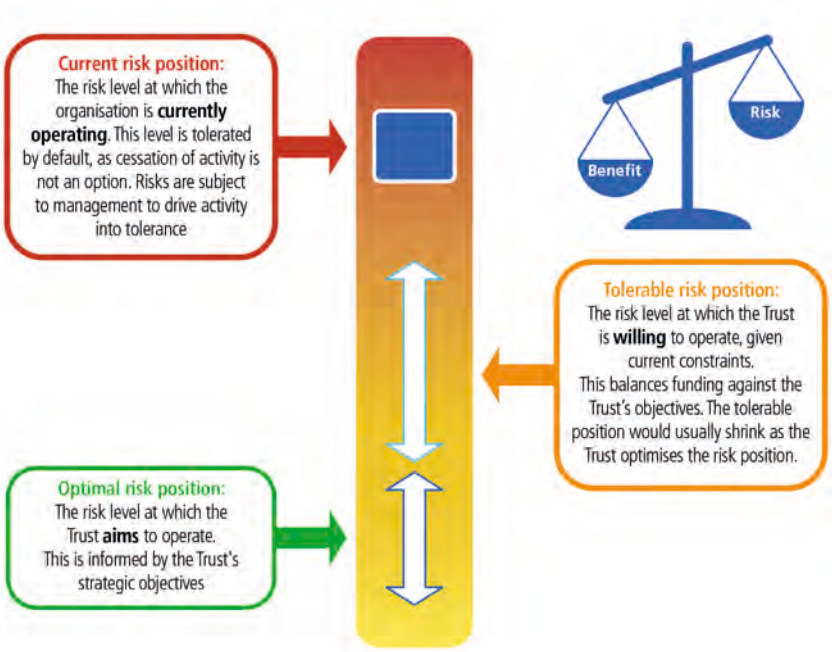
Risk Appetite & Risk Tolerance

The UK Corporate Governance Code states that 'the Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives'. This means that at least once a year, we should consider the types of risk we may wish to exploit and/or can tolerate in the pursuit of objectives.

Risk Appetite is the decision about the level of risk that the Trust is prepared to accept, after balancing the potential opportunities and threats a situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.

Risk Tolerance is the boundaries within which the Board is willing to allow the true day-to-day risk profile of the Trust to fluctuate while executing strategic objectives in accordance with the Trust's Strategy and Risk Appetite.

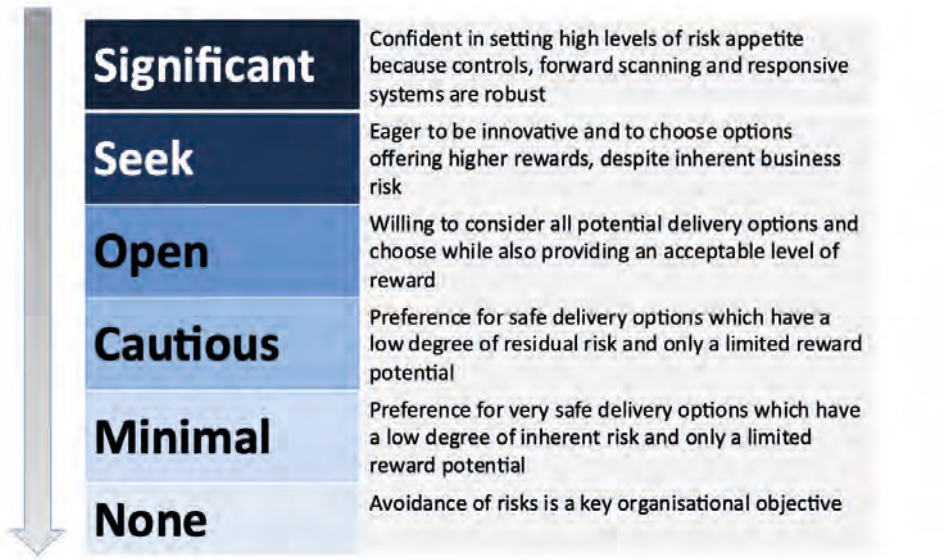
The infographic below provides a high-level overview of the journey of a risk from its current risk position to its optimal risk position, recognising some risks may be tolerated in line with the level of risk the Trust is willing to operate within.



Risk Appetite Scale

As part of considering our appetite to risk, we have used the following Scale to support the development of our Risk Appetite Statement which outlines our appetite and tolerance to risk when pursuing our Strategic Aims and Ambitions.

The Trust seeks to manage risks in accordance with our Risk Appetite Statement.



Risk Appetite Statement

In 2022/23, we reviewed and updated our Risk Appetite Statement in conjunction with the Good Governance Institute (GGI) and this was endorsed by the Board. This was reviewed again for 2023/24 as part of the annual cycle, and approved with no changes at the Board of Directors Meeting in June 2023.

We will use this Risk Appetite Statement to support our strategic decisions and to monitor progress with the Strategic Risks to the delivery of our Aims and Ambitions.

We also want our operational teams to feel confident in using the Board-approved Risk Appetite and Tolerance to give confidence when making decisions about how much risk to take (appetite) and how much risk we can operate with (tolerance).

The Risk Appetite Statement* set by the Board is as follows:

Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. However, to **Consistently Provide Excellent Care**, we recognise that, in pursuit of this overriding objective, we may need to take other types of risk which impact on different organisational aims. Overall, our risk appetite in relation to consistently providing excellent care is cautious – we prefer safe delivery options with a low degree of residual risk, and we work to regulatory standards.

We have an open appetite for those risks which we need to take in pursuit of our commitment to create a **Great Place to Work**. By being open to risk, we mean that we are willing to consider all potential delivery options which provide an acceptable level of reward to our organisation, its staff and those who it serves. We tolerate some risk in relation to this aim when making changes intended to benefit patients and services. However, in recognising the need for a strong and committed workforce this tolerance does not extend to risks which compromise the safety of staff members or undermine our trust values.

We also have an open appetite for risk in relation to our strategic ambition to **Deliver Value for Money** and our strategic aim to **offer a range of high-quality specialist services to patients in Lancashire and South Cumbria**, maintaining and strengthening our position as the leading tertiary care provider in the local system, where we can demonstrate quality improvements and economic benefits. However, we will not compromise patient safety whilst innovating in service delivery. We are also committed to work within our statutory financial duties, regulatory undertakings, and our own financial procedures which exist to ensure probity and economy in the trust's use of public funds.

We seek to be **Fit for the Future** through our commitment to working with partner organisations in the local health and social care system to make current services sustainable and develop new ones. We also seek to lead in **driving health innovation through world class Education, Training & Research** by employing innovative approaches in the way we provide services. In pursuit of these aims, we will, where necessary, seek risk - meaning that we are eager to be innovative and will seek options offering higher rewards and benefits, recognising the inherent business risks.

**This may be subject to change in the three year cycle of this strategy*

Strategic Risks

In developing the Risk Appetite Statement, we have reviewed each of our Strategic Risks to determine the level of risk that we aim to operate with (appetite) and the level that we are prepared to operate with (tolerance). The risk appetite and tolerances shown below were approved by the Board of Directors in June 2023.

Strategic Risks - Appetite*

Strategic Risks		Risk Appetite Statement	Rationale
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities &...	Risk to delivery of Strategic Ambition: Consistently Deliver Excellent Care	Cautious	Our Trust has an Always Safety First strategy. In pursuit of this strategy, we recognise there may an be adverse impact on other aims but we are not open to risking non-compliance with regulatory standards.
	Risk to delivery of Strategic Ambition: A Great Place to Work	Open	We are willing to accept some risk where there is a potential to improve recruitment, retention and employees' personal development.
	Risk to delivery of Strategic Ambition: Deliver Value for Money	Open	We are willing to accept quantifiable and well-controlled financial risk where there are tangible benefits and opportunities to restore financial balance, e.g. invest to save programmes.
	Risk to delivery of Strategic Ambition: Fit for the Future	Seek	We are willing to consider all possible solutions to providing sustainable healthcare for local communities, while maintaining a low tolerance for risks to quality or patient safety.
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research		Seek	We are willing to pursue innovative options in pursuit of world class education, training and research. By its nature, innovation involves stepping away from tried and tested options.
Risk to delivery of Strategic Aim to offer a range of high quality specialist services to patients in Lancashire and South Cumbria		Open	We are willing to take risks where there are clear opportunities to streamline and modernise services, whilst retaining our own tertiary status.

Strategic Risks - Tolerance*

Strategic Risks		Risk Tolerance Level	Rationale
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities &...	Risk to delivery of Strategic Ambition: Consistently Deliver Excellent Care	1-6	We are not willing to tolerate moderate (or worse) harm, however there will always remain a small possibility of adverse outcomes despite the fullest range of safety measures being put in place.
	Risk to delivery of Strategic Ambition: A Great Place to Work	4-8	Whilst recognising that the need to meet unprecedented demand for services and to make significant changes will impact on our workforce, the safety and wellbeing of staff is a priority and we are guided by our shared values.
	Risk to delivery of Strategic Ambition: Deliver Value for Money	8-12	Acute trusts face considerable financial and operational changes which are heavily influenced by external factors outside of our direct control. Transformational changes needed to meet this challenge inevitably carry a degree of risk.
	Risk to delivery of Strategic Ambition: Fit for the Future	8-12	To transform our services, develop our infrastructure and mature system leadership arrangements we will need to consider all possible solutions to drive innovation and therefore tolerate some degree of risk.
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research		9-12	We recognise that investments in education, training and research can take time to generate the expected benefits for the trust, and that new ways of working have a higher inherent risk than established methods.
Risk to delivery of Strategic Aim to offer a range of high quality specialist services to patients in Lancashire and South Cumbria		6-9	We are willing to take risks where there are clear opportunities to streamline and modernise services but are unwilling to lose our own tertiary status.

**These may be subject to change in the three year cycle of this strategy*

Risk Maturity

As part of our Risk Management Policy, we use a bespoke risk maturity matrix, building on a respected Institute of Internal Audit model. This tool is recognised by our Internal Auditors Mersey Internal Audit Agency (MIAA) and considers the following factors as part of the review to provide an assessment of the embeddedness and effectiveness of the risk management processes being applied.

- Leadership, management & culture.
- Roles & Responsibilities.
- Processes.
- Monitoring & feedback.

The overall conclusions can broadly be made against the following risk maturity definitions:

Level 5
Risk enabled

Driven by the Board, staff at all levels actively consider issues of risk in all areas of activity and develop control and assurance processes to manage those risks / risk management and internal controls fully embedded into the operations.

Level 4
Risk managed

Staff throughout the organisation are aware of the importance and the organisations response to risk Enterprise approach to risk management developed and communicated.

Level 3
Risk defined

The organisation has considered risk management, and put in place strategies led from a risk management team / strategy and policies in place and communicated. Risk appetite defined.

Level 2
Risk aware

The organisation is aware of risk management responsibilities, and needs to embed systems/ scattered silo based approach to risk management.

Level 1
Risk naive

The organisation has little or no awareness of the importance of risk management / no formal approach developed for risk management.

As part of this Strategy, our ambition is to achieve Level 5 of Risk Maturity in the next three years and we will conduct annual assessments to monitor our progress.

The Strategy

The strategy has been divided into three sections:

(i) **Insight**: Improve our understanding of Risk Management at the Trust by drawing intelligence from multiple sources, internally and externally.

(ii) **Involvement**: Supporting, training, and involving key staff groups will enhance their understanding and maturity in Risk Management and we will use this as a vehicle to improve how we manage risk within the organisation.

(iii) **Improvement**: The Trust will support continuous and sustainable improvement, with everyone learning to improve Risk Management within the organisation, to reduce risk to patients, staff and stakeholers.

Through this strategy we recognise the opportunity to shape a forward-thinking culture that supports the Trust to mitigate and reduce strategic and operational risks for our patients, staff and other stakeholders.

Our ambition is to become an organisation that achieves the highest level of Risk Maturity (Level 5 – Risk Enabled).

This is important to ensure there is a culture that supports active and consistent management of risks, where staff feel confident to speak up and raise concerns about issues that affect safety and quality outcomes, finance and performance, and staff and patient experience.

Key enablers and stakeholders are identified within the strategy, specifically creating the infrastructure for improving Risk Management, which will enhance the arrangements to assure the Board through the Board Assurance Framework (BAF).

The successful delivery of this strategy is underpinned by culture, leadership, engagement and education programmes of work.

Measurement

The improvement measures are identified within the insight section of the strategy and these will be monitored through the review of data and information at the new Risk Management Group. These include:

- Introduction of new risk e-learning training package
- Introduction of Risk Management Workshops
- Reduction in long-standing risks
- Reduction in operational high risks
- Reduction in confidential risks
- Improvements in Risk Maturity ratings

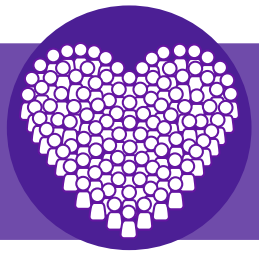
Our Big Plan strategy

Our Values

Our aim is to always provide excellent care with compassion from all of our sites including:

- Chorley and South Ribble Hospital
- Royal Preston Hospital
- The Specialist Mobility and Rehabilitation Centre (SMRC)
- Finney House Community Healthcare Hub (CHH)
- Our community and satellite sites.

We are a values driven organisation. Our values were designed by our staff and patients, and are embedded in the way we work on a day to day basis:



Being Caring and Compassionate

Being caring and compassionate is at the heart of everything we do, we will understand what each person needs and strive to make a positive difference in whatever way we can.

Recognising Individuality

We appreciate differences, making staff and patients feel respected and valued.

Seeking to Involve

We will actively get involved and encourage others to contribute and share their ideas, information, knowledge and skills in order to provide a joined up service.

Building Team Spirit

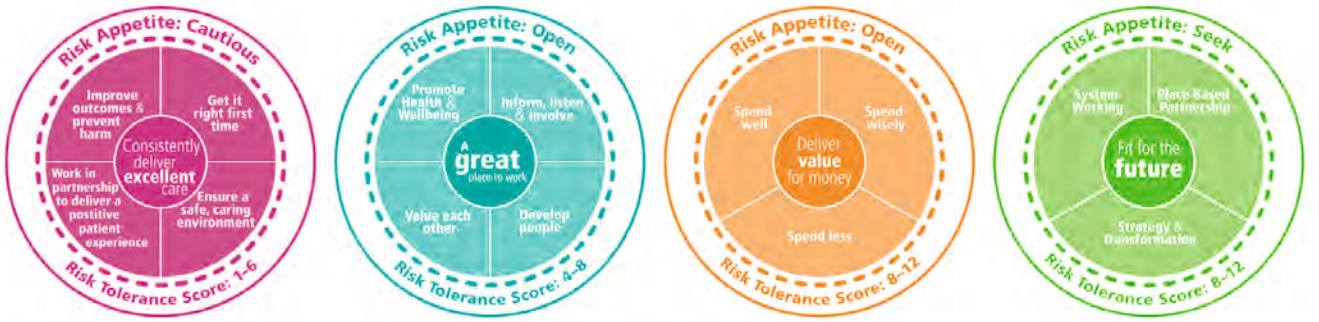
We will work together as one team with shared goals doing what it takes to provide the best possible service.

Taking Personal Responsibility

We are each accountable for achieving improvements to obtain the highest standards of care in the most professional way, resulting in a service we can all be proud of.

Alignment to Trust Objectives

The objectives in this plan are derived from the Trust's core objectives. Currently all risks on the active Risk Register at the Trust are aligned to a Trust Ambition or Aim to ensure there is a structure and process in place to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives. This Strategy looks to support the refinement of the Trust's approach to managing all risks aligned to the Trust's Aims and Ambitions.



Trust aim: To offer a range of high quality specialist services to patients in Lancashire and South Cumbria

Risk Appetite: Open — **Risk Tolerance Score 6–9**

Trust aim: To drive health innovation through world class education, training and research

Risk Appetite: Seek — **Risk Tolerance Score 9–12**

How will we work differently?

Through this strategy the role of leaders will be defined across our organisation. This section of the strategy contains an outline of how this will be achieved and how our teams will work together to build our Insight, Involve and learn from best practice, and Improve our risk profile and maturity. Through development of the new Risk Management Group, we intend to capture and share learning and become a centre of excellence for our risk and assurance processes.

Our clinical and corporate teams will work together to implement this strategy.

Insight: Teams will work together to improve our understanding of Risk Management at Lancashire Teaching Hospitals by drawing intelligence from multiple sources internally and externally. Risk data and information will be scrutinised in different ways through the new Risk Management Group. This will ensure a shared understanding of our key strategic and operational risks, and provide a platform to resolve complex cross-divisional/cross-Trust/cross-boundary issues, to support organisational and system-based controls and solutions.

Involvement: Our strategy has been designed to involve staff through workshops and provide them with the right education to improve their skills, understanding and confidence to tackle risks. The draft strategy was circulated widely amongst divisional and corporate teams to ensure the final product identifies what matters most. The strategy will remain responsive as each year progresses with the ability to add to and take away as priorities change.

Improvement: The Board of Directors have committed to adopting a robust improvement methodology across our organisation. The strategy will be underpinned by underpinned by this and our teams will work together to deliver effective and sustainable change in our highest risk areas. Learning from improvements in our risks will be shared widely with staff.

Delivering the Plan

The new Risk Management Group, with representation from Executive Directors, Corporate and Divisional Leadership Teams and Multi-disciplinary Governance Professionals, will oversee the implementation of this Strategy, the group will focus on the three major areas of work: insight, involvement and improvement.

The new group will aim to create a flattened hierarchy to identify improvement priorities ('insights'), further improving the involvement of our staff and stakeholders in designing the improvements required ('involvement') and overseeing the improvements in the organisational risk maturity ('improvement').

The deliverables outlined in this strategy will be delivered through the Risk Management Group, who will use the intelligence created to inform future priorities of 'Our Big Plan'.

Progress will be monitored through the Risk Management Group and an annual report will be produced.

The Risk Maturity Assessments will be a key vehicle to test the deliverables of the strategy and an overview will be reported to the Risk Management Group

The strategy is applicable to all areas of the organisation and we will support teams to mature their risk arrangements.

The action plan will be reviewed quarterly to ensure delivery continues to remain on track and to ensure it continues to fully align with Our Big Plan.

The strategy will be considered as a fundamental part of the organisation and will evolve each year, considering broader learning elicited through other strategies across the organisation.

Our clinical and corporate teams will work together to implement this strategy.

The 3 Year Risk Management Implementation Plan

1. INSIGHT	AIM

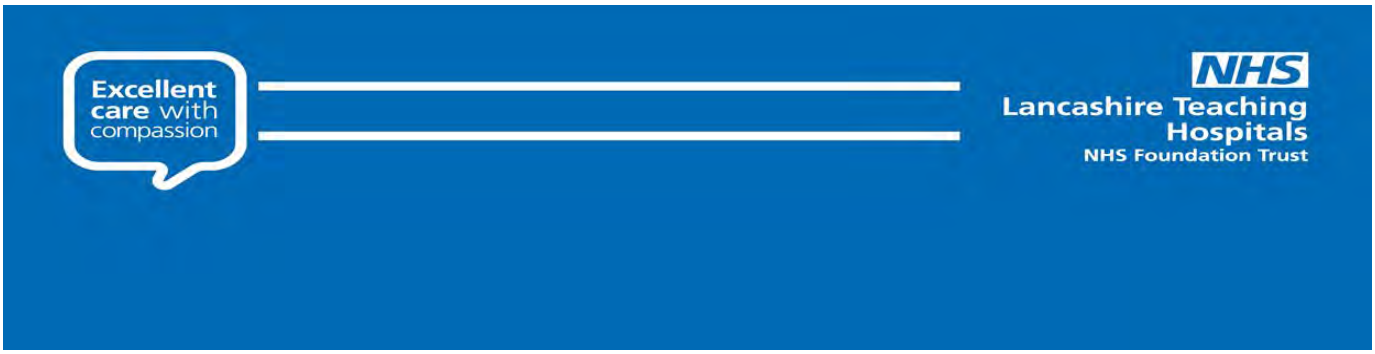
Improve our understanding of Risk Management at Lancashire Teaching Hospitals by drawing intelligence from multiple sources internally and externally. Adopt and promote key risk management principles by:

- implementing a risk management group to enable a deeper understanding of the organisational risks, and to support cross-divisional, cross-Trust and cross-boundary learning and improvements.
- gaining an understanding on how risk management software can improve organisational governance and risk management.
- supporting the development of patient safety priorities through learning from incidents, complaints, claims, patient feedback, safety inspections, external reviews and events and other ad hoc assessments etc, which may impact on the Trust's ability to meet its objectives and targets.
- carrying out deep dives into long-standing risks.
- understanding the national risk profile.

Year 1	Year 2	Year 3
Driving improvement Implementation of a Risk Management Group to oversee and monitor risk management across the Trust.	**Driving improvement** Use intelligence from the Risk Management Group to inform improvement priorities.	**Driving improvement** Review and refine approach.
Governance Embedding and fully utilising Risk Management KPIs through the Governance Dashboard on the BI portal, with the aim of sustained compliance (≥80%) with KPIs across the Trust.	**Governance** Divisional and Trustwide focus on Risk Management KPIs through the Governance Dashboard on the BI portal with the aim of sustained compliance (≥90%) with KPIs across the Trust.	**Governance** Speciality focus on Risk Management KPIs through the Governance Dashboard on the BI portal with the aim of sustained compliance (≥95%) with KPIs across the Trust.
Deep Dives Completion of thematic reviews on 10% (circa 50) of active risks to support the understanding and development of organisational and system-based controls and solutions.	**Deep Dives** Based on learning from Year 1, complete thematic reviews on a further 10% (circa 50) of active risks to support further refinement and development of organisational and system-based controls and solutions.	**Deep Dives** Based on learning from Year 1 and 2, complete thematic reviews on a further 10% (circa 50) of active risks to support further refinement and development of organisational and system-based controls and solutions.
Risk-based Priorities Review of all operational High Risks to support a systems-based approach to the development of the Trust's Patient Safety Priorities in line with the National Patient Safety Strategy.	**Risk-based Priorities** Annual Review of all operational High Risks to support a systems-based approach to the identification of organisational priorities and programmes of work, aligned to the Strategic Aims and Ambitions.	**Risk-based Priorities** Annual Review of all operational High Risks to support a systems-based approach to the identification of organisational priorities and programmes of work, aligned to the Strategic Aims and Ambitions.
Understanding National Risks Annual Review of National Risk register issued by the Government to ensure that Local risks align to National Risks, as appropriate.	**Understanding National Risks** Annual Review of National Risk register issued by the Government to ensure that Local risks align to National Risks, as appropriate.	**Understanding National Risk**s Annual Review of National Risk register issued by the Government to ensure that Local risks align to National Risks, as appropriate.
Technology Review of Risk Management Software available on the market to ensure the Trust is utilising the best possible software package to support and enhance risk management and risk maturity across the Trust.	**Technology** Annual Software review to ensure format and structure of system supports the Trust's Risk Management and Risk Maturity processes.	**Technology** Annual Software review to ensure format and structure of system supports the Trust's Risk Management and Risk Maturity processes.

2. INVOLVEMENT	AIM	
Supporting, training, and involving key staff groups will enhance their understanding and maturity in Risk Management and we will use this as a vehicle to improve how we manage risk within the organisation. Plans include: • a refreshed organisational approach to Risk Management training • targeted training for specialist groups • risk management workshops with divisional leads, departmental leads and the Board to listen, learn and evolve Risk Management in the organisation.		
Year 1	**Year 2**	**Year 3**
Risk Management Education and Training Refresh the requirements for Risk Management Training with an organisational Training Needs Analysis.	**Risk Management Education and Training** Implementation of an E-Learning Risk Management Training package, with data reported through the Trust's educational data reporting in line with the Training Needs Analysis.	**Risk Management Education and Training** Achieve sustained ≥90% compliance with E-learning Risk Management Training Package.
Targeted training for specialists Enhanced Deep Dive training for Multi-Disciplinary Governance Professionals to enable cascade of Deep Dive reviews across Trust.	**Targeted training for specialists** Evaluate the additional training for Multi-Disciplinary Governance Professionals from Year 1 and develop new/enhanced training for year 2.	**Targeted training for specialists** Evaluate the additional training for Multi-Disciplinary Governance Professionals from the first two years and develop new/ enhanced training for year 3.
Learning and Evolving Together Roll out of Risk Management Workshops for Divisional and Departmental Leads to listen, learn and improve on how we tackle risk, together.	**Learning and Evolving Together** Refine and improve Risk Management Workshops building on year 1 learning.	**Learning and Evolving Together** Evaluate Risk Management Workshops learning and determine any further staff groups that would benefit from Risk Management Workshops.
Board Development Annual Board Workshop to review the Risk Appetite and Tolerances.	**Board Development** Annual Board Workshop to review the Risk Appetite and Tolerances.	**Board Development** Annual Board Workshop to review the Risk Appetite and Tolerances.

3. IMPROVEMENT	AIM	
The Trust will support continuous and sustainable improvement, with everyone learning to improve Risk Management within the organisation, to reduce risk to patients, staff and stakeholders. **Improvement' work aims to develop and support Risk Management improvement programmes that prioritise the most important issues with risk mitigation, utilising effective improvement methods where this is possible**		
Year 1	**Year 2**	**Year 3**
Risk-based Decisions Creation of a Decision Support Tool to support decision making in line with the Trust Risk Tolerance and Risk Appetite statement.	**Risk-based Decisions** Review learning from year 1 and revise as necessary. Further embed the use of the Decision Support Tool to ensure Risk Appetite and Risk Tolerance is used to support decision making.	**Risk-based Decisions** Review learning from year 1 and 2, and revise as necessary. Further embed the use of the Decision Support Tool to ensure Risk Appetite and Risk Tolerance is used to support decision making.
Improved Triangulation Evolving the Risk Register to ensure that financial cost and impact is documented on each risk.	**Improved Triangulation** Evolving the Risk register to enhance learning from Risk Management and to enable easier triangulation with learning from other Governance processes (.i.e Incident Management, Patient Experience & Patient Advice and Liaison Service (PALS) etc).	**Improved Triangulation** Review the learning from year 1 and 2, and further refine as indicated.
Improved Reporting Evolving and developing more intuitive and informative Risk Management reports to Divisional Improvement Forums, Risk Management Group and Committees of the Board.	**Improved Reporting** Annual review of risk report content and format to ensure the most intuitive and informative reports in place.	**Improved Reporting** Annual review of risk report content and format to ensure the most intuitive and informative reports in place.
Confidential Risks Evolve and embed the confidential risk process to ensure tracking of confidential cultural risks.	**Confidential Risks** Aim to reduce the total confidential risks at the end of year 1 by 10% (amount TBC at end of year 1).	**Confidential Risks** Aim to reduce the total confidential risks at the end of year 2 by a further 10% (amount TBC at end of year 2).
Long-standing Risks Reduce long standing risks (risks active for 5 years or more) by 15% (reduce by 13).	**Long-standing Risks** Reduce long standing risks (risks active for 5 years or more) by a further 15% (reduce by 11).	**Long-standing Risks** Reduce long standing risks (risks active for 5 years or more) by a further 15% (reduce by 10).
Operational High Risks Reduce operational high risks (scoring ≥15) by 15% (reduce by 15).	**Operational High Risks** Reduce operational high risks (scoring ≥15) by a further 15% (reduce by 13).	**Operational High Risks** Reduce operational high risks (scoring ≥15) by a further 15% (reduce by 11).
Defining key programmes of work Implementation of an annual Divisional and Trust-wide Risk Maturity Assessment with documented tracking of each year's outcomes, presented to the Risk Management Group.	**Defining key programmes of work** All Specialities and Divisions to achieve level 4 rating (Risk Managed) of Risk Maturity.	**Defining key programmes of work** All Specialities and Divisions to achieve level 5 rating (Risk Enabled) of Risk Maturity.



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AUTHOR: Hajara Ugradar	**JOB TITLE:** Deputy Associate Director of Risk and Assurance	**DIVISION:** Corporate Governance	**DEPARTMENT:** Risk Management
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VALIDATED BY: Audit Committee		**DATE:** 21 September 2023	
RATIFIED BY: Board of Directors		**DATE:** 5th October 2023	
(NOTE: Review dates may alter if any significant changes are made).		**REVIEW DATE:** 28 February 2026	

AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
13.0	17 February 2023	Appendix 8 Confidential Risk Management Protocol	Updated all sections of the protocol following some practical changes to the process.	10.02.23
14.0	05 October 2023	Throughout Document	Reference to Risk Management Strategy	04.09.23
14.0	05 October 2023	Throughout Document	Updated Executive Team job titles.	04.09.23
14.0	05 October 2023	Section 4.1.2 LTHTR Ambitions	Strategic Ambitions infographics updated	04.09.23
14.0	05 October 2023	Section 4.2.7 and 4.2.8	Moved research to reflect change in portfolio of Chief People Officer to Director of Continuous Improvement	04.09.23

14.0	05 October 2023	Section 4.3.1.2, 4.3.1.3 and throughout	Added new Risk Management Group and updated Senior Leadership Team to reflect this. Amendments to reflect introduction of Risk Management Group throughout the document.	04.09.23
14.0	05 October 2023	Section 4.7.2	Additions made to Risk tolerance section	04.09.23
14.0	05 October 2023	Section 4.8.3 – figure 3	Figure 3 updated to reflect addition of Risk Management Group and the escalation arrangements	04.09.23
14.0	05 October 2023	Section 4.9, Table 4	Amendments to table 4 for overview of risk levels, management, monitoring and escalation to reflect introduction of Risk Management Group.	04.09.23
14.0	05 October 2023	Section 4.13	Amendments to risk management training to reflect a refreshed training needs analysis	04.09.23
14.0	05 October 2023	Section 5	Risk Maturity graphic updated	04.09.23
14.0	05 October 2023	Appendix 1	Governance Structure and Feeder Groups updated	04.09.23
14.0	05 October 2023	Appendix 2	Updated the reporting arrangements to include Risk Management Group	04.09.23
14.0	05 October 2023	Appendix 3, section 9 – mitigating action plans	Updated to include the 5 T's (Treat, Transfer, Tolerate, Terminate, Take the Opportunity).	04.09.23
14.0	05 October 2023	Appendix 3, section 10	Updated target risk rating guidance	04.09.23
14.0	05 October 2023	Appendix 9 – divisional measurable objectives	Section deleted as this will be monitored via the strategy and impact assessment changed to Appendix 9	04.09.23

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? Yes
Document for Public Display: No
Evidence reviewed by Library Services: Not Applicable

CONTENTS

1. SUMMARY

Risk management is an integral part of Lancashire Teaching Hospitals NHS Foundation Trust's (LTHTR) management activity and is a fundamental pillar in embedding high quality, sustainable services for the people who access its services. As a large and complex organisation delivering a range of services in a challenging operational and financial environment, the organisation accepts that risks are an inherent part of the day-to-day life of the Trust. Through a systematic approach to assessing, recording and managing risks the Trust fosters both a proactive and responsive culture in mitigating threats to its business, and in doing so, working towards the achievement of its strategic objectives.

The Trust understands that it must have in place robust and effective controls to mitigate the inherent risks involved in delivering healthcare, whether they be clinical or non-clinical. The Trust has in place a framework that allows the Trust to plan effectively to mitigate risks that may present themselves over time but that also enables the Trust to be agile in mitigating emergent risks that present themselves through the course of the Trusts' day-to-day operation.

The Board of Directors intend to use the risk management processes outlined within this Policy as a means to lead the organisation forward to deliver a quality service and achieve excellent results. The Board of Directors is committed to ensuring that risks are managed appropriately in line with the Trust's Risk Management Strategy, this policy, the Trust's risk appetite and risk tolerances and mandatory and best or good practice requirements. The purpose of the Risk Management Policy is to create a culture that supports and encourages employees to effectively manage risk.

1.1 The Ideal Risk Management Framework

This relates to a working model in which:

- The organisation's management understand the risks to which it is exposed and deals with them in an informed, proactive manner;
- Required risk management practices are an accepted and natural part of the way in which the organisation operates.

This policy sets out in detail the framework the Trust has in place and the steps staff should take to identify, assess, record and manage the risks that present themselves and in doing so working towards the delivery of strategic aims and objectives. In particular, the policy sets out the following:

- The Risk Management Process – How risks are identified, assessed, managed, controlled, reviewed and recorded at each level of the organisation (departmental, divisional, corporate and strategic).
- How the Board receives assurances that risks are being identified, managed, controlled and reviewed effectively.
- Those in the Trust with key roles and responsibilities for co-ordinating and undertaking risk management activities.

- The role of the Board Assurance Framework (BAF).
- The role of Risk Registers.
- How Risks are monitored and escalated.
- The information mechanisms the Trust uses to identify risk patterns.
- How the Trust learns lessons from themes identified from risks.

2. PURPOSE

LTHTR's Risk Management policy has been produced to assist all members of the organisation in understanding how the Trust manages risk, both strategically and operationally and serves as a practical guide to advise staff in the identification, management and reasonable control of the risks associated with providing healthcare at all levels of the Trust. Furthermore, the policy has been produced to outline how the Trust takes an integrated, whole-system approach to managing risks which is not separate to, or in addition to, the day-to-day management of the Trust.

The purpose of this policy is to provide a framework through which LTHTR can:

- Ensure staff understand what risk and risk management is in the context of an NHS Foundation Trust.
- Ensure staff understand the purpose of the operational and strategic risk registers and their role in the context of the BAF.
- Embed a positive risk management culture throughout the Trust that supports and encourages employees to effectively manage risk.
- Ensure that there are effective and comprehensive risk management systems and processes in place to identify, assess, monitor and mitigate current and future risks, including cultural risks, and that these are continually reviewed, scrutinised and monitored.
- Ensure staff are aware of their duties in relation to risk management, with clearly defined roles and responsibilities for individuals within the organisation in relation to identification, management, review, approval and escalation of risks.
- Ensure staff are aware and understand how to manage risk in line with the Trust Risk Appetite Statement and Risk Tolerances, in order for the Trust to meet its strategic objectives.
- Ensure staff are aware of the systems and processes for the management of risk at local, divisional and organisational level along with the committee structures in place to support effective risk management throughout the Trust.
- Set out how to provide assurances that effective risk management is being undertaken at all levels of the Trust.
- Ensure staff understand how risks are to be escalated through the organisation.
- Describe to staff the information mechanisms the Trust uses to identify risk patterns.
- Describe how the Trust learns lessons from themes identified from risks.
- Ensure continued compliance with current and future standards and legislation.

3. SCOPE

This document applies to all employees of the Trust and is led by managers at all levels to ensure that risk management is a fundamental consideration of the Trust's approach to Safety, Quality, Workforce, Finance, Performance, Education, Research and Corporate Governance.

4. POLICY

4.1 How the Trust sets its Strategic Aims & Ambitions

Each year as part of its Annual Planning process the Board of Directors meets to agree the Trust's aims to achieve in the coming year in line with its ambition, vision and values and in line with the requirements set out by the Department of Health, NHS England and the Trust's Regulatory Bodies (such as NHS Improvement and the Care Quality Commission). This process results in the refresh of the Trust's Strategy 'Our Big Plan' which details the Trust's Strategic Aims & Ambitions.

4.1.1 LTHTR Strategic Aims

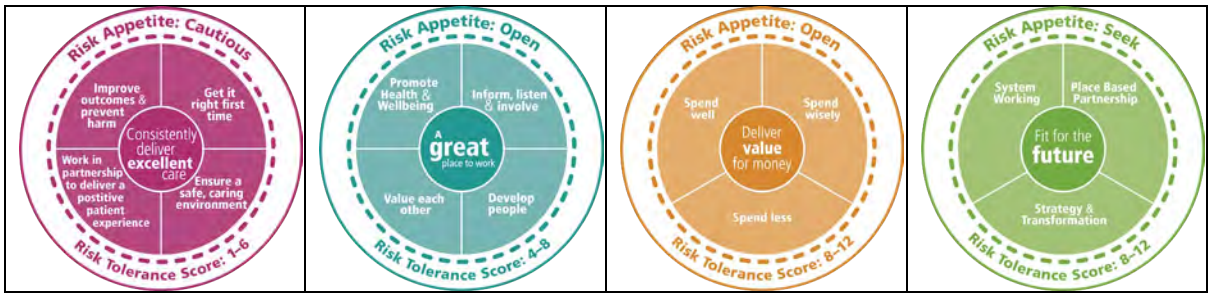
The Trust's Strategic Aims are:

- To provide outstanding and sustainable healthcare to our local communities,
- To offer a range of high quality specialist services to patients in Lancashire and South Cumbria,
- To drive health innovation through world class education, training and research.

These will be delivered through the Trust's Strategy 'Our Big Plan' which is underpinned by four ambitions.

4.1.2 LTHTR Ambitions

The Trust's four Strategic Ambitions are:



4.1.3 Supporting Plans

Delivery of the Trust's Our Big Plan strategy is supported by a range of other detailed plans including the Always Safety First, Patient Experience and Involvement, Workforce and Organisational Development, Equality and Inclusion, Finance, Clinical

Services, Communications, Continuous Improvement, Digital and Health Informatic, Education and Training and Research and Innovation Strategies.

In addition, a new Risk Management Strategy has been developed which describes the Trust's approach to continually improve and mature our Risk Management arrangements over the next three years.

4.2 Duties/Roles

4.2.1 Board of Directors

The Board of Directors is responsible for:

- Providing leadership and direction for effective risk management within the Trust.
- Reviewing the effectiveness of internal controls (its infrastructure) which includes; Safety, Quality, Workforce, Finance, Performance, Education, Research and Corporate Governance.
- Setting the Strategic Aims, Ambitions, Risk Appetite and Risk Tolerance.
- Taking a pro-active lead in the communication of risk management duties.
- Ensuring that an appropriate Trust Committee Structure is in place so that the Trust's Risk Management activity is subject to appropriate levels of oversight and scrutiny. A copy of the Trust's Committee structure is detailed in Appendix 1. These are supported by clear Terms of Reference.
- Overseeing and approving the BAF which comprises of the Strategic and escalated Operational Risks, on at least, a quarterly basis.
- Delegates responsibility for the annual review of the BAF to the Audit Committee.
- Ensuring that non-Executive Directors act as scrutinisers, ensuring that Risk Management is properly addressed and that the processes to support the Board of Directors in relation to risk, are robust.
- Informing and escalating risks of concern to the Integrated Care Board (ICB).

4.2.2 Chief Executive

The Chief Executive has overall responsibility and accountability for the Risk Management activity within the Trust and provides clear visible leadership, ensuring that the implementation of the Risk Management Policy and Risk Management Strategy is delegated to the Executive Directors and through the Management structure of the Trust.

4.2.3 Chief Medical Officer

The Chief Medical Officer is the joint Executive lead (with the Chief Nursing Officer) for the mitigation of risks that relate to the delivery of clinical activities (Clinical Risk). The Chief Medical Officer works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of Clinical Risk is undertaken. The Chief Medical Officer is the responsible officer for medical staffing in

the organisation and is responsible for the professional leadership of Clinical Scientists, Pharmacists and Psychology. The Chief Medical Officer is the Trust's Caldicott Guardian and has responsibility for Medicines Safety and Management, Mortality and Radiation. In addition to these responsibilities the Chief Medical Officer is responsible for the development and deployment of the Clinical Strategy.

4.2.4 Chief Nursing Officer

The Chief Nursing Officer is the joint Executive lead (with the Chief Medical Officer) for the mitigation of risks that relate to the delivery of clinical activities (Clinical Risk). The Chief Nursing Officer works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of the Clinical Risk is undertaken. In addition, the Chief Nursing Officer has responsibility for the professional leadership of the Nursing, Midwifery & AHP workforce, Infection Prevention and Control, Safeguarding (adults and children), Patient Experience and Engagement, Maternity and Children's services alongside being the lead for clinical service regulatory inspections. The Chief Nursing Officer is also the Executive Lead for Health and Safety and the accountable Director in ensuring that lessons are learned, shared, and communicated to staff when things go wrong. Alongside the Chief People Officer, the Chief Nursing Officer is the joint Executive lead for Equality, Diversity and Inclusion.

4.2.5 Chief Operating Officer

The Chief Operating Officer is the Executive lead for the management of risks to the Trust's operational activity and performance (Performance Risks). The Chief Operating Officer works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of Operational and Performance Risks are undertaken. In addition, the Chief Operating Officer is responsible for operational delivery of the Clinical Services, Emergency Preparedness, Resilience and Response (EPRR) and the management of the Divisional Improvement and Accountability processes.

4.2.6 Chief Finance Officer

The Chief Finance Officer is the Executive lead with overall accountability for the management of financial governance and risk and, as the Trust's Senior Information Risk Owner (SIRO), is also responsible for the management of Information Governance and Security and Capital and Estates. In addition to this, the Chief Finance Officer is responsible for the identification, scoping definition and implementation of an Information Governance and Security Risk Programme and lead for 'Use of Resources' regulatory inspections.

4.2.7 Chief People Officer

The Chief People Officer is the Executive lead for the management of risks to the Trust's workforce and education activity. The Chief People Officer works closely with the Chief Executive and other Directors to ensure a whole systems approach to the

management of Workforce and Education Risks is undertaken. In addition to this, the Chief People Officer is responsible for Equality, Diversity and Inclusion alongside the Chief Nursing Officer, Freedom to Speak Up arrangements, Well Led and Education regulatory inspections.

4.2.8 Non-Voting Members

There are a number of non-voting members of the Board who work closely with the Chief Executive and other Directors to ensure a whole systems approach to Strategy and Planning, Continuous Improvement and Transformation, Research, Informatics and Digital, Communication and Engagement, and lead on the management of risks in these areas.

4.2.9 Company Secretary

The Company Secretary is responsible for the overall corporate governance and legal arrangements that underpin effective risk management across the organisation, including ensuring the Trust is compliant with the NHS Code of Governance, which sets out best practice principles and processes to facilitate good governance, contribute to better organisational performance and provide safe, effective services for patients.

4.2.10 Associate Director of Risk and Assurance

The Associate Director of Risk and Assurance is nominated as the Trust's 'Risk Champion' with overall responsibility for the management of the Risk Management Framework. The Associate Director of Risk and Assurance reports into the Chief Nursing Officer. Their role provides leadership for the implementation of the Trust's Risk Management Policy and the Risk Management Strategy, ensuring that the Trust consistently monitors and evaluates the effectiveness of its systems of internal control. The Associate Director of Risk and Assurance, supported by the Deputy Associate Director of Risk and Assurance works closely with the Chief Executive and other Directors to ensure a whole systems approach to the management of risk is undertaken.

They are responsible for providing professional leadership to Corporate and Divisional Operational Governance Leads and for ensuring regulatory standards are met, including reviewing and monitoring trends in the Trust's NHS Resolution and Clinical Negligence Scheme for Trusts (CNST) premiums and jointly with the Associate Director of Safety and Learning responsible for the oversight of delivery of Governance Key Performance Indicators.

4.2.11 Associate Director of Safety and Learning

The Associate Director of Safety and Learning is responsible for the delivery of the Risk Management Framework through the oversight and operational delivery of Safety and Learning, including Health and Safety. The Associate Director of Safety and Learning is jointly responsible with the Associate Director of Risk and Assurance for providing

professional leadership to Corporate and Divisional Operational Governance Leads, for the oversight of delivery of Governance Key Performance Indicators and for ensuring regulatory standards are met. The Associate Director of Safety and Learning also reports into the Chief Nursing Officer.

4.2.12 Deputy Associate Director of Risk and Assurance

The Deputy Associate Director of Risk and Assurance has responsibility for co-ordinating updates to the BAF, which involves liaising with the Executive Directors with lead responsibility to ensure the BAF reflects the principal strategic risks associated with failure of the organisation to meet its aims and ambitions and the actions being taken by the Trust to mitigate such risks.

The Deputy Associate Director of Risk and Assurance is responsible for the management of the Head of Risk and Datix Systems and in conjunction with the Associate Director of Risk and Assurance and Associate Director of Safety and Learning, leads on co-ordinating the implementation of the Trust's Risk Management Framework, Risk Management Policy, the Risk Management Strategy, and the operational activities that underpin them. They will achieve this by:

- Providing professional leadership to Corporate and Divisional Operational Governance Leads.
- Ensuring co-ordination and oversight for the Trust's Risk Registers.
- Supporting the Company Secretary in enabling clear information flow and accountability at appropriate levels to maintain the BAF.
- Providing advisory support to the Trust's Divisional Management Team and Divisional Governance Leads Teams in the identification of Divisional Risks and the management of Divisional Risk Registers.
- Providing Quality Assurance guidance to Divisional Governance Leads.
- Ensuring oversight of the Trust's electronic Risk Management System.
- Ensuring oversight of information and reports for Corporate and Divisional colleagues to assist with the management of Risk Registers.
- Providing support, advice and training to the Divisions in the principles of risk.
- Reviewing and monitoring regulatory standards relating to the management of risk.
- Ensuring the quality of risk management meets the required expectations.
- Ensuring a whole systems approach to the management of risk is undertaken.
- Ensuring capability building for all employees regarding risk management.

4.2.13 Head of Risk and Datix Systems, and Corporate Governance & Risk Team

The Corporate Governance & Risk Team provides operational support to the Head of Risk and Datix Systems and Deputy Associate Director of Risk and Assurance by:

- Supporting implementation of the Risk Management Policy and Risk Management Strategy within the organisation.
- Supporting Corporate and Divisional Management Teams, Risk Owners and Risk Handlers in maintaining and monitoring the quality of Risk Registers,

including ensuring appropriate identification and assessment of risk, the adequacy of risk descriptions, the adequacy of controls and assurances, action plans and justification of risk scoring.
- Maintaining and maturing the Trust's electronic Incident & Risk Management System (DATIX) through the Datix Development Programme.
- Producing information, reports and dashboards for Corporate and Divisional colleagues to assist with the management and monitoring of Risk Registers.
- Providing support, advice and training to the Divisions in the principles of risk.
- Undertaking deep dives reviews of risks to support improved decision making.

4.2.14 Divisional Director for Estates, Facilities and Capital

The Divisional Director of Estates, Facilities and Capital is responsible for ensuring the safe maintenance of property and services in line with statutory estate compliance including pre-planned maintenance of the health and safety portfolio relating to security, violence and aggression, fire safety, environmental management, medical devices management, facilities provision and all aspects of estate and facilities business continuity.

The Divisional Director will:

- Support Managers and staff with the identification and management of estate related Health and Safety risks.
- Liaising with the Trust's Health and Safety Manager and Associate Director of Safety and Learning in the identification and management of estate Health and Safety risks.

4.2.15 Divisional Leadership Team - Divisional Directors, Divisional Medical Directors, Divisional Nursing, Midwifery &/or AHP Directors

All Divisional Leadership Team members have responsibility for the risk management activity in their Division, including:

- Providing leadership for Risk Management activities in their Division.
- Promoting and supporting the implementation of the Risk Management Policy and Risk Management Strategy.
- Monitoring and delivery of Governance and Risk key performance indicators contained within the Governance dashboard.
- Setting relevant and effective Divisional Objectives, which collectively ensure the delivery of Trust's Strategic Objectives as set out in the Trust's Our Big Plan Strategy.
- Identifying principal operational risks which threaten the delivery of Divisional Objectives and establishing the Divisional Risk Register.
- Safeguarding the Divisional Risk Register and escalating any divisional risks scoring 15 and above to the Risk Management Group or Senior Leadership Team meeting by exception, should the Risk Management Group not hold a meeting.

- Monitoring the Risk Mitigation activities within their Division to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Policy.
- Quality assuring, monitoring and where appropriate challenging the scoring of risks to ensure consistency with the Risk Matrix.
- Ensuring that Divisional Risk Management activity is owned; discussed and reviewed at Divisional Board and relevant Divisional meetings (including Divisional Safety and Quality, Workforce and Finance and Performance meetings).
- Ensuring that staff are given necessary information, instruction, training and supervision in relation to Risk Management activities and are aware of their duties in relation to risk management identification, management, review and escalation of risks.
- Ensuring staff are made aware of risks within their work environment and of their personal responsibilities for Risk Management.
- Ensure staff are aware and understand how to manage risk in line with the Trust Risk Appetite Statement and Risk Tolerances.
- Presenting Risk Management reports to the Trust Management Board, Trust Committees and Risk Management Group (or Senior Leadership Team meeting by exception where the Risk Management Group do not meet) where required.
- Management of the identified risks within their Division/Department, including the escalation of risks, where appropriate.
- Promoting and embedding an ‘open’ and ‘just’ culture.
- Monitoring that all relevant Risk Assessments are undertaken, reviewed and documented appropriately.
- Ensuring lessons learnt from risks are shared across the Division.

4.2.16 Divisional Governance Lead and Team

All Divisional Governance Leads and their teams have responsibility to facilitate the section 4.2.15 above and in addition to this facilitate for the division:

- Identifying any operational risks that exist within the Division that threaten the achievement of Divisional and Strategic Objectives as set out in the Our Big Plan Strategy.
- Providing support, advice and training in relation to Risk Management Activities in their Division.
- Promoting and supporting the implementation of the Risk Management Policy and Risk Management Strategy.
- Understanding and promoting awareness of the Trust’s infrastructure for the management and mitigation of risk.
- Ensure staff are aware of their duties in relation to risk management identification, management, review and escalation of risks, including use of the Datix System.
- Ensure staff are aware and understand how to manage risk in line with the Trust Risk Appetite Statement and Risk Tolerances.

- Monitoring the Risk Mitigation activities within their Division to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Policy.
- Quality assuring, monitoring, and where appropriate, challenging the scoring of risks to ensure consistency with the Risk Matrix.
- Undertaking Quality Assurance checks in accordance with guidance provided by the Associate Director of Risk and Assurance, and Associate Director of Safety and Learning.
- Promoting and embedding an 'open' and 'just' culture.
- Ensuring that Divisional Risk Management activity is discussed and reviewed at relevant Divisional meetings.
- Undertaking Divisional administration on their Divisional Risk Register in Datix producing information and reports for Corporate and Divisional colleagues to assist with the management of Risk Registers.
- Supporting and ensuring Key Governance and Risk Performance Indicators are being delivered.
- Ensuring lessons learnt from risks are shared across the Division.

4.2.17 Managers

Associate Divisional Medical Directors, Clinical Directors, Clinical Business Unit Managers, Speciality Business Managers, Matrons, Professional Leads. The Senior Managers have responsibility for supporting their Division in the management of risks including:

- Identifying any operational risks that exist within the Specialty, Clinical Business Unit and/or Division that threaten the achievement of Divisional and Strategic - Objectives as set out in the Our Big Plan Strategy.
- Providing support, advice and training in relation to Risk Management activities in their Specialty, Clinical Business Unit and/or Division.
- Promoting and supporting the implementation of the Risk Management Policy and Risk Management Strategy.
- Understanding and promoting awareness of the Trust's infrastructure for the management and mitigation of risk.
- Ensure staff are aware of their duties in relation to risk management identification, management, review and escalation of risks, including use of the Datix System.
- Ensure staff are aware and understand how to manage risk in line with the Trust Risk Appetite Statement and Risk Tolerances.
- Monitoring the Risk Mitigation activities within their Division to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Policy.
- Quality assuring, monitoring and where appropriate challenging the scoring of risks to ensure consistency with the Risk Matrix.
- Promoting and embedding an open and 'just' culture.
- Presenting Risk Management reports to Specialty and Divisional Meetings where required.

- Ensuring that Divisional Risk Management activity is discussed and reviewed at relevant Speciality Governance Meetings, Divisional Governance Meetings and the Divisional Board meetings.
- Supporting and ensuring Key Governance and Risk Performance Indicators are being delivered.
- Ensuring lessons learnt from risks are shared within relevant departments.

4.2.18 All Ward, Department Managers and Clinicians have responsibility for supporting their Division in the management of their risks including:

- Identifying any operational risks that exist within the Ward/Department that threaten the achievement of Divisional and Strategic Objectives as set out in the Our Big Plan Strategy.
- To support the delivery of the Trust Risk Management Policy and Risk Management Strategy in accordance with their role.
- Understanding and promoting awareness of the Trust's infrastructure for the management and mitigation of risk.
- Monitoring activities within their Speciality, Service, Ward/Department to ensure compliance with all Trust Strategies and policies.
- Promoting and embedding an open and 'just' culture.
- Awareness of the Trust's infrastructure for the management and mitigation of risk.
- Monitoring activities within their Specialty, Service, Ward/Department to ensure risks are identified, assessed and entered onto the Trust Risk Register.
- Monitoring the Risk Mitigation activities within their Specialty, Service, Ward/Department Area to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the Risk Management Policy.
- Ensuring that Specialty, Service, Ward/Department Area of Risk Management Activity is discussed and reviewed at relevant meetings.
- Ensuring that staff are given necessary information, instruction, training and supervision in relation to risk management activities, including use of the Datix System.
- Providing information to the Divisional Governance meetings on the identified risks within their Specialty, Service, Ward/Department.
- Ensuring staff are made aware of risks within their work environment and of their personal responsibilities for risk management.
- Informing the Divisional Management team of Risks that are being escalated to the Divisional Risk Register, where required.
- Supporting and ensuring Key Governance and Risk Performance Indicators are being delivered.
- Ensuring lessons learnt from risks are shared within relevant departments

4.2.19 All Employees

All Employees have responsibility for supporting their Division in the management of their risks including:

- Reporting incidents and near misses using the Datix Incident Reporting System. The Trust accepts that the reporting of adverse events or near misses is on an 'open' and 'just' culture basis.
- Complying with the Trust Induction and Mandatory Training Programmes.
- Complying with the Trust Guidance and Instructions to protect the health, safety and welfare of anyone affected by the Trust's business.
- To support the delivery of the Trust Risk Management Policy and Risk Management Strategy, in accordance with their role.
- Awareness of the Trust's Risk Management systems and processes.
- Reporting identified risks to the relevant Senior Managers, Service, Ward/Departmental Managers and Clinicians to ensure risks are identified, assessed and entered onto the Trust Risk Register.
- Undertaking and completing any Risk Mitigation activities that are assigned to them.
- Ensuring that they obtain the necessary information, instruction, training and supervision in relation to risk management activities.
- Ensuring they are aware of risks within their work environment and of their personal responsibilities for risk management.
- Acceptance of personal responsibilities for maintaining a safe environment. Awareness of local emergency procedures, systems and processes.
- Provision of safe practice in their relevant specialty/role.
- Taking reasonable care of patients, their personal and colleagues' safety.
- Demonstrating a commitment to the Trust's Always Safety First agenda.

4.2.20 Staff Side Representatives

- To work in collaboration with Managers to promote risk management reporting by representing views and concerns, seeking to involve and ensuring fairness and equality.

4.3 Corporate Governance Committee Structure to Support the Risk Management Reporting Processes

The Trust will ensure that an appropriate Trust Committee Structure is in place to ensure that the Trust's Risk Management activity is subject to appropriate levels of oversight and scrutiny.

A Risk Management Organisational Structure is in place, which supports the accountability arrangements within the Trust for Risk Management and ensures that all risks are properly considered and escalated to the Board as required. Through this structure, the Board of Directors ensures that adequate resources and support systems are in place to enable the Trust to effectively manage threats to its business objectives.

The Corporate Committee Structure detailing all those committees and groups which have responsibility for risk and facilitates the management and delegated responsibility for implementing risk management systems within the Trust is shown in

Appendix 1. These are supported by clear Terms of Reference. The approved Terms of Reference for the Trust's Committees is held by the Company Secretary's Office.

4.3.1 How the Board or High Level Risk Committees Review the Organisation Wide Risk Register

4.3.1.1 Board of Directors

The Board of Directors is responsible for ensuring the effectiveness of the Trust's infrastructure and has overarching responsibility for the Risk Management Strategy, and Framework.

The Board works actively to promote and demonstrate the values and behaviours which underpin the delivery of good governance and pro-active risk management, including being open and transparent.

The Board is accountable for all aspects of its business (i.e. safety, quality, workforce, finance, performance, education, research and corporate governance). The Board will systematically engage with patients, the public, staff and stakeholders on its objectives and plans, including hearing patient stories at Board meetings, undertaking patient safety walk rounds by members of the Board and wider communication events.

The Board is responsible for producing an Annual Governance Statement, which provides evidence of the robustness of the Trust's system of internal control. This is informed by the Head of Internal Audit Opinion and is subject to scrutiny by external auditors.

The Board has delegated aspects of the delivery of its functions to Board Committees and designated staff. These are described in Standing Orders and the Scheme of Reservation and Delegation. The Board, however, retains accountability and receives assurance on the delivery of its functions through the Board Committees and designated staff.

The Board of Directors is responsible for approving the addition or removal of risks to the BAF.

If the Board of Directors needs to be made aware of an emergent risk, the risk assessment may then be fast-tracked for consideration at Board or the appropriate Committee of the Board. In this scenario, the risk assessment must be approved by the Chief Executive and the Associate Director of Risk and Assurance, who will facilitate inclusion on the Board of Directors or Committee of the Board agenda.

The Board of Directors is responsible for informing and escalating risks of concern to the Integrated Care Board (ICB).

4.3.1.2 Risk Management Group

The Risk Management Group is the high level risk group which receives details of all high operational risks (15 and above) for escalation from Divisional Boards and the Corporate Operational Risk Register. It may also in the course of fulfilling its duties, receive details of other risks in the organisation, irrespective of the score. Each Division is scheduled to present their Risk Register according to the Schedule of Business.

The Risk Management Group is an operational group, not a Board Committee and provides the interface between the Board and the rest of the organisation. It has a key role in managing the assurance process; one of its key roles is defining the criteria for admission of risks onto the BAF by rejecting those high scoring risks through effectively challenging the risk content and/or score or by accepting those high scoring risks which warrant further oversight through escalation to the relevant committees of the Board. The Risk Management Group meeting also ensures there is a shared understanding and awareness of each of the Division's risks and allows the ability to escalate actions that are outside of a Division's control and/or create organisational or cross-divisional solutions.

The Trust Board must also ensure that any escalated operational risks that are on the BAF are reviewed bi-monthly. Risks recorded on the BAF that are well managed and have adequate controls may move back to the appropriate Operational Risk Register, as long as there is documented evidence that the risk will continue to be actively managed and monitored at Divisional Level.

4.3.1.3 Senior Leadership Team meeting

The Senior Leadership Team meeting is an operational group, not a Board Committee and provides the interface between the Board and the rest of the organisation.
The Risk Management Group is the primary group to oversee Risk Management within the organisation. However, due to the cycle of meetings, there will be months where the Risk Management Group does not hold a meeting in its normal cycle and during these periods, the Senior Leadership Team can be used as a means to escalate any urgent risks that may warrant further escalation to Committees of the Board or the Board of Directors meeting.

4.3.1.4 The Audit Committee

The Audit Committee is responsible for monitoring the effectiveness of the Trust's infrastructure and internal control system, including Risk Management and is responsible for providing assurance to the Board that this structure and these processes are appropriate and effective. This includes the formal approval of the Trust's Annual Governance Statement. The lead Executive for Audit Committee is the Chief Finance Officer.

4.3.1.5 The Safety and Quality Committee

The Safety and Quality Committee is responsible for the following Risk Management Activities:

- Reviewing any Strategic Risks and high scoring operational risks aligned to the Safety & Quality Committee at each meeting to facilitate a Trust-wide approach to mitigations.
- Identifying any deficiencies in the identification and management of Safety & Quality Risks and delegating responsibility to the relevant Executive Lead.
- Receive Assurance from the relevant Executive Lead that risks within their remit have been appropriately scrutinised.
- Review and accept or reject operational risks presented to the committee. Consider any further escalation to the Board of Directors where appropriate.
- Identifying, managing and monitoring Strategic Risks aligned to the Safety and Quality Committee.
- Provide assurance to the Board of Directors that Safety & Quality Risks have been appropriately scrutinised and to escalate any concerns regarding the identification and management of Safety & Quality Risks.
- The lead Executive for the Safety & Quality Committee is the Chief Nursing Officer.

Safety risk management is a fundamental component of the Trust's Always Safety First Strategy. Where an operational safety risk is high and spans across divisions, the mitigations and actions to reduce risk are overseen by the Always Safety First Committee using clinical leadership to engage stakeholders, governance, data and continuous improvement methodology to drive actions and ownership and reduce risk. Any concerns are escalated to the Safety and Quality Committee who seek assurance that appropriate controls are in place as described above.

4.3.1.6 The Workforce Committee

The Workforce Committee is responsible for the following Risk Management Activities:

- Reviewing any Strategic Risks and high scoring operational risks aligned to the Workforce Committee at each meeting to facilitate a Trust-wide approach to mitigations.
- Identifying any deficiencies in the identification and management of Workforce Risks and delegating responsibility to the relevant Executive Lead.
- Receive Assurance from the relevant Executive Lead that risks within their remit have been appropriately scrutinised.
- Receive assurance on the management of cultural risks and confidential risks from the Raising Concerns Group or the Divisional Improvement Forums.
- Review and accept or reject escalated operational risks. Consider any further escalation to the Board of Directors where appropriate.
- Identifying, managing and monitoring Strategic Risks aligned to the Workforce Committee.

- Providing assurance to the Board of Directors that Workforce Risks have been appropriately scrutinised and to escalate any concerns regarding the identification and management of Workforce Risks.
- The lead Executive for Workforce Committee is the Chief People Officer.

4.3.1.7 The Finance and Performance Committee

The Finance and Performance Committee is responsible for the following Risk Management Activities:

- Reviewing any Strategic Risks and high scoring operational risks aligned to the Finance and Performance Committee at each meeting to facilitate a Trust-wide approach to mitigations.
- Identifying any deficiencies in the identification and management of Finance and Performance Risks and delegating responsibility to the relevant Executive Lead.
- Receive Assurance from the relevant Executive Lead that risks within their remit have been appropriately scrutinised.
- Review and accept or reject escalated operational risks. Consider any further escalation to the Board of Directors where appropriate.
- Identifying, managing and monitoring Strategic Risks aligned to the Finance and Performance Committee.
- Providing assurance to the Board of Directors that Finance and Performance Risks have been appropriately scrutinised and to escalate any concerns regarding the identification and management of Finance and Performance Risks.
- The lead Executive for Finance Committee is the Chief Finance Officer.

4.3.1.8 The Education, Training and Research Committee

The Education, Training and Research Committee is responsible for the following risk management activities:

- Reviewing any Strategic Risks and high scoring operational risks aligned to the Education, Training or Research Committee at each meeting to facilitate a Trust wide approach to mitigation.
- Identifying any deficiencies in the identification and management of Education, Training and Research Risks and delegating responsibility to the relevant Executive Lead.
- Receive Assurance from the relevant Executive Lead that risks within their remit have been appropriately scrutinised.
- Review and accept or reject escalated operational risks. Consider any further escalation to the Board of Directors where appropriate.
- Identifying, managing and monitoring Strategic Risks aligned to the Education, Training and Research Committee.
- Providing assurance to the Board of Directors that Education, Training and Research risks have been appropriately scrutinised and to escalate any

concerns regarding the identification and management of Education, Training or Research risks.
- The Executive Lead for Education, Training and Research Committee is the Chief People Officer.

4.3.1.9 The Council of Governors

The Council of Governors (CoG) is responsible for the following risk management activities:

Collectively, governors play a key role in holding the Non-Executive Directors to account and to raise issues and concerns in a constructive manner. Their level of involvement and influence is a critical element to an effective risk management framework due to their experience and knowledge. This policy will continue to build the role of the CoG going forward as part of the assurance framework on quality governance and will enable reporting back to the CoG, any improvements made to service delivery. The CoG has a pivotal role in approving the Trust's Auditors and being a critical friend on patient experience via the CoG subgroups set up.

4.4 Risk Register Systems and Software

The Trust uses the Risk module of the Datix System to identify and manage active risks and archive any controlled risks. This is a system that is well established and is in widespread use within the NHS and the wider Health Economy.

The Risk module serves as the Trust's Risk Register and contains the following:

- Strategic Risk Registers.
- Corporate Department Risk Registers.
- Committee Risk Registers.
- Divisional Risk Registers.
- Specialty Risk Registers.
- Service/Ward/Departmental Risk Registers.

Details of what is contained in the Risk module is described in Section 4.8.4.

The Risk Register module is available to all staff across the Trust who have a user account on Datix. The full risk register (except confidential risks) is accessible to allow cross Divisional or Departmental working on risk mitigation and to promote transparency of the Risk Register.

The benefit of using a single system is that it ensures a single source of the truth for Risk Register information, supports risks management standards to be maintained, and improves oversight of risk within the Trust.

Where a member of staff does not normally have access to a computer but has requested to 'view' the Risk Register, this should be facilitated by their line manager or supervisor at the earliest opportunity.

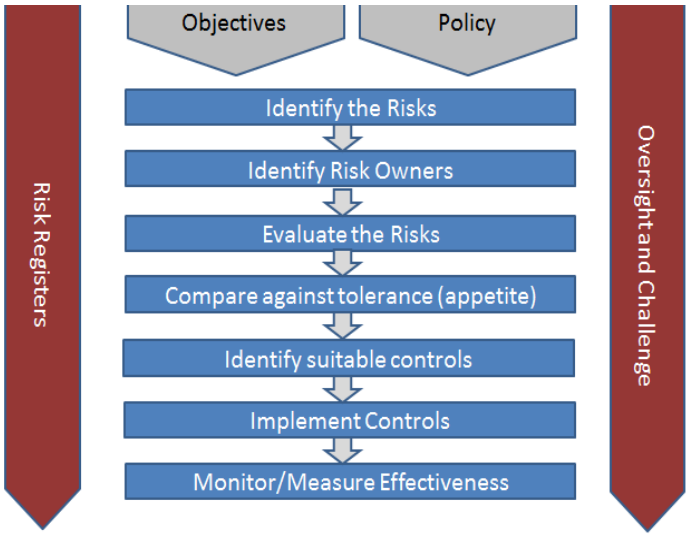
4.5 What is Risk and Risk Management?

A Risk: is an uncertain event or set of events which, should it occur, will have an effect upon the achievement of objectives. This consists of a combination of the level or scale of impact should the event occur, and the likelihood of the event occurring which can be evaluated via a risk assessment being undertaken.

A Risk Assessment: is the evaluation of an uncertain event that can interfere with the delivery of a Trust objective.

Risk Management: is in simple terms, the activity required to identify, assess and manage threats to achieving objectives. The Trust's Board is responsible for putting in place the necessary infrastructure to enable the Trust to achieve its strategic objectives.

Figure 1 – Whole System Approach to Risk and Risk Management



In simple terms, Risk Management is the activity required to proactively and responsively identify, assess and manage threats to the achievement of objectives.

At a very top level, the Trust's Board is responsible for putting in place the necessary infrastructure to enable the Trust to achieve its strategic objectives. As the infrastructures in place at Acute NHS Foundation Trusts are largely the same from Trust to Trust and have been in place for a long period of time, they are ingrained in the operational activity of Trusts; as such, the infrastructure is not always recognised by staff as being key to the management of risk and in delivering strategic objectives.

The Trust has in place a whole systems approach to Risk Management which is articulated in **Figure 1 above**; each of the steps in the Risk Management process is articulated in detail in Appendix 2 and 3.

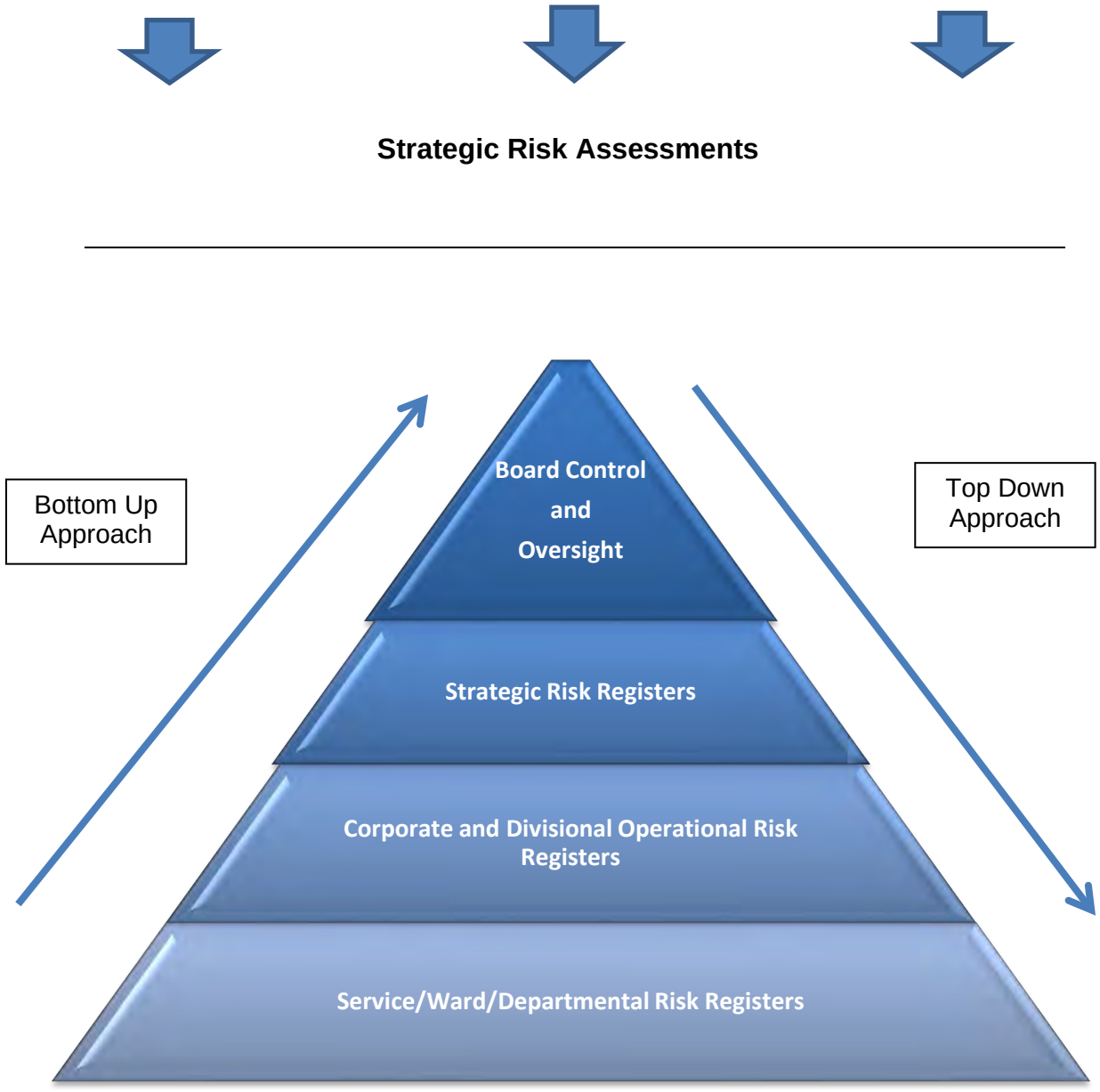
4.6 Risk Management: Two Key Approaches

In undertaking Risk Management activity there are two key approaches that the Trust takes: the top down and the bottom-up approach.

Table 1: Describes the Trust's Top Down and Bottom Up approach to Risk Management

Top Down (Identifying Strategic Risks)	The Trust undertakes Strategic Risk Management through Executive Management and Committee structures that enables the identification, assessment and recording of strategic risks which threaten the achievement of the Trusts' Strategic Objectives. The management of Strategic risks also consider the implementation and monitoring of controls and mitigating actions. (Strategic Risks may also be identified through the monitoring and reporting of Operations risks).
Bottom Up (Identifying Operational Risks)	The Trust undertakes operational Risk Management activity through staff working in adherence to the Trust's Risk Management Policy. Operational Risks may present themselves via incidents, complaints, claims, patient feedback, safety inspections, external review, ad hoc assessments etc., which may impact on the Trusts ability to meet its objectives and targets.

Figure 2 – Risk Management Activity – Top down and Bottom up approach



4.7 Risk Appetite Statement and Risk Tolerances

The Trust recognises that:

- it is operating in a collaborative healthcare economy where patient safety, quality of service and organisational viability is vitally important.
- there is always a level of inherent risk in the provision of acute healthcare which must be accepted or tolerated, but which must also be actively and robustly monitored, controlled and scrutinised.
- it has finite resources in terms of staff, equipment and finances available to it in the delivery of healthcare services.

4.7.1 Risk Appetite Statement

In response to the above factors the Trust will seek to manage risks in accordance with a Risk Appetite Statement. Each risk will be aligned to a Strategic Aim or Ambition and the appetite should be considered in line with the Boards agreed Risk Appetite Statement relevant to the Strategic Aim or Ambition, as outlined in Table 2 and the Risk Appetite Statement below.

Risk Appetite: is the decision about the level of risk that the Trust is prepared to accept, after balancing the potential opportunities and threats a situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.

The Risk Appetite Statement set by the Board is as follows:

Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. However, to **Consistently Provide Excellent Care**, we recognise that, in pursuit of this overriding objective, we may need to take other types of risk which impact on different organisational aims. Overall, our risk appetite in relation to consistently providing excellent care is cautious – we prefer safe delivery options with a low degree of residual risk, and we work to regulatory standards.

We have an open appetite for those risks which we need to take in pursuit of our commitment to create a **Great Place to Work.** By being open to risk, we mean that we are willing to consider all potential delivery options which provide an acceptable level of reward to our organisation, its staff and those who it serves. We tolerate some risk in relation to this aim when making changes intended to benefit patients and services. However, in recognising the need for a strong and committed workforce this tolerance does not extend to risks which compromise the safety of staff members or undermine our trust values.

We also have an open appetite for risk in relation to our strategic ambition to **Deliver Value for Money** and our strategic aim to **offer a range of high-quality specialist services to patients in Lancashire and South Cumbria,** maintaining and strengthening our position as the leading tertiary care provider in the local system, where we can demonstrate quality improvements and economic benefits. However, we will not compromise patient safety whilst innovating in service delivery. We are also committed to work within our statutory financial duties, regulatory undertakings, and our own financial procedures which exist to ensure probity and economy in the trust's use of public funds.

We seek to be **Fit for the Future** through our commitment to working with partner organisations in the local health and social care system to make current services sustainable and develop new ones. We also seek to lead in **driving health innovation through world class Education, Training & Research** by employing innovative approaches in the way we provide services. In pursuit of these aims, we will, where necessary, seek risk - meaning that we are eager to be innovative and will seek options offering higher rewards and benefits, recognising the inherent business risks.

Table 2 – Summarises the Trust's Strategic Aims & Ambitions and its associated risk appetite.

Strategic Risks		Risk Appetite	Rationale
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities &…	Risk to delivery of Strategic Ambition: Consistently Deliver Excellent Care	Cautious	Our Trust has an Always Safety-First strategy. In pursuit of this strategy, we recognise there may be an adverse impact on other aims but we are not open to risking non-compliance with regulatory standards.
	Risk to delivery of Strategic Ambition: A Great Place to Work	Open	We are willing to accept some risk where there is a potential to improve recruitment, retention and employees' personal development.
	Risk to delivery of Strategic Ambition: Deliver Value for Money	Open	We are willing to accept quantifiable and well-controlled financial risk where there are tangible benefits and opportunities to restore financial balance, e.g., invest to save programmes.
	Risk to delivery of Strategic Ambition: Fit for the Future	Seek	We are willing to consider all possible solutions to providing sustainable healthcare for local communities, while maintaining a low tolerance for risks to quality or patient safety.
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research		Seek	We are willing to pursue innovative options in pursuit of world class education, training and research. By its nature, innovation involves stepping away from tried and tested options.
Risk to delivery of Strategic Aim to offer a range of high-quality specialist services to patients in Lancashire and South Cumbria		Open	We are willing to take risks where there are clear opportunities to streamline and modernise services, whilst retaining our own tertiary status.

4.7.2 Risk Tolerance

All identified Risks will be required to have a target score which is the level of risk that may be tolerated in order to consider a risk reasonably controlled. Each risk will be aligned to a Strategic Aim or Ambition and the target score should be considered in line with the Boards agreed Risk Tolerance relevant to the Strategic Aim or Ambition, as outlined in Table 3.

Risk Tolerance: is the boundaries within which the Board is willing to allow the true day-to-day risk profile of the Trust to fluctuate while executing strategic objectives in accordance with the Trust's Strategy and Risk Appetite.

Table 3 – Summarises the Trust's Strategic Aims & Ambitions and its associated risk tolerance.

Strategic Risks		Risk Tolerance	Rationale
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities &…	Risk to delivery of Strategic Ambition: Consistently Deliver Excellent Care	1-6	We are not willing to tolerate moderate (or worse) harm, however there will always remain a small possibility of adverse outcomes despite the fullest range of safety measures being put in place.
	Risk to delivery of Strategic Ambition: A Great Place to Work	4-8	Whilst recognising that the need to meet unprecedented demand for services and to make significant changes will impact on our workforce, the safety and wellbeing of staff is a priority, and we are guided by our shared values.
	Risk to delivery of Strategic Ambition: Deliver Value for Money	8-12	Acute trusts face considerable financial and operational changes which are heavily influenced by external factors outside of our direct control. Transformational changes needed to meet this challenge inevitably carry a degree of risk.
	Risk to delivery of Strategic Ambition: Fit for the Future	8-12	To transform our services, develop our infrastructure and mature system leadership arrangements we will need to consider all possible solutions to drive innovation and therefore tolerate some degree of risk.
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research		9-12	We recognise that investments in education, training and research can take time to generate the expected benefits for the trust, and that new ways of working have a higher inherent risk than established methods.
Risk to delivery of Strategic Aim to offer a range of high-quality specialist services to patients in Lancashire and South Cumbria		6-9	We are willing to take risks where there are clear opportunities to streamline and modernise services whilst maintaining and strengthening our position as the leading tertiary care provider in the local system.

4.8 Risk Management Framework (including Board Assurance Framework, Strategic Risk Registers and Operational Risk Registers)

4.8.1 The Board Assurance Framework

The **Board Assurance Framework** (BAF) provides a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives and is made up of two parts the **Strategic Risk Register** and the **Operational Risk Register**.

- **Strategic Risks** are those risks that threaten the delivery of the strategic objectives and are not likely to change over time.
- **Operational Risks** are those that sit on the divisional and corporate risk registers and may affect and relate to the day to day running of the organisation. They mainly affect internal functioning and delivery and are managed at the appropriate level within the organisation.

The BAF records organisation wide strategic risks that include risks identified in relation to the Business objectives, corporate objectives and the Care Quality Commission (CQC) Standards. The BAF enables the Board to demonstrate how it has identified and met its assurance needs. Every risk on the BAF is assigned to an Executive Director who is responsible for reporting on progress to the Board of Directors via Committees of the Board. The BAF is presented to the Board of Directors meeting on a bi-monthly basis.

4.8.2 Trust Wide Strategic Risks

As part of the Annual Planning process, following the establishment of the Trust's Strategic Aims and Ambitions, the Board will identify any organisation wide strategic risks that may threaten the achievement of the Trust's Strategic Aims and Ambitions. The Board will then establish what the strategic risks are and identify and review the controls and systems the Trust has in place to mitigate these risks. The 'Our Big Plan' Strategy is the framework that is in place to deliver the Trust's aims and ambitions.

Each strategic risk is aligned to a Committee of the Board where updates, progress and appropriate challenge of risk management is presented at each meeting, which in turn feeds into the BAF. Each Strategic Risk is reviewed and revised monthly by Executive Directors.

Through the BAF, the Trust will document all its Strategic Risks, the key controls that are in place to manage and mitigate them and which Executive Director is leading on the mitigation. The Strategic Risks are monitored as part of the BAF at every Board of Directors meeting, where the Trust's Executive and Non-Executive Directors review and challenge the levels of assurance offered. Should a gap be identified in the control management and mitigation of the risk, the gap will be managed operationally through the creation of a new operational risk on the Trust Risk Register.

The Board will undertake the final validation of any new Strategic Risk Assessments and agree inclusion of new risks on the Strategic Risk Register.

Updates to Board are supplemented by a summary dashboard which details the strategic risks alongside initial, target and actual bi-monthly scores to provide a visual overview of the direction of change in score over time.

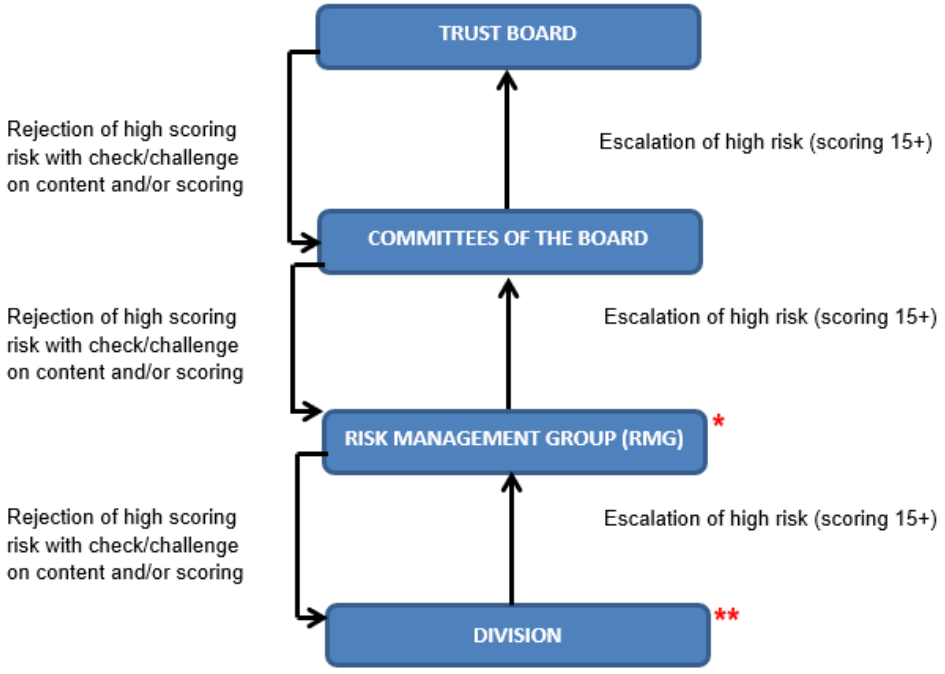
4.8.3 Operational Risks and the Trust Risk Register System

To provide oversight and scrutiny of the Operational Risk Management Activity, Risk Registers are available at a Corporate, Committee, Divisional, Specialty and Ward/Departmental level. To ensure oversight of this, Governance and Risk dashboards are in place that are included in the Divisional Improvement Forums and a formal cycle of business scheduled for review at the Senior Leadership Team meeting.

All operational risks are aligned to the Trust ambitions and in turn aligned to Committees of the Board.

Any operational risks that have been rated as 'High' (Risk Score of 15 to 25) are maintained on Divisional Risk Registers and escalated via Divisional Boards alongside any high scoring Corporate operational risks to the Risk Management Group meeting and subsequently to the Board via Committees of the Board as shown in Figure 3.

Figure 3 – Escalation of High (15-25) Operational Risks



* In the absence of the Risk Management Group meeting, urgent risk escalations can be made via the Senior Leadership Team (SLT) meeting to Committees of the Board.

** This could include escalation from Divisional Board, Divisional Safety and Quality Committee, Divisional Finance and Performance Committee or Divisional Workforce Committee

The Board of Directors are responsible for informing and escalating risks of concern from Trust Board to the Integrated Care Board (ICB).

Having a formal process in place allows for control around the risk details and allows for appropriate challenge of the information prior to escalation to Board receiving the details as part of the BAF. Operational Risks are scored in line with the National Patient Safety Agency (NPSA) scoring matrix found in Appendix 7.

Through reviewing and monitoring Operational Risk Registers through its Board, Committee, Divisional Specialty and Ward/Departmental structures, the Trust gains assurance as to the appropriateness and effectiveness of Risk Management activity at all levels of the Trust.

4.8.4 Risk Register Format

The Risk Registers are recorded into the Datix System using a standard template and the severity of each risk is rated according to the consequence/likelihood Risk Assessment Matrix from the National Patient Safety Agency. The Data fields included in the standard template are detailed in Appendix 5.

The operational risk registers identify and record the following:

- The Location of the Risk (Site, Division, Specialty and Department).
- The Risk Handler and Risk Owner.
- The date the Risk was identified.
- The description of the Risk.
- The Source of Risk.
- The principal Trust Ambition the risk impacts upon.
- The Committee of the Board that the risk is aligned to.
- Key Performance Indicators that are at risk.
- The controls that are in place to assist in securing delivery of the objectives or Key Performance Indicators.
- The assurances (including levels of assurance) that enable evidence to be gained that our controls are effective.
- The current Risk rating - the Risk rating with the current controls in place.
- The mitigation strategy for the Risk.
- The Mitigating Actions that are being taken to reduce the risk that will improve the level of control and assurance on the risk.
- The target Risk rating - the Risk rating with the mitigating actions completed in line with the Trust Risk Appetite Statement and Risk Tolerance.
- The review frequency and date of next review.
- The review history.
- Any supporting documents or evidence attached to the Risk.

These in turn facilitate the ability to produce risk register reports and dashboards.

4.9 Operational Risk Levels, Management, Monitoring and Escalation

As a 'Clinically Led Organisation' the Trust believes that operational risks are best managed by the Clinicians and Managers that are directly affected by that risk. These Clinicians and Managers should also receive appropriate and robust guidance, support and oversight from the Divisional and Trust Management teams, Assurance Committees and functional experts.

The frequency at which a Risk should be reviewed is determined by the risk score with higher scoring risks requiring more frequent review. Any risk rated as 'High' (15-25) must be reviewed monthly and any risk rated as 'Significant' (risk score 8-12) must be reviewed on at least a quarterly basis. Risk Review frequency guidance is included in Appendix 6.

The robust and overlapping monitoring and escalation processes will ensure that risks are not managed by Clinicians or Managers without sufficient authority, experience and knowledge to mitigate the risk and that risks are identified and escalated as quickly as possible. Table 4 contains an overview of these processes – note that there may be some slight differences based on the nuanced governance structures of some specialities.

Table 4: Overview of Risk Levels, Management, Monitoring and Escalation

Risk Level	Impact/ Management	Monitoring	Escalation
Service/ Ward/ Department	Impacts on a single ward/department on a site. Managed by a Ward/ Department Lead Clinician or Manager	Ward/Departmental 'Governance Meetings.	Speciality Governance Meetings. Clinical Business Unit Governance Meetings. Divisional Governance Meetings.
Specialty	Impacts on multiple wards/departments or sites within a speciality. Managed by a Specialty Lead Clinician or Manager	Specialty Governance Meetings. Clinical Business Unit Governance Meetings. Divisional Governance Meetings.	Clinical Business Unit Governance Meetings. Divisional Governance Meetings.
Divisional	Impacts on multiple specialities within a division. Normally managed by a member of the	Specialty Governance Meetings.	Divisional Improvement Forums (DIFs), Risk Management Group, Senior

Risk Level	Impact/ Management	Monitoring	Escalation
	Divisional Triumvirate	Clinical Business Unit Governance Meetings Divisional Governance Meetings.	Leadership Team meeting (as appropriate).
Trustwide	Impacts on multiple Divisions or all Divisions. Managed by relevant Lead Clinician or Manager	Specialty Governance Meetings. Clinical Business Unit Governance Meetings Divisional Governance Meetings, Risk Management Group, Senior Leadership Team meeting (as appropriate).	Divisional Improvement Forums (DIFs), Risk Management Group, Senior Leadership Team meeting (as appropriate), Associate Director of Risk and Assurance / Associate Director of Safety and Learning, Committees of the Board, Board of Directors.

4.10 The Risk Management Process

The Risk Management process is the activity required to identify, assess and manage risks in order to achieve its objectives. Risk Assessment and Management Guidance, and Flow Chart are included in Appendix 3 and 4.

4.11 How Operational Risks are added to the Trust Risk Register

All Trust Staff with a Datix user account can add a new risk to the Risk Register. There are specified mandatory data items that must be completed before a new risk can be saved; this is to ensure that minimum data requirements are achieved. Staff who do not have a password for the Datix system should speak to the Ward/Department Manager to raise risk matters. The Ward/Department Manager has a responsibility to respond to any risk identified to them.

All newly created divisional risks are held in a ‘Pending Tray’ until they have been subjected to a Quality Assurance check by the Divisional Governance or Corporate Lead, and a check and challenge process undertaken. The purpose of the ‘pending Tray’ is to prevent the inadvertent addition of duplicate or near duplicates of existing risks and to ensure that risk assessments have been completed to the standard required by this Policy.

The decision to approve or decline a Risk from the 'Pending Tray' will be taken at the Divisional/Departmental Governance Meeting.

If a Risk requires urgent approval, it can be approved by the Associate Director of Risk and Assurance, Associate Director of Safety and Learning or Deputy Associate Director of Risk and Assurance. In such cases, the relevant meeting will be informed of the urgent approval and the reason for the urgent approval.

4.12 Controlling Risks on the Trust Risk Register

When a Risk Handler or Owner believes that a risk has been suitably mitigated and can now be controlled, they must submit a risk control request through Datix. The risk will then be subject to a Quality Assurance check by the Divisional Governance Lead, and a Check and Challenge process, if required at the Divisional/Departmental Governance meeting.

This is to ensure that all action plans have been completed, the appropriate and effective controls in place and that the risk is at an inherent level that can be managed through the Trusts normal operational activities and procedures.

The decision to approve or to decline the control request, and the reason for doing so, will be recorded in the Divisional Governance meeting minutes and should also be detailed on the Notepad section of the risk record on Datix prior to placing into the "Controlled Risks" approval status.

Risks that are rated as High would not normally be eligible for control under any circumstances. However, should there be considered to be a legitimate reason to do this, it would need discussion with the Associate or Deputy Associate Director of Risk and Assurance to ensure the right approvals are sought, and through the appropriate governance route.

4.13 Risk Management Training

The Trust has a refreshed Training Needs Analysis (TNA) which will be delivered through the Risk Management Strategy. This will be reviewed each year to consider strengthening the training around risk management topics.

4.14 Risk Reports

The following types of standardised Risk reports will be produced at Board of Directors Level:

- Board Assurance Framework detailing those strategic and operational risks that may compromise the achievement of the Trusts' Objectives.

The following types of standardised Risk reports will be produced at Committee Level:

Summary Position and Exceptions which will include, but is not limited to:

- Changes in Risk Ratings.
- Themes and Profiles.
- Content of Strategic Risks.
- Details of operational high risks aligned to the relevant assurance committee.

The following types of - Risk reports will be produced at Divisional Level:

- Changes in Risk Ratings.
- Risk Performance Key Performance Indicators.
- Risks pending approval decision.
- Risks that have been controlled.
- Risks overdue for review.
- Risks that have 'No controls in Place.'
- Risks with 'No open actions in place.'
- Open mitigating actions with no progress recorded.
- Themes and Profiles.
- Risk Register report

There may be some variations to the above between the different Divisions.

A risk register report template is detailed in Appendix 6.

4.15 Reporting on the Triangulation of Risk Information and Risk Themes

The Trust seeks to triangulate information, especially thematic profiles and trend analysis, with similar information that is produced in respect of Complaints, Incident Management, Audit, Mandatory Training, National Institute for Health and Care Excellence (NICE) Guideline compliance.

The purpose of this is to act as an 'Early Warning System' to enable the early identification of potential problems so that early action can be taken to reduce or remove these problems.

Key Performance Indicators related to Governance and Risk Maturity are included within the Governance Dashboard which is presented at Divisional Meetings, Divisional Improvement Forums and the Risk Management Group. Relevant indicators are also included in the Integrated Performance Report to Safety and Quality Committee and Board.

4.16 Assurance (including Internal and External Audit)

The Trust Board via the Audit Committee will receive assurances on the effectiveness of the risk management framework annually by receiving the Head of Internal Audit

Opinion following the Internal Audit reviews undertaken throughout the year and reported to the Audit Committee.

4.16.1 Benefits of an Assurance System

An assurance system achieves a number of benefits:

- Provides confidence in the operational working of the Trust.
- Maximises the use of resources available in terms of audit planning, avoiding duplication of effort.
- Ensures assurances are appropriately gathered, reported and that the governance structure is working as intended.
- Identifies any potential gaps in assurances relating to key risks and key controls, and that these are understood and accepted or addressed, as necessary.
- Supports the preparation of the Annual Governance Statement and regular assurance reports.

4.16.2 Types, Sources and Levels of Assurance

There are three types of assurance, which are referred to as the three lines of defence:

Level 1 - Departmental Assurance

- Local Management Oversight – direct management assurances.

Level 2 - Corporate Assurance

- Corporate Oversight – internal assurance sources (including assurance committees), independent from direct management assurance sources.

Level 3 - Independent Assurance

- Independent Oversight – External Auditors, Internal Auditors, Regulators, External Benchmarking etc.

4.16.3 Assurance Values

- Independent assurance is used to confirm management assertions and is often seen as of highest value. This is however dependent on many other factors as noted below including:
    - Age – the time elapsed since assurance was obtained, this may erode the value of assurance.
    - Durability – whether it endures as a permanent assurance on an historical matter e.g., Auditors Report on Financial Statements, or loses relevance over passage of time e.g. clinical audit.
    - Relevance – the degree to which assurances align to specific areas or objectives over which it is required.
    - Reliability – trustworthiness of the source of assurance.
    - Independence – the degree of separation between the function over which assurance is sought and the provider of assurance.

4.16.4 Independent External Assurance

The Board receives independent assurance(s) that a Risk Management System is in place that meets with the requirements of the Risk Management Standards through the process of internal and external audit and from external assessments, reviews and benchmarking, for example:

- Care Quality Commission visits/inspections.
- National Audits.
- Reviews of external independent reports.
- Integrated Care Board (ICB) Serious Incident Panel.
- Health and Safety Inspections.
- Other Regulatory Inspections
- External Audit Reports.
- Internal Audit reports from externally appointed 3rd party.
- Royal College reviews.
- Annual Head of Internal Audit Opinion.
- National Staff Surveys.
- NHS Resolution Reports.
- National Patient Satisfaction Surveys.
- Patient Led Assessments of the Care Environment (PLACE) Inspections.
- OFSTED inspection.

4.16.5 Internal Assurance

The Trust will seek assurance that risks are being appropriately identified and managed through the following:

- Trust Board Integrated Performance Report.
- Performance Reviews.
- Key Performance Indicators including internal standards.
- Minutes.
- Committee Reports.
- Divisional Management Board Reports.
- Annual Quality Accounts.
- Clinical audits.
- Development and review of Risk Registers.
- Compliance levels within the CQC Assessments, Board Assurance Framework/Corporate Risk Register.
- The Annual Governance Statement.
- Benchmarking activity.
- Compliance with mandatory induction and training standards.
- Response to Medical Devices Alert (MDA)/National Patient Safety Audit (NPSA)/Estates and Facilities (EFA) alerts and hazard notices.
- Incident investigations.
- Incident, claims and complaints trends.

- Patient and staff attitude surveys.
- Corporate Quality Reviews.
- Walkabouts.
- Safety Triangulation Accreditation Review (STAR) ensures that suitable evidence exists to support adherence with regulatory and accreditation standards. The STAR Team provides support for such reviews.

4.16.6 Key Stakeholders Assurance

In addition to the internal routes for raising concerns and risk, there are formal mechanisms by which our key stakeholders can raise risk concerns.

These include:

- Regular contract and performance review meetings.
- Incident and Serious Incident process.
- Complaints process.
- Claims process.
- Regulators.

4.16.7 Other Risk Assessments

A wide variety of 'Risks Assessments' are systematically identified and reported throughout the Trust. In most cases it is not appropriate that these 'Risk Assessments' are entered into the Trust Risk Register as 'Risks.' Detailed below are some of the most common of these 'Risks Assessments.'

4.16.8 Patient Risk Assessments	A wide variety of Patient-related Risk Assessments may take place including; Bed Rails, Falls, Hydration, Nutrition and Tissue Viability etc. These risk assessments should be recorded within the Patient's individual record.
4.16.9 Safety Incident Reporting	Specific detail regarding the Safety Incident risk assessment process can be found in the Trusts 'Adverse Incident Reporting, Management and Investigation Policy and Procedure.'
4.16.10 Complaints	Specific detail regarding the Complaints risk assessment processes can be found in the Trusts 'Customer Care and PALS Policy and Procedure'.
4.16.11 Litigation .	Specific detail regarding the Litigation risk assessment processes can be found in the Trusts 'Policy and Procedure for handling Clinical Negligence, Personal Injury, Property Expense Claims and Personal Property Losses'
4.16.12 Workplace, Environment, Health and Safety and Security Assessments	Specific detail regarding the Workplace, Environment, Health and Safety and Security risk assessment processes can be found in the Trusts' Health and Safety Policy.

4.16.13 Clinical Audit	Specific detail regarding the Clinical Audit risk assessment processes can be found in the Trusts' Clinical Audit Policy and Procedure. Clinical Audit is a key component of the assurance framework, as such, regular clinical audit performance activity reports as presented to the Audit Committee for oversight and coordination with the Internal Audit plan. Dependent on the extent of non-compliance it may be appropriate to place these on the risk register. This would need to be carefully assessed by the relevant clinician or manager.
4.16.14 NICE Guidance and Standards	Specific detail regarding the NICE publications and Quality Standards risk assessment processes can be found in the Trusts' Implementation of NICE publications and Quality Standards Procedure. Dependent on the extent of non-compliance it may be appropriate to place these on the risk register. This would need to be carefully assessed by the relevant clinician or manager.
4.16.15 Project Risk Assessments	Specific detail regarding the risk assessment processes for project risks can be found in the project documentation.
4.16.16 Internal and External Reviews/Reports	Risks that are identified from internal and external audit reports and other reviews, assessments and accreditation, would need to be carefully assessed by the relevant Clinician or Manager to ascertain if the risk should also be placed on to the Trust Risk Register.

4.17 Risk Management link to Business Planning and Programme Management

As part of the Trust's annual business planning cycle, key risks alongside material business cases will be considered to ensure business and operation plans reflect the issues and risks that are most critical to the success of the organisation. This process will consider a range of factors including integrated financial and non-financial information along with any key safety and quality priorities. In order to effectively develop and maintain services, this will also ensure speciality, divisional and Trust-wide plans anticipate demand and capacity and ensure plans are aligned to regional and national priorities**.**

All new significant projects or programmes of work throughout the year will also routinely consider risks to the project, service, department, division or organisation. Where possible, project risk assessments will consider potential upsides and downsides along with sensitivity analysis and other tools.

4.18 Confidential Risk Management

Confidential Risks: are those which specifically reference risks regarding teams or individuals in the organisation and need to be managed in a sensitive and confidential manner.

A confidential risk typically will be a high level cultural concern or leadership issue which may be impacting on the effective running of the team or department (such as patient safety concerns, quality of care, working relationships, grievances, team dynamics, freedom to speak up concerns, multiple Datix incidents, external review or external concerns being raised), it could involve several individuals as well potentially there being previous attempts to bring about performance improvements or a resolution to the issues through local line management or engagement with corporate teams in the wider Trust. Confidential risks are escalated and actions discussed by the Divisional Management Teams and Executive Team members at Part II of the Divisional Improvement Forum.

The reporting of a confidential risk supports the Trust in understanding Trust-wide culture, being able to work collaboratively to address risks, undertake organisation wide and system wide learning from issues in order to improve the quality of care, patient safety and staff experience.

All colleagues have an obligation to report risks to allow the organisational system to improve and create a restorative just and learning culture, where issues are dealt with proactively, in collaboration and without fear of retribution.

Appendix 8 outlines the Risk Management Process for Confidential Risk Management.

4.19 Dissemination and Implementation

This Policy will be distributed and communicated as outlined in the Distribution Plan section.

5. AUDIT AND MONITORING

Risk reporting and monitoring is in place within each Division through a Governance Dashboard with specific key performance indicators including risk, audit, and incident and safeguarding management. -

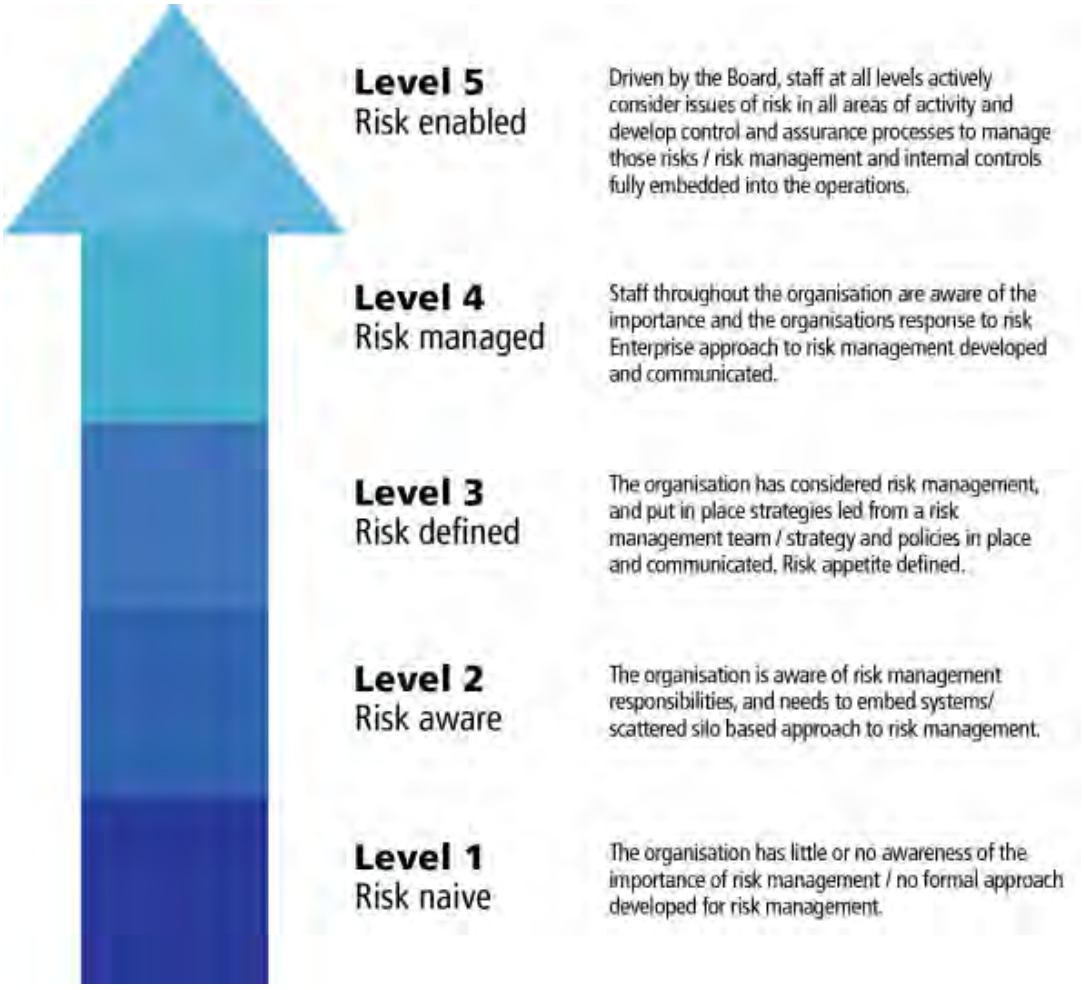
Performance against key governance and risk metrics are monitored at Divisional Improvement Forums with a high risks dashboard for each Division presented at the Risk Management Group to facilitate organisational wide learning.

Where gaps are identified action plans are developed to improve performance and action is taken as required. Performance indicators and benchmarks are routinely refined and updated.

As part of the Trust's Risk Management Strategy and Policy, it is expected that all clinical Divisions will conduct an annual review of risk management, using a bespoke risk maturity matrix, building on a respected Institute of Internal Audit model, a process facilitated by the Governance Managers & Leads in each division. This tool is recognised by the Trust's Internal Auditors Mersey Internal Audit Agency (MIAA) and considers the following factors as part of the review to provide an assessment of the embeddedness and effectiveness of the risk management processes being applied by the Divisions.

- Leadership, management & culture.
- Roles & Responsibilities.
- Processes.
- Monitoring & feedback.

The overall conclusions are broadly made against the following risk maturity definitions:



The Board of Directors receive assurance on the effectiveness of the organisation's Risk Management Processes from the Audit Committee which is informed by the Annual Assurance Framework review undertaken by the Internal Auditors, and the Head of Internal Audit Opinion. This in turn informs the Annual Governance Statement.

Arrangements are also made as part of the Annual Internal Audit Plan agreed by the Audit Committee, for periodic audits to be carried out to provide assurances to the Board that the Risk Management System in place conforms to the requirements of the Divisional Measurable Objectives (Appendix 9) and CQC standards.

6. TRAINING

TRAINING Is training required to be given due to the introduction of this policy? **No, See Section 4.13**

7. DOCUMENT INFORMATION

ATTACHMENTS	
Appendix Number	Title
Appendix 1	Trust Corporate Governance Committee Structure
Appendix 2	Risk management reporting arrangements
Appendix 3	The Risk Assessment and Management Process Guidance
Appendix 4	Risk Assessment and Risk Management Process Flow Chart
Appendix 5	Summary of the Risk Register Data Fields
Appendix 6	Risk Review Report Template
Appendix 7	NPSA Scoring Matrix
Appendix 8	Confidential Risk Management Protocol
Appendix 9	Divisional Measurable Objectives
Appendix 10	Equality and Diversity Impact Assessment Tool

OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	Title and web links from the document library
RMP-HS-102	Risk Assessment and the Process for Use of Risk Registers
TP-27	Policy and Procedure for Handling Clinical Negligence, Personal Injury, Property Expense Claims and Personal Property Losses
TP-24	Customer Care and PALS policy and procedure
TP-113	Clinical Audit Policy and Procedure
RMP-C-98	Implementation and Management of NICE Guidance
RMP HS 114	Adverse Incident Reporting, Management and Investigation Policy and Procedure
TP-16	Health and Safety Policy
TP-149	Duty of Candour
To be added upon approval	Risk Management Strategy
To be added upon approval	Patient Safety Incident Response Framework (PSIRF) Policy

To be added upon approval	Patient Safety Incident Response Plan (PSIRP)

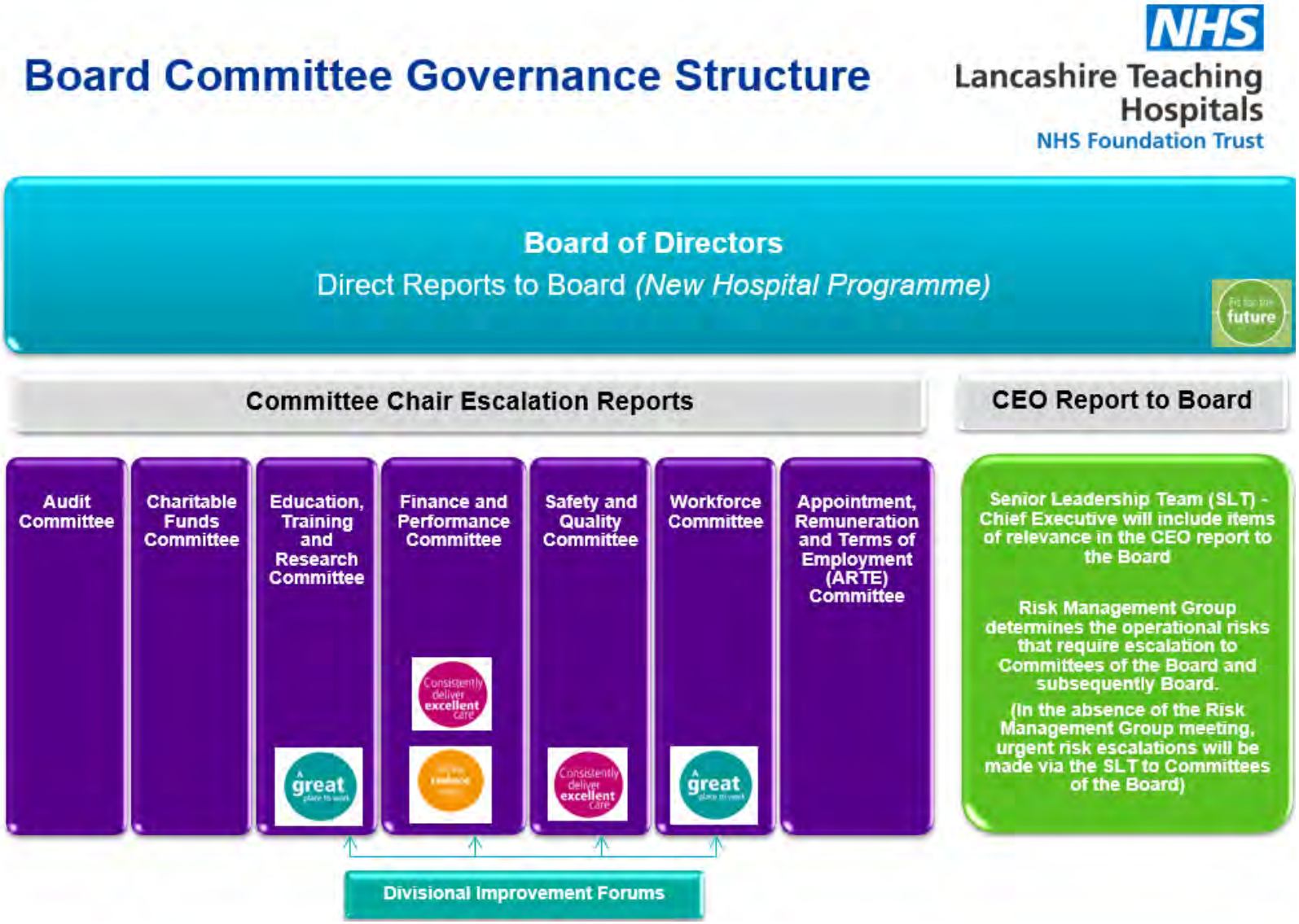
SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full** **References checked by library 22/09/2020**	
Number	References
1	Lancashire Teaching Hospitals NHS Foundation Trust Licence
2	Care Quality Commission (2015) Acute hospitals: provider handbook
3	Department of Health & Social Care website https://www.gov.uk/government/organisations/department-of-health
4	NHS England website https://www.england.nhs.uk/
5	NHS Resolution website https://resolution.nhs.uk/
6	Care Quality Commission - The Fundamental Standards https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards
7	National Patient Safety Agency (2008) *A risk matrix for risk managers*. London, NPSA.
Bibliography	
NHS Commissioning Board (2013) *Reservation of Powers to the Board & Delegation of Powers.*	
NHS Litigation Authority (2013) *NHSLA Risk Management Standards 2013-14.* London, NHSLA.	
The Management of Health and Safety at Work Regulations 1999 https://www.legislation.gov.uk/uksi/1999/3242/contents/made	
National Patient Safety Agency (2004) *Seven Steps to Patient Safety: the Full Reference Guide.* London, NPSA.	
National Patient Safety Agency (2009) *Being Open Framework*. London, NPSA.	

DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	Definition
ALARP	As Low As Reasonably Practicable
BAF	Board Assurance Framework
CQC	Care Quality Commission
HSE	Health and Safety Executive
MHRA	Medicines and Healthcare Products Regulatory Agency
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health and Care Excellence
NPSA	National Patient Safety Agency
TNA	Training Needs Analysis
TMB	Trust Management Board

CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	Job Title	Date Consulted
Board of Directors		October 2023
Audit Committee		September 2023
Divisional and Corporate Leadership Teams and Executive Management Team		September 2023
Divisional Governance Teams		September 2023

DISTRIBUTION PLAN	
Dissemination lead:	Deputy Associate Director of Risk and Assurance
Previous document already being used?	Yes
If yes, in what format and where?	Electronic, heritage library system, hard copy
Proposed action to retrieve out-of-date copies of the document:	Knowledge and library to replace with updated version. Any paper copies to be removed and placed in confidential waste.
To be disseminated to:	Trust wide
Document Library	Heritage
Proposed actions to communicate the document contents to staff:	Include in the LTHTR weekly Procedural documents communication– New documents uploaded to the Document Library

Appendix 1 TRUST CORPORATE GOVERNANCE COMMITTEE STRUCTURE



FEEDER GROUPS TO COMMITTEES OF THE BOARD

Lancashire Teaching Hospitals NHS Foundation Trust

Charitable Funds Committee
Rosemere Management Committee
Education, Training and Research Committee
Apprenticeships Strategy and Assurance Committee; Training Compliance and Assurance Committee; Education Quality and Performance Subcommittee; Education Finance and Business Subcommittee; Research and Innovation Subcommittee; Divisional Improvement Forum
Finance and Performance Committee
Capital Planning Forum; Emergency Preparedness, Resilience and Response (EPRR) Committee; Information Governance and Records Committee; Senior Information Risk Owner/Asset Information Owner Working Group; Digital and Health Informatics Divisional Board; New Hospitals Programme (monthly and quarterly reports); ICS, ICP and PCB system updates; Divisional Improvement Forum
Safety and Quality Committee
Infection Prevention and Control Group; Safeguarding Board; Mortality and End of Life Care Committee; Ethics Committee; Always Safety First Committee; Medicines Governance Committee; Safety and Learning Group; Patient Experience Involvement Group; Health and Safety Governance; Divisional Improvement Forum
Workforce Committee
Health and Wellbeing Group; Temporary Staffing Group; Raising Concerns Group; Equality, Diversity and Inclusion Group; Divisional Improvement Forum
Audit Committee
Risk Management Group

Appendix 2 - RISK MANAGEMENT REPORTING ARRANGEMENTS

Document	Presented to	Frequency	By
Board Assurance Framework	Board of Directors and Committees of the Board	At each meeting	Associate Director of Risk and Assurance/Deputy Associate Director of Risk and Assurance
Board Assurance Framework	Audit Committee	At each meeting	Associate Director of Risk and Assurance/Deputy Associate Director of Risk and Assurance
Operational High Risk Register	Risk Management Group	At each meeting	Associate Director of Risk and Assurance/Deputy Associate Director of Risk and Assurance
Risk Management Policy	Board of Directors	Annually	Associate Director of Risk and Assurance/Deputy Associate Director of Risk and Assurance
Escalation of high risks from Risk Management Group (or Senior Leadership Team meeting should the Risk Management Group not meet and there is an urgent escalation needed)	Committees of the Board	At each meeting (as part of Strategic Risk Paper)	Executive Lead aligned to strategic risk (supported by Corporate Governance Team)
Annual Governance Statement	Audit Committee	Annually	Company Secretary/Associate Director of Risk and Assurance
Escalation of Confidential Risks	Workforce Committee	At each meeting (in Part II)	Divisional Management Team
Escalation of Confidential Risks	Divisional Improvement Forums	At each meeting (in Part II) (Except if deemed not	Divisional Management Team

Document	Presented to	Frequency	By
		required by the Chair)	
Divisional Risk Reports	Risk Management Group	At each meeting (on a cycle)	Divisional Management Team
Governance Dashboard	Divisional Improvement Forums	At each meeting	Divisional Management Teams

See Appendix 8 for further information on Confidential Risk Reporting arrangements.

Appendix 3 - THE RISK ASSESSMENT & MANAGEMENT PROCESS GUIDANCE

1. Identifying the Risks to Objectives:

Risks can be identified from a variety of different sources through the operation of the Trust's business; these sources can include, but are not limited to:

Proactive Processes:	• Planning Processes • General Observations • Internal/External Audits
Reactive processes:	• Incidents • Complaints • Claims • Inspections/Assessments/Accreditations/Reviews • Regulatory Assessments

2. Types of Risk

Risks to Safety:	• Risks that could result in accidental death, disability or severe distress to patients, visitors, contractors and/or staff • Risks that could result in unintentional harm • Risks that may be less serious but are more frequent or could affect a large number of patients/staff
Risks to Reputation:	• Risks that could lead to adverse publicity or affect the reputation of the Trust • Risks that could lead to litigation or may be the cause of a formal complaint • Risks that could affect the Division / CO or Group in meeting corporate objectives (e.g. failure to meet service delivery targets / operational loss or delay / national requirements)
Risks to Resources:	• Risks that could result in financial loss to the Trust • Risks to service provision • Risks to equipment / buildings • Risks to staff retention

3. Risk Handler - and Risk Owner:

When a risk is identified, a Risk Handler and Risk Owner must be assigned to take responsibility for the assessment and ongoing management of the risk and the actions to mitigate the risk.

The Risk Handler	should be the person that will have 'day-to-day' responsibility for the assessment and management of the risk and updating the Datix System, as such Risk Handlers must have the requisite authority to make the required decisions.
The Risk Owner	should be the person that will have 'managerial' responsibility for the oversight of the risk. They will also provide direction and management support where appropriate to the Risk Handler; as such Risk Owners must have the requisite authority to make the required decisions.

Below is simplified example of the types of Risk Handlers and Owners that might occur in a nursing, medical and service management context but these are examples and not prescriptive as each risk is different.

Nursing	**Risk Handler**	**Risk Owner**
Intra-Divisional	Ward Manager/Sister	Matron
	Matron	Deputy Nursing, Midwifery & AHP Director
Extra-Divisional Escalation	Deputy Divisional Nurse Director	Divisional Nurse Director
	Deputy Chief Nursing Officer	Chief Nursing Officer
Medical	**Risk Handler**	**Risk Owner**
Intra-Divisional Escalation	Consultant	Clinical Lead
	Consultant/Clinical Lead	Clinical Director
Extra-Divisional Escalation	Clinical Director	Deputy Chief Medical Officer
	Deputy Chief Medical Officer	Chief Medical Officer

Service Management	**Risk Handler**	**Risk Owner**
Intra-Divisional Escalation	Department/Unit/Ward Manager	Specialty Business/Clinical Business Unit Manager
	Specialty Business/Clinical Business Unit Manager	Divisional Director
Extra-Divisional Escalation	Divisional Director	Deputy Chief Operating Officer
	Deputy Chief Operating Officer	Chief Operating Officer

4. Risk Assessments and Systematic Approach

A Risk Assessment is the evaluation of any risk that has been identified that can interfere with the achievement of a Trust objective. These assessments are a vital part

of identifying what is being done to mitigate risks, how effective this mitigation is in practice and what further mitigation is required.

Upon completion of a Risk Assessment, it is the responsibility of the either the Risk Handler or Risk Owner to record the Risk Assessment on Datix. Where possible risk assessments can and should be directly entered into the Datix system to avoid unnecessary duplication of effort.

All Risk Assessments must include the following:

- The Location of the risk (Division, Department, Specialty and Site)
- The Risk Handler and Risk Owner
- The Trust Ambition that is at risk
- The date the risk was identified
- The risk title and description of the Risk
- The source of the risk i.e. how the risk has come to be identified
- The controls that are in place to assist in securing delivery of the objectives or Key Performance Indicators
- The assurances that enable evidence to be gained that our controls are effective
- The mitigation or control strategy for the Risk
- The current risk rating - the risk rating with the current controls in place
- The Source of risk
- The Mitigating Actions that are being taken to reduce the risk that will improve the level of control and assurance on the risk
- The target residual risk rating - the risk rating when the mitigating actions are completed
- The Review Frequency and Date of next review
- The Review history
- Any supporting documents or evidence attached to the Risk

All new risks are held in Pending ‘Pending Tray’ until they have been subjected to:

- A Quality Assurance check by the Divisional Governance Lead, and a check and challenge process at the Divisional Governance meeting.

The purpose of the ‘Pending Tray’ is to prevent the inadvertent addition of duplicate or near duplicates of existing risks and to ensure that risk assessments have been completed to the standard required by this Policy.

5. Risk Title

Risks must be titled in a clear and concise way and localised as much as possible to avoid confusion with similar risks across the organisation E.g. [Brief Description] at [localised name] e.g., Staffing levels on Ward 12.

6. Description of the risk and the consequences of the risk occurring

It is important that Risk Descriptions are both concise and contain sufficient information to allow a reader to understand the risk. The Risk description should include a summary of the cause and nature of the risk (the 'If'), the circumstances in which the risk may occur or worsen (the 'Then'), a statement of the plausible reasonable impacts (the 'So').

Some examples of 'If, Then, So' risk descriptions are detailed in the table below:

If	Then	So
In the current financial climate,	Failing to maintain appropriate staffing levels,	Resulting in poor service delivery/increased complaints.
Due to ineffective maintenance/failure to recognise wear and tear,	Key equipment breakdowns will increase,	Resulting in cancellation of lists.
Due to lack of leadership opportunities,	Failing to develop skills of existing staff,	Resulting in a lack of staff incentive to be retained/seek promotion.
Due to system failures,	Non availability of patient notes,	Leading to patient treatment being delayed, unsafe or cancelled.
Due to difficulties in recruiting,	Insufficient consultant staff to fulfil rota,	Resulting in rota being covered by staff working longer hours, which may adversely affect decision making ability.

IMPORTANT Do's and Don'ts when writing a risk description:

- **Do** include objective statements and facts
- **Do not** include subjective personal opinions and views
- **Do not** include abbreviations and acronyms, unless they are in very common usage e.g. NHS
- **Do not** include Personal Identifiable Data of Patients or Visitors in the Risk Description. Do not include Personal Identifiable Data of colleagues in the Risk Description unless it is directly relevant to the Risk.

7. Controlling Risks

The existing controls that are in place for the risk need to be detailed. It is worth taking some time with this section and perhaps consulting with colleagues to ensure that all relevant controls have been identified and documented.

Describe what controls are currently in place to control the risk, typically these include, policies, procedures, guidelines, training, formal structures and organisational arrangements, etc.

Record each control individually and identify if there are any gaps in the control and the effectiveness of that Control. Identify and record any internal or external sources of assurance which are already in place e.g. performance monitoring reports, audits, reviews, incident reports, committee/group minutes etc. and any gaps in these assurances.

Below are some examples of controls and the information that should be recorded:

Control Type	Trust Procedure	Capital Bid Request	Managerial Oversight
Control	An agreement is in place with an agency to provide appropriately qualified x-ray staff	Capital Bid for replacement Radiography equipment	Manager oversight of staffing rota
Gap in Control	Agency requires 7 days' notice to provide suitable staff	Capital Bid may not be successful	Cannot ensure availability of staff at short notice
Effectiveness of Control	Mostly Adequate	Partly Adequate	Partly Adequate
Assurance - Internal	Monitoring of performance against agreement	Capital Bid requests subject to approval by Finance and Performance Committee	Verbal report to senior manager
Assurance - External		External Audit of Capital bid requests	
Gaps in Assurance	None identified	None identified	Assurance can only reactively identify problems not proactively address them
Adequacy of Assurance	Significant Assurance	Limited Assurance	Limited Assurance

The overall effectiveness of all the controls that are in place should be determined and recorded in the Risk Register, the three levels of control effectiveness are:

- Fully Controlled
- Partly Controlled
- No Controls in Place

8. The Current Risk Score

Utilise the NPSA Risk Scoring Matrix and guidance to quantify the risk in terms of its current impact of the risk arising and the current likelihood of the risk arising. The matrix is in Appendix 7 of the Trust Risk Management Policy.

9. Mitigating Action Plans

The Mitigating Action Plan will detail how the Risk will be mitigated and managed to reduce the risk that will improve the level of control and assurance on the risk. All active risks should have at least one active mitigating action plan in progress.

When determining mitigating actions, consider the Five T's. Generally speaking, Risk management responses can be a mix of five main actions; transfer, tolerate, treat, terminate or take the opportunity – known as the Five T's. These are not prescriptive and should be used as guidance when considering mitigation actions.

- **Treat:** by far the greatest number of risks will be mitigated in this way with a positive action to treat and reduce the risk. The purpose of taking action to reduce the chance of the risk occurring is not necessarily to completely eradicate the risk as this is not always possible, but to contain it to an acceptable level.

- **Transfer:** for some risks, when all reasonable action has been taken to mitigate the risk, the best response may be to transfer the risk to another party. Some common ways to do this could include buying insurance to cover a particular consequence for example, or by supporting a third party to take the risk in another way. Often, transferring a risk can have other impacts, such as a financial cost or lack of control in activity, so careful consideration should be given to transferring a risk to understand what impact that may have on the organisation and whether it may have any unintended consequences.

- **Tolerate:** the ability to do anything about some risks may be limited, or the cost of taking any action may be disproportionate to the potential benefit gained. This course of action is common for large external risks. In these cases, the response may be to tolerate the risk. The decision to tolerate a risk should be considered carefully and should be considered alongside the Board Risk Appetite Statement and tolerance levels which can be found in section 4.7.1 and 4.7.2 of the Risk Management Policy. Also, section 4.12 of the policy describes what to do if the desired tolerance levels have been achieved, and a risk is considered to be controlled.

- **Terminate**: the risk by doing things differently thus removing the risk where it is feasible to do so. This could be by taking an informed decision not to become involved in a risk situation, such as terminating a service, although consideration would need to be given to what other risks this would create. Section 4.12 of the policy describes what to do if the desired tolerance levels have been achieved, and a risk is considered to be controlled.

- **Take the Opportunity:** This is a situation where you may actively take advantage of the uncertainty of a situation, as an opportunity to benefit. An example could be if there were two services that didn't have enough staff, one may take the opportunity to amalgamate those services and reduce the overall risk to both services.

Each Mitigating Action should include the items detailed in the below table:

Section	Explanation/Example
Action Type	Staff training – selected from a drop-down list
Action Title	Training Plan
Action Owner	Normally but not always this is the 'Risk Assessor' e.g. Relevant Ward Manager
Person Responsible	This is the person who will complete the action e.g. relevant Practice Educator
Start Date	The date the action will start on
Reminder Date	The date on which a reminder for the action to be completed should be issued, normally this would be a week or a month before target date, this date can be changed if required
Target Date	The date the action should be completed by (this date can be changed in required)
Action Status	Ongoing, Closed, Removed - selected from a drop-down list
Action Completed Date	The date the action was completed upon

The 'Person Responsible' for the completion of the action should record progress towards completion on a regular basis, preferably as the progress occurs.

The 'Action Owner' should scrutinise the progress reported by the 'Person Responsible' to ensure it is of sufficient quality and to ensure that regular progress is being recorded.

Overdue progress updates can be escalated to:

- Divisional Governance Meetings.
- Associate Director of Risk and Assurance.
- Committees.

Key aspects to consider when developing an action plan in order to mitigate/reduce the risk are summarised below.

- What are the existing controls?
- Are there any gaps?
- What further controls are practical and sustainable? (Check with staff who work in the area).
- Is the design of the control right? Is it helping you achieve your objectives?
- What further actions are needed to manage the risk?

- How will you assure that the control measures implemented will remain effective and not result in the risk re-emerging?

Action Plans should be focused on gaps in controls and should include the following:

- A list any actions that are needed to manage the risk indicating the agreed time scale for each action.
- A designated person must be identified to take responsibility for each action on the list.
- Each action identified should be SMART (**S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imely).
- Action plans must be appropriate to the level of the current risk.
- Action target dates and risk review dates should be set in accordance with the level of risk, and compliance with these must be monitored appropriately through the relevant committee.

10. Target Risk Rating

All identified Risks will be required to have a target score which is the level of risk that may be tolerated in order to consider a risk reasonably controlled. Each risk will be aligned to a Strategic Aim or Ambition and the target score should be considered in line with the Boards agreed Risk Tolerance relevant to the Strategic Aim or Ambition, as outlined below. See section 4.7.2 of the Risk Mamnagement policy for more information on Risk Tolerance.

Strategic Risks		Risk Tolerance
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities &…	Risk to delivery of Strategic Ambition: Consistently Deliver Excellent Care	1-6
	Risk to delivery of Strategic Ambition: A Great Place to Work	4-8
	Risk to delivery of Strategic Ambition: Deliver Value for Money	8-12
	Risk to delivery of Strategic Ambition: Fit for the Future	8-12
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research		9-12
Risk to delivery of Strategic Aim to offer a range of high-quality specialist services to patients in Lancashire and South Cumbria		6-9

11. Risk Monitoring and Review

It is mandatory that all risks have a defined review frequency and scheduled review date that is compliant with the guidance detailed in Appendix 4.

When a Risk review is due the Risk Handler is expected to undertake a review of the Risk and its associated actions to ensure that appropriate mitigation action is in progress and that the Risk is updated accordingly. They should complete the risk review action automatically created by Datix to cover:

- Review Date.
- Reviewed By.
- Details of Review.

The Risk Owner is expected to provide appropriate oversight and scrutiny over the work undertaken by the Risk Handler. The Divisional Governance meetings are also expected to provide appropriate oversight and scrutiny over their Divisional risks, especially risks that are rated as 'High.'

Overdue Risk reviews are escalated to:

- Divisional Governance Meetings.
- Deputy Associate Director of Risk and Assurance.
- Associate Director of Risk and Assurance.

The Datix system stores all previous Risk reviews as evidence to show the progress taken in updating and mitigating this Risk.

12. Risk Archiving and Record Management

The record of a Risk, including all its previous versions, from its creation through the period of its 'active' management, then into its 'inactive' archive retention is fully maintained within the Datix system. This includes all risks that have been added to Datix system since it went "live." All these records are available within the Datix system and can be immediately accessed if required.

To ensure the easy identification and reporting of 'active' risks, all Risks in the Datix system are assigned one of the following statuses as is appropriate:

- Pending – The risk is in 'pending' tray and is still under assessment.
- Active – The risk is 'assigned' to a 'Handler' and 'Owner' and it is being actively mitigated.
- Controlled– The risk has appropriately mitigated and has been controlled and archived.

The Trust Risk Register can be 'filtered' to show all the risks that are allocated each of the above statuses. 'Assigned' risks can also be 'filtered' by the Division or the Site they have been allocated to.

Appendix 4 – RISK ASSESSMENT AND RISK MANAGEMENT FLOW CHART PROCESS

Risk Management – Trust Risk Register, Life Cycle and Process

Ongoing Risk Register Processes: Risk Review, Quality Assurance and Reporting (Oversight and Scrutiny)
Risk -> Risk Review -> Quality Assurance -> Reporting: Oversight and Scrutiny

Risk Identification Assessment and Acceptance	
Risk Identification	Local Level: Variety of means and methods staff are encouraged to identify and report risks
Entry on to Risk Register	Local Level: Risk Identifier, Risk Assessor or Risk Manager
Quality Assurance Check	Divisional Governance Lead and/or Corporate Governance team, ensures appropriate standards
Acceptance	Divisional Governance Meeting and/or Corporate Governance Team

	Handler	Owner	Gov Lead	Corp .Go	Dept/Ward	Divisional	Committee	Trust Board
Low Risk Score 1-3	Yes	Yes	Periodic Assessment depends on size of Division	Periodic Assessment as Required / Identified	Yes	Periodic Reporting depends on the size of the Division	Periodic reporting as appropriate within Board reporting template	Periodic reporting as appropriate within Board reporting template
Moderate Risk Score 4-6	Yes	Yes	Periodic Assessment depends on size of Division	Periodic Assessment as Required / Identified	Yes	Periodic Reporting depends on the size of the Division	Periodic reporting as appropriate within Board reporting template	Periodic reporting as appropriate within Board reporting template
Significant Risk Score 8-12	Yes	Yes	Yes	Periodic Assessment as Required / Identified	Variable depends on the nature of Risk	Periodic Reporting depends on the size of the Division	Periodic reporting as appropriate within Board reporting template	Periodic reporting as appropriate within Board reporting template
High Risk Score 15-25	Yes	Yes	Yes	Yes	Variable depends on the nature of Risk	Yes	Yes as per escalation	Yes as per escalation

Risk Closure	
Risk Closure Request	Local Level: Risk Assessor or Risk Manager
Quality Assurance Check	Divisional Governance Lead and or Corporate Governance Team, ensures appropriate standards.
Closure Decision	Divisional Governance Meeting and/or Corporate Governance team

Risk Review Frequency Guidance

The frequency of review for a Risk should be based upon the profile and seriousness of that Risk. The below table provides guidance on normally appropriate review frequencies based upon the Risk Rating of the Risk.

Risk review Frequency			
Risk Rating / Score	**Minimum Frequency**	**Maximum frequency**	**Range or Review Frequencies**
Low Risk 1- 3	Annual	Quarterly	Annual, Six Monthly, Quarterly
Moderate 4- 6	Quarterly	Bi - Monthly	Quarterly, Monthly
Significant 8-12	Quarterly	Monthly	Quarterly, Monthly
High Risk 15-25	Monthly	Daily	Monthly, Bi-weekly, Weekly

NPSA Risk Matrix – for reference

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

Risk Review Process	
Automated Process Manual Checks	All Risks have a specified Risk Review Date that is compliant with the review frequency. Reminder email auto-generated 3 days before review date, on review date and each 7 days after review date. =
Reviewers	Risk Handlers should review and update the Action Plan and Control Status of the Risk. Risk Owners should review and challenge the information provided by the Risk Assessor.
Quality Assurance	Divisional Governance Lead (or Corporate Governance team) assess the quality of the reviews undertaken by the Risk Handler and Owner and provide feedback and advice as required.

Reporting: Oversight and scrutiny	Oversight and Scrutiny of the Risk Register is carried out from 'Ward to Board.' Multiple oversights for higher scoring Risks are provided at Divisional, Committee and Board Level. -

Appendix 5 – SUMMARY OF THE RISK REGISTER DATA FIELDS

Orange denotes mandatory fields; grey denotes system generated fields.

Section	Data Item
System Data	Risk Number
	Version
	Risk Level
	Current Status
Location Details	Division
	Site
	Department
	Specialty
Manager Details	Risk Assessor
	Risk Manager
Link to Objectives	Trust Objectives
	Sub Objectives
	KPI Details
	Oversight Committee
Risk Details	Date Identified
	Risk Title
	Risk Description
	Additional
Existing Controls in Place	Control Type
	Details of Control
	Gaps in Control
	Effectiveness of Control
	Assurance – Internal
	Assurance - External
	Gaps in Assurance
	Adequacy of Assurance
	Overall Control
	Risk Mitigation Strategy

Section	Data Item
Current Risk Assessment	Current Risk Severity Score
	Current Risk Likelihood Score
	Current Risk NPSA Rating
	Risk Group
	Risk Type
	Source of Risk
	Commissioner related
Action Plans	Action Priority
	Action Title / Summary
	Action Detail
	Action Owner
	Person Responsible
	Start Date
	Target Date
	Reminder Date
	New Progress
	Progress History
	Action Status
	Action Completed date
Target Risk Levels	Target Date
	Target Risk Severity Score
	Target Risk Likelihood Score
	Target Risk NPSA
Risk Review	Review Frequency
	Next Review Date
	Review Date
	Reviewed By
	Details of Review
Supporting Documentation	Any Items of Supporting Documentation that have been added

Appendix 6 – RISK REGISTER REPORT TEMPLATE

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Risk ID:	Risk Title:	Risk Description						
Trust Ambition:		Risk Grades:	Initial		Current		Target	
Trust Sub-Ambition:		Risk Rating Tracker						
Risk Owner								
Risk Handler								
Committee								
Controls		Assurances			Actions Plan / Progress Notes			
Gaps in Controls		Gaps in Assurances			Review Update Description			

N.B. The report format produced from Datix will include all of the above data fields but will have a slightly different structure, due to the technical parameters of the reporting function within Datix.

Appendix 7 – NPSA SCORING MATRIX

Table 1a Consequence scores (Impact or severity)
Choose the most appropriate domain for the identified risk from the left-hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. Other domains should be considered to determine if there are any other consequences which could influence the severity.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/ disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service sub-optimal Informal complaint/inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/competence	Short-term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attendance for mandatory/key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training/key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract/ payment by results Claim(s) >£1 million
Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 1b (additional guidance and examples relating to risks impacting on the safety of patients, staff or public)

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable event An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Additional examples	Incorrect medication dispensed but not taken Incident resulting in a bruise/graze Delay in routine transport for patient	Wrong drug or dosage administered, with no adverse effects Physical attack such as pushing, shoving or pinching, causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling (no time off work required)	Wrong drug or dosage administered with potential adverse effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2/3 pressure ulcer Healthcare-acquired infection (HCAI) Incorrect or inadequate information /communication on transfer of care Vehicle carrying patient involved in a road traffic accident Slip/fall resulting in injury such as a sprain	Wrong drug or dosage administered with adverse effects Physical attack resulting in serious injury Grade 4 pressure ulcer Long-term HCAI Retained instruments/ material after surgery requiring further intervention Haemolytic transfusion reaction Slip/fall resulting in injury such as dislocation/fracture/ blow to the head Loss of a limb Post-traumatic stress disorder Failure to follow up and administer vaccine to baby born to a mother with hepatitis B	Unexpected death Suicide of a patient known to the service in the past 12 months Homicide committed by a mental health patient Large-scale cervical screening errors Removal of wrong body part leading to death or permanent incapacity Incident leading to paralysis Incident leading to long-term mental health problem Rape/serious sexual assault

Table 2a Likelihood scores (broad descriptors of frequency)

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

Table 2b Likelihood scores (time-framed descriptors of frequency)

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

Table 2c Likelihood scores (probability descriptors)

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Probability Will it happen or not?	<0.1 per cent	0.1–1 per cent	1–10 per cent	10–50 per cent	>50 per cent

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

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

Risk Scoring and Grading

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
2. Use **table 1a or 1b** to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.
3. Use **table 2a** determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome (**table 2b**). If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as

the lifetime of a project or a patient care episode (**table 2c**). If a numerical probability cannot be determined, use the probability descriptions to determine the most appropriate score.

4. Calculate the risk score by multiplying the consequence by the likelihood: C (consequence) × L (likelihood) = R (risk score) The risk matrix in **table 3** shows both numerical scoring and colour bandings. For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	Significant risk
15 - 25	High risk

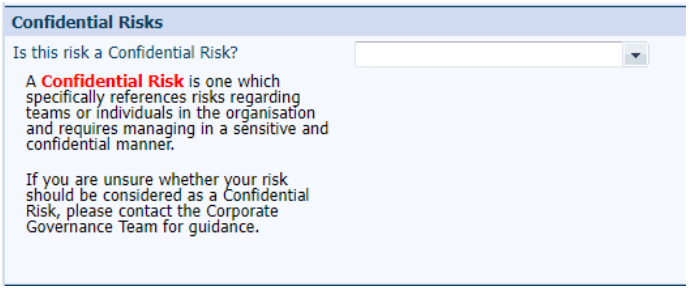
Appendix 8– CONFIDENTIAL RISK MANAGEMENT PROTOCOL

A “Confidential Risk” is one which specifically references risks regarding teams or individuals in the organisation and requires managing in a sensitive and confidential manner. A confidential risk typically will be a high level cultural concern or leadership issue, it is likely to be having an impact on the effective running of the team or department (such as patient safety concerns, quality of care, working relationships, grievances, team dynamics, freedom to speak up concerns, multiple Datix incidents, external review or external concerns being raised), it could involve several individuals as well potentially there being previous attempts to bring about performance improvements or a resolution to the issues through local line management or engagement with corporate teams in the wider Trust. The reporting of a confidential risk supports us in understanding our culture, being able to work collaboratively to address risks, undertake organisation wide and system wide learning from issues in order to improve the quality of care, patient safety and staff experience.

This Protocol provides a framework to ensure appropriate actions are taken to manage confidential risks. All colleagues have an obligation to report risks to allow the organisational system to improve and create a restorative just and learning culture, where issues are dealt with proactively, in collaboration and without fear of retribution.

Datix System Configuration

The confidential risks will be recorded using Datix as it is an established risk reporting system. The Risk Register form design on Datix has a section at the point of input of any new risk which enables the risk to be identified as a Confidential Risk (a Yes/No field). This is accompanied by a definition of what is classed as a Confidential Risk on the form design to guide Datix users.



Should the Confidential Risk be related to an individual(s), no names of staff would be included in risk record descriptions or within controls or assurances to maintain the utmost confidentiality.

To alleviate concerns that a Confidential Risk record could be tampered with to make a confidential risk public, the question on Datix indicating that the record is a Confidential Risk will be made ‘Read Only.’ A request for any change on this field would need to come to the Head of Risk & Datix Systems who can amend, thus making the record secure. Should the Head of Risk & Datix Systems be unavailable, the request should be made to the Associate Director of Risk & Assurance or the Deputy Associate Director of Risk & Assurance.

Access

A series of permission security groups, which are applied to the profile set up on the Datix System Administration, grant or deny access to such confidential risks based upon a user's job role as specified by Executives in September 2021 and approved at Executive Management Group in October 2021.

The series of permission security groups are designed to protect the confidentiality of the risks, especially when it could be relating to specific teams or individuals. It is important that confidentiality is always maintained when recording and discussing these risks in order to protect the individuals involved as it is likely the situation will be personally and professionally challenging for them and we need to treat colleagues with dignity and respect, finding ways to support improvement and learning in a transparent manner. The confidential risk reporting process should not be seen as a 'sanction' or 'prejudgement' as this will go against the culture we are trying to create of compassion, no blame, learning, involving colleagues in improvements, giving colleagues a voice and shared accountability.

The following groups of staff will be given access to Confidential Risks:

- Divisional Management Teams (DND/DMD/DD) and HR Business Partner for the Division the risk is aligned to.
- Executive Team.
- Deputy Chief People Officer.
- Corporate Governance and Risk Team on a need to know basis for reporting purposes.

Any exceptions to this will be discussed and agreed with the Head of Risk & Datix Systems and can also be approved by Associate Director of Risk & Assurance, Deputy Director of Workforce & Organisational Development, or the Executive Team.

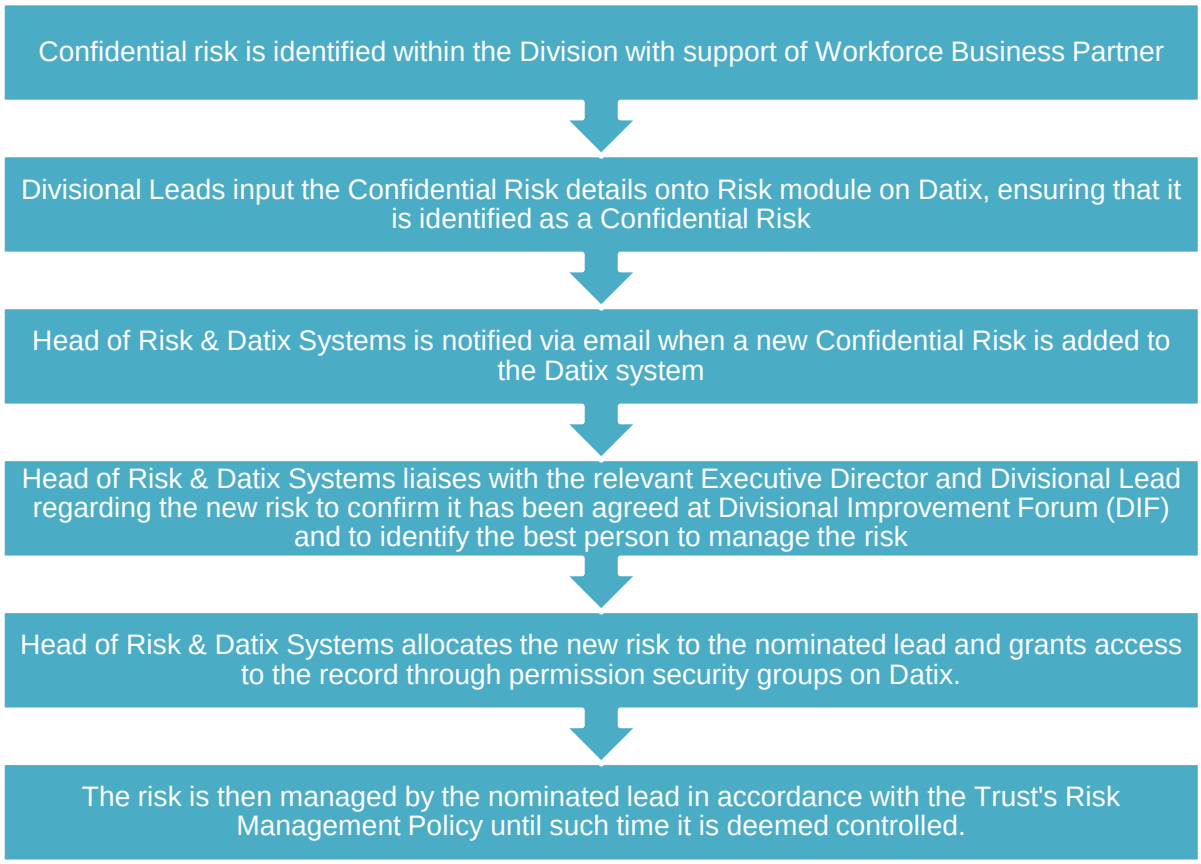
Security Group Number	Security Group Title	Security Group permission
1	RISK – Access – Access to all confidential risks	Provides access to all risks identified as being a confidential risk
2	RISK – Access Denied – Access Denies to all confidential risks	Denies access to all risks identified as being a confidential risk
3	RISK – Access – Access to confidential risks in user's Division	Provides access to all risks identified as being a confidential risk within the Division that is detailed on the user's account
4	RISK – Access Denied – Access denied to confidential risks not in user's Division	Denies access to all risks identified as being a confidential risk that are outside the Division that is detailed on the user's account
5	RISK – Access – Access to confidential risks where named as Handler	Provides access to all risks identified as being a confidential risk within the Division that are allocated to the user as Handler
6	RISK – Access – Access to confidential risks where named as Owner	Provides access to all risks identified as being a confidential risk within the Division that are allocated to the user as Owner

7	RISK – Email – Email notification when a new confidential risk is recorded on Datix	Datix will send an automatic email when a new confidential risk is recorded on the Datix system.

Management of Confidential Risks

The flow chart in figure 1 depicts the Confidential Risk management proposal.

Figure 1 – Confidential Risk Management Flowchart



Roles and Responsibilities

Divisions

- The Divisional Directors (Divisional Nursing Director, Divisional Medical Director or Divisional Director) are responsible for escalating any Confidential Risks at the DIFs and seeking agreement that they should be placed on the Confidential Risk section of the Risk Register on Datix. It is acknowledged that it may not always be clear what may be classed as a Confidential Risk in the early stages, the Division Directors should feel comfortable to raise any concerns during the Divisional Improvement Forum Confidential Risk discussion to have an open conversation about concerns and if the risk needs to be progressed through this process.

- The Divisional Directors are responsible for inputting the Confidential Risk information on Datix and ensuring that the risk is managed on Datix in line with the Trust's Risk Management Policy.
- The Division is responsible deciding who the nominated lead is for formulating and managing an action plan in response to the Confidential Risk identified, making sure that the Confidential Risk is updated on Datix to reflect progress.
- The Division is responsible for seeking additional support to progress or inform any action plan such as from the Freedom to Speak Up Guardian, Human Factors, Continuous Improvement and Workforce and Organisational Development etc.
- The Division is responsible for making the team or individuals aware of any concerns, engaging them in sharing their view of the issues and working in partnership to bring about improvements.
- Should there be a Confidential Risk identified within the Corporate Division, due to there being no DIF for the Corporate Division, the escalation should take place to the Executive Management Team for agreement that the Confidential Risk be placed on the Risk Register in Datix, and for oversight on managing the action plan.
- The Associate Director of Risk & Assurance, Deputy Associate Director of Risk & Assurance and Head of Risk & Datix Systems will support with the inputting of any Corporate Division Confidential Risk information on Datix and ensuring that the risk is managed in line with the Trust's Risk Management Policy.

<u>Workforce and Organisational Development Department</u>

- The Workforce and Organisational Development Department will provide support, professional advice and where needed, deliver interventions to enable the action plan to be progressed.
- The Divisional Workforce Business Partner will be the liaison point in the first instance between the Division and the Workforce and Organisational Development Department, with colleagues from across the Department being engaged to support the progression of actions where needed based on their area of expertise.
- The Workforce and Organisational Development Department will be responsible for reviewing themes from all the Confidential Risks to determine wider organisational learning in partnership with the Chief People Officer, colleagues from the Risk Management Team and Freedom to Speak Up Guardian where applicable via the Raising Concerns Meeting. The Raising Concerns Meeting will be used to share themes and to triangulate new information, patterns or issues, and where required the Chief People Officer will escalate new concerns to the Part 2 meeting of the Divisional Improvement Forum for further discussion, risk recording and potential action plan development.
- Where there is a lack of progress against the action plan or improvements are not being made to team, service or individual performance despite intervention, it may be necessary for the Chief People Officer to raise concerns to the Board of Directors via the Workforce Committee or Safety and Quality Committee.

<u>Head of Risk & Datix Systems</u>

- The Head of Risk & Datix Systems is responsible for providing scrutiny to any newly recorded Confidential Risks and consulting the Divisional Triumvirates regarding

newly recorded Confidential Risks as part of the validation and risk allocation process.

- The Head of Risk & Datix Systems will provide support through Divisional Boards – Part II for the update and review of the Confidential Risks on the Datix system, ensuring that Risk Handlers update controls, assurance and action plans as required.
- The Head of Risk & Datix Systems will support with the provision of Confidential Risk information to Trust meetings, as required.

Expectations of Risk Content and Management

The risk description should clearly articulate what the risk is. However, should refrain from identifying any individuals to maintain the utmost confidentiality. The Controls, Gaps in Controls, Assurances and Gaps in Assurances sections should be completed as per the usual expectation for all risks in the Trust's Risk Management Policy.

It is acknowledged that an Action Plan for Confidential Risks will most likely be formulated outside of the Datix system. In order to maintain confidentiality and in recognition of the restrictive access to the Confidential Risks detailed above, there is no expectation for all Actions to be detailed within the Actions Section of the Confidential Risk record on Datix. Instead, it is acceptable for a Document version of the Action Plan to be attached in the Documents Section of the Confidential Risk record on Datix and for updated versions to be uploaded to the Risk record over time.

Once the risk is managed to an acceptable level and the relevant assurances have been obtained that the risk is reasonably controlled, the information should be presented to Divisional Improvement Forum for approval that the risk can be controlled. Once approval is obtained, the risk can move from "Active Risks" to "Controlled Risks" on the Datix system and the relevant information recorded to document why the risk is controlled, in the same manner for any other risk on the system.

A user guide to assist users adding a new Confidential Risk and/or managing a Confidential Risk on Datix is included at the end of this appendix.

Reporting and Assurance

Data regarding Confidential Risks is included within Divisional Risk KPIs and statistics within the Monthly Governance Dashboard on the BI Portal, however the risk level detail remains restricted in Datix and the Dashboard provides quantity data only.

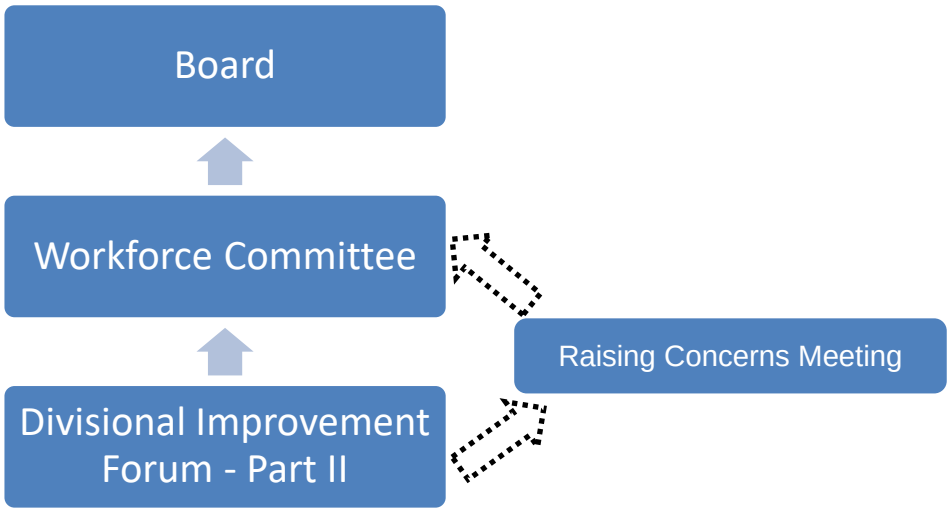
A bi-monthly Divisional Improvement Forum Chair's report will be produced and presented to Workforce Committee, giving update and oversight of current scores and progress of mitigating action plans.

Cycle of Business for Reporting

The below table details the outline frequency of Confidential Risk discussion and report compilation although this will fit in with Committee/Group dates and cycles of business, which are subject to change:

	Mode	Responsibility	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Confidential Risk paper to Executive Management Team	Paper	Head of Risk & Datix Systems	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Confidential Risk discussion at Divisional Improvement Forum (DIF) Pt II	Discussion (with risks on screen live)	Divisional Triumvirates, Workforce Business Partners	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
High Scoring Confidential Risks Information to Risk Management Group	Paper (data only)	Associate Director of Risk & Assurance, Head of Risk & Datix Systems		✓	✓		✓	✓		✓	✓		✓	✓
Bi-monthly Confidential Risk Overview at Raising Concerns Group	Paper (virtual on-screen)	Associate Director of Risk & Assurance, Head of Risk & Datix Systems		✓		✓		✓		✓		✓		✓
Bi-monthly Production of DIF Chair report for Workforce Committee	Chair's report	Associate Director of Risk & Assurance supported by Associate Director of Workforce & Education	✓		✓		✓		✓		✓		✓	
Bi-monthly Production of Raising Concerns Chair report for Workforce Committee	Chair's report	Freedom to Speak Up Guardian	✓		✓		✓		✓		✓		✓	
Overview - Board of Director's Part II	Paper	Deputy Chief People Officer		✓						✓				

Flowchart of escalation of Confidential Risks information



Should Workforce Committee review the Confidential Risk Chairs report and consider that a Confidential Risk is of significant concern and requiring more focused attention, the Confidential Risk can be escalated to Board Part II, through the usual Risk Management Structure.

An example of the Chair's report to Workforce Committee is below.

Confidential Risks – Datix User Guide

Adding a new Confidential Risk on Datix

To add a new Confidential Risk, follow the exact same process as adding any other risk to the Risk Register on Datix detailing

- Risk title
- Risk description
- Initial score
- Location of risk

Once the above is detailed, there is now an additional question enabling the identification of a Confidential Risk. This is a “Yes/No” field and to identify the risk as a Confidential Risk, select “Yes.”

Complete the rest of the new risk form identifying

- the key information regarding the risk’s identification
- whether the risk is out of the Division’s control
- whether there are any documents to attached

…and then press “Submit” at the bottom of the form.

Moving a new Confidential Risk onto the Active Register on Datix

When a new Confidential Risk is recorded on the Datix system, the system will send an automatic email notification to the Head of Risk & Datix Systems. They will then liaise with the Divisional Triumvirate to check that the risk is a genuine Confidential Risk that has been agreed to be added to Datix through Divisional Improvement Part II Forum, and who should be the Risk Owner and Risk Handler. If not yet agreed through the Divisional Improvement Forum Part II process, this will be discussed at the next meeting and a decision made.

Once confirmed to be a genuine Confidential Risk, the Head of Risk & Datix Systems will place the risk onto the Active Register and will allocate the record to the necessary Risk Owner and Handler, as agreed with the Divisional Triumvirate. The Head of Risk & Datix Systems will also ensure that access is opened to the record as appropriate (see Protocol for detail) and will notify the relevant Workforce Business Partner to inform them of a new Confidential Risk in their area.

Managing an Active Confidential Risk on Datix

The Confidential Risk should be managed on Datix in line with the Trust Risk Management Policy, in the same manner that any other risk would be.

All controls, gaps in controls, assurances and gaps in assurances should be documented in the appropriate sections on the risk record.

It is acknowledged that an Action Plan for Confidential Risks will most likely be formulated outside of the Datix system. In order to maintain confidentiality and in recognition of the restrictive access to the Confidential Risks detailed above, there is no expectation for all Actions to be detailed within the Actions Section of the Confidential Risk record on Datix. Instead, the Action Plan document should be attached in the Documents Section of the Confidential Risk record on Datix and for updated versions to be uploaded to the Risk record in the Documents section.

Once the risk is managed to an acceptable level and the relevant assurances have been obtained that the risk is reasonably controlled, the information should be presented to Divisional Improvement Forum for approval that the risk can be controlled. Once approval is obtained, the risk can move from “Active Risks” to “Controlled Risks” on the Datix system and the relevant information recorded to document why the risk is controlled, in the same manner for any other risk on the system.

Example Bi-monthly DIF Chair's report for Confidential Risks template

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

70 YEARS OF THE NHS 1948 - 2018

Chair's Report

Committee:	Divisional Improvement Forum – Part II			
Data and time:	[INSERT]			
Location:	[INSERT]			
Chairperson and role:	[INSERT]			
Core membership:	[INSERT]			
Attendance:	**Quorate:**	[INSERT]	**Not Quorate:**	[INSERT]
If not quorate, state reason:				

Update on Confidential Risks:

Specialty	Current Score	Target Score	Risk Theme	Date of Last Review on Datix

Items for positive escalation from Mitigating Action Plans: (where a previously challenging matter has been successfully resolved, assurance can be provided & organisational wide	1.
	2.
	3.

learning might be available for sharing)	4.
Items for negative escalation from Mitigating Action Plans: (where a challenging matter has not yet been successfully resolved, assurance cannot yet be provided & organisational wide learning might be available, but the 'parent' committee needs to be aware)	1. Xxx **Actions:**
	2. Xxx **Actions:**
	3. Xxx **Actions:**
	4. Xxx **Actions:**
	5. Xxx **Actions**:
Name of committee for escalation: (parent committee)	Workforce Committee – Part II
Chair's Narrative on the meeting: (if applicable, covering points otherwise not discussed elsewhere in the template)	
Date, Time & Location of next meeting:	

Appendix 9 – EQUALITY, DIVERSITY & INCLUSION IMPACT ASSESSMENT

Lancashire Teaching Hospitals NHS Foundation Trust

Equality, Diversity & Inclusion Impact Assessment Form

Department/Function	Governance			
Lead Assessor	Simon Regan			
What is being assessed?	Risk Management Policy			
Date of assessment	14.08.2023			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☐
	Service Users	☐	Staff Inclusion Network/s	☐
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☒
	Board of Directors, Executive Management Team, Senior Leadership Team members, Corporate and Divisional Governance Leads			

1) What is the impact on the following equality groups?

Positive:	**Negative:**	**Neutral:**
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments:** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Neutral	
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief (includes non-belief)	Neutral	
Sexual orientation	Neutral	
Age	Neutral	
Marriage and Civil Partnership	Neutral	

Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights, social)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	The policy sets out a clear standardised process on the management of risk that aims to reduce any risk of inequality in the management of risk.

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

ACTION PLAN SUMMARY

Action	**Lead**	**Timescale**
Not applicable	Not applicable	Not applicable

HOW THE NHS CONSTITUTION APPLIES TO THIS DOCUMENT

WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Principles	Tick those which apply	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Pledges	Tick those which apply
1. The NHS provides a comprehensive service, available to all.	√	1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.	√
2. Access to NHS services is based on clinical need, not an individual's ability to pay.	√	2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.	√
3. The NHS aspires to the highest standards of excellence and professionalism.	√	3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.	√
4. The patient will be at the heart of everything the NHS does.	√	4. Provide support and opportunities for staff to maintain their health, wellbeing and safety.	√
5. The NHS works across organisational boundaries.	√	5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.	√
6. The NHS is committed to providing best value for taxpayers' money.	√	6. To have a process for staff to raise an internal grievance.	√
7. The NHS is accountable to the public, communities and patients that it serves.	√	7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.	√

WHICH AIMS OF THE TRUST APPLY? Click here for Aims	Tick those which apply	WHICH AMBITIONS OF THE TRUST APPLY? Click here for Ambitions	Tick those which apply
1. To offer excellent health care and treatment to our local communities.	√	1. Consistently deliver excellent care.	√
2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria.	√	2. Great place to work.	√
3. To drive innovation through world-class education, teaching and research.	√	3. Deliver value for money.	√
		4. Fit for the future.	√

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Review of Fit and Proper Person Policy following publication of NHSE Fit and Proper Person Test Framework for Board Members

Report to:	Board of Directors	**Date:**	5 October 2023
Report of:	Company Secretary	**Prepared by:**	J Foote
Part I	✓	**Part II**	

Purpose of Report

For assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary:

On 2 August 2023 NHSE published its framework setting out the detail of how it expects fit and proper person testing for Board directors and other positions of influence to be undertaken, with the guidance coming into effect from 1 October 2023. The framework is highly prescriptive and has therefore required a significant review of the current Fit & Proper Persons Policy approved by the Trust.

The Board is recommended to adopt the framework and approve the policy.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Executive Team 20 September 2023

1. Current Revision

The updated policy is attached as an appendix to the report. This sets out the framework in full for adoption as the FPP policy going forward, whilst recognising some local factors distinct to the Trust:

These 'local factors' are:

- The explicit statement of those posts to which the framework applies
- The recognition that the test for hosted posts sits with the board to which those posts report
- The recognition that owned or controlled subsidiaries, as arm's length vehicles of the Trust also fall within the scope of the policy
- The acknowledgement that the F&PP test is distinct and separate from other pre-employment checks covered by HR polices.

2. Financial implications

No additional costs

3. Legal implications

Statutory Requirement (Regulation 5, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014)

4. Risks

The clarity of the new framework should mitigate against any gaps in application of the process.

6. Impact on stakeholders

Clarity of guidance supports positive stakeholder relations and instils confidence.

7. Recommendations

Having reviewed the documents, the Board of Directors is asked to:

Approve the Fit & Proper Person Policy, including the adoption in full of the NHSE Fit and Proper Person Test Framework for Board Members.

DOCUMENT TYPE: **Policy**		**UNIQUE IDENTIFIER:** TP-240	
DOCUMENT TITLE: Fit and Proper Persons Policy		**VERSION NUMBER:** 2.0	
		STATUS: Ratified	
SCOPE: Executive and Non-Executive Directors and senior managers remunerated through the Very Senior Managers pay policy		**CLASSIFICATION:** Organisational	
AUTHOR: Jennifer Foote	**JOB TITLE:** Company Secretary	**DIVISION:** Corporate	**DEPARTMENT:** Trust Board
REPLACES: Fit and Proper Persons Policy 1.1		**HEAD OF DEPARTMENT:** Jennifer Foote	
VALIDATED BY: Trust Board		**DATE:** 5 October 2023	
RATIFIED BY:		**DATE:**	
(NOTE: Review dates may alter if any significant changes are made).		**REVIEW DATE:**	

AMENDMENT HISTORY

Version No.	Date of Issue	Page/Selection Changed	Description of Change	Review Date

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**
Document for Public Display: **No**
Evidence reviewed by Library Services N/A

CONTENTS

1. Introduction

1.1. NHS England has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles.

1.2. Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (referred to as the 2014 regulations) recommends that a statutory Fit and Proper Person's Requirement (FPPR) be imposed on health service bodies.

1.3. This policy sets out the NHSE framework for adoption in full by the Trust, together with the posts within the Trust expected to be covered by the framework.

1.4. This document supersedes any previous versions of this policy.

2. Purpose of this Policy / Procedure

The purpose of this policy is to ensure the Trust complies with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement, through the full implementation of the NHSE Fit and Proper Person Test Framework for Board Members.

3. NHSE Framework

3.1 On 2 August 2023, NHSE published its Fit and Proper Person Test Framework for Board Members.

3.2 The framework is adopted in full and shall be used as the guidance under which the Trust shall implement and discharge its duties in respect of Fit & Proper Person requirements.

3.3 Where any discrepancy or anomaly may occur between the NHSE Fit and Proper Person Test Framework for Board Members and any other policy or guidance covering the same, the NHSE guidance shall take precedence.

3.4 Any question on the application of the Framework shall be as decided by the Chair on the advice of the Company Secretary.

3.5 The Framework Document is set out as an appendix to this policy.

4. Scope

4.1. This policy and procedure applies to all Board-level appointments, that is Executive and Non-Executive Directors and those senior managers remunerated through the Very Senior Managers pay policy and where their post carries a degree of influence at Board level.

The following posts are subject to the arrangements outlined in this policy:

a) The Chair of the Trust

b) Non-Executive Directors appointed to the Board of Directors (including Associate Non-Executive Directors)

c) The Chief Executive

d) Executive Directors who are designated to vote at Board meetings

e) Non-voting Directors who are remunerated through the Very Senior Managers pay policy

f) the Company Secretary

g) the Operations Director, Finance

It includes permanent and interim positions (where that interim position is longer than for a period of six weeks).

4.2 This policy does not apply to any VSM or similar post hosted by the Trust, where the Fit & Proper Person framework requirements shall be undertaken and applied by the organisation or board that the hosted post reports to.

4.3 However, this policy shall apply to any subsidiary or other vehicle or arm's length body that may be owned or controlled by the Trust.

4.4 Any checks or assessments undertaken under this policy and associated framework are undertaken in addition to the Trust's comprehensive pre-employment checking processes as determined by the NHS employment standards and as administered by the HR Dept. These do not fall within the remit of this policy.

4.5 As required by s.3.7.1 of the attached framework, the Trust shall undertake a basic DBS check of all directors. However, any Executive or Non-Executive role that falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006 shall be subject to an enhanced check.

4.6 A failure or refusal by a candidate for appointment to comply with any of the procedures set out in the framework will immediately disqualify that person from the proposed appointment.

4.7 The Chief People Officer (Executive Directors) or the Trust Chair (Non-Executive Directors and CEO) will notify any prospective candidate for appointment as soon as is practicable if that person is determined to be ineligible under this policy.

5. Audit and Monitoring

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report and act on findings.	Group / committee / individual responsible for ensuring that the actions are completed
F&PP	Annual self-attestation	Chair/CoSec	Annually	ARTE	ARTE

6. Training

TRAINING Is training required to be given due to the introduction of this policy? N/a		
Action by	**Action required**	**Implementation Date**

7. Document Information

ATTACHMENTS	
Appendix Number	Title
A	NHS England Fit and Proper Person Test Framework for board members
B	Equality, Diversity & Inclusion Impact Assessment Form

OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	Title and web links from the document library
	The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement

SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS N/A **References in full**	
Number	References
1	
2	
3	
Bibliography	
	v

CONSULTATION WITH STAFF AND PATIENTS N/A Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	Job Title	Date Consulted

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Contents

Section 1: Introduction

1.1 Background

The Kark Review (2019) was commissioned by the government in July 2018 to review the scope, operation and purpose of the Fit and Proper Person Test (FPPT) as it applies under the current Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This included looking at how effective the FPPT is:

> "… in preventing unsuitable staff from being redeployed or re-employed in the NHS, clinical commissioning groups, and independent healthcare and adult social care sectors."

The review highlighted areas that needed improvement to strengthen the existing regime.

The specific recommendations from the Kark Review (2019) have been detailed in Appendix 1.

1.2 Purpose and benefits

This document supports the implementation of the recommendations from the Kark Review, and promotes the effectiveness of the underlying legal requirements by establishing a Fit and Proper Person Test Framework (also known as the 'Framework'). The purpose is to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

The Framework is effective from 30 September 2023 and should be implemented by all boards going forward from that date. NHS organisations are not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

The Framework should be read in conjunction with the NHS Constitution, NHS People Plan, People Promise and forthcoming NHS Leadership Competency Framework for leaders at board level. This Framework supports transparency and should be the start of an ongoing dialogue between board members about probity and values. It should be seen as a core element of a broader programme of board development, effective

appraisals and values-based (as well as competency-based) appointments – all of which are part of the good practice required to build a 'healthy' board.

The aim of strengthening the FPPT is to prioritise patient safety and good leadership in NHS organisations. The Framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations.

The Framework will be fair and proportionate and has been developed with the intention to avoid unnecessary bureaucratic burden on NHS organisations.

Ensuring high standards of leadership in the NHS is crucial – well-led NHS organisations and better-led teams with both strong teamwork and strong governance translate into greater staff wellbeing and better clinical care. This requires accountable board members with both outstanding personal conduct and professional capabilities to effectively oversee NHS organisations that are often under significant financial restraint and operating in a highly regulated environment with public and political scrutiny.

As the FPPT assessment is on an individual basis, rather than in relation to the board as a whole, it is envisaged that aspirant board members who can demonstrate the characteristics described above should not be deterred from seeking to join the board of a more challenged NHS organisation. The FPPT assessment is one of general competence to act as a board member, and situational context should therefore be taken into account.

Ensuring that board members are demonstrating the right behaviours will help the NHS drive its cultural initiatives: namely, to foster a culture of compassion, respect and inclusion, and a feeling of belonging; as well as setting the tone at the top to encourage a listening and speaking up culture.

1.3 Applicability

The Framework applies to the board members of NHS organisations. Within this guidance, the term 'board member' is used to refer to:

- both executive directors and non-executive directors (NEDs), irrespective of voting rights
- interim (all contractual forms) as well as permanent appointments

- those individuals who are called ‘directors’ within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Those individuals who by virtue of their profession are members of other professional registers, such as the General Medical Council (GMC) or Nursing and Midwifery Council (NMC), should still be assessed against this Framework if they are a board member at an NHS organisation.

The Framework is designed to assess the appropriateness of an individual to effectively discharge their duties in the capacity of a board member.

It is recognised that some organisations may want to extend the FPPT assessment to other key roles, for example, to those individuals who may regularly attend board meetings or otherwise have significant influence on board decisions. The annual submission requirement is, however, limited to board members only.

Within this guidance, the term ‘NHS organisations’ refers to those institutions to which the Framework will apply; for the purposes of this Framework, this includes:

- NHS trusts
- NHS foundation trusts
- integrated care boards (ICBs)
- the following arm’s length bodies in the first instance:
  - Care Quality Commission (CQC)
  - NHS England.

ICB chairs will need to consider FPPT assessment on a member-by-member basis and take into account assurance received from other recruiting/appointing organisations, for example, in the case of partner members.

1.4 Personal data

Personal data relating to the FPPT assessment will be retained in local record systems and specific data fields in the NHS Electronic Staff Record (ESR). The information contained in these records will not routinely be accessible beyond an individual’s own organisation. There will be no substantive change to the data controller arrangements from those already in place for ESR.

Although, as set out below, NHS England will not have day-to-day access to the system or its content, NHS England recognises that it may be considered a (joint) controller of the ESR fields because as the commissioner of the ESR module and author of the Framework, it has a role in determining the nature and purposes of processing.

The organisations that are uploading the content (and determining what is said about each board member), and the NHS Business Services Authority (as the main commissioner of ESR), will also each be a data controller. For the purposes of Article 26 UK GDPR, NHS England has put in place 'transparent arrangements' to set out its responsibilities in this respect.

NHS England has established that the most relevant lawful basis for processing the FPPT data contained in ESR is set out in Article 6(1)(e) UK GDPR. This is on the basis that the processing of personal data is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller (that is, the employer, or indeed NHS England in connection with any role it fulfils as a joint controller).

The aim of the maintaining a record of FPPT outcomes in ESR is to significantly improve the management of the NHS, and ultimately the experience and outcomes for patients, and is therefore in the public interest and done as part of the exercise of the functions of the organisation concerned.

As special category data would be processed as part of the maintenance of the ESR FPPT data fields, controllers will also rely on one of the lawful bases for processing set out in Article 9 UK GDPR: Articles 9(2)(b) – employment; 9(2)(g) – statutory/public functions; and 9(2)(h) (read with Schedule 1, paragraph 2 of the Data Protection Act 2018). This covers processing that is 'necessary for the management of the health service.'

NHS England recognises the requirements of Article 5(1) UK GDPR, and that personal data should be processed lawfully, fairly and transparently. In line with all other ESR data fields, fair processing information will be available to the users of the ESR system. Current ESR fair processing information can be found in the NHS Electronic Staff Record (ESR) privacy notice. The Framework and related guidance documents also help discharge transparency-related obligations.

Information that is the personal data of the applicant is exempt from the Freedom of Information Act under section 40(1) and any request should be processed under section

7 of the DPA. Regulation 5(3) of the EIR is the equivalent provision and has the same effect.

Arrangements for dispute resolution or request for review of content of data (in ESR and local records), or relating to the FPPT assessment outcome, are set out in the guidance document for chairs.

The launch of the Framework will involve NHS England and participating data controllers (NHS trusts, foundation trusts and integrated care boards) communicating to all board members in their organisation whose details will be included in ESR, in advance of the FPPT Framework (and standard reference tools) going live on 30 September 2023. By doing so directors will be afforded the opportunity to object if they have concerns regarding the proposed use of their data, and NHS England and participating data controllers will be able to consider these concerns and amend their approach if necessary. An example of a board member FPPT privacy template is attached at Appendix 6. Organisations should ensure that an appropriate policy document is in place in relation to special category data.

Section 2: Context

2.1 Current fit and proper persons regulations

In 2014, the government introduced a 'fit and proper person' requirement, via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 'Regulations').

This sets out the requirements for a FPPT which applies to directors and those performing the functions of, or functions equivalent or similar to the functions of, a director in all NHS organisations registered with the CQC, which includes all licence holders and other NHS organisations to which licence conditions apply. For the purposes of this guidance, we have referred to these individuals as 'board members'.

Regulation 5 recognises that individuals who have authority in NHS organisations that deliver care are responsible for the overall quality and safety of that care. The regulation requirements are that:

a) the individual is of good character

b) the individual has the qualifications, competence, skills and experience that are necessary for the relevant office or position or the work for which they are employed

c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed

d) the individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity

e) none of the grounds of unfitness specified in part 1 of Schedule 4 apply to the individual.

The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged

b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland

c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986

d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it

e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland

f) the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

The good character requirements referred to above in Regulation 5 are specified in Part 2 of Schedule 4 to the Regulated Activities Regulations, and relate to:

a) whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence

b) whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

Integrated care boards (ICBs) are statutory bodies with the general function of arranging for the provision of services for the purposes of the health service in England and are NHS bodies for the purposes of the 2006 Act. The main powers and duties of ICBs are to commission certain health services as set out in sections 3 and 3A of the 2006 Act.

ICBs, together with the CQC and NHS England, are within scope of this Framework. One of the recommendations made by Tom Kark KC was to extend the scope of the FPPT into certain arm's length bodies (ALBs) to:

> "…bolster the strength and width of the test, as well as to put a stop to 'the revolving door,' the FPPT should be extended to commissioners as well as other arms-length bodies. It was described as 'incongruous' that it did not apply to commissioners."

2.2 Related principles and values

This section summarises relevant principles and values that underpin the Framework and provide additional context to understand its aims.

2.2.1 NHS Constitution

The NHS Constitution states:

> The NHS belongs to the people.
>
> It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives.
>
> It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need when care and compassion are what matter most.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

2.2.2 NHS guiding principles

The seven guiding principles that govern the way the NHS operates, and define how it seeks to achieve its purpose:

1. The NHS provides a comprehensive service, available to all.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. The patient will be at the heart of everything the NHS does.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities, and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair, and sustainable use of finite resources.
7. The NHS is accountable to the public, communities, and patients that it serves.

2.2.3 NHS values

These principles are underpinned by the core NHS values, which have been derived from extensive discussions with staff, patients and the public. The values are integral to creating a culture where patients come first in everything the NHS does.

These values are not intended to be limiting. Individual NHS organisations should use them as a basis on which to develop their own values, adapting them to local circumstances. The values should be taken into account when developing services with partner NHS organisations, patients, the public and staff.

The six core values are:

1. Working together for patients.
2. Respect and dignity.
3. Commitment to quality of care.

4. Compassion.
5. Improving lives.
6. Everyone counts.

2.2.4 The Nolan Principles of Standards in Public Life

NHS board members, in their capacity as public office holders, are expected to abide by the 'Nolan Principles' as defined by the Committee on Standards in Public Life:

1. Selflessness
   - Holders of public office should act solely in terms of the public interest.
2. Integrity
   - Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family or their friends. They must declare and resolve any interests and relationships.
3. Objectivity
   - Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
4. Accountability
   - Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
5. Openness
   - Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
6. Honesty
   - Holders of public office should be truthful.
7. Leadership

- Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

Section 3: FPPT Framework

The Framework sets out:

- When the full FPPT assessment is needed, which includes self-attestations (see sections 3.2 and 3.3).
- New appointment considerations (section 3.4).
- Additional considerations in specific situations such as joint appointments, shared roles and temporary absences (section 3.5).
- The role of the chair in overseeing the FPPT (section 3.6).
- The FPPT core elements to be considered in evaluating board members (section 3.7).
- The circumstances in which there will be breaches to the core elements of the FPPT (regulation 5) (section 3.8).
- The requirements for a board member reference check (section 3.9).
- The requirements for accurately maintaining FPPT information on each board member in the ESR record[1] (section 3.10).
- The record retention requirements (section 3.11).
- Dispute resolution (section 3.12).
- Quality assurance over the Framework (section 4).

Ultimate accountability for adhering to this framework will reside with the chair of an NHS organisation.

Throughout this document and the associated guidance, the term ‘ESR’ refers to the FPPT data fields in ESR. It is important to note that:

- Information held in ESR about board members is accessible by a limited number of senior individuals within their own organisation only.
- There is no access to FPPT information about board members in one organisation by another organisation or individual.

ESR provides a tool for individual organisations to record that testing has been carried out for the chair, who has overall accountability for the FPPT within their organisation. It

[1] For the purpose of the FPPT framework, ‘ESR’ refers to the FPPT data fields in ESR.

also records that testing is complete and enables reports to be run at local level as an audit trail of completed testing and sign off.

ESR is not a public register – there is no access to it by the public/externally. It provides a tool to help support chairs record some of their key FPPT requirements and provides a sign-off facility in one place. It is good practice for NHS organisations to report on the high-level outcome of the FPPT assessments in the annual report or elsewhere on their websites.

3.1 FPPT overview

The duty to take account of 'fit and proper person' requirements is pervasive, continuous and ongoing. However, for the purposes of the Framework, NHS England considers it appropriate for NHS organisations to be able to consistently demonstrate, on an annualised basis, that a formal assessment of fitness and properness for each board member has been undertaken. NHS organisations should consider carrying out the assessment alongside the annual appraisal.

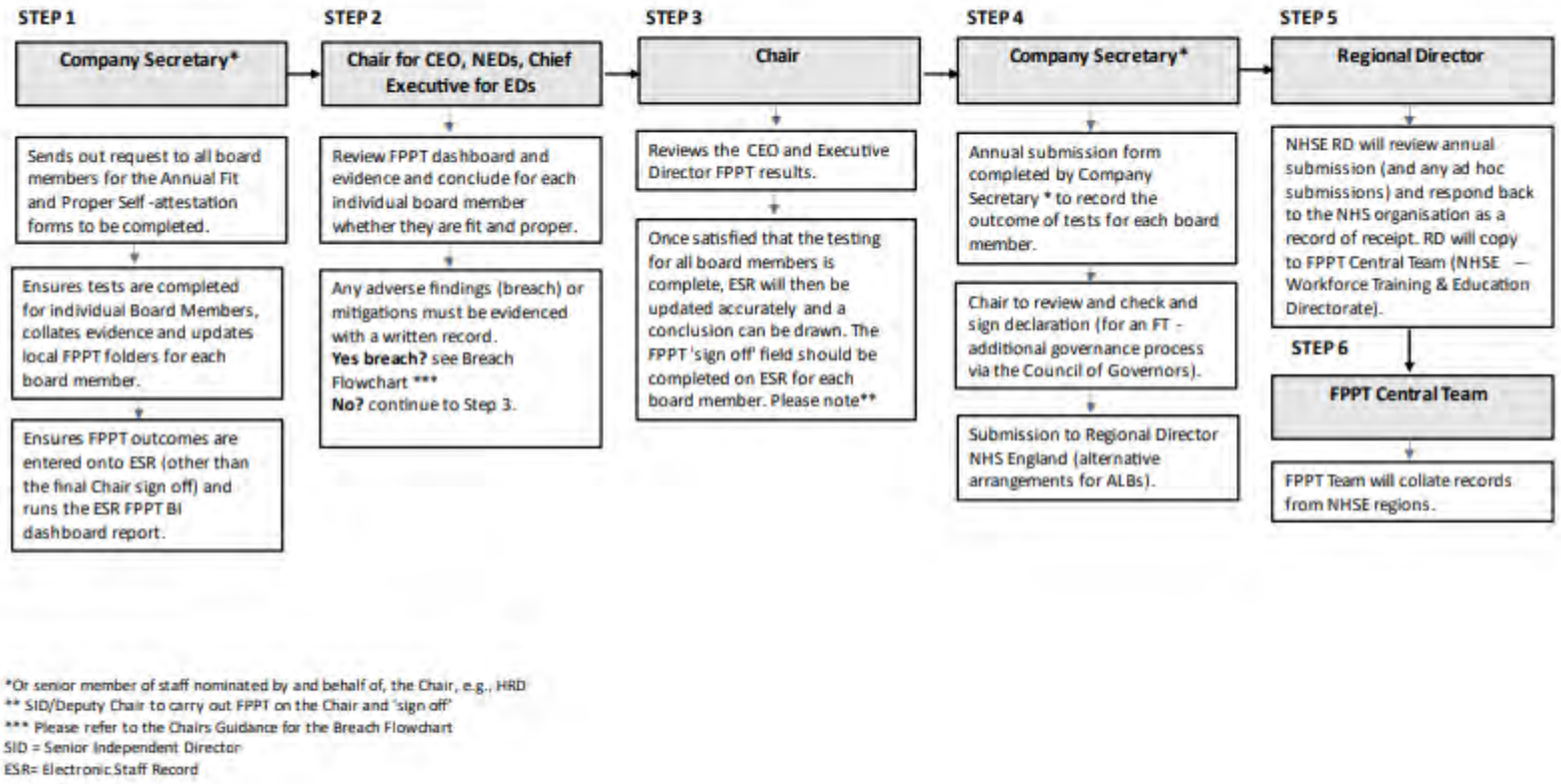
Chairs should ensure that their NHS organisation can show evidence that appropriate systems and processes are in place to ensure that all new and existing board members are, and continue to be, fit and proper (that is, the board members meet the requirement of Regulation 5), and that no appointments breach any of the criteria set out in Schedule 4 of the regulations.

Such systems and processes include (but are not limited to) recruitment, induction, training, development, performance appraisal, governance committees, disciplinary and dismissal processes.

As such, the chair in each NHS organisation will be responsible for ensuring that their organisation conducts and keeps under review a FPPT (in line with the list in section 3.2 below) to ensure board members are, and remain, suitable for their role.

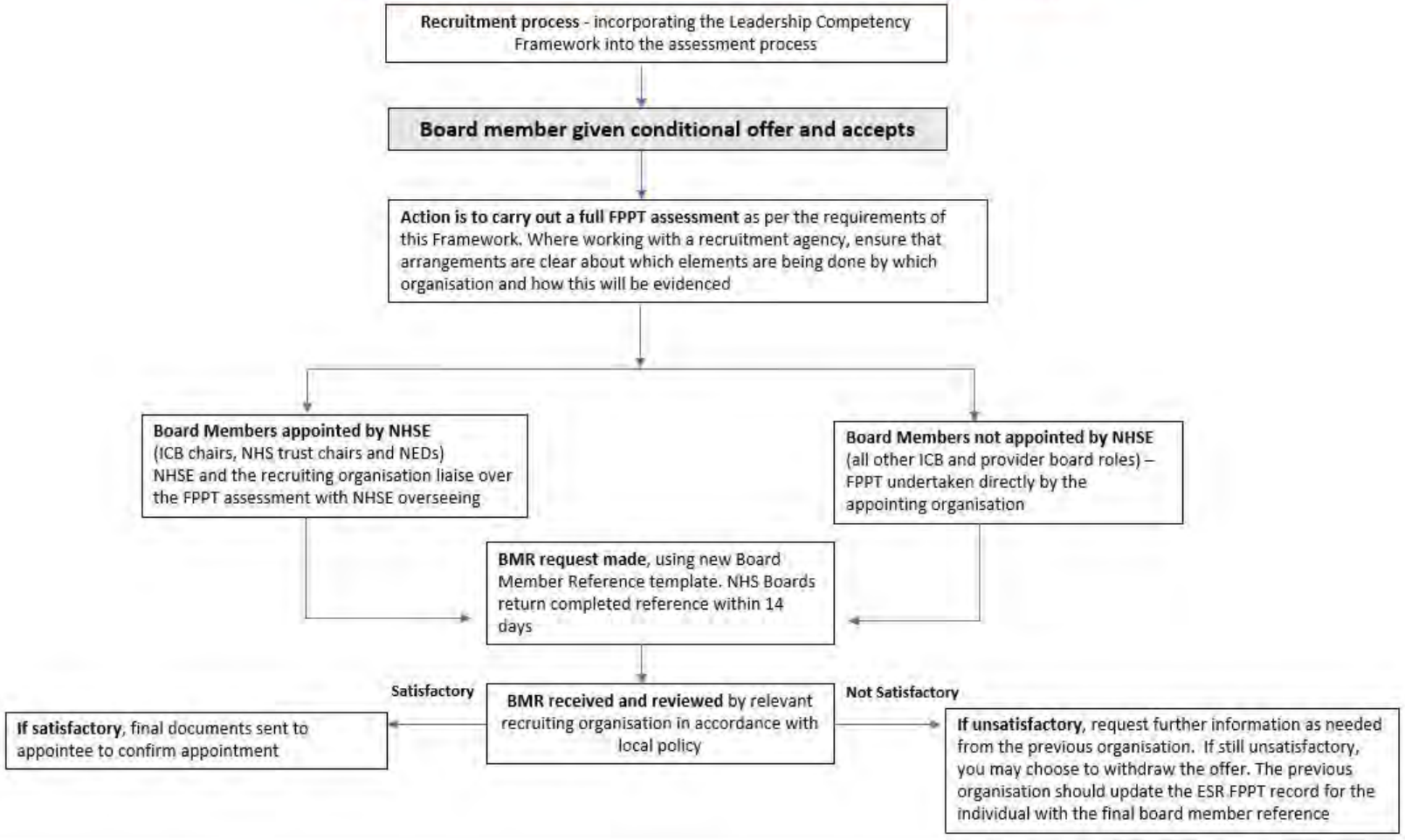
In evaluating a board member's fitness, a decision is expected to be reached on the fitness of the board member that is in the range of decisions that a reasonable person would make. NHS England recognises that chairs will need to make judgements about the suitability of board members and will support balanced judgements made in the spirit of the Framework.

The suggested approach to the assessment, including the Board Member Reference process, is set out in the three flow charts below and is also described in more detail in the supporting chairs' guidance document.

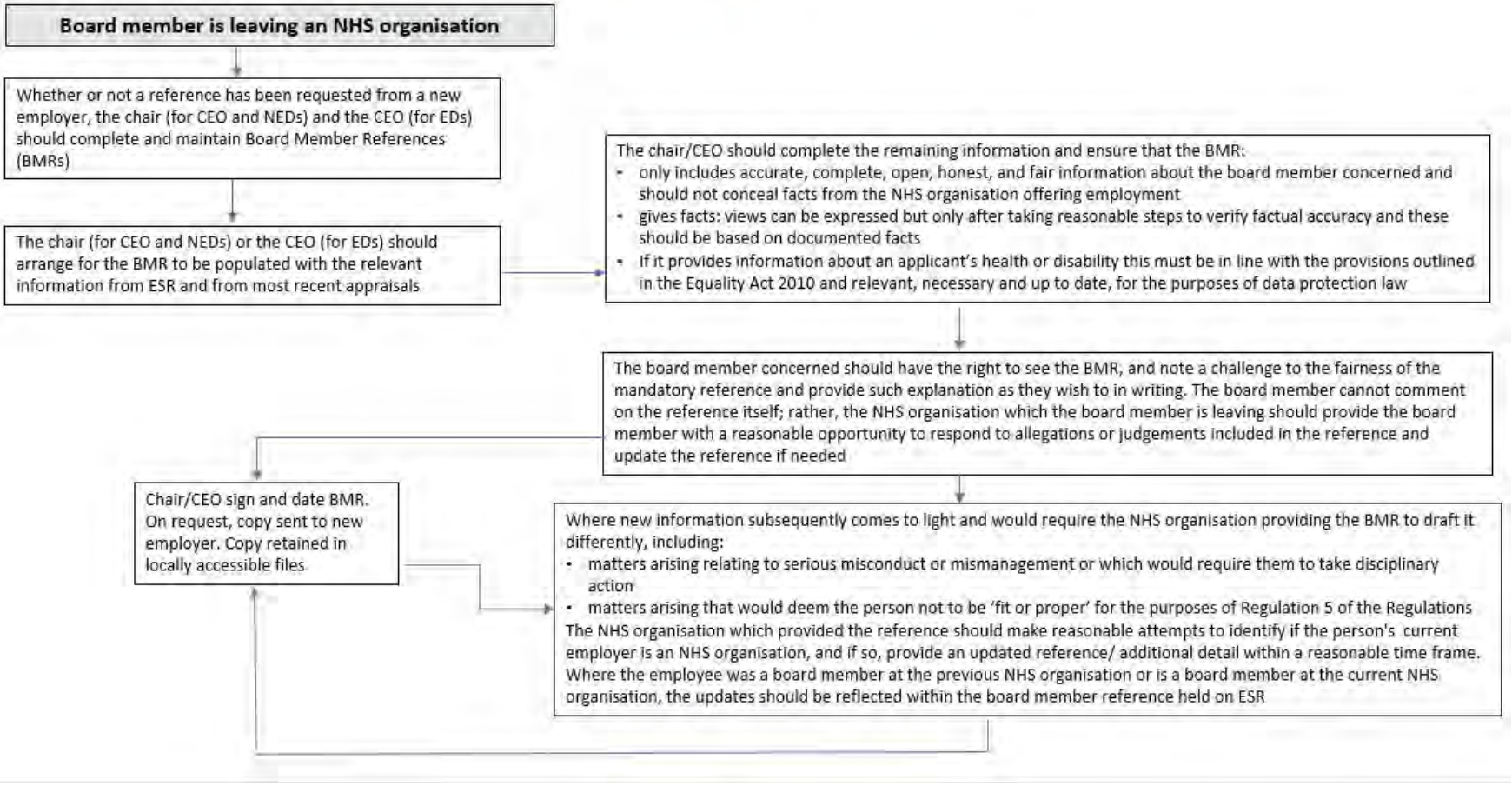


*Or senior member of staff nominated by and behalf of, the Chair, e.g., HRD
** SID/Deputy Chair to carry out FPPT on the Chair and 'sign off'
*** Please refer to the Chairs Guidance for the Breach Flowchart
SID = Senior Independent Director
ESR= Electronic Staff Record

Board Member Reference (BMR) – for appointments



Board Member Reference (BMR) – for leavers



3.2 Full FPPT assessment

A documented, full FPPT assessment – a complete assessment by the employing NHS organisation against the core elements (detailed in section 3.7) – will be needed in the following circumstances:

1. New appointments in board member roles, whether permanent or temporary, where greater than six weeks, this covers:
    a. new appointments that have been promoted within an NHS organisation
    b. temporary appointments (including secondments) involving acting up into a board role on a non-permanent basis
    c. existing board members at one NHS organisation who move to another NHS organisation in the role of a board member
    d. individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside the NHS.
2. When an individual board member changes role within their current NHS organisation (for instance, if an existing board member moves into a new board role that requires a different skillset, eg chief financial officer).
3. Annually; that is, within a 12-month period of the date of the previous FPPT to review for any changes in the previous 12 months.

Note: for points 1a, 1b and 1c above (new appointments) the full FPPT will also include a board member reference check (see section 3.9).

For points 2 and 3 above, the board member reference check will not be needed.

The exact requirements for the initial FPPT assessment versus the annual FPPT assessment thereafter are detailed in section 3.10.1.

3.3 Self-attestation

Every board member will need to complete an annual self-attestation, to confirm that they are in adherence with the FPPT requirements. Self-attestations will be a necessary step that forms a part of the full FPPT assessment (see Appendix 3).

3.4 New appointments

NHS organisations should be able to demonstrate that appointments of new board members are made through a robust and thorough appointment process.

As such, no new appointments should be made to the post of board member unless the appointee concerned can demonstrate they have met the FPPT requirements as detailed in section 3.7 of this document.

As part of conducting the initial appointment process for a board member, an inter-authority transfer (IAT)[2] could be submitted to identify any of the applicant's previous or current NHS service/employment history. Alternatively, other arrangements could be made to collate the relevant information. This should also help identify any potential duplicate employment accounts for the appointee, eg when someone has more than one NHS role on ESR.

For the initial appointment of NHS trust chairs and ICB chairs only, once the NHS organisation has obtained board member references and completed the fit and proper person assessment, FPPT approval should be sought from the NHS England Appointments Team before they commence their role.

3.5 Additional considerations

There will be additional considerations when applying the FPPT for joint appointments across NHS organisations, shared roles within the same NHS organisation and periods of temporary absence. These additional considerations have been detailed below.

3.5.1 Joint appointments across different NHS organisations

Additional considerations are needed where there are joint appointments to support closer working between NHS organisations in the health and care system.

For instance, where joint appointments of a board member can help foster joint decision-making, enhance local leadership and improve the delivery of integrated care. Joint appointments may occur where:

- two or more NHS organisations want to create a combined role

[2] An IAT is an electronic way of gathering information from an employer for an applicant's previous or current NHS service using the ESR system. How to complete an Inter Authority Transfer (IAT) check in NHS Jobs user guide (nhsbsa.nhs.uk)

- two or more NHS organisations want to employ an individual to work across the different NHS organisations in the same role.

In the scenario of joint appointments, the full FPPT would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the chair of the other contracting NHS organisation to ensure that the board member is fit and proper to perform both roles.

The host/employing NHS organisation will then provide a 'letter of confirmation' (Appendix 4) to the other contracting NHS organisation to confirm that the board member in question has met the requirements of the FPPT.

The chair of the other contracting NHS organisation has the responsibility to keep the host/employing NHS organisation abreast of changes and any matters that may impact the FPPT assessment of the board member.

Where there is a joint appointment, the host/employing NHS organisation responsible for the FPPT should also lead on conducting the joint appraisal and ensure adequate input from the other contracting NHS organisation.

Where the joint appointment results in a new board member (for the NHS organisation in question), it will constitute a new appointment and as such, the host/employing NHS organisation should provide a 'letter of confirmation' to the other NHS organisation(s).

For the avoidance of doubt, where two or more organisations employ or appoint (in the case of a chair or NED) an individual for two or more separate roles at the same time, each organisation has a responsibility to complete the FPPT.

If the FPPT assessment at one organisation finds an individual not to be FPP, the chair should update their counterpart of any other NHS organisation(s) where the individual has a board-level role and explain the reason. To note, the issue at one organisation may be one of role-specific competence, which may not necessarily mean the individual is not FPP at the other organisation.

3.5.2 Shared roles within the same NHS organisation

Where two individuals share responsibility for the same board member role (eg a job share) within the same NHS organisation, both individuals should be assessed against the FPPT requirements in line with sections 3.2 and 3.3.

3.5.3 Temporary absence

For the purpose of the FPPT process, a temporary absence is defined as leave for a period of six consecutive weeks or less (eg sick leave, compassionate leave or parental leave) and where the NHS organisation is leaving the role open for the same board member. As such there is no requirement to approve another permanent individual for the role of board member.

Where there is a temporary absence, it is expected that the HR director/company secretary will liaise with the chair and chief executive to ensure temporary cover is provided; and to ensure that local internal systems are adequately updated to record the start and projected end date of the temporary absence.

Where an individual is appointed as temporary/interim cover and is not already assessed as fit and proper, the NHS organisation should ensure appropriate supervision by an existing board member.

A full FPPT assessment should be undertaken for an individual in an interim cover role exceeding six weeks. Therefore, if the interim cover is expected to be in post for longer than six weeks, the NHS organisation should look to commence the FPPT assessment as soon as possible. Where the period of temporary absence is extended beyond six weeks, the FPPT assessment should commence as soon as the NHS organisation is aware of the extension. This FPPT assessment should be carried out in line with the requirements under section 3.2.

3.6 Role of the chair in overseeing FPPT

Chairs are accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of their NHS organisation is maintained to support an effective FPPT regime. As such, chairs' responsibilities are as below:

a) Ensure the NHS organisation has proper systems and processes in place so it can make the robust assessments required by the FPPT.

b) Ensure the results of the full FPPT, including the annual self-attestations for each board member, are retained by the employing NHS organisation.

c) Ensure that the FPPT data fields within ESR are accurately maintained in a timely manner.

d) Ensure that the board member references/pre-employment checks (where relevant) and full FPPT (including the annual self-attestation) are complete and adequate for each board member.

e) Ensure an appropriate programme is in place to identify and monitor the development needs of board members.

f) On appointment of a new board member, consider the specific competence, skills and knowledge of board members to carry out their activities, and how this fits with the overall board.

g) Conclude whether the board member is fit and proper.

h) Chairs will also complete an annual self-attestation that they themselves are in continued adherence with the FPPT requirements. On an annual basis, chairs should confirm that all board members have completed their own FPPT self-attestation and that the FPPT is being effectively applied in their NHS organisation.

i) Ensure that for any board member approved to commence work or continue in post despite there being concerns about a particular aspect of the FPPT, they document the reason(s) as to why there has been an issue about whether a board member might not be fit and proper and the measures taken to address this. A local record of this should be retained. A summary of this should also be included in the annual FPPT submission form (Appendix 5) to the relevant NHS England regional director.

Accountability for ensuring a new board member meets the FPPT assessment criteria will reside with the chair. In making such decisions the chair will be supported by existing processes and committees.

In considering their overall assessment of board members, chairs should confirm points d) and g) are adequately addressed, and where relevant for point i), appropriate action has been taken to address any concern.

It is good practice for the chair to present a report on completion of the annual FPPT in accordance with local policy, to the board in a public meeting and, where applicable, to the Council of Governors for Non-Executive Directors, for information.

3.6.1 Overseeing the role of the chair

Chairs will be subject to the same FPPT requirement, as per sections 3.2 and 3.3. In completing their own annual self-attestation, chairs will effectively be confirming that they have adequately addressed points a), b), c), e), f) and h) of section 3.6 above.

The accountability for ensuring that chairs in NHS trusts, foundation trusts and ICBs meet the FPPT assessment criteria will reside with NHS England regional directors, as is also the case for the chairs' annual appraisals.

For the chairs of NHS England and the CQC, this accountability will reside with the Department of Health and Social Care (DHSC).

Annually, the senior independent director (SID) or deputy chair will review and ensure that the chair is meeting the requirements of the FPPT.

If the SID and deputy chair are the same individual, another NED should be nominated to review the chair's FPPT on a rotational basis.

Once the NHS organisation has completed their annual FPPT assessment of the chair, they should sign this off within ESR. The annual FPPT submission, which summarises the results of the FPPT for all board members in the organisation, is then sent to the relevant NHS England regional director.

In relation to foundation trusts, there are no proposed changes to the Council of Governors' responsibilities in relation to the chair's FPPT assessment as it is not within the scope of the Framework to do so. However, as the chairs' annual appraisals are presented to the Council of Governors for information, the same should be the case for a summary of the outcome of the FPPT for non-executive board members.

This information can be retained by the Council of Governors as part of future considerations for any reappointments. Similarly, the Council of Governors should be informed of a satisfactory initial FPPT assessment for new chair and NED appointments.

3.7 FPPT assessment – core elements

This section of the Framework details the core elements that should be included in an FPPT assessment. The checks that underpin the core elements reflect the assessment criteria per Regulation 5 and Schedule 4 of the Regulations.

The full FPPT assessment will constitute an assessment against each of the core elements detailed below and should be conducted in accordance with section 3.2. Individual board members should complete self-attestations to confirm they are fulfilling the core elements of the FPPT assessment, as described below.

NHS organisations should assess board members against the following three core elements when considering whether they are a fit and proper person to perform a board role:

- Good character.
- Possessing the qualifications, competence, skills required and experience.
- Financial soundness.

Note: the FPPT checks relating to these core elements will be in addition to standard employment checks, as per the NHS organisation's recruitment and selection procedures and NHS Employers' pre-employment check standard. This can include CV checks, self-declarations, Google searches, proof of qualifications, proof of identity, right to work, etc.

The section below, which considers both Regulation 5 and Schedule 4 of the Regulations, explains matters that the NHS organisation should take account of in relation to the three core elements.

When an NHS organisation assesses a board member against these core elements in relation to being a fit and proper person, they should consider the nature, complexity and activities of their NHS organisation.

3.7.1 Good character

There is no statutory guidance as to how 'good character' in Regulation 5 of the 2014 Regulations should be interpreted. Chairs should be aware of the elements to consider when assessing good character (as detailed below).

To encourage openness and transparency, these should not be considered as a strict checklist for compliance, but rather as points for a conversation between the chair (or chief executive for executive board members) and a prospective board member during the appointment process. This will in turn emphasise the ongoing benefits of openness and transparency among board members.

When assessing whether a person is of good character, NHS organisations should follow robust processes to make sure that they gather appropriate information, and must have regard to the matters outlined in Part 1 and Part 2 of Schedule 4, namely:

- Convictions of any offence in the UK.
- Convictions of any offence abroad that constitutes an offence in the UK.
- Whether any regulator or professional body has made the decision to erase, remove or strike off the board member from its register, whether in the UK or abroad.

As such, NHS organisations should conduct:

- A search of the Companies House register to ensure that no board member is disqualified as a director.
- A search of the Charity Commission's register of removed trustees.
- A Disclosure and Barring Service (DBS) check in line with their local policy requirements:
  - each NHS organisation should outline within their local policy the relevant DBS check (basic, standard, enhanced or enhanced with barred lists) required for each individual board member role
  - in defining the required DBS level, NHS organisations should identify those board roles that fall within the definition of a 'regulated activity', as defined by the Safeguarding Vulnerable Groups Act 2006, as required barred list checks.
- A check with the relevant professional bodies where appropriate.

It is not possible to outline every character trait that a person should have, but it is expected that processes followed take account of a person's honesty, trustworthiness, reliability, integrity, openness (also referred to as transparency), respectfulness and ability to comply with the law.

Furthermore, in considering that a board member is of 'good character,' the relevant NHS organisation should also consider the following in relation to the individual in question:

- Compliance with the law and legal processes.
- Employment tribunal judgements relevant to the board member's history.

- Settlement agreements relating to dismissal or departure from any healthcare-related service or NHS organisation for any reason other than redundancy.
- A person in whom the NHS organisation, CQC, NHS England, people using services and the wider public can have confidence.
- Adherence to the Nolan Principles of Standards in Public Life.
- The extent to which the board member has been open and honest with the NHS organisation.
- Whether the person has been the subject of any adverse finding or any settlement in civil proceedings, particularly in connection with investment or other financial business, misconduct, fraud or the formation or management of a body corporate.
- Whether the person has been involved – as a director, partner or concerned in management – with a company, partnership or other organisation that has been refused registration, authorisation, membership or a licence to carry out a trade, business or profession.
- Whether the person has been a director, partner or concerned in the management of a business that has gone into insolvency, liquidation or administration while the person has been connected with that organisation or within one year of that connection.
- Whether the person involved as a director, partner or concerned with management of a company has been investigated, disciplined, censured, suspended, or criticised by a regulatory or professional body, a court or tribunal, whether publicly or privately.
- Any other information that may be relevant, such as an upheld/ongoing or discontinued (including where a board member has left the NHS organisation prior to an investigation being completed):
  - disciplinary finding
  - grievance finding against the board member
  - whistleblowing finding against the board member
  - finding pursuant to any trust policies or procedures concerning board member behaviour.

3.7.1.1 Serious mismanagement or misconduct

To comply with Regulation 5, consideration of good character should also ensure, as far as possible, the individual has not been responsible for, contributed to or facilitated any

serious misconduct or mismanagement (whether unlawful or not) in the course of delivering CQC-regulated activity, in England or equivalent activities elsewhere.

In determining what amounts to 'serious misconduct or mismanagement,' beyond the decision by a court or professional regulators regarding individuals, context is paramount. Normally these would require to be findings of serious misconduct or mismanagement that are upheld after a disciplinary process.

NHS organisations should consider the mismanagement and misconduct behaviours in relation to the services they provide, the role of the board member/individual and the possible adverse impact on the NHS organisation or confidence in its ability to carry out its mandate and fulfil its duties in the public interest.

As part of reaching an assessment as to whether any actions or omissions of the board member amount to 'serious misconduct or mismanagement', NHS organisations should consider whether an individual board member played a central or peripheral role in any wider misconduct or mismanagement.

The NHS organisation should also consider whether there are any aggravating or mitigating factors; for instance (including but not limited to):

- The extent to which the conduct was deliberate and reckless.
- The extent to which the conduct was dishonest.
- Whether the issues are frequent or have continued over a long period of time.
- If lack of experience contributed to the issue that has been remediated through training.
- The extent to which the board member (or aspirant board member) demonstrates insight and self-reflection in relation to the conduct/issues identified.

Although NHS organisations have information on when convictions, bankruptcies or similar matters are to be considered 'spent', there is no time limit for considering serious misconduct or responsibility for failure in a previous role, for the purposes of Regulation 5.

Below are some examples of misconduct and mismanagement that NHS organisations would be expected to conclude as amounting to serious misconduct or

mismanagement, unless there are exceptional circumstances that make it unreasonable to determine that there is serious misconduct or mismanagement.

It is impossible to produce a definitive list of all matters that would constitute serious misconduct or mismanagement and, as such, the list below is not exhaustive.

This list sets the minimum expectations and should be read in conjunction with local policy expectations/requirements to determine whether or not a board member has been involved in serious misconduct or mismanagement:

- Fraud or theft.
- Any criminal offence other than minor motoring offences at work (although this and the issues set out in this section may be relevant to assessing whether an individual is of good character more generally).
- Assault.
- Sexual harassment of staff.
- Bullying or harassment.
- Discrimination as per the Equality Act 2010.
- Victimisation (which falls within the scope of the Equality Act 2010) of staff who raise legitimate concerns.
- Any conduct that can be characterised as dishonest, including:
  - deliberately transmitting information to a public authority or to any other person, which is known to be false
  - submitting or providing false references or inaccurate or misleading information on a CV.
- Disregard for appropriate standards of governance, including resistance to accountability and the undermining of due process.
- Failure to make full and timely reports to the board of significant issues or incidents, including clinical or financial issues.
- Repeated or ongoing tolerance of poor practice, or failure to promote good practice, leading to departure from recognised standards, policies or accepted practices.
- Continued failure to develop and manage business, financial or clinical plans.

In assessing whether misconduct or mismanagement was ‘serious’, regard should be had to all the circumstances. For instance, an NHS organisation could consider isolated

incidences of the following types of behaviour to amount to misconduct or mismanagement that does not reach the threshold of seriousness:

- Intermittent poor attendance.
- Failure to follow agreed policies or processes when undertaking management functions where the failures had limited repercussions or limited effects or were for a benevolent or justifiable purpose.

3.7.2 Qualifications, competence, skills required and experience

NHS organisations need to have appropriate processes for assessing and checking that the candidate holds the required qualifications and has the competence, skills and experience required.

For instance, where possible, checking the websites of the professional bodies to confirm that where required the board member holds the relevant and stated qualification.

Where NHS organisations consider that a board member role requires specific qualifications (for example, the chief financial officer being an accredited accountant, or the chief medical officer being a GMC-registered doctor), they should make this clear and should only appoint those candidates who meet the required specification, including any requirements to be registered with a professional body.

As such, job descriptions and person specifications should be clear in detailing required skills and relevant qualifications and/or memberships. These should be reviewed to ensure that they are appropriate and tailored for each board role.

In assessing competence, skills and experience for the purposes of the FPPT, the NHS organisation should look to use the outcome of their appraisal processes for board members, which will be based on the NHS Leadership Competency Framework (LCF) for board level leaders: a framework that will apply to all NHS organisations.

Given the appraisal process will feed into the full FPPT assessment, the appraisal process should be of an appropriate frequency and should give due consideration to assessing good character and conduct (that is, a behavioural assessment).

The NHS LCF provides guidance for the competence categories against which a board member should be appointed, developed and appraised. The LCF covers the following six competence categories:

- Setting strategy and delivering long term transformation.
- Leading for equality.
- Driving high quality, sustainable outcomes.
- Providing robust governance and assurance.
- Creating a compassionate and inclusive culture.
- Building trusted relationships with partners and communities.

In assessing whether a board member has the competence, skills and experience to be considered fit and proper, the FPPT assessment will:

- not just consider current abilities, but also have regard to the formal training and development the board member has undergone or is undergoing
- take account of the NHS organisation (its size and how it operates) and the activities the board member should perform
- consider whether the board member has adequate time to perform and meet the responsibilities associated with their role.

Regarding formal training:

- NHS organisations should ensure any necessary training is undertaken by board members where gaps in competency have been identified.
  - As such, a tailored learning development plan and training framework should support board members.
  - Both the development plan and training should be updated and delivered respectively with an appropriate frequency.

- Training constitutes continued development for board members.
  - Those consistently failing to undergo required training in a timely manner should be deemed to have missed an important obligation, and appropriate action should be taken in line with the NHS organisation's policies and procedures.
  - In turn, this may mean that a board member is not fit and proper.

3.7.2.1 Reasonable adjustments

In assessing if a board member can properly perform tasks to the requisite level of competence and skill for the office or position for which they are appointed,

consideration will be given to their physical and mental health in accordance with the demands of the role and good occupational health practice.

This means all reasonable steps must be made to make adjustments for people to enable them to carry out their role. As a minimum, these must be in line with requirements to make reasonable adjustments for employees under the Equality Act 2010; to prevent discrimination as defined by the Act.

Hence when appointing a person to a role, NHS organisations should have processes for considering their physical and mental health in line with the requirements of the role.

As such, NHS organisations should undertake occupational health assessments (OHA) for potential new board member appointments, in circumstances where the individual in question has indicated a physical or mental health condition as part of pre-employment checks (eg medical assessment questionnaire).

The results of the OHA should be evaluated, and relevant reasonable adjustments should be made in line with the requirements under the Equality Act 2010, so an individual can carry out their role.

While the OHA will not form part of the annual FPPT, it is an integral component of the recruitment process checks to ensure that the NHS organisation can demonstrate that they have taken account of and made any such reasonable adjustments for those in board member roles. This obligation is ongoing in relation to those with disabilities for the purposes of the Equality Act 2010.

The statutory duty to make reasonable adjustments must be considered on an ongoing basis and applies where a disabled person is put at a substantial disadvantage.

3.7.3 Financial soundness

NHS organisations must seek appropriate information to assure themselves that board members do not meet any of the elements of the unfit person test set out in Schedule 4 Part 1 of the regulations.

Robust processes should be in place to assess board members in relation to bankruptcy, sequestration, insolvency and arrangements with creditors. This, as a minimum, will include search of the insolvency and bankruptcy register and checks over county court judgement (CCJ) or high court judgement for debt.

3.8 Breaches to core elements of the FPPT (Regulation 5)

Regulation 5 will be breached if:

1. A board member is unfit on the grounds of character, such as:
   - an undischarged conviction
   - being erased, removed or struck-off a register of professionals maintained by a regulator of healthcare, social work professionals or other professional bodies across different industries
   - being prohibited from holding a relevant office or position (see section 3.7.1).

2. A board member is also unfit on the grounds of character if they have been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying out a regulated activity.

3. A board member is unfit should they fail to meet the relevant qualifications or fail to have the relevant competence, skills and experience as deemed required for their role.

4. A board member is unfit on grounds of financial soundness, such as a relevant undischarged bankruptcy or being placed under a debt relief order.

5. An NHS organisation does not have a proper process in place to make the robust assessments required by the Regulations.

6. On receipt of information about a board member's fitness, a decision is reached on the board member that is not in the range of decisions a reasonable person would be expected to reach.

With regards to the above points, it is acknowledged that there could be circumstances where, for instance, board members are deemed competent but do not hold relevant qualifications.

In such circumstances there should be a documented explanation, approved by the chair, as to why the individual in question is deemed fit to be appointed as a board member, or fit to continue in role if they are an existing board member. This should be recorded in the annual return to the NHS England regional director (Appendix 5 part 2).

Furthermore, there may be a limited number of exceptional cases where a board member is deemed unfit (that is, they failed the FPPT) for a particular reason (other than qualifications) but the NHS organisation appoints them or allows them to continue their current employment as a board member.

In such circumstances there should be a documented explanation as to why the board member is unfit and the mitigations taken, which is approved by the chair. This should be submitted to the relevant NHS England regional director for review, either as part of the annual FPPT submission for the NHS organisation, or on an ad hoc basis as a case arises.

The NHS organisation shall determine breaches based on points 1 to 4, whereas any regulatory inspections, such as a CQC inspection will determine breaches of points 5 and 6.

3.9 Board member references

3.9.1 Content of the references

A standardised board member reference is being introduced to ensure greater transparency, robustness and consistency of approach when appointing board members within the NHS.

The aim of this is to help foster a culture of meritocracy, ensuring that only board members who are fit and proper are appointed to their role, and that there is no recycling of unfit individuals within the NHS.

The Leadership Competency Framework will help inform the ‘fitness’ assessment in FPPT. This is in line with the Kark Review’s (2019) recommendations on professional standards.

The Leadership Competency Framework references six competency domains which should be incorporated into all senior leader job descriptions and recruitment processes. It will also form the core of board appraisal frameworks, alongside appraisal of delivery against personal and corporate objectives.

The competency domains in the Leadership Competency Framework should be taken into account when the board member reference is written. It is recognised that no board director will be able to demonstrate how they meet all the competencies in the framework. What is sought as part of the board member reference is evidence of broad

competence across each of the six competency domains, and to ensure there are no areas of significant lack of competence which may not be remedied through a development plan.

Board level leaders will be asked to attest to whether they have the requisite experience and skills to fulfil minimum standards against the six competency domains. This attestation will be reviewed by the board director's line manager and overseen by the organisation's chair. The attestation record will be captured on ESR.

The annual attestation by board members is expected to be undertaken at the same time as the annual appraisal process and assessment of competence against the six competency domains will also be used to guide the board member's development plan for the coming year. The line manager will also capture stakeholder feedback as part of the appraisal process and summarise competence against each of the six competency domains. (A board member appraisal framework will be published ahead of the 2023/2024 appraisal process to support this process.) The annual appraisals of the past three years will then be used to guide the board member's reference.

NHS organisations will need to request board member references, and store information relating to these references (see section 3.10) so that it is available for future checks; and use it to support the full FPPT assessment on initial appointment.

NHS organisations should maintain complete and accurate board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and board member references should be retained locally.

Board member references will apply as part of the FPPT assessment when there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:

a. New appointments that have been promoted within an NHS organisation.
b. Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.
c. Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside of the NHS.

d. Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

It is important that board member references checks are carried out in accordance with the data protection principles, as set out within data protection law. In particular, the process should be undertaken fairly, and the information generated should be accurate and up to date.

Requests for board member references should not ask for specific information on whether there is a settlement agreement/non-disclosure agreement in place.

The board member reference request instead asks for any further information and concerns about an applicant's fitness and propriety, relevant to the FPPT to fulfil the role as a director, be it executive or non-executive.

Information on settlement agreements should be retained locally (where applicable) and included in the overall consideration of the fit and proper status of the individual in question.

If there is a historical settlement agreement/non-disclosure agreement already in place which includes a confidentiality clause, NHS organisations should seek permission from all parties prior to including any such information in a board member reference.

Going forward, NHS organisations should consider inclusion of a term in any proposed settlement agreement to state that information about the settlement agreement can be included in ESR, and in doing so will not be a breach of confidence.

The existence of a settlement agreement does not, in and of itself determine that a person is not fit or proper to be a board member.

The board member reference is based on the standard NHS reference and includes additional requests for information as follows (relevant to the FPPT):

- Information regarding any discontinued, outstanding, or upheld complaint(s) tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the organisation's policies and procedures (for example, under the trust's equal opportunities policy).

- Confirmation of any discontinued, outstanding or upheld disciplinary actions under the trust's disciplinary procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct.

- Any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the FPPT to fulfil the role as a director, be it executive or non-executive.

Discontinued investigations are included in the reference request to identify issues around serious misconduct and mismanagement and to deliberately separate them from issues around qualifications, competence, skills, and experience (which it is believed can be remedied) and health (which it is believed can improve), unless such competence and/or health issues could potentially lead to an individual not meeting the requirements of the FPPT.

Investigations (irrespective of reason for discontinuance) should be limited to those which are applicable and potentially relevant to the FPPT, and examples are as follows (this is not an exhaustive list and consideration will be needed on a case-by-case basis):

- Relating to serious misconduct, behaviour and not being of good character (as described in the FPPT Framework).
- Reckless mismanagement which endangers patients.
- Deliberate or reckless behaviour (rather than inadvertent behaviour).
- Dishonesty.
- Suppression of the ability of people to speak up about serious issues in the NHS, eg whether by allowing bullying or victimisation of those who speak up or blow the whistle, or any harassment of individuals.
- Any behaviour contrary to the professional Duty of Candour which applies to health and care professionals, eg falsification of records or relevant information.

The reason for discontinuing (including not commencing) an investigation should be recorded, including whether an investigation was not started or stopped because a compromise, confidentiality or settlement agreement was then put in place (recognising that such an agreement is not necessarily a conclusion that someone is not fit and proper for the purposes of the FPPT).

It will be necessary as a matter of fairness for the employee to have had an opportunity to comment on information that is likely to be disclosed as part of any reference request i.e., as part of any disciplinary procedures/action. NHS organisations should develop local policy about who provides references, when they are provided and what will/will not be included.

NHS organisations should take any advice that they deem necessary in an individual case where they have assessed that the employee or prospective employer is likely to bring a claim.

3.9.2 Obtaining references

At least one board member reference should be obtained when an NHS organisation is appointing a board member.

- For board members:
  - An NHS organisation should obtain a minimum of two board member references (using the board member reference template) where the individual is from outside the NHS, or from within the NHS but moving into the board role for the first time.
  - These two references should come from different employers, where possible.

- For an individual who moves from one NHS board role to another NHS board role, across NHS organisations:
  - Where possible one reference from a separate organisation in addition to the board member reference for the current board role will suffice.
  - This is because their board member reference template should be completed in line with the requirements of the framework so that NHS organisations can maintain accurate references when a board member departs.

- For a person joining from another NHS organisation:
  - The new employing/appointing NHS organisation should take reasonable steps to obtain the appropriate references from the person's current employer as well as previous employer(s) within the past six years.
  - These references should establish the primary facts as per the board member reference template.

- Where an employee is entering the NHS for the first time or coming from a post which was not at board member level:

- The new employing NHS organisation should make every practical effort to obtain such a reference which fulfils the board member reference requirements.
- In this scenario, the NHS organisation will determine their own reasonable steps to satisfy themselves they have pursued relevant avenues to obtain the information on potential incoming individuals through alternative means.
- For example, if a chief financial officer is joining from financial services, they can check the financial services register, or request for a mandatory reference under the financial services regulations.

It is acknowledged that where the previous employer is not an NHS organisation, there may be greater difficulty in obtaining a standardised NHS board member reference.

Nonetheless, for new appointments from outside of the NHS, employers should seek the necessary references to validate a period of six consecutive years of continuous employment (or provide an explanation for any gaps), or training immediately prior to the application being made.

In such cases where references from previous employers are unattainable for the previous six years, additional character or personal references should be sought. Character and personal references should be sought from personal acquaintances who are not related to the applicant, and who do not hold any financial arrangements with that individual.

References should never be used as the sole grounds for assessing an applicant's suitability for a post. Where negative issues are included in a reference, information should be carefully considered and weighed up against the wider range of evidence gathered as part of the recruitment process.

NHS organisations should aim to investigate negative information by sensitively raising it with the individual concerned, giving them the opportunity to explain the situation in more detail and/or, where appropriate, give them a chance to outline any learning from past mistakes or experiences to obtain the necessary assurances about their suitability for a role.

If a reference reveals something which is incompatible with the requirements of Regulation 5 of the Regulations, the individual should not be appointed to the role.

An NHS organisation should obtain references before the start of the board member's appointment. The NHS organisation requesting the reference should make it clear that this is being requested in relation to a person being appointed to the role of board member, or for other purposes linked to the board member's current employment.

The obligation to obtain a reference for a potential candidate for employment/ appointment in the role of board member applies irrespective of how the previous employment ended, for instance, resignation, redundancy, dismissal or fixed term work or temporary work coming to an end.

Where a potential candidate for employment/appointment in the role of board member has a gap between different employments, all reasonable efforts should be made to ensure that references covering those periods/gaps are obtained.

References should be obtained in writing (either via hardcopy or email) and NHS organisations will need to satisfy themselves that both the referee and the organisation are bona fide.

From time to time the information provided in a reference may contradict the information provided by board members.

There may be a reasonable explanation for apparent discrepancies and NHS organisations should proceed sensitively to seek the necessary assurances directly with the board member. In exceptional circumstances where there is serious misdirection, employers may feel it appropriate to report their concerns to the NHS Counter Fraud Authority.

Where an NHS organisation is unable to fully evidence that the incoming board member is fit and proper because of gaps in the board member reference, they may continue to hire the individual but should clearly document within ESR the gaps in relation to the board member reference and the reasons/mitigations for being comfortable with employing/appointing the board member.

In this scenario, the employing NHS organisation also should be able to demonstrate that they have exercised all reasonable attempts to obtain the missing information.

3.9.3 Providing references

An NHS organisation should aim to provide a reference to another NHS organisation within a 14-day period, which starts from the date that the reference request was

received. However, it should be acknowledged thar there are occasions of exceptional circumstances, and references may take more than 14 days to provide.

The references referred to above are for a request made in relation to the individual being appointed to the role of board member, or for other purposes linked to the board member's current employment.

Where a current board member moves between different NHS organisations, a board member reference form following a standard format (Appendix 2) should be completed by the employer and signed off by the chair of that NHS organisation.

The previous NHS organisation should provide information in relation to that which occurred:

- in the six years before the request for a reference
- between the date of the request for the reference and the date the reference is given
- in the case of disciplinary action, serious misconduct and/or mismanagement at any time (where known).

NHS organisations should also consider when providing the reference:

- That the process captures accurate, complete, open, honest and fair information about the board member concerned.
  - As such, references should not conceal facts from the NHS organisation offering employment.
- References should give established facts that are part of the history of the person.
  - It is unfair to give partial facts if those result in the offer being withdrawn, for example where this causes the recipient NHS organisation to assume the information is missing because it is negative, so the offer is withdrawn.
  - Views can be expressed but only after taking reasonable steps to verify factual accuracy and should be based on documented facts.
- The reference should be fair, such that the employee concerned should have the right to note a challenge to the fairness of the mandatory reference and provide such explanation as they wish to in writing.
  - This does not mean that the board member can comment on the reference itself; rather, that the NHS organisation (which the board member is leaving)

has provided those board members with a reasonable opportunity to respond to allegations or judgements upon which the reference is based.

  - Hence a board member's opinions are not required to be included within the reference, but should be appropriately considered when drafting them.
  - Where the NHS organisation providing the reference has not offered the employee the opportunity to previously (at the time the matter occurred) comment on the allegation, they ought to do so before including that allegation within the reference, rather than leaving the allegation out of the reference.
- Where the reference provides information about an applicant's health or disability this must be in line with the provisions outlined in the Equality Act 2010 and be relevant, necessary, and up to date, for the purposes of data protection law.

3.9.4 Revising references

If an NHS organisation has provided a reference to another NHS organisation about an employee or former employee, and has subsequently:

- become aware of matters or circumstances that would require them to draft the reference differently
- determined that there are matters arising relating to serious misconduct or mismanagement
- determined that there are matters arising which would require them to take disciplinary action
- concluded there are matters arising that would deem the person not to be 'fit or proper' for the purposes of Regulation 5 of the Regulations,

the NHS organisation that provided the reference should make reasonable attempts to identify if the person's[3] current employer is an NHS organisation and, if so, provide an updated reference/additional detail within a reasonable timeframe.

Where the employee was a board member at the previous NHS organisation or is a board member at the current NHS organisation, the updates should be reflected within the board member reference.

[3] For the avoidance of doubt, this refers to executive board members employed by an NHS organisation and non-executive board members who have been appointed.

Revised references between NHS organisations should cover a six-year period from the date the initial board member reference was provided, or the date the person ceased employment with the NHS organisation, whichever is later. The exception to this are matters that constitute serious misconduct or mismanagement: details of such events should be provided irrespective of time period.

3.9.5 Board member reference template

The board member reference template provided should be used by NHS organisations.

This Framework, along with the board member reference template, sets out the minimum requirements for a reference. An NHS organisation can provide information in relation to additional matters if it deems it necessary to do so.

If references are provided for the role of board member, or for other purposes linked to the board member's current employment, the NHS organisation providing the reference should look to complete all sections of the template even where the NHS organisation requesting the reference does not specifically ask for it.

As mentioned previously, NHS organisations should maintain board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer.

Therefore, the template should be completed, and retained locally in an accessible archive, for departing board members even where they have indicated they are moving onto a non-NHS role and/or performing a role that is not on the board, or where they have indicated they are to retire.

Often in these circumstances the individual may go on to act in the capacity of a board member at a future date, even if it is just on a temporary basis, for example to cover staff shortages.

3.10 Electronic Staff Record (ESR)

NHS Business Services Authority (NHSBSA) hosts ESR on behalf of the NHS, as commissioned by the Department for Health and Social Care.

New data fields in ESR will hold individual FPPT information for all board members operating in the NHS and will be used to support recruitment referencing and ongoing development of board members. The FPPT information within ESR is only accessible within the board member's own organisation and there is no public register.

ESR will hold information about each board member in line with the criteria detailed below in section 3.10.1.

NHS England will use its network of regional directors in a direct oversight role to ensure that individual NHS organisations (within the designated regions) are completing their FPPT, via annual submissions to the NHS England regional directors.

The CQC will continue in its regulatory role and as such may determine that reviews are required over the data integrity and controls that a particular NHS organisation has in relation to the records held in ESR.

There should be limited access to ESR in accordance with local policy and in compliance with data protection law. It is reasonably expected that the following individuals have access to the FPPT fields in ESR:

- chair
- chief executive officer (CEO)
- senior independent director (SID)
- deputy chair
- company secretary
- human resources director (HRD)/chief people officer (CPO).

Access will also be provided to relevant individuals within the CQC at a local level, where this information is necessary for their roles, noting the CQC's ability to require information to be provided to it under Regulation 5(5) of the Regulations.

The ESR FPPT data fields need to be maintained to ensure information about the serving board member is current. This will mean that ESR is specifically updated for:

- all board members within an NHS organisation
- new board members who have been appointed within an NHS organisation
- whenever there has been a relevant change to one of the fields of FPPT information held in ESR (as per section 3.10.1 below)
- updates for annual completion of the full FPPT
- annual completion of FPPT confirmed by chairs.

It will be the responsibility of each NHS organisation to ensure that ESR remains current and is updated for relevant changes in a timely manner. As a minimum it is expected

that each NHS organisation conducts an annual review to verify that ESR is appropriately maintained.

The chair will be accountable for ensuring that the information in ESR is up to date for their organisation.

NHS organisations will need to establish policies and procedures for collating the relevant information in an accurate, complete and timely manner for updating ESR.

NHS organisations will need to establish a process for individuals to access and exercise their rights in connection with the information held about them, in accordance with the requirements of data protection law.

3.10.1 Information held in ESR

The information that ESR will hold about board members is detailed below and also summarised in the FPPT checklist.

The supplementary guidance document provides specific step-by-step instructions for NHS organisations to update and maintain ESR.

The FPPT assessment on initial appointment of a board member will cover all points mentioned below:

- First name*
- Second name/surname*
- Organisation* (that is, current employer)
- Staff group*
- Job title* (that is, current job description)
- Occupation code*
- Position title*
- Employment history:*
  - This would include detail of all job titles, organisation departments, dates, and role descriptions.
  - Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, would not need to be explained.
- Training and development
- References:*

  - Available references from previous employers, board member references, including resignations or early retirement.
- Last appraisal and date
- Disciplinary findings
  - That is, any upheld finding pursuant to any trust policies or procedures concerning employee behaviour, such as misconduct or mismanagement, this includes grievance (upheld) against the board member, whistleblowing claims against the board member (upheld) and employee behaviour upheld finding.
- Any ongoing and discontinued investigations relating to Disciplinary/ Grievance/Whistleblowing/Employee behaviour should also be recorded.
- Type of DBS disclosed* †
- Date DBS received* †
- Disqualified directors register check
- Date of medical clearance* (including confirmation of OHA)
- Date of professional register check (eg membership of professional bodies)
- Insolvency check
- Self-attestation form signed
- Social media check
- Employment tribunal judgement check
- Disqualification from being a charity trustee check
- Board member reference*
- Sign-off by chair/CEO.

It should also be noted that the national insurance number is an additional check where there may have been a change of name highlighted in the initial or annual assessment.

The annual FPPT requires an NHS organisation to validate all fields above – except for:

* Fields marked with an asterisk (*) – these do not require validation as part of the annual FPPT unless a specific reason arises. However, these fields should still be updated in the event of a change to the information held.

† While not requiring annual validation, DBS checks will be done on a three-year cycle.

3.11 Record retention

The ESR FPPT data fields will retain records of completed tests to support the FPPT assessments. All supporting documents/records in relation to the FPPT will be held locally by each individual NHS organisation.

As such, an NHS organisation should establish, implement and maintain adequate policies and procedures to comply with GDPR and the NHS Records Management Code of Practice.

The NHS Records Management Code of Practice sets out expectations in relation to retaining actual staff documents/records for a period of six years.

However, NHS organisational case documents/records may be retained for longer than the standard six years, based on the facts of the case. This will be a local decision for each NHS organisation.

When determining how long to retain documents/records in relation to disciplinary and similar cases and where applicable, NHS organisations should make an assessment as to the severity of the misconduct and/or mismanagement and its impact to the FPPT. The more serious the issue the longer the retention period should be.

In relation to ESR, the information and accompanying references should be kept career long, which at a minimum should be until the 75th birthday of the board member.

3.12 Dispute resolution

1. Data and information

Where a board member identifies an issue with data held about them in relation to the FPPT, they should request a review which should be conducted in accordance with local policies in the first instance.

Where this does not lead to a satisfactory resolution for the board member, the following options are available:

- For NHS England-appointed board members (NHS trust chairs and NEDs and ICB Chairs) – the matter should be escalated to the NHS England Appointments Team.
- For chairs not appointed by NHS England – a further request for review can be made to the SID or deputy chair who would establish a process proportionate to

the matter being considered; for example, establishing a panel with at least one independent member.

- For all other board members (including NHS England-appointed board members, and chairs not appointed by NHS England where the above processes have not led to a satisfactory conclusion), the options could include:
  - referring the matter to the ICO
  - (For executive director roles only*) taking the matter to an employment tribunal (ET)
  - instigating civil proceedings.

2. Outcome of FPPT assessment

Where a board member disagrees with the outcome of the FPPT assessment and they have been deemed ‘not fit and proper,’ the following options are available:

- For NHS England-appointed board member roles – the matter should be escalated to the NHS England Appointments Team for investigation in accordance with extant policy and procedure.
  - Where this results in a board member being terminated from their appointed role, a BMR** must be completed and retained by the local organisation in accordance with the Framework.
- For non-NHS England-appointed roles (executive and non-executive) – local policy and constitution arrangements should be followed first.
  - NHS organisations may wish to take their own legal advice or seek advice from NHS England.

At any point, employees have the right to take the matter to an ET*.

* Chair and non-executive board members cannot take their organisation to ET unless in relation to discrimination, but they can instigate civil proceedings.

** Exit BMR to be drafted by local chair for non-executive directors [NEDs] (with support from the NHS England Appointments Team), and by the NHS England Appointments Team for chairs.

Section 4: Quality assurance and governance

To ensure that the FPPT is being adequately embedded within NHS organisations there will need to be quality assurance checks conducted by the CQC, NHS England and an external/independent review. The quality assurance checks over the various parts of the FPPT Framework have been detailed below.

4.1 CQC quality assurance

The CQC's role is to ensure NHS organisations have robust processes in place to adequately perform the FPPT assessments, and to adhere to the requirements of Regulation 5 of the Regulations. As such, as part of the Well Led reviews, CQC will consider the:

- quality of processes and controls supporting the FPPT
- quality of individual FPPT assessments
- board member references, both in relation to the new employing NHS organisation but also in relation to the NHS organisation which wrote the reference
- collation and quality of data within the database and local FPPT records.

In doing so the CQC will have regard to the evidence that exists as to whether the board members meet the FPPT. For example, this includes, but is not limited to, checking the following forms of evidence:

- That the NHS organisation in question is aware of the various guidelines on recruiting board members and that they have implemented procedures in line with this best practice.
- Personnel files of recently appointed board members (including internal appointments of existing staff).
- Information or records relating to appraisals for board members.
- References and personal development plans.

The CQC may intervene where there is evidence that proper processes have not been followed or are not in place for FPPT. While the CQC does not investigate individual board members, it will pass on all information of concern that is received about the fitness of a board member to the relevant NHS organisation.

The CQC will notify NHS organisations of all concerns relating to their board member and ask them to assess the information received. The board member to whom the case refers will also be informed.

NHS organisations should then detail the steps they have taken to assure the fitness of the board member and provide the CQC with a full response within 10 days. The CQC will then carefully review and consider all information.

Where the CQC finds that the NHS organisation's processes are not robust, or an unreasonable decision has been made, they will either:

- contact the NHS organisation for further discussion
- schedule a focused inspection
- take regulatory action in line with their enforcement policy and decision tree if a clear breach of regulation is identified.

4.2 NHS England quality assurance

NHS England will have oversight through receipt and review of the annual FPPT submissions to the relevant NHS England regional director from NHS organisations.

4.3 Internal audit/external review

Every three years, NHS organisations should have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments. The internal audit should include sample testing of FPPT assessment and associated documentation.

NHS organisations should consider inclusion of FPPT process and testing in the specification for any commissioned Well-Led/board effectiveness reviews.

4.4 Governance

For good governance, organisations should be clear about the reporting arrangements across the FPPT cycle. This is likely to include:

- an update to a meeting of the board in public to confirm that the requirements for FPPT assessment have been satisfied at least annually
- consideration by the Audit Committee, for example where there is a related internal or external audit review included in the audit programme

- relevant information to the Council of Governors (CoG) in an NHS foundation trust as described in section 4.5 below.

4.5 NHS foundation trusts – appointment and removal of the chair and non-executive directors

The document 'Your statutory duties- A reference guide for NHS foundation trust governors' refers to the role of the CoG in appointing and removing the chair and NEDs. The FPPT Framework should be considered alongside this document and the local trust constitution. The CoG in an NHS foundation trust:

- Should continue to make chair and NED appointments in accordance with their statutory duties and local constitution. These continue to be subject to satisfactory recruitment checks, and this will now include consideration of the initial FPPT assessment.
- Should continue to '…receive performance information for the chair and other non-executive directors as part of a rigorous performance appraisal process …' in accordance with their local constitution. Performance appraisals will now include application of the LCF in accordance with the Framework.
- Should be advised of any outcome from a non-executive board member (including the chair) FPPT assessment as 'not fit and proper.' Dependent on the circumstances and in accordance with the local constitution, the CoG would be involved as appropriate with any subsequent removal process, where applicable.

The CoG should receive support from the SID and/or the company secretary and use the governance arrangements already in place in their trusts, such as the nomination committee.

4.5 Integrated care boards

ICBs should apply the Framework alongside relevant statutory requirements and the existing requirements of their organisation's constitution.

APPENDIX B

New starter/annual NHS FPPT self-attestation

Every board member should complete the template (over the page) annually and this attestation should be submitted to the company secretary on behalf of the chair.

Fit and Proper Person Test annual/new starter* self-attestation

Lancashire Teaching Hospitals NHS Foundation Trust

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years:
  - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

Appendix C: The board member reference template

Board Member Reference

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

[Date]

Human resources officer/name of referee

Recruitment officer

External/NHS organisation receiving request

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants:

To be used only AFTER a conditional offer of appointment has been made.
Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.

1. Name of the applicant (1)	
2. National Insurance number or date of birth	

3. Please confirm employment start and termination dates in each previous role

A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)
B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)

Job Title:
From:
To:

Job Title
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A):

(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)

5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board*	Starting:	Current:

positions applied for)		
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		
7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		

9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)		
Date DBS check was last completed.	Date	
Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		
11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □
Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other	Yes □	No □

matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)		
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS** • **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		

14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12)

Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Appendix D

Lancashire Teaching Hospitals
NHS Foundation Trust

Equality, Diversity & Inclusion Impact Assessment Form

Department/Function	Corporate			
Lead Assessor	Jennifer Foote			
What is being assessed?	Code of Business Conduct			
Date of assessment	March 2023			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☐
	Service Users	☐	Staff Inclusion Network/s	☐
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☐
	Please give details: None – N/A			

1) What is the impact on the following equality groups?			
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups		**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments:** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?	
Race (All ethnic groups)	Neutral		
Disability (Including physical and mental impairments)	Neutral		
Sex	Neutral		
Gender reassignment	Neutral		
Religion or Belief (includes non-belief)	Neutral		
Sexual orientation	Neutral		
Age	Neutral		
Marriage and Civil Partnership	Neutral		
Pregnancy and maternity	Neutral		

Other (e.g. caring, human rights, social)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	N/A

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

ACTION PLAN SUMMARY

Action	**Lead**	**Timescale**

HOW THE NHS CONSTITUTION APPLIES TO THIS DOCUMENT

WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? **Click here for guidance on Principles**	Tick those which apply	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? **Click here for guidance on Pledges**	Tick those which apply
1. The NHS provides a comprehensive service, available to all.	☐	1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.	x
2. Access to NHS services is based on clinical need, not an individual's ability to pay.	☐	2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.	☐
3. The NHS aspires to the highest standards of excellence and professionalism.	x	3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.	☐
4. The patient will be at the heart of everything the NHS does.	☐	4. Provide support and opportunities for staff to maintain their health, wellbeing and safety.	☐
5. The NHS works across organisational boundaries.	☐	5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.	☐
6. The NHS is committed to providing best value for taxpayers' money.	☐	6. To have a process for staff to raise an internal grievance.	☐
7. The NHS is accountable to the public, communities and patients that it serves.	x	7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.	☐

WHICH AIMS OF THE TRUST APPLY? **Click here for Aims**	Tick those which apply	WHICH AMBITIONS OF THE TRUST APPLY? **Click here for Ambitions**	Tick those which apply
1. To offer excellent health care and treatment to our local communities.	☐	1. Consistently deliver excellent care.	x
2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria.	☐	2. Great place to work.	☐
3. To drive innovation through world-class education, teaching and research.	☐	3. Deliver value for money.	☐
		4. Fit for the future.	x

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Data Quality Assurance Report							
Report to:	Board			**Date:**	5 October 2023		
Report of:	Chief Information Officer			**Prepared by:**	D Hudson, T Caton		
Part I	√			**Part II**			
Purpose of Report							
For assurance	☐	**For decision**	☐	**For information**	☒		

Executive Summary:

The purpose of this report is to inform the Board in relation to current data quality assurance activities and provides an update in relation to data quality performance.

The Report details performance in relation to:

- Data Quality Team activities
- Update in relation to Data Quality Risks
- Waiting List Minimum Dataset Data Quality
- National Data Quality Assurance Dashboard and Maturity Index
- External Data Quality Assurance actions

The Board is asked to note current Data Quality Assurance activities and the on-going developments that support further improvements to data quality assurance processes and data quality clinical engagement.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☐
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Data Quality Assurance Update Report

1. Background/Context

The benefits of using routine health care data for planning, policy making, and research, future demand, and quality of service are well established. Using data for these purposes requires that data is high quality, timely, complete and accurately coded. As part of Board Assurance and in response to actions identified in the Trusts Well Led Review this paper sets out the effective processes used to monitor, manage and report on the quality of data.

This report provides an overview of current data quality assurance activities within the Trust to assure the quality of data used for reporting.

Introduction

Data quality is defined as the state of accuracy, completeness, reliability, validity, timeliness and systemic consistency that makes data fit for purpose. Acceptable data quality is crucial to operational processes and to the reliability of Trust performance reporting. The use of high quality information leads to better decision making to improve patient care and safety.

Poor data quality puts organisations at significant risk in terms of damaging stakeholder trust, weakening frontline service delivery, incurring financial loss, poor forward planning and poor value for money.

Data Quality Assurance (DQA) compliments and underpins the principles of Information, Clinical, Research and Corporate Governance, which ensure that personal data is dealt with legally, securely and efficiently, in order to deliver the best possible care. The current climate of scrutiny from audit bodies and the Information Commissioner's Office enforces the requirement, with significant risk of potential fines for non-compliant practice.

This paper sets out actions to date undertaken to maintain data quality standards within the Trust.

2. Discussion

Internal and External Scrutiny

Information Governance

Information Governance (IG) is the way in which the NHS handles all organisational information - in particular the personal and sensitive information of patients and employees. Information Governance provides a framework that ensures information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care. The DQA team continues to undertake data quality assurance initiatives to support IG compliance and the delivery of quality assured data collection and collation processes.

The data quality assertion of the 'Data Protection and Security Toolkit' (1.7 – effective data quality controls are in place) has been completed for the 2023 baseline submission and evidence supplied. The MIAA overall assurance level across all standards was rated as **significant assurance**.

Data Quality Assurance Activities

Harris Flex (previously Quadramed) Masterfile Maintenance

The Trust is working with Harris Flex CPR to implement a programme of work to update all Commissioner allocation master files to the latest version available. This includes:

- Postcode
- GP and Practice
- Health Authority
- Clinical Commissioning Groups (CCG's)

Work remains ongoing on Harris Flex Test system to finalise robust process to ensure Flex reference tables are consistent with national standards and incorporate the latest available updates. The work is monitored through the Harris Flex Customer Care Board as appropriate. The work of the group will seek to minimise system data quality risks as well as improve SUS activity reporting. It is expected that once the work is complete quarterly updates to masterfiles will move into business as usual process.

This will address the issues raised in Risk 54 GP Masterfile maintenance on Harris Flex.

Secondary Uses - Completeness & Validity Audits

Part of the rolling audit programme is review of patient casenotes and assessment against the HSCIC – NHS Information Governance – Data Output Quality Standards. This details the minimum standards of completeness and validity across a range of key demographic and activity driven data items.

However due to the continued pressures following the COVID pandemic and the increase in volumes of validations and change to documentation processes and priorities the programme continues to be on hold.

Shared Care Record - SCR (formerly Lancashire Person Record Exchange Service (LPRES)) – update

The SCR project aims to establish data interoperability across the health and social care system in Lancashire. The process allows the exchange of personal identifiable data, including discharge summaries, PACS images, patient care summaries, medication information and clinical correspondence.

Currently the following documents are being transferred electronically direct to GP systems within the North West Region catchment area: -

- Immediate Hospital Discharge Information produced from Flex CPR
- Trauma & Orthopaedic, Colposcopy and Colorectal clinic letters
- Advice & guidance documents
- GP Patient Death Notifications

The DQA team monitor rejected records, updating patient details where necessary and ensuring timely receipt of clinical information. Rejected records are resent either electronically to the correct practice following review and update on Harris Flex or printed and posted if the practice is not part of SCR.

The table below shows a summary of records transferred via SCR for the GP practices April 2023 – August 2023.

Month	Total Records Sent	Total Rejected	% of records	No. EMIS issue	No. True Rejections (inc NOP, dupes etc)	True rejections as a % of all records sent	True rejections as a % of rejected records
April	23130	714	3.09%	103	611	2.64%	85.57%
May	25267	570	2.26%	25	545	2.16%	95.61%
June	26121	672	2.57%	56	616	2.36%	91.67%
July	25443	613	2.41%	30	583	2.29%	95.11%
August	24260	544	2.24%	21	523	2.16%	96.14%
Total	**124221**	**3113**	**2.51%**	**235**	**2878**	**2.32%**	**92.45%**

Rejection Reasons:-

- Not registered at GP practice IHDI sent to
- Baby – delay in registering at GP practice
- GP patient registered with practice, not on SCR system
- Duplicate IHDIs being sent to Practices

There are minimal numbers of summaries being posted for GP practices that are not currently part of SCR. Savings on consumables and posting for discharge summaries and letters achieved to-date in this financial year is £12,232.48

Current developments for incorporation into SCR include the transfer of all clinical documentation via the digital dictation process. This will again further decrease the volume of documents being posted and increase the savings. However this will have an impact on the DQA team and the volume of rejections requiring review, update and resending.

Data Completeness and Validity

The Data Quality Team has a key role in identifying missing and incomplete documentation that directly impacts on activity and income levels. This role includes highlighting to divisions outpatient appointments that have not been documented as either patient attended or Did Not Attend and gives divisions the opportunity to action these historical appointments on the system.

The tables below show the volume of activity identified and updated by the DQA team:

Month (2023-24)	Attended	DNA	Cancelled	Pended
April	241	110	11	457
May	355	121	10	748
June	237	150	10	560
July	229	105	14	465
Total Appts	1062	486	45	2230

There has been some improvement in the volume of appointments not fully documented, resulting in a decrease in the number of records requiring review and update on Harris Flex CPR. However, there is still ample scope for further improvement to ensure records are recorded in real time or as near to it as possible.

Data Quality Newsletters

The Data Quality Assurance team also published a newsletter in August 2023 giving an update on:

- Data Quality & Compliance Group
- Audit Programme
- DQ/IG Presentations
- Patient demographics
- Welcome to new team member
- Updates on the SCR(LPRES) project
- Update on movement of data quality assurance staff

DQA Newsletter August 23.pdf

Data Quality Risks

The Data Quality Assurance Team undertake regular audit tasks to identify risk areas, working with services to implement remedial/improvement actions through the corporate quality improvement programme. A full risk assessment has been completed for each item; these are held locally on the Business Intelligence Risk Log.

The Team continue to monitor the key risks and remedial actions identified to sustain improvements and minimise risks. The table below shows the current risks to key data quality items and how they are being mitigated.

RA No	Risk Item	Issue	Action 2023-24	Update
54	Harris Flex GP Masterfile maintenance (current rating 12)	In-active GPs linked to patient records. In-accurate GP records in Masterfile on Harris Flex. Continued misdirected correspondence.(NOPs).	Move to ODS quarterly updates. Increase volume of documents transferred via SCR.	Harris flex team working with BI & DQA to establish process to upload files onto TEST PROD. Standing item on bi- weekly applications call with Harris team.

				Digital dictate process live – due to transfer letters via SCR
122	Corporate system recording issues. In-accurate recording of patient data/activity (current rating 12)	Variety of in-accurate event documentation. Incomplete linking across activity flows.	Review SUS issues on key data items. Continue to review functionality to improve correction of data on Harris Flex.	Additional Harris flex validation reports implemented. Working on supporting divisions with identifying reasons for issues with activity recording
1207	Inability to meet the monthly clinical coding submission standards (current rating 9)	Non-availability of comprehensive coded data. Timeframe for reviewing / coding data.	Improvement Action plan Draft Bespoke Harris Flex report Review inpatient to outpatient activity reporting Implement onsite / agile working	Action plan implemented, coding compliance 100% at flex Bespoke report finalised. Team agile working.

Following ongoing data quality issues in relation to the implementation of the Trusts theatres system and wider system documentation risks identified above the Trust has engaged with Grant Thornton to undertake a data quality and pathway review to provide independent external assurance in relation to data recording and capture. Grant Thornton brings over 15 years' experience working with NHS organisation to ensure that activity data accurately reflects the care delivered by organisations. Key activities focussed on:

- Desk based longitudinal analysis and review of activity over the last 4 years
- On site review of hypothesis identified through analysis and desk based review
- Targeted review of urgent care
- Consolidated findings – identify areas of risk to activity baselines and make recommendations for improvement

Recommendations from the initial findings are as follows:

- The categorisation of Chorley's emergency department as type 3 (due to not being a 24-hour department) impacts on the value of the Healthcare Resource Groups (HRGs) being assigned to the activity being treated as there is a flat rate tariff for type 3 emergency care.
- The review also identified areas omission and errors in treatment and investigation code recording which means that the complexity of cases (and subsequent HRG assignment) is under-reported.
- There are high levels of errors and omissions for outpatient procedures across different specialties, reflecting both over and undercharging. Our analysis and testing found that accuracy of outpatient coding is poor, with procedures undertaken omitted, or not coded correctly in line with national coding standards to reflect the care being given in this setting, or ensure accurate HRG assignment.
- Coding in admitted patient care (APC) is low risk and supported by good processes enacted by the central coding team. There are opportunities to digitalise some high volume, low complexity work, such as haemodialysis and endoscopy, which would enable codes to focus their time on more complex areas.

In addition, a Trust Data Quality & Compliance Group has been established to act on Grant Thornton recommendations, to resolve data quality and documentation compliance issues following enhancements made within systems such as Harris Flex, Opera Theatre system, Sectra Radiology System and Badgernet maternity system and to mitigate the above risks. The system changes fully support recording of activity and clinical pathways from pre-referral advice, out-patients, to diagnostics, and patient admissions, however adherence to workflow can vary. The group will work in line with the 6 dimensions of good data quality:

- Accuracy
- Completeness
- Consistency
- Timeliness
- Validity
- Uniqueness

The group will bring together a range of Digital, Business Intelligence, Data Quality, Training, Clinical Business Unit staff to address ongoing data quality issues and risks.

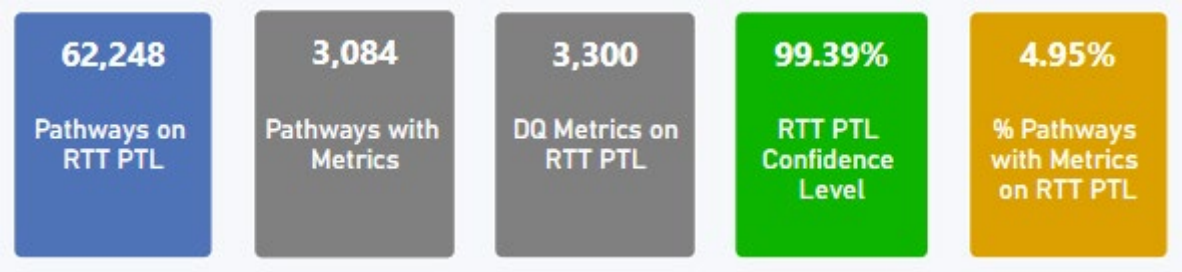
External Data Quality Assurance Monitoring

Elective Recovery - Waiting List National Minimum Dataset

As part of the elective recovery drive all acute trusts were mandated to provide a weekly record level waiting list extract covering referral to treatment, diagnostic and planned/surveillance care. The dataset is a mandated requirement for organisations and has been approved by the NHS Digital Data Standards Board. The data is being used to better understand and manage the waiting list position as part of the National Elective Restoration Programme, as well as being a key component of the elective care recovery fund (ERF) data validation gateway. It is expected that the WLMDS submissions will become the main source of reported waiting time performance data for Trusts with the phasing out of aggregated returns. The information within the WLMDS will also be used to populate waiting time information displayed in the My Planned Care Platform.

Nationally a Data Quality Reporting tool (LUNA) has been developed to support Trusts in making improvements to the quality and consistency of the datasets. Organisations submissions are assessed against 20 key data quality standards and assigned an overall data confidence level. The current week position for the Trust is shown below. The Trust confidence level score of 99.39% is above the national target of 95%, with the weekly trend showing sustained compliance and improvement. Of the total pathways submitted just 5% of records have been identified with a data quality flag that may warrant further review. Actions are ongoing to further improve the completeness and validity of submissions.

Current Week – Confidence Level



Confidence Level Trend

	17/09/2023	10/09/2023	03/09/2023	27/08/2023	20/08/2023	13/08/2023	06/08/2023	30/07/2023	23/07/2023
RTT PTL Confidence Level	99.39%	99.35%	99.36%	99.35%	99.33%	99.34%	99.33%	99.34%	99.33%

Data Quality Maturity Index (DQMI)

The DQMI is a monthly national publication intended to raise the profile of data quality in the NHS by providing data submitters with timely and transparent information in relation to the quality of key data submissions. The DQMI scores are based on the completeness, validity, coverage and use of default values within core data items held within key datasets submitted nationally by the Trust to the Secondary Uses Service. Data items monitored include NHS number, date of birth, gender, postcode, speciality and consultant as well as dataset specific items. Overall and dataset specific scores for the Trust are shown below for the period to end June 2023. Scores for all datasets are extremely positive showing a consistently high performance score during 2023/24. The Trust performs at well above the national average of 88% across all datasets.

	Overall	Emergency Care Dataset	Admitted Patient Care Dataset	Out-Patient Dataset
National Average	88	82.9	94.8	94.5
Lancashire Teaching	91.2	87.0	99.3	98.2

Scores by individual data items within each dataset are show in Appendix 1. The summary position shown below indicates a consistent compliance score with 7 fields worse than the national average.

Data Set	Key Fields	Compliant Fields	Var	% Compliance
OP	14	14	0	100.00%
APC	22	21	-1	95.45%
ECDS	31	25	-6	80.65%
	67	**60**	**-7**	89.55%

Plans in place to implement further improvements to the content of the ECDS data flow now that the nationally mandated requirement to submit daily ECDS has been implemented.

Clinical Coding Completeness

The Clinical Coding Team continues to ensure the availability of comprehensively coded data in line with the national flex and freeze timetable. During 20222/23 the Coding team maintained a coding completeness level at flex above 90% and 100% at freeze. This position has been maintained into 2023/24 plans are in place to improve to above 95% at flex during 2023/24.

The Coding Team Business Plan sets out the overall strategy for the future development of the Coding Service incorporating:

- Wider programme of internal audit to enhance coder skill sets including the appointment of a dedicated Audit & Quality Manager to drive quality improvements within the Clinical Coding team
- Fully implemented an enhanced End Coder system that supports additional quality and consistency checks. The upgrade of 3M Medicode system to Medicode 360 will provide additional audit and consistency capability.
- Engaged with IQVIA to implement their Clinical Coding Analytics tool plus 12 days consultancy over the next 6 months to identify opportunities to enhance the depth of admitted care clinical coding and support the development of outpatient coding completeness.

3. Financial Implications

Noted in the narrative if relevant.

4. Legal Implications

None to note.

5. Risks

Data Quality risks are noted in the narrative.

6. Impact on Stakeholders

Noted in the narrative if relevant.

7. Recommendations

It is recommended that:

The Board note current Data Quality Assurance activities, internal and external monitoring processes and the on-going developments that support further improvements to data quality assurance and data quality engagement.

Appendix 1 –DQMI Dataset Compliance

Trust coverage compared to the national average for key data items for the period to Apr-June 2023. This is a coverage dashboard not a check of the accuracy of content.

Data Item	Trust June 2023	National Average	Variance	Rating	Actions
OUTPATIENT KEY DATA ITEMS					
ACTIVITY TREATMENT FUNCTION CODE	96.20%	96.20%	0.00%		
ADMINISTRATIVE CATEGORY CODE	100.00%	94.80%	5.20%		
CARE PROFESSIONAL MAIN SPECIALTY CODE	96.20%	95.80%	0.40%		
CONSULTANT CODE	96.20%	91.50%	4.70%		
ETHNIC CATEGORY	92.90%	79.50%	13.40%		
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	99.60%	88.40%	11.20%		
NHS NUMBER	99.90%	81.90%	18.00%		
NHS NUMBER STATUS INDICATOR CODE	100.00%	98.90%	1.10%		
ORGANISATION CODE (CODE OF COMMISSIONER)	99.70%	95.40%	4.30%		
PERSON BIRTH DATE	100.00%	93.90%	6.10%		
PERSON GENDER CODE CURRENT	100.00%	98.00%	2.00%		
POSTCODE OF USUAL ADDRESS	99.80%	91.20%	8.60%		
SITE CODE (OF TREATMENT)	100.00%	88.30%	11.70%		
SOURCE OF REFERRAL FOR OUTPATIENTS	94.90%	91.30%	3.60%		
ADMITTED CARE KEY DATA ITEMS					
ACTIVITY TREATMENT FUNCTION CODE	100.00%	96.60%	3.40%		
ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)	100.00%	98.30%	1.70%		
ADMISSION METHOD (HOSPITAL PROVIDER SPELL)	100.00%	97.60%	2.40%		
CARE PROFESSIONAL MAIN SPECIALTY CODE	100.00%	95.80%	4.20%		
CONSULTANT CODE	100.00%	91.50%	8.50%		
DECIDED TO ADMIT DATE	99.90%	54.90%	45.00%		
DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	100.00%	99.00%	1.00%		
DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)	94.90%	97.30%	-2.40%		Mandatory field in Flex to improve coverage
DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)	100.00%	96.60%	3.40%		
ETHNIC CATEGORY	90.50%	79.50%	11.00%		
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	99.60%	88.40%	11.20%		
NHS NUMBER	99.90%	81.90%	18.00%		
NHS NUMBER STATUS INDICATOR CODE	100.00%	98.90%	1.10%		
ORGANISATION CODE (CODE OF COMMISSIONER)	99.70%	95.40%	4.30%		
ORGANISATION CODE (CODE OF PROVIDER)	100.00%	97.70%	2.30%		
PATIENT CLASSIFICATION CODE	100.00%	98.60%	1.40%		

PERSON BIRTH DATE	100.00%	93.90%	6.10%		
PERSON GENDER CODE CURRENT	100.00%	98.00%	2.00%		
POSTCODE OF USUAL ADDRESS	99.70%	91.20%	8.50%		
PRIMARY DIAGNOSIS (ICD)	99.90%	87.50%	12.40%		
SITE CODE (OF TREATMENT)	100.00%	88.30%	11.70%		
SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)	100.00%	97.80%	2.20%		
EMERGENCY CARE DATASET KEY DATA ITEMS					
CHIEF COMPLAINT (SNOMED CT)	94.30%	79.30%	15.00%		
ACUITY (SNOMED CT)	99.90%	88.60%	11.30%		
DIAGNOSIS (SNOMED CT) - FIRST	64.40%	68.20%	-3.80%		
ARRIVAL DATE	100.00%	100.00%	0.00%		
ARRIVAL TIME	99.90%	99.40%	0.50%		
INITIAL ASSESSMENT DATE	100.00%	91.30%	8.70%		
INITIAL ASSESSMENT TIME	99.80%	89.70%	10.10%		
DATE SEEN FOR TREATMENT	99.00%	90.50%	8.50%		
TIME SEEN FOR TREATMENT	98.60%	90.50%	8.10%		
DEPARTURE DATE	99.90%	98.50%	1.40%		
DEPARTURE TIME	99.90%	97.90%	2.00%		
NHS NUMBER	99.30%	81.90%	17.40%		
NHS NUMBER STATUS INDICATOR CODE	99.90%	98.90%	1.00%		
ATTENDANCE SOURCE (SNOMED CT)	99.90%	96.70%	3.20%		
DISCHARGE STATUS (SNOMED CT)	98.80%	91.30%	7.50%		
DISCHARGE FOLLOW-UP (SNOMED CT)	98.70%	70.20%	28.50%		
DISCHARGE DESTINATION (SNOMED CT)	98.70%	87.10%	11.60%		
DISCHARGE INFO GIVEN (SNOMED CT)	0.80%	6.70%	-5.90%		Slight improvement since incorporation via ECDS V3.0 Implementation plan
ETHNIC CATEGORY	98.10%	79.50%	18.60%		
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	99.40%	88.40%	11.00%		
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	98.20%	83.50%	14.70%		
PERSON BIRTH DATE	100.00%	93.90%	6.10%		
PERSON STATED GENDER CODE	100.00%	82.50%	17.50%		
POSTCODE OF USUAL ADDRESS	99.50%	91.20%	8.30%		
ARRIVAL MODE (SNOMED CT)	99.90%	96.70%	3.20%		
ATTENDANCE CATEGORY	100.00%	96.90%	3.10%		
PROCEDURE (SNOMED CT) - FIRST	98.60%	76.90%	21.70%		
PROCEDURE DATE - FIRST	47.50%	68.70%	-21.20%		Continued improvement since incorporation via ECDS V3.0 Implementation plan
PROCEDURE TIME - FIRST	44.40%	52.00%	-7.60%		
CLINICAL INVESTIGATION (SNOMED CT) - FIRST	44.50%	70.40%	-25.90%		
INJURY INTENT (SNOMED CT)	15.00%	38.20%	-23.20%		