East Lancashire Hospitals
NHS Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

Personal

Effective

East Lancashire Hospitals NHS Trust

TRUST BOARD PART 1 MEETING

12 SEPTEMBER 2018, 14:30,

SEMINAR ROOM 6, ROYAL BLACKBURN HOSPITAL

AGENDA

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

OPENING MATTERS				
TB/2018/079	**Chairman's Welcome**	Chairman	v	
TB/2018/080	**Open Forum** To consider questions from the public	Chairman	v	
TB/2018/081	**Apologies** To note apologies.	Chairman	v	
TB/2018/082	**Declaration of Interest Report** To note the directors register of interests and note any new declarations from Directors.	Company Secretary	d✓	Information/ Approval
TB/2018/083	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 11 July 2018.	Chairman	d✓	Approval
TB/2018/084	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2018/085	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2018/086	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2018/087	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information
TB/2018/088	**Award of Honorary Professor and Honorary Senior Clinical Lecturer Posts**	Chief Executive	d✓	Information
QUALITY AND SAFETY				
TB/2018/089	**Patient Story** To receive and consider the learning from a patient story.	Director of Nursing	p	Information/ Assurance
TB/2018/090	**Corporate Risk Register** To receive an update on the Corporate Risk Register and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Medical Director	d✓	Information
TB/2018/091	**Board Assurance Framework** To receive an update on the Board Assurance Framework and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Medical Director	d✓	Approval

TB/2018/092	**Serious Incidents Requiring Investigation Report** To receive information in relation to incidents in month or that may come to public attention in month and be assured about the associated learning.	Medical Director	d✓	Information/ Assurance
STRATEGY				
TB/2018/093	**Health and Wellbeing Strategy**	Director of HR and OD	d✓	Information/ Approval
TB/2018/094	**Culture and Leadership**	Director of HR and OD	p	Information
ACCOUNTABILITY AND PERFORMANCE				
TB/2018/095	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed: • Introduction (Chief Executive) • Performance (Director of Operations) • Quality (Medical Director) • Workforce (Director of HR and OD) • Safer Staffing (Director of Nursing) • Finance (Director of Finance)	Executive Directors	d✓	Information/ Assurance
GOVERNANCE				
TB/2018/096	**Emergency Preparedness Statement – Update and Delegated Authority Request**	Director of Operations	v	Information/ Approval
TB/2018/097	**Annual Board Report Medical Appraisal and Revalidation 2017/2018**	Medical Director	d✓	Approval
TB/2018/098	**Audit Committee Update Report** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information/ Assurance
TB/2018/099	**Finance and Performance Committee Update Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information/ Assurance
TB/2018/100	**Quality Committee Update Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information/ Assurance
TB/2018/101	**Trust Charitable Funds Committee Update Report** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information/ Assurance
TB/2018/102	**Remuneration Committee Update Report** To note the matters considered by the Committee in discharging its duties	Chairman	d✓	Information/ Assurance
TB/2018/103	**Trust Board Part Two Information Report** To note the matters considered by the Committee in discharging its duties	Chairman	d✓	Information
FOR INFORMATION				
TB/2018/104	**Any Other Business** To discuss any urgent items of business.	Chairman	v	

TB/2018/105	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2018/106	**Board Performance and Reflection** To consider the performance of the Trust Board, including asking: • Has the Board focussed on the appropriate agenda items? Any item(s) missing or not given enough attention? • Is the Board shaping a healthy culture for the Board and the organisation and holding to account? • Are the Trust's strategies informed by the soft intelligence from local people's needs, trends and comparative information? • Does the Board give enough priority to engagement with stakeholders and opinion formers within and beyond the organisation?	Chairman	v	
TB/2018/107	**Date and Time of Next Meeting** Wednesday 14 November 2018, 2.30pm, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.	Chairman	v	

East Lancashire Hospitals NHS Trust

TRUST BOARD PART ONE REPORT

Item 82

12 September 2018

Purpose Information

Title	Directors' Register of Interests
Author	Mrs A Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary

Summary: Section 5 of the Trust's Standing Orders describes the duties and obligations of Board Members in relation to declaring interests. The Register is available for public inspection and following a recommendation from the audit carried out by the Mersey Internal Audit Agency (MIAA) Anti-Fraud Specialist, it shall be presented 3 times a year to the Trust Board.

Recommendation: The Board is asked to note the presented Register of Directors' Interests and Board Members are invited to notify the Company Secretary of any changes to their interests within 28 days of the change occurring and complete the online forms for all the declarations relating to the financial year 2018/19.

Report linkages

Related to key risks identified on assurance framework	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

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

(82) Directors' Register of Interests

Directors' Register of Interests

Name and Title	Interest Declared	Date last updated
Professor Eileen Fairhurst Chairman	• Professor at Salford University - until 31.12.2017. • Trustee, Beth Johnson Foundation - until 31.03.2017. • Chairman of Bury Hospice – from 23.01.2017 until 04.06.2018 • A member of the Learning, Training & Education (LTE) Group Higher Education Board – until 12.3.2017. • Chairman of the NHS England Performers Lists Decision making Panel (PDLP).	19.06.2018.
Kevin McGee Chief Executive	Spouse is the Director of Finance and Commercial Development at Warrington and Halton Hospitals NHS Foundation Trust	26.05.2018.
Patricia Anderson Non-Executive Director	• Accountable Officer at Wigan Borough CCG until 31.05.2018. • Public Sector Director of One Partnership (LIFTCO) January 2015 until 31.05.2018.	22.08.2018.
John Bannister Director of Operations	Positive Nil Declaration.	09.05.2018.
Stephen Barnes Non-Executive Director	• Chair of Nelson and Colne College. • Member of the National Board of the Association of Colleges - from 02.03.2017. • Vice Chair of the National Council of Governors of the Association of Colleges - from 02.03.2017.	09.05.2018.

Name and Title	Interest Declared	Date last updated
Martin Hodgson Director of Service Development	Positive Nil Declaration.	09.05.2018.
Christine Hughes Director of Communications and Engagement	Positive Nil Declaration.	09.05.2018.
Naseem Malik Non-Executive Director	• Independent Assessor- Student Loans Company- Department for Education - Public Appointment. • Fitness to Practice, Panel Chair: Health & Care Professions Tribunal Service (HCPTS) - Independent Contractor. • Investigations Committee Panel Chair - Nursing & Midwifery Council (NMC) - Independent Contractor. • Member of the Law Society. • Fellow of The Royal Society of Arts. • NED and SID at Lancashire Care NHS Foundation Trust - until 29.07.2016. • Worked for Blackburn Borough Council (now Blackburn with Darwen Borough Council) in 1995/6. • NED at Blackburn with Darwen Primary Care Trust from 2004 until 2010. • Relative (first cousin) is a GP in the NHS (GP Practice). • Relative (brother-in-law) is a Mental Health Nurse.	06.06.2018.

Name and Title	Interest Declared	Date last updated
Kevin Moynes Director of Human Resources & Organisational Development	• Governor of Nelson and Colne College – until 01.02.2018. • Spouse works for HEE (NW) as Head of Workforce Transformation.	09.05.2018.
Christine Pearson Director of Nursing	Spouse is the Head of Medicines Optimisation, at Heywood, Middleton & Rochdale Clinical Commissioning Group	09.05.2018.
Damian Riley Medical Director	• National Clinical Assessment Service (NCAS) Clinical Assessor and Trainer - small amounts of work are undertaken in this role and funded by NCAS. • Member of British Medical Association Registered with General Medical Council. • Spouse is and employee - GP in Dyneley House Surgery, Skipton. • Sister is an employee of pharmaceutical company Novartis.	09.05.2018.
Richard Slater Non-Executive Director	Positive Nil Declaration.	09.05.2018.
Richard Smyth Non-Executive Director	• Consultant Solicitor with DLA Piper UK LLP Law Firm. DLA Piper undertakes work for the NHS. • Spouse is a Lay Member of Calderdale CCG. • Spouse is a Patient & Public Involvement and Engagement Lay Leader for the Yorkshire and Humber Patient Safety Translational Research Centre, based at Bradford Institute for Health Research, Bradford Royal Infirmary. • Sister is an advanced clinical nurse practitioner	09.05.2018.

Name and Title	Interest Declared	Date last updated
	with Pennine Acute Hospitals Trust based at the Royal Oldham hospital. • Member of the Law Society.	
Professor Michael Thomas Non-Executive Director	• Vice-Chancellor of UCLAN.	09.05.2018.
Michael Wedgeworth Associate Non-Executive Director	• Assistant Priest at Blackburn Cathedral since 1995. • Honorary Canon of Blackburn Cathedral since 2003 • Member of the Lancashire Health and Well-Being Board from 2011 to 2017. • Elected Public Governor at Lancashire Care Foundation Trust and Chair of the Patient Experience Group until April 2017. • Chair of Healthwatch Lancashire until December 2017. • Healthwatch Representative on NHS governing bodies and Trusts since 2015. • Member of the Lancashire and South Cumbria Sustainability and Transformation Programme Board and its workstream on Acute and Specialised Services since 2015. • NED Representative for the Pennine Lancashire system on the Lancashire and South Cumbria Sustainability and Transformation Partnership Board (now the Integrated Care Organisation Board).	09.05.2018.

Name and Title	Interest Declared	Date last updated
David Wharfe Non-Executive Director	Positive Nil Declaration.	09.05.2018.
Jonathan Wood Director of Finance	Spouse is the Director of Finance at the Oldham Care Group Hospital, part of Pennine Acute Hospitals NHS Trust. Pennine Acute Hospitals currently form part of the 'hospital chain' with Salford Royal Hospitals Foundation Trust.	09.05.2018.

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary

22 August 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 83

12 September 2018

Purpose Action

Title	Minutes of the Previous Meeting
Author	Miss K Ingham, Assistant Company Secretary
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The draft minutes of the previous Trust Board meeting held on 11 July 2018 are presented for approval or amendment as appropriate.

Report linkages

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

Impact

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

Previously considered by: NA

(83) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST
TRUST BOARD MEETING, 11 JULY 2018
MINUTES

PRESENT

Professor E Fairhurst	Chairman	Chair
Mr K McGee	Chief Executive	
Mr J Bannister	Director of Operations	Non-voting
Mr S Barnes	Non-Executive Director	
Mr M Hodgson	Director of Service Development	
Mrs C Hughes	Director of Communications and Engagement	Non-voting
Mr K Moynes	Director of HR and OD	Non-voting
Mrs C Pearson	Director of Nursing	
Dr D Riley	Medical Director	
Mr R Smyth	Non-Executive Director	
Mr M Wedgeworth	Associate Non-Executive Director	Non-voting
Mr J Wood	Director of Finance	

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Associate Director of Corporate Governance/ Company Secretary	
Mrs J Butcher	Staff Guardian/Freedom to Speak Up Officer	For Item TB/2018/065
Miss K Ingham	Company Secretarial Assistant	Minutes
Mrs A Shaw	Chair, North Lincolnshire and Goole NHS Foundation Trust	Observer

APOLOGIES

Mrs P Anderson	Non-Executive Director
Miss N Malik	Non-Executive Director/ Vice Chair
Mr R Slater	Non-Executive Director
Professor M Thomas	Non-Executive Director
Mr D Wharfe	Non-Executive Director/Vice Chair

TB/2018/052 CHAIRMAN'S WELCOME

Professor Fairhurst welcomed the Directors to the meeting. She extended a warm welcome to Mrs Anne Shaw, Chair at North Lincolnshire and Goole NHS Foundation Trust (NLAG) who would be observing the meeting. Professor Fairhurst confirmed that Mrs Shaw and Dr Peter Reading, Chief Executive of NLAG had recently written to the Board to express their thanks for the support which ELHT has given to their Trust in recent months.

TB/2018/053 OPEN FORUM

There were no questions from the public.

TB/2018/054 APOLOGIES

Apologies were received as recorded above.

TB/2018/055 DECLARATIONS OF INTEREST

The updates to the register of interests were noted.

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

TB/2018/056 MINUTES OF THE PREVIOUS MEETING

Directors having had the opportunity to review the minutes of the previous meeting approved them as a true and accurate record.

RESOLVED: The minutes of the meeting held on 9 May 2018 were approved as a true and accurate record.

TB/2018/057 MATTERS ARISING

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

TB/2018/058 ACTION MATRIX

All items on the action matrix were reported as complete or were to be presented as agenda items at this meeting or subsequent meetings.

RESOLVED: The position of the action matrix was noted.

TB/2018/059 CHAIRMAN'S REPORT

Professor Fairhurst reported that, since the last meeting, she had attended the ground

breaking ceremony for the Phase Eight development at the Burnley General Teaching Hospital site and work was now well underway. She went on to confirm that she had attended a workshop with Mr McGee and colleagues at the University of Central Lancashire (UCLan) and Blackburn with Darwen Borough Council to discuss developing ways of working collaboratively across the area. In addition, Professor Fairhurst attended the joint ELHT and UCLan Medical Education Conference at Ewood Park, which was an exciting event. The event culminated in an awards ceremony where a number of the Trust's staff received awards for their work with undergraduate medical students.

Finally Professor Fairhurst confirmed that she, Mr McGee and Mrs Pearson had attended the NHS 70th anniversary service at Westminster Abbey, which was a fascinating service and included many individuals who had experience of healthcare before the inception of the NHS and those who have received treatment in recent years, such as one of the young ladies who had been injured in last year's terror attack in Manchester.

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

TB/2018/060 **CHIEF EXECUTIVE'S REPORT**

Mr McGee presented his report to the Directors and highlighted a number of items for information. He confirmed that NHSI and NHSE were undertaking a significant piece of work to align their work across regional teams. The northern region will be split in two, with the North West regional team based in Manchester and the remainder of the northern region will be covered by the North East regional team.

Mr McGee went on to echo the comments made by Professor Fairhurst in relation to the NHS 70th anniversary service at Westminster Abbey and drew Directors' attention to the local events which had taken place to mark the anniversary. Mrs Hughes reported that the Trust had launched the ELHT&Me charity £1 million appeal at one of these events with great success. She went on to confirm that across the celebratory week the Trust had been part of two live broadcasts, both for local radio stations: 2BR and BBC Radio Lancashire.

Mr McGee confirmed that the Trust Seal has been used on a number of occasions since the last meeting all of which related to estates matters.

Directors noted the work being undertaken to enforce the Trust's smoke-free site policy and the need to continue to pursue this matter with vigour.

Mr McGee highlighted the work being undertaken to date across the Trust in relation to ensuring compliance with the GDPR legislation. Mr Wood emphasised the significant volume of work which was required to ensure compliance and provided a brief overview of

the rights of individuals regarding the way their data is processed under the new regulation.

Mr McGee reported that he had been immensely proud to receive an honorary fellowship at the University of Central Lancashire on 18 July 2018.

Mrs Pearson highlighted the celebrations which had been undertaken in the Trust for International Day of the Midwife and International Nurses Day; both celebrations took place in May 2018. She went on to confirm that AMU A and AMU B had both received three green ratings against the Nursing Assessment and Performance Framework (NAPF) and had both presented their work to their respective SPEC panels with recommendations to the Board for 'silver ward status' to be granted. Following a brief discussion on this matter, Directors approved the recommendation.

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

The Directors agreed that wards AMU A and AMU B be granted 'silver ward status'.

TB/2018/061 PATIENT STORY

Mrs Pearson read out the patient story on behalf of the patient. She provided a brief overview of the reasons for admission and treatment by the Cardiology team, ward B18 and the Trust's Chemotherapy service. She confirmed that the patient had suffered a loss of energy which over a period of three weeks became worse; resulting in the patient having a heart attack. Following initial treatment, a number of tests were carried out to determine the underlying cause, which was identified as amyloidosis, a rare disease where particular proteins build up in the organs and inhibit their functioning. Directors noted that, whilst there is no cure for the disease, chemotherapy can treat the problem and reduce the risks of future complications.

Mrs Pearson reported that the patient had been unsure about what to expect from the chemotherapy treatment and the follow-up bone marrow tests, but the care team had explained the treatment and potential side effects to him. The patient expressed his gratitude to the care team and commented that they upheld his dignity throughout the treatment process.

Mr McGee commented that at the recent Patient Safety Congress event, which he had attended, there had been a discussion around the ways in which Trusts could move from receiving patient stories to involving patients in the design and development of services. He asked that the Board give some thought to the ways in which the Trust could do this in the future. Mrs Pearson confirmed that some of the 'Lean programme' work which the Trust was

involved in included working closer with patients and their families as partners in designing the services.

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

TB/2018/062 CORPORATE RISK REGISTER

Dr Riley presented the report and provided an overview of the changes which had been proposed to the register for the Board's consideration. Directors noted that three risks (IDs 7067, 1810 and 5791) had been recommended for de-escalation and, therefore, removal from the risk register. Mr McGee confirmed that the Trust had written a letter to NHSE and NHSI requesting that a regional event is held in order to develop a suitable plan to ensure the appropriate and timely treatment of patients with mental health needs, particularly those who present at the Emergency Departments.

Dr Riley provided an update on the management of Risk ID 7583: Loss of facility for Containment Level 3 in pathology and the work being carried out with the Health and Safety Executive (HSE) regarding this issue.

Dr Riley went on to provide a summary of the issues which had been raised with regard to the central alerting system (CAS) and the remedial work which was being undertaken to ensure that all CAS alerts are acted upon and that historical actions have been completed.

RESOLVED: **Directors received the report and approved the updates to the Corporate Risk Register.**

Mr McGee to update on feedback received from NHSI and NHSE regarding the regional event that had been requested relating to mental health patients.

TB/2018/063 BOARD ASSURANCE FRAMEWORK ANNUAL REVIEW (BAF)

Dr Riley referred the Directors to the previously circulated report. He provided an overview of the work carried out since the last meeting, to complete the annual review of the document. Mr Smyth confirmed that the Audit Committee had not yet been able to discuss the BAF due to the time constraints at its last meeting. A separate session of the Audit Committee would be arranged to undertake this task before the next Trust Board session in September 2018.

Professor Fairhurst asked that the next iteration of the document recognise the challenges of the system working, as some of the risks on the BAF are relevant across the system, not just across the Trust. Mr McGee commented that the document provided a good understanding

of the risks to the Trust.

RESOLVED: **Directors received, discussed and approved the revised Board Assurance Framework pending any revisions made by the Audit Committee, following its review of the document.**
The next iteration of the document will recognise the challenges of system working.

TB/2018/064 SERIOUS INCIDENTS REQUIRING INVESTIGATION REPORT

Dr Riley presented the report to the Directors and gave an overview of the content, drawing particular attention to the sections regarding the serious incidents recorded on the StEIS system; duty of candour declarations; and the detailed duty of candour improvement plan which had been developed following the limited assurance report from the Mersey Internal Audit Agency (MIAA).

Dr Riley gave an overview of the findings of the MIAA report and the changes that have already been implemented to the duty of candour process, such as: daily monitoring of reporting to ensure duty of candour is served within the required 10 day timeframe; aligning of the policy to the Open and Honest Policy; and implementation of a requirement for duty of candour training.

Directors noted the new process for immediately managing any Never Events which occur in theatres and the implementation of the 10,000ft initiative, which is a way to stop all unnecessary sound in a theatre to allow the surgeon to concentrate completely on their work. Dr Riley went on to provide an overview of the 10,000ft initiative and confirmed that he and Mr Robert Tomlinson, who had designed the initiative, had been invited to join the CQC at a national event to discuss 'Never Events'. Professor Fairhurst asked that a note of thanks be recorded in the minutes to Mr Tomlinson on behalf of the Board for his work on the initiative.

Directors briefly discussed the relationships between senior/executive management and the consultant body, which were noted to be good. It was suggested that work could be undertaken to further develop the relationship between the Non-Executive Directors and the consultant body in the Trust and ensure the Board visibility across the organisation. Dr Riley extended an open invitation to the Non-Executive Directors to attend the monthly Clinical Leaders' Forum meetings.

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

TB/2018/065 STAFF GUARDIAN ANNUAL REPORT

Mrs Butcher attended the meeting to present the annual report of the Staff Guardian. She gave an overview of the report and highlighted the increase in contacts made to the Staff Guardian in the past twelve months; identification of the recurring reasons for contact, with the top three themes being: support throughout HR processes; potential bullying by the manager; and lack of engagement/support regarding departmental changes.

In response to Mr Barnes's question, Mrs Butcher confirmed that there was a formal process map detailing how issues raised with the Staff Guardian are managed and escalated as necessary. Directors noted that this was included in the new policy, which was in the process of being reviewed and ratified.

Mr Wood asked Mrs Butcher what, from her perspective, were the benefits of the mediation process. Mrs Butcher confirmed that the Trust's mediation service had had a positive impact across the Trust and there had been a number of successful mediation sessions since the service had been in operation.

Mrs Hughes suggested that there was an opportunity to share some general messages with staff in order to reduce the need for signposting queries.

RESOLVED: Directors received the update provided and noted its contents.
Mr Moynes and Mrs Butcher will look into developing a series of messages for cascade to staff.

TB/2018/066 PENNINE LANCASHIRE PLAN

Mr McGee referred Directors to the previously circulated document and highlighted the New Model of Care which aims to put patients at the centre of their care. He sought comments from Directors prior to the Board and other Pennine Lancashire ICS organisations approving the plan.

Mr Barnes welcomed the document and commented that it made sense to have all organisations across the Pennine Lancashire footprint working towards the content of the document in a cohesive manner.

Directors approved the plan for submission

RESOLVED: Directors received the report provided and noted its contents.
Directors approved the plan for submission.

TB/2018/067 INTEGRATED PERFORMANCE REPORT

Mr McGee introduced the report to the Directors and confirmed that the report related to the

period to the end of May 2018. He went on to state that the Trust was at a crucial part of the year in terms of the number of staff who would be taking annual leave over the coming two months and the start of preparations for the winter period.

a) Performance

Mr Bannister reported that the Emergency Department four hour standard was 86.14% for the Pennine Lancashire system for the month of May 2018 and it was in line with the overall improvement trajectory. He went on to confirm that there was a significant programme of work being undertaken in relation to the emergency care pathway, which would support the improvements required in relation to the performance of the four hour standard.

Directors noted that there had been three 12 hour trolley wait breaches in the month; all were patients with mental health needs. Mr Bannister highlighted the improvements made in relation to the ambulance handover times and confirmed that 93.8% of patients who attended the Trust via ambulance were handed over in under 21 minutes. The Trust achieved the referral to treatment incomplete pathway (RTT) standard for May at 93.3%, but the diagnostic wait standard had not been achieved in the month. Mr Bannister confirmed that the two week and 62 day cancer standards had been met for the month of April, but the two week symptomatic breast standard had been narrowly missed.

Directors noted that delayed transfers of care had improved again in the month, with rates now standing at 2.9% against a national threshold of 3.5%. There were no breaches of the 28 day re-booking standard for those patients who had their surgery cancelled in the month, although there had been a total of 59 patients who had their procedures cancelled on the day.

Mr Smyth commented that the efforts undertaken to improve performance against the four hour standard were clearly showing a positive effect, given that performance had improved in the month by 6% and the number of patients seen through the department in the month had also increased by 8%.

In response to Professor Fairhurst's question, Dr Riley suggested that the good weather which the area has experienced in the recent months had not had the expected impact on the reduction of patient numbers, due to their being more patients presenting with respiratory difficulties rather than cold weather related illnesses.

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

b) Quality

Dr Riley reported that the Trust had identified three cases of clostridium difficile in May. He went on to confirm that Hospital Standardised Mortality Ratio (HSMR) remained below the expected levels and Summary Hospital-level Mortality Indicator (SHMI) remained in line with the expected position. Directors noted that there was a backlog of Mortality Structured Judgement Reviews due to the need to provide adequate training to those undertaking the reviews. Dr Riley confirmed that the backlog would be rectified in advance of the next Trust Board meeting in September 2018. Professor Fairhurst asked that the good news about the reduction in the number of reviews required under the regulation be communicated to the public.

Dr Riley suggested that the mental health related CQUIN was presenting a challenge as the Trust was only able to partially comply with the requirements and the non-compliant elements were beyond the control of the Trust.

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

Dr Riley will provide an update at the next meeting in relation to the training of staff to undertake Structured Judgement Reviews.

c) Workforce

Mr Moynes reported that sickness in May 2018 was 4.49% and had begun to reduce in line with the seasonal variations, although the rates were higher than the same time last year. Staff turnover was noted to be under the 12% threshold despite vacancies and turnover increasing slightly in the month.

Mr Moynes confirmed that there were 75 vacancies open for medical staff, and a further 23 individuals were in the pre-employment checks process.

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

d) Safer Staffing

Mrs Pearson reported that nursing and midwifery staffing continued to be a significant challenge for the Trust during May, partially due to the use of escalation areas. She confirmed that there were five areas which were below the 80% fill rate for nursing staff in the month and that staffing is reviewed at a number of points across the day.

Mrs Pearson reported that international recruitment continues with an average appointment

time of 40 weeks for individuals between the job offer being accepted and them commencing in post.

In response to Mr McGee's question, Mrs Pearson highlighted the work which Mr Stove, Assistant Chief Executive, had been undertaking in conjunction with UCLan regarding possible employment and training of nurses from Kosovo.

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

Mrs Pearson will provide an update on the work being undertaken with UCLan regarding the possible employment of nurses from Kosovo.

e) Finance

Mr Wood reported that the Trust had agreed the revised Trust control total of an underlying deficit of £15,800,000 and confirmed that, whilst this is a significant challenge, the Trust has plans in place to achieve the identified savings and achieve the financial target. He went on to report that the Trust would be eligible for the Provider Sustainability Funding (PSF) of around £8,000,000, pending achievement of the associated targets. Directors noted the cash position of the Trust at the end of May.

Mr McGee reported that the Finance Team had recently received a level three national accreditation, which is awarded for excellent practice. Directors congratulated Mr Wood and the Finance Team for their efforts and continued high performance.

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

TB/2018/068 ANNUAL AUDIT LETTER

Mr Wood referred Directors to the previously circulated document and confirmed that it had already been presented to and discussed by the Audit Committee members. Directors noted that the letter provided confirmation of the external auditors' review of the Trust's performance in relation to the 2017/18 financial year. Mr Wood confirmed that the auditors had been very complimentary of the Trust in relation to both the annual accounts and the annual report. Mr Smyth highlighted to the Board that the Trust received a good all round report from the auditors, which in the current environment was exceptional.

RESOLVED: **Directors received the annual audit letter for information.**

TB/2018/069 AUDIT COMMITTEE UPDATE REPORT

Mr Smyth presented the report and confirmed that the report covered three meetings, including the meeting on 24 May to approve the Trust's financial accounts and annual report for 2017/18 and the meeting held on 25 June to approve the Quality Account prior to submission to the Regulators.

Mr Wedgeworth left the meeting at this point (16.35)

He went on to confirm that a full report of the meeting held on 2 July 2018 would be provided to the next Trust Board session, but highlighted the discussions which had taken place at the Committee meeting regarding section 9.1.4 of the Standing Financial instructions. Mr Smyth provided a summary of the debate that had taken place at the previous Audit Committee meetings and Trust Board sessions in relation to the document. He went on to report that the Committee had discussed the proposal for the Executive Team to approve the remuneration of staff who were outside the Agenda for Change pay scales, but were not covered by the Executive Directors' terms of service, but felt that that there needed to be some independence or overview of these arrangements by the Remuneration Committee. They agreed to propose the following wording for section 9.1.4: *"The Remuneration Committee will receive a report by the Chief Executive on the remuneration and conditions of service for those employees who are not Executive Directors or employed under the terms of Agenda for Change"*. Following a brief discussion, the Board approved the revised section for inclusion in the Trust's Standing Financial Instructions.

RESOLVED: Directors received the report and noted its contents.
Directors approved the proposed revisions to section 9.1.4 of the Standing Financial Instructions.

TB/2018/070 FINANCE AND PERFORMANCE COMMITTEE UPDATE REPORT

Mr Barnes presented the report form the Finance and Performance Committee on behalf of Mr Wharfe and confirmed that the Committee had received an informative report from the Trust Education Directorate in relation to the future training and recruitment plans for the Trust. The Committee had also reviewed its terms of reference with the proposal for the Director of HR and OD to no longer be a formal member of the Committee. The Board approved the proposed change and ratified the revised terms of reference for the Committee.

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

The Board approved the revised terms of reference for the Committee.

TB/2018/071 QUALITY COMMITTEE UPDATE REPORT

Dr Riley presented the report on behalf of Miss Malik and drew Directors' attention to the discussions undertaken at the meeting, particularly those around the End of Life Care Annual Report and the Safe Working Hours for Doctors and Dentists in Training Report. Directors noted that the Trust had recently received a revalidation visit from UNICEF in relation to the Baby Friendly Gold Award, the results of which were awaited. Dr Riley confirmed that the report relating to the recent internal audit of the Trust's Duty of Candour processes had been presented to the Committee along with the internal action plan for improvement. Monitoring of the plan will take place through the Committee and the management response had also been presented to the most recent Audit Committee meeting.

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

The Board will receive and update regarding the outcome of the UNICEF Baby Friendly Gold Award revalidation visit when available.

TB/2018/072 TRUST CHARITABLE FUNDS COMMITTEE UPDATE REPORT

Mr Barnes presented the report for information and highlighted the pledging of £34,000 from the ISSA Foundation for new equipment for the Trust's neonatal service.

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

TB/2018/073 REMUNERATION COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

TB/2018/074 TRUST BOARD PART TWO INFORMATION REPORT

The report was presented to the Board for information.

TB/2018/075 ANY OTHER BUSINESS

Mrs Bosnjak-Szekeres reported that at the last Quality Committee meeting the Director of Operations had requested to step down from the membership and be replaced by the

Deputy Director of Operations as an attendee at the Committee meetings. She went on to confirm that the Committee members had considered the request and had agreed to it, pending a formal change to the terms of reference. She asked the Board to formally approve this change to the Committee's terms of reference. The Board approved the proposed change to the terms of reference for the Quality Committee.

RESOLVED: **Directors approved the requested change to the Quality Committee terms of reference.**

TB/2018/076 OPEN FORUM

There were no questions from the public.

TB/2018/077 BOARD PERFORMANCE AND REFLECTION

Professor Fairhurst invited comments and observations about the meeting from the Directors. The Directors commented that the members had attended to a range of matters and had received good levels of assurance. Dr Riley referred Directors back to the Pennine Lancashire Plan and commented that he would be keen to gain a better understanding of the timelines for public engagement and consultation. Mr Hodgson suggested that some initial engagement had taken place, but that formal consultation is yet to commence.

Directors noted the significant number of items that had been discussed under quality, safety and governance and the lack of items relating to strategy, although it was suggested that this may be due to the time of year and where the Board business cycle is currently at.

Dr Riley suggested that it may be of benefit to review and refresh the Trust's Clinical Strategy and potentially produce a Pennine Lancashire Clinical Strategy. Mr Wood commented that the Board had not yet had an opportunity to consider the impact that a new Secretary of State for Health and Social Care may have on future developments in the sector.

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

TB/2018/078 DATE AND TIME OF NEXT MEETING

The next Trust Board meeting will take place on Wednesday 12 September 2018, 14:30, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 85

12 September 2018

Purpose Information

Title	Action Matrix
Author	Miss K Ingham, Assistant Company Secretary
Executive sponsor	Professor E Fairhurst, Chairman

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objective Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2018/014: National Staff Survey Results	The Trust's Health and Wellbeing Strategy will be presented to a future Trust Board meeting for approval.	Director of HR and OD	September 2018	Agenda Item September 2018
TB/2018/062: Corporate Risk Register	Mr McGee to update on feedback received from NHSI and NHSE regarding the regional event that had been requested relating to mental health patients.	Chief Executive	September 2018	Verbal Update
TB/2018/063: Board Assurance Framework Annual Review (BAF)	The next iteration of the document will recognise the challenges of system working.	Associate Director of Corporate Governance/ Company Secretary	September 2018	Agenda Item September 2018
TB/2018/065: Staff Guardian Annual Report	Mr Moynes and Mrs Butcher will look into developing a series of messages for cascade to staff.	Director of HR and OD	September 2018	Verbal Report
TB/2018/067: Integrated Performance Report	**Quality:** Dr Riley will provide an update at the next meeting in relation to the training of staff to undertake Structured Judgement Reviews. **Safer Staffing:** Mrs Pearson will provide an update on the work being undertaken with UCLan regarding the possible employment of nurses from Kosovo.	Medical Director Director of Nursing	September 2018 September 2018	Verbal Report Verbal Report

Item Number	Action	Assigned To	Deadline	Status
TB/2018/071: Quality Committee Update Report	The Board will receive and update regarding the outcome of the UNICEF Baby Friendly Gold Award revalidation visit when available.	Director of Nursing	September 2018	Verbal Report

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 87

12 September 2018

Purpose Information

Title	Chief Executive's Report
Author	Mr L Stove, Assistant Chief Executive
Executive sponsor	Mr K McGee, Chief Executive

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

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Recruitment and workforce planning fail to deliver the Trust objective Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

Introduction

1. Board members are asked to note the Chief Executive's report. The report, as normal, is split into three parts. Part one details major national initiatives, part two picks up on internal initiatives and part three is a summary of the Chief Executive's diary. The report continues to highlight how busy the Trust has been each month and also shows the progress that is being made on a number of fronts.

National Updates

2. Hospital vending machines that offer **healthy snacks** lead to NHS staff and patients consuming more water and dried fruit and **fewer crisps and sugary drinks**. A trial in one NHS Trust, in partnership with the Department of Health and Social Care (DHSC), removed unhealthier snacks from 11 cold drinks machines and six machines selling mixed snacks. It then added healthier products and positioned them so they were easily visible.
3. The BMJ reported on the 2017/18 DHSC accounts **"the true picture of provider finances shows a tough year ahead"** and what this means for NHS Trusts. They highlighted that the DHSC breached its revenue budget by around £85m and that NHS Improvement's 2017/18 quarter four figures put the sector position £960m in the red.
4. Tens of thousands of **children** are being given **antidepressants** despite warnings that the pills may harm developing brains for little benefit. A report in a national newspaper states that one in six adults in England used antidepressants last year — an increase of almost half a million since 2015. The figures include more than **70,000** people under 18 and almost 2,000 children of primary school age.
5. The number of **hospital beds for people with acute mental health conditions** has **fallen by almost 30% since 2009**. New official figures show that the number of beds for those with some of the most serious conditions - including psychosis, serious depression leading to suicidal feelings and eating disorders - has fallen from 26,448 in 2009 to 18,082 in the first quarter of this year.
6. The new Health and Social Care Secretary, Matt Hancock, has said he would give **GPs** alternatives to **"unsophisticated drugs"** and pledged to expand schemes to treat patients with mental health problems through social activities. Mr Hancock is promising £4.5m to help dozens of areas to set up **"social prescribing"** schemes as alternatives to medicine for people who are lonely or suffering from mental health problems.

7. Ministers are edging towards a retirement levy that would spread the burden while avoiding hitting young taxpayers which could be **a solution to the social care crisis**. According to Age Concern, 1.4 million older people are not getting the help they need to carry out essential everyday tasks such as washing and dressing, a 20% increase in only two years.
8. Data from Public Health England (PHE) shows **record numbers of children are classed as severely obese** by the time they leave primary school, ten times as many as thirty years ago.
9. Heatwave takes NHS 'back to winter conditions' - The NHS was **"back to winter conditions" as temperatures led to a surge of patients suffering dehydration and breathing problems.** NHS bosses said that operations were being delayed because beds were being taken up by older people sent from care homes, and that ageing hospital buildings were putting patients and staff at risk in the sweltering heat.
10. Official figures reveal growing **shortages of doctors, nurses, midwives and therapists** as a leading think tank warns that nursing vacancies are one of the 'biggest threats' facing the NHS.
11. Previously unpublished figures by NHS England show that **growing numbers of critically ill patients are coming to harm as a result of inadequate care.** The number of patients in hospital in England who are suffering harm in serious incidents because of delays in their treatment has risen significantly over the last two years from 1,027 in 2016-17 to 1,515 last year.
12. New freedom of information data reveals that **NHS staff are being attacked every 23 minutes** as hospital Trusts are forced to spend half a million pounds a year each on security.
13. **Senior NHS leaders**, including former NHS Improvement chief Jim Mackey and Northern Care Alliance NHS Group chief Sir David Dalton, **have welcomed a debate on emergency targets,** but warned that scrapping the four hour standard completely could be "too dangerous".
14. A leaked report commissioned by NHS England has revealed that **thousands of women have to cope alone with mental health problems caused by pregnancy or giving birth** because they cannot access the necessary help.
15. New figures from NHS Improvement has revealed that the **NHS has saved £324m in a year by switching from pricey branded drugs to cheaper generic versions.**

16. Children as young as **12 will be among the first patients** to be treated on the NHS **for gaming addiction.** This follows the World Health Organisation's (WHO) decision to classify gaming addiction as a medical disorder.
17. A conference at the Royal Society of Medicine reported that trauma surgeons warned that **knife crime is putting a strain on NHS resources,** with blood supplies depleted and victims having to spend months in hospital beds. The latest figures from the Office for National Statistics showed that knife crime, gun crime and murder rose nationally for the fourth consecutive year, with knife crime up by more than 20%.
18. Government **plans for a new NHS whistleblowing service have come in for criticism from MPs over "conflict of interest"** concerns about letting NHS hospitals investigate themselves.
19. The alcohol-based hand rubs that hospitals use to prevent infection are becoming less effective. Research from the University of Melbourne found a type of **hospital superbug is becoming increasingly tolerant of alcohol** – the key component of current disinfectant hand rubs.
20. The community network, established by NHS Providers and NHS Confederation, issued a letter to the leaders of NHS England and NHS Improvement **about the role of community services within the upcoming NHS plan**.
21. Figures from the Department of Education show that the **total number of people starting NHS apprenticeships** has fallen by more than a third in the past three years.
22. Some NHS **staff have been angered by the recent pay deal** for more than a million workers, complaining that they are not receiving the increases they had been promised.
23. The **Royal College of General Practitioners (RCGP) has called for an emergency cash injection of £2.5bn** to help struggling surgeries cope with demand and offer patients appointments within a reasonable time.
24. A **text message alert system could reduce deaths from sepsis** after a trial at one hospital led to a sevenfold increase in the number of patients getting drugs in time. Staff recorded a patient's temperature, pulse, blood pressure and consciousness on a handheld device and if a pattern suggested that the patient might have sepsis, which can be fatal, their doctor or nurse was sent a text.
25. A report shows that **twice the number of girls are admitted to hospital for self-harm** than 20 years ago.

26. Research on the nation's wellbeing, by Outcomes Based Healthcare, has found **a fifth of people in England cannot expect good health beyond their 30th birthday.**
27. NHS Blood and Transplant has put out an **urgent appeal for donations** because blood stocks have fallen below the level deemed necessary to meet current needs.
28. NHS England has been urged to **reverse a policy of withholding money** from a £200m cancer transformation fund from areas breaching the 62-day target.
29. The chair of the **Royal College of GPs (RCGP) urged health officials** to lift barriers slowing down recruitment from overseas.
30. The Labour Party reveals that some **NHS Trusts are hiring "temporary" agency workers for as long as 13 years at a time**. Figures gathered under Freedom of Information requests show that in total the NHS has spent £16.9bn on agency staff since 2012/13 – an average of £2.8bn a year.
31. The HSJ reports **that Matt Hancock, the new Health and Social Care Secretary**, has ordered a review of plans to switch desktop computers used by the Department of Health and Social Care and other arms-length bodies to new IT systems.
32. New research which suggests that **closing hospital emergency departments does not result in more deaths but neither does it improve outcomes for patients.**
33. The Care Quality Commission **(CQC) is considering introducing universal standard operating procedures for clinicians in a bid to cut the number of never event mistakes** across the NHS.
34. Comments from Lord Drayson, a former science minister, argue that **the NHS has a "responsibility to society" to make money out of patient data** rather than allowing the profits to be captured by US technology companies.
35. The average **GP now works less than three-and-a-half days a week** - and just one in 20 trainee doctors intends to do the job full-time.
36. A national report shows that the **introduction of major trauma centres as part of A&E** reforms under which ambulances can bypass their nearest hospital have saved the lives of more than 1,600 patients since their introduction in 2012.
37. The HSJ covers comments from the British Medical Association which suggest that the union will take a tougher stance with the government over planned reforms to consultant contracts.

38. Quarterly targets for **patients with suspected cancer** to see a hospital consultant within two weeks have been missed for the first time since records began in 2008.

Local Developments

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

a) **Use of the Trust Seal -** On 11 July 2018 – Deed of Amendment ELHT&Me Charity. The document was signed by the Chairman and the Chief Executive.

b) **Use of the Trust Seal** - On 13 August 2018 – Plans relating to the transfer in connection to the sale of Gas Governor Site in Burnley, between ELHT and Cadent Gas Limited. The documents were signed by the Chief Executive and the Director of Finance.

40. **ELHT has had some lovely events taking place across the organisation to rejoice at the NHS turning 70.** They have reflected the heart and spirit of ELHT, and its ongoing commitment to its patients, its community and its colleagues. One such event was ELHT being specially chosen by the Royal Mint to take part in its Great British Coin Hunt. We were one of ten NHS organisations across England to release the special 'NHS' design 10p coins. Staff, patients and visitors had the opportunity to receive a coin via their change when using any one of the Trust's restaurants.

41. It gave me great pleasure to speak at the **HSJ Patient Safety Congress** in Manchester sharing how we overcame our safety challenges. Patient safety is, of course, the NHS's and ELHT's most important duty. The NHS is committed to patient safety and is clear about that commitment. It is also at the very heart of ELHT's vision and values, which was acknowledged by the congress as our improvement work featured in both the programme for the event, and the shortlist for the **Patient Safety Awards**.

42. Chris Pearson, Director of Nursing has agreed to be the Executive Lead for **Learning Disabilities** for ELHT which is great news.

43. **We welcomed the CQC's Inspection teams** in August as they held staff focus groups over two days and across the two main hospital sites – Blackburn and Burnley. Anecdotal evidence is encouragingly reporting staff's views and their discussions with the inspections to have gone very well, with a positive theme throughout. The re-arranged focus group for our BME staff will be held at the end of September. A week-long inspection of our services is scheduled for the 24-28

September. Preparations are in full swing and everyone is ready to show the very best ELHT has to offer when the inspectors visit again.

44. The CQC Inspection teams also made their **unannounced visit to our community and older people's services** on 28 August. It was inspiring to hear how our staff embraced the opportunity to rise to the occasion and showcase their services. Initial high-level feedback from the CQC was around how impressively the Community Hospitals, district nursing services and integrated neighbourhood teams work together.

45. Plans have been put in place and a **major announcement made, to push the vision of Burnley becoming a 'university town'**. The significant expansion and long term commitment planed in Burnley by UCLan will go on to make huge positive impacts across the whole East Lancashire region. ELHT is actively supporting the University's education strategy by working in collaboration with UCLan, Burnley Borough Council and a group of influential local business leaders. The strategy is designed to meet the existing and emerging skills' needs of Burnley and East Lancashire. It is anticipated that the numbers of UCLan students in Burnley will rise from under 400 to 2,000 by 2021 and up to 4,000 by 2025.

46. ELHT has, for a long time, been highlighting the importance of effective discharges, timeliness and the contribution made by all staff – not just those in ED – in achieving the four hour standard. ELHT has relaunched its **'Every Minute Matter's** campaign, focussing on safe and effective flow of patients throughout the organisation. There will be training and information events and staff meetings to support the programme.

Summary of Chief Executive's Meetings for July 2018

02/03/18	EY support session to UEC Systems - RBTH
03/07/18	NHS70 celebration tea party – RBTH
04/07/18	Integrated Care System Board – Preston
04/07/18	UEC Session – Preston
05/07/18	The 70th Birthday of the NHS – Westminster, London
09/07/18	Partnership Delivery Group – Nelson
09/07/18	HSJ Patient Safety Awards – Manchester
10/07/18	HSJ Patient Safety Awards – Manchester
11/07/18	Trust Board – RBTH
18/07/18	Honorary Fellowship Award – Preston
19/07/18	A&E Delivery Board preparation Meeting – RBTH

19/07/18 NHSI Lean Programme - Blackburn
19/07/18 Accountable Health and Care Partnership Leaders Forum – Blackburn
20/07/18 NHS NWLA Board Meeting – Preston
25/07/18 Making it Happen Programme – Nelson
26/07/18 Diagnostic Project Group Meeting – Preston
27/07/18 System Teleconference – RBTH
27/07/18 Team Brief – RBTH
27/07/18 NHSI/ELHT Catch Up – RBTH
27/07/18 Team Brief – BGTH
27/07/18 Team Brief – PCH
31/07/18 EY Workshop – RBTH

Summary of Chief Executive's Meetings for August 2018

01/08/18 ICG system Board – Preston
01/08/18 Therapy Garden Opening - PCH
02/08/18 A&E Delivery Board – RBTH
02/08/18 Meeting with Kate Hollern MP – RBTH
03/08/18 Provider Board – Preston
06/08/18 Pennine Lancs Meeting – Preston
07/08/18 Employee of the Month – RBTH
07/08/18 Place Based Population Meeting with NHS PH – RBTH
08/08/18 Meeting with EL CCG – RBTH
09/08/18 GGI Board Development Programme – London
13/08/18 ELHT/UCLan Strategic Board – RBTH
14/08/18 A&E Delivery Board Preparation Meeting – RBTH
15/08/18 AO's, CEO's and STP Executive Meeting – Preston
15/08/18 Meeting with LCFT – RBTH
16/08/18 Meeting with Professor Singh – Teleconference
17/08/18 Meeting with EY – RBTH
18/08/18 NHS Quarterly Board Meeting – Teleconference

Summary of Chief Executive's Meetings for September 2018

03/09/18 NHS NWLA Meeting – Manchester
03/09/18 DHSC Officials – Teleconference
04/09/18 Accountable Health and Care Partnership Leaders Forum – Blackburn

05/09/18	ICG System Board – Preston
05/09/18	NHSE Expo – Manchester
06/09/18	NHSE Expo – Manchester
07/09/18	NHSI Use of Resources – RBTH
10/09/18	Regional Delivery Board Workshop – Leeds
12/09/18	Trust Board CQC Preparation Meeting – RBTH
12/09/18	Trust Board – RBTH
13/09/18	Partnership Delivery Group – Pendle
13/09/18	Evening walkabout, Meet the CEO and Chairman – RBTH
17/09/18	Meeting with the CEO of Burnley Council – Burnley
18/09/18	A&E Delivery Board Preparation Meeting – RBTH
19/09/18	Trust Board CQC Preparation Meeting – RBTH
19/09/18	Health Debate – Blackburn
19/09/18	ELHT AGM – RBTH
20/09/18	Pennine Lancashire VCF Leadership Group – RBTH
24/09/18	Interview for the joint ELCCG/BwD CCG Accountable Officer – Blackburn
24/09/18	NHS Confed Labour Party Conference Dinner – Liverpool
25/09/18	CQC Well Led Visit - ELHT
26/09/18	CQC Well Led Visit - ELHT
27/09/18	CQC Well Led Visit – ELHT

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 88

12 September 2018

Purpose Information

Title	Award of Honorary Professor and Honorary Senior Clinical Lecturer Posts
Author	Mr K McGee, Chief Executive
Executive sponsor	Mr K McGee, Chief Executive

Summary: The Trust has been working closely with the University of Central Lancashire (UCLan) in the development of a Joint strategy for education and research. In recognition of the contribution that ELHT staff are making to this work, UCLan have awarded a number of clinical staff posts as either Honorary Professors or Honorary Senior Clinical Lecturers.

Recommendation: The Board is asked to note the information presented in the report.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objective Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: NA

Award of Honorary Professor and Honorary Senior Clinical Lecturer Posts

1. The Trust has been working closely with the University of Central Lancashire (UCLan) in the development of a Joint strategy for education and research. In recognition of the contribution that ELHT staff are making to this work, UCLan have made a number of prestigious awards to clinical staff.
2. I am very pleased to be able to announce the award of the title of Honorary Professor to a number of senior clinical staff in the Trust. In recognition of commitment to education, strategic partnership and research, the title of **Honorary Professor** has been bestowed upon the following consultants:
   a) Professor Lee-Suan Teh
   b) Professor Damien Lynch
   c) Professor Robin Paton
   d) Professor Scott Garg
   e) Professor Anton Krige
   f) Professor Damian Riley
3. Many congratulations go also to the consultants who have been awarded **Honorary Senior Clinical Lecturer** status:
   a) Anna Macpherson
   b) Chintan Sanghvi
   c) Fawad Zaman
   d) Fizan Younis
   e) Gary Cousin
   f) Iain Crossingham
   g) John Dean
   h) Manu Shah
   i) Martin Maher
   j) Naseem Ghazali
   k) Nasira Misfar
   l) Saifudin Khalid
   m) Shalom Srirangam
   n) Shenaz Ramtoola
   o) Simon Hill
   p) Surya Narayan

4. This is a huge achievement, and it acknowledges and celebrates the contributions and efforts of our many clinical colleagues.
5. Our strategic partnership with UCLan will continue to grow and develop so helping to attract our workforce of the future, ultimately benefiting the delivery of patient care across the whole of Lancashire.

Kevin McGee, Chief Executive, 30 August 2018.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 90

12 September 2018

Purpose Action

Title	Corporate Risk Register Report
Author	Mr D Tita, Risk Manager
Executive sponsor	Dr D Riley, Executive Medical Director /Deputy Chief Executive

Summary: The report presents an overview of the Corporate Risk Register (CRR) and some risks which have been recommended by Divisions/Corporate areas to the RAM for approval for inclusion onto the CRR. The Corporate Risk Register is presented for approval with changes in month highlighted in the body of the report.

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objective Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Introduction

1. The Risk Assurance Meeting (RAM) has delegated responsibility for verifying, reviewing, scrutinising, monitoring and approving the Corporate Risk Register (CRR). The changes recommended by the RAM and Patient Safety Risk Assurance Committee to the Corporate Risk Register are set out in this report. Directors have also reviewed their risks to reflect any changes in the current risk profile. The main thrust of this report is to provide information and assurance that there are effective processes, systems, mechanisms and governance arrangements in place to robustly manage the Trust Corporate Risk register.

2. There are currently nine live risks on the CRR which are as follows:

Risk	Title	Current Score
7010	Aggregated Risk - Failure to meet internal & external financial targets in year will adversely impact the continuity of service Risk Rating	20
7457	Failure to have PACS operating effectively adversely impacts patient care and performance	16
7684	Failure to provide assurance of regulatory compliance for safety alerts received through the Central Alerting System	15
7583	Loss of facility for Containment Level 3 in pathology	15
7529	Risk of not attaining the CQUIN for Hepatitis C treatment pathways through the Operational Delivery Network hub based at ELHT	15
1810	Failure to meet service needs due to lack of Trust capacity impacts adversely on patient care	15
5790	Aggregated risk - Failure to reduce medical locum costs will adversely impact financial sustainability and patient care	15
5791	Aggregated Risk Failure to reduce nursing & midwifery agency costs will adversely impact financial sustainability & patient care	15
7067	Aggregated Risk - Failure to secure timely MH treatment impacts adversely on patient care & safety and quality	15

3. The following two risks were discussed at the RAM and pending further information will be reviewed again before being discussed at Patient Safety & Risk Assurance Committee and the Quality Committee:

a) Risk 6664 - Vascular Centre Status - This risk is currently scored at 15 due to the Trust potentially losing vascular centre status and the service attached to it. These services have an income plan of approximately £7.9 million; the service specification requirements are not being met resulting in the decommissioning of the service.

b) Risk 7330 and Risk 7123 - Potential breach of Patient data, loss of / or reduced income and failure to identify and monitor safeguarding concerns in a timely manner and Inadequate Safeguarding Information Recorded in Maternity Notes.

4. Both of the above risks were scoring 15, however, it was agreed at the RAM for these risks to be combined into one overarching risk as they are closely associated with each other. The new risk under 7330 has been scored at 20; however, this is subject to a further review at the RAM.

Risks discussed for de-escalation from the Corporate Risk Register:

5. No risks were considered for de-escalation from the CRR.

New Risks reviewed by the RAM with a view to them being included on the Corporate Risk Register:

6. The following risks were presented for review and discussion at the RAM with regards to being incorporated onto the CRR:

a) Risk 6664 – Vascular Centre Status – **recommended for inclusion on the CRR (see above),**

b) Combined Risks 7330 and 7123 – Potential breach of Patient data, loss of / or reduced income and failure to identify and monitor safeguarding concerns in a timely manner and Inadequate Safeguarding Information Recorded in Maternity Notes – **recommended for inclusion on the CRR as a combined risk, pending further review and additional information (see above).**

c) Risk 7649 – Asbestos – **not recommended for inclusion on the CRR.**

d) Risks 2636 (Inability to maintain establishment of Consultant Histopathologists) and 7679 (Excessive Patient Wait for Treatment/ Failure of RTT and Cancer targets in Urology) that were deferred from the meeting in July for discussion in August, have within time been reviewed and downgraded by their handlers to 9 and 12 respectively. Hence, these were not presented for consideration and approval for inclusion onto the CRR at the RAM.

Corporate Risk Register (Appendix 1):

7. The current Corporate Risk Register is attached as appendix 1, whilst appendix 2 provides a one page representation of all risks on the CRR by showing their current score.

Conclusion

8. The Board is asked to note the assurances provided in relation to the ongoing management of the risks on the Corporate Risk Register and to approve this report.

David Tita, Trust Risk Manager, August 2018

Appendix 1: The Corporate Risk Register – Current Risks					
Title:	Aggregated Risk - Failure to provide timely Mental Health treatment impacts adversely on patient care & safety and quality				
ID	7067	Current Status	Live Risk Register – all risks accepted	Opened	06/10/2016
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 2 Consequence:3 Total: 6
Risk Handler:	Jill Wild	Risk Owner:	John Bannister	Linked to Risks:	2161 - Failure to provide sufficient skilled staffing for the needs of Tier 4 patients on the Paediatrics Ward will adversely continue - (12) 7582 -Inability to meet the needs of high risk mental health patients on in patient wards within ICG - (8)
What is the Hazard:	Mental Health patients with decision to admit may have extended waits for bed allocation.		What are the risks associated with the Hazard:		• Breach of 4 hour standard in ED • Breach of 12 hour trolley wait standard in ED • Impact on patient care • Risk of harm to other patients • Impact on staffing to monitor/ manage patient with MH needs
What controls are in place:	• Development of LCFT Clinical Decision Unit • Frequent meetings to minimise risk between senior LCFT managers and Senior ELHT managers to discuss issues and develop pathways to mitigate risk including; • Mental Health Shared care policy, • OOH Escalation pathway for Mental health patients, • Instigation of 24hrs a day Band 3 MH Observation staff.		Where are the gaps in control:		• Unplanned demand • ELCAS only commissioned to provide weekday service • Limited appropriately trained agency staff available

	• In Family Care – liaison with ELCAS • Monthly performance monitoring • Monitoring through Pennine Lancashire improvement pathway • Monitoring by Lancashire and Cumbria Mental Health Group • Twice weekly review of performance at Executive Team teleconference • Discussion and review at four times daily clinical flow meeting • Introduction of mental health triage service within ED		
What assurances are in place:	• Ongoing meetings with LCFT and commissioners • Regular review at Divisional and Executive team level • Appropriate management structures in place to monitor and manage performance • Appropriate monitoring and escalation processes in place to highlight and mitigate risks • Ongoing monitoring of patient feedback through a variety of sources • Escalation of adverse incidents through internal & external governance processes • Appropriate escalation and management policies and procedures • Joint working with external partners • Daily system teleconferences • A&E Delivery Board monitoring	What are the gaps in assurance:	Other agency capacity and availability of s136 facilities
Actions to be carried out			

Per linked risks
Risk mitigation action plans are appended to each of the linked risks and are reviewed by the Divisions on an on-going basis with assurances being provided to Divisional meetings.

Title:	Failure to meet service needs due to lack of Trust capacity impacts adversely on patient care				
ID	1810	Current Status	Live Risk Register – all risks accepted	Opened	05/07/13
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 3 Total: 9
Risk Handler:	Tony McDonald	Risk Owner:	John Bannister	Linked to Risks:	2310 - Failure to deliver 18 week Referral to treatment waiting times has an adverse impact on staff and patients (12), 3835 - Failure to appoint to vacant oncologist posts is impacting on service delivery and provision of safe, personal, effective care (16), 7587 - (There is a risk that patient's in ED at RBH are not always receiving optimal care due to a lack of embedded clinical systems- 12) 7108 - Extreme escalation areas open in response to capacity issues in ICG - (15)
What is the Hazard:	• Lack of bed capacity across the Trust can lead to extreme pressure resulting in a delayed delivery of the optimal standard of care across departments. • At times of extreme pressure this increase in the numbers of patients within the emergency pathway makes medical/nursing care difficult and impacts on clinical flow		What are the risks associated with the Hazard:	• Patients being managed on trolleys in the corridor areas of the emergency /urgent care departments impacting on privacy and dignity. • Delay in administration of non-critical medication. • Delays in time critical patient targets (four hour standard, stroke target) • Delay in patient assessment • Potential complaints and litigation.	

			• Potential for increase in staff sickness and turnover. • Increase in use of bank and agency staff to backfill. • Lack of capacity to meet unexpected demands. • Delays in safe and timely transfer of patients
What controls are in place:	• Daily staff capacity assessment • Daily Consultant ward rounds • Establishment of specialised flow team • Bed management teams • Delayed discharge teams • Ongoing recruitment • Ongoing discussion with commissioners for health economy solutions • ED/UCC/AMU will take stable assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley • ED/UCC/AMU will take stable assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley • Introduction of Full Capacity Protocol • Refined 2 hourly patient flow meetings	Where are the gaps in control:	Trust has no control over the number of attendees accessing ED/UCC services
What assurances are in place:	• Regular reports to a variety of specialist and Trust wide committees • Consultant recruitment action plan • Escalation policy and process • Monthly reporting as part of Integrated Performance Report • Weekly reporting at Exec Team • System Oversight by Pennine Lancashire A+E Delivery Board	What are the gaps in assurance:	None identified
Actions to be carried out			
Numerous actions are incorporated within the Emergency Care Pathway Redesign Programme which forms part of the Trust's Transformation			

Programme Review the impact of the newly introduced Full Capacity Protocol and refined patient flow meetings Development of Ambulatory and Emergency Care Unit and new pathways
Notes: Mitigating actions are deployed on a daily basis at an operational level to reduce the risk to patient care.

Title:	Aggregated risk – Failure to reduce medical locum costs will adversely impact financial sustainability and patient care				
ID	5790	Current Status	Live Risk Register – All risks accepted	Opened	11/09/15
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 3 Total: 9
Risk Handler:	Simon Hill	Risk Owner:	Damian Riley	Linked to Risks:	4488 - Inadequate Senior Doctor Cover for MFOP - (12), 7268 - Clinical, financial and organisational risks of (SOS) and T&O short and long term rota gaps – (9), 5557 - (Adequate Medical Staffing - 12) 3835 - Failure to appoint to vacant oncologist posts is impacting on service delivery and provision of safe, personal, effective care - (16), 7401- There is a risk that patients may not receive timely clinical care due to a lack of junior doctor cover on medical wards in ICG - (10)
What is the Hazard:	Gaps in medical rotas require the use of locums to meet service needs at a premium cost to the Trust		What are the risks associated with the Hazard:	• Escalating costs for locums • Breach of agency cap • Unplanned expenditure • Need to find savings from elsewhere in budgets	
What controls are in place:	Divisional Director sign off for locum usage Ongoing advertisement of medical vacancies Consultant cross cover at times of need		Where are the gaps in control:	Reduction in agency staffing costs form previous year has already been demonstrated, however, the availability of medical staff to fill permanent posts continues in some areas, linked to regional or national shortages in some specialties	
What assurances are in place:	Directorate action plans to recruit to vacancies		What are the gaps in assurance:	None identified.	

	Reviews of action plans and staffing requirements at Divisional meetings Reviews of action plans and staffing requirements at trust Board meetings and Board subcommittees Reviews of plans and staffing requirements at performance meetings Analysis of detailed monthly report through AMG (Agency Monitoring Group). Areas for targeted action understood		
Actions to be carried out			
Per individual linked risks Ongoing recruitment and innovative packages offered Workforce transformation and new models of skill mix On-going pressure to reduce locum rates			
All requests to exceed capped rates to be approved by medical directorate on a case by case basis.			

Title:	Aggregated risk – Failure to reduce nursing and midwifery agency costs will adversely impact financial sustainability and patient care				
ID	5791	Current Status	Live Risk Register – all risks accepted	Opened	11/09/15
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 3 Consequence: 5 Total: 15	Target Rating:	Likelihood: 4 Consequence: 2 Total: 8
Risk Handler:		Risk Owner:	Christine Pearson	Linked to Risks:	3804 - Failure to recruit and retain nursing staff across inpatient wards and departments may result in inadequate nurse staffing - (12) 7496 - There is a risk of failing to deliver financial balance against the ICG nursing budget - (12)
What is the Hazard:	Use of agency staff is costly in terms of finance and levels of care provided to patients		What are the risks associated with the Hazard:	• Breach of agency cap • Agency costs jeopardising budget management	
What controls are in place:	• Daily staff teleconference • Reallocation of staff to address deficits in skills/numbers • Ongoing reviews of ward staffing levels and numbers at a corporate level • 6 monthly audit of acuity and dependency to staffing levels • Recording and reporting of planned to actual staffing levels • E-rostering • Ongoing recruitment campaigns • Overseas recruitment as appropriate • Establishment of internal staff bank arrangements • Senior nursing staff authorisation of agency usage		Where are the gaps in control:	• Unplanned short notice leave • Non elective activity impacting on associated staffing • Break downs in discharge planning • Individuals acting outside control environment	

	• Monthly financial reporting		
What assurances are in place:	• Daily staffing teleconference with Director of Nursing • 6 monthly formal audit of staffing needs to acuity of patients • Exercise of professional judgement on a daily basis to allocate staff appropriately • Monthly report at Trust Board meeting on planned to actual nurse staffing levels • Active progression of recruitment programmes in identified areas	What are the gaps in assurance:	
Actions to be carried out			
All current planned actions completed as shown in "what controls are in place" Non-Medical Bank and Agency Group			
Risk mitigation action plans are appended to each of the linked risks and are reviewed by the Divisions on an on-going basis with assurances being provided to Divisional meetings.			

Title:	Aggregated Risk – Failure to meet internal and external financial targets in year will adversely impact the Continuity of Service Risk Rating				
ID	7010	Current Status	Live Risk Register – all risks accepted	Opened	25/08/16
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 5 Consequence: 4 Total: 20	Target Rating:	Likelihood: 4 Consequence: 3 Total: 12
Risk Handler:	Allen Graves	Risk Owner:	Jonathan Wood	Linked to Risks:	1487 - Failure to deliver the SRCP- (12) 1489 - Failure to meet the activity and income targets - (12) 6692 - Risk to safe, personal and effective service delivery due to lack of quality information from Community IT systems (EMIS) - (15)
What is the Hazard:	Failure to meet the targets will result in the Trust having an unsustainable financial position going forward and the likely imposition of special measures		What are the risks associated with the Hazard:	• If Divisions deliver their SRCP and meet their Divisional financial plans the Trust will achieve its agreed control total. • Breach of control totals will likely result in special measures for the Trust, adverse impact on reputation and loss of autonomy for the Trust • Sustainability and Transformational funding would not be available to the Trust • Cash position would be severely compromised	
What controls are in place:	• Standing Orders • Standing Financial Instructions • Procurement standard operating practice and procedures • Delegated authority limits at appropriate levels • Training for budget holders • Availability of guidance and policies on Trust intranet • Monthly reconciliation		Where are the gaps in control:	Individual acting outside control environment in place	

	• Daily review of cash balances • Finance department standard operating procedures and segregation of duties		
What assurances are in place:	• Variety of financial monitoring reports produced to support planning and performance • Monthly budget variance undertaken and reported widely • External audit reports on financial systems and their operation • Monthly budget variance undertaken by Directorate and reported at Divisional Meeting • Monthly budget variance report produced and considered by corporate and Trust Board meetings • internal audit reports on financial system and their operation	What are the gaps in assurance:	
Actions to be carried out			
Per individual linked risks			
Notes: Risk mitigation action plans are appended to each of the linked risks and are reviewed by the Divisions on an on-going basis with assurances being provided to Divisional meetings.			

Title:	Failure to have PACS operating effectively adversely impacts patient care and performance				
ID	7457	Current Status	Live Risk Register – all risks accepted	Opened	30/08/17
Initial Rating	Likelihood: 5 Consequence: 4 Total: 20	Current Rating:	Likelihood: 4 Consequence: 4 Total: 16	Target Rating:	Likelihood: 3 Consequence: 4 Total: 12
Risk Handler:	Neil Fletcher	Risk Owner:	Johnathon Wood	Linked to Risks:	7552 - PACS downtime - (16)
What is the Hazard:	• Lack of data available while treating patient could cause harm		What are the risks associated with the Hazard:	• Delays in patient pathway. • Downtime in clinics and theatres • Poor patient experience • Failure of backup systems • Increased complaints.	
What controls are in place:	• Discussions with Managed Equipment Service • Backup systems involving getting physical or disk copies of images		Where are the gaps in control:	Unpredictable unavailability	
What assurances are in place:	• Regular reports to a variety of specialist and Trust wide committees		What are the gaps in assurance:	None identified	
Actions to be carried out					
Ongoing discussions with supplier being led by Director of Finance					

Title:	Loss of facility for Containment Level 3 in pathology				
ID	7583	Current Status	Live Risk Register – all risks accepted	Opened	26/11/17
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 1 Consequence: 3 Total: 3
Risk Handler:	Pamela Henderson	Risk Owner:	Johnathon Wood	Linked to Risks:	N/A
What is the Hazard:	• Changes to air pressure have caused rips and bubbling of the vinyl wall covering. If the wall covering integrity is damaged beyond immediate repair the CL3 facility will be put out of use.		What are the risks associated with the Hazard:	• Chemicals used to treat contaminants will not be contained within the L3 facility	
What controls are in place:	• Ongoing daily inspection and remedial action in response to vinyl covering issues		Where are the gaps in control:	None identified	
What assurances are in place:	• Ongoing discussions and reporting with PFI partners on a daily basis		What are the gaps in assurance:	None identified	
Actions to be carried out					
Discussion with PFI partners and specialists progressing to remedy issues. Consort have taken on the proposed refurbishment and plans are going out to tender in the near future.					

Title:	Failure to provide assurance of regulatory compliance for safety alerts received through the Central Alerting System				
ID	7684	Current Status	Live Risk Register – all risks accepted	Opened	11/04/2018
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 3 Consequence: 5 Total: 15	Target Rating:	Likelihood: 1 Consequence: 5 Total: 5
Risk Handler:	John Houlihan	Risk Owner:	Damian Riley	Linked to Risks:	N/A
What is the Hazard:	A review of the policy arrangements for the management of central alerting system notifications (formerly safety alert broadcast system) noted formal processes to identify the dissemination and communication of safety alerts and safety critical information across the Trust and of procedural controls in monitoring and auditing its effectiveness through a nominated Committee or Group are not robust enough or effective		What are the risks associated with the Hazard:	The communication of safety alerts and other safety critical information issued through the Central Alerting System helps NHS and other organisations, including independent providers of health and social care, to enact upon potential risks of harm or death to staff, patients and public safety. All of which if not properly controlled, may; * Result in the issue of enforcement action and fines * Impact upon claims management and the ability to defend liability claims * Affect CQC registration and license to operate requirements * Affect the commercial viability, credibility and reputation of the Trust	
What controls are in place:	* A robust enough system remains in place to receive safety alert notifications issued by the Medicines and Healthcare Products Regulatory Agency through the Central Alerting System * A robust enough system remains in place of acknowledging		Where are the gaps in control:		

	safety alert notifications as required within two days of issue through the Central Alerting System Work remains continuous in developing, harmonising and improving the systems and processes by which safety alerts are managed so as to form a unified approach across the Trust. Submission of Central Alerting		
What assurances are in place:	PSRAC Reporting	What are the gaps in assurance:	
Actions to be carried out			
System Performance Report highlighting a review of existing controls, gap analysis and recommended recovery plan for implementation of further controls to be presented for approval at the Patient Safety and Risk Assurance Committee and actions to receive assurance on any outstanding alerts taken. SOP to be developed with DATIX module. Ongoing assurance to be provided to PSRAC			

Title:	Risk of not attaining the CQUIN for Hepatitis C treatment pathways through the Operational Delivery Network hub based at ELHT				
ID	7529	Current Status	Live Risk Register – all risks accepted	Opened	17/10/2017
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 3 Consequence: 5 Total: 15	Target Rating:	Likelihood: 2 Consequence: 3 Total: 6
Risk Handler:	Matt Sutcliffe	Risk Owner:	John Bannister	Linked to Risks:	N/A
What is the Hazard:	Financial risk due to CQUIN contract for HCV ODN delivery of pathways. Updated triggers for CQUIN received in October 2017 with measure and payments that require strategic involvement across the network. Quarter 3 and Trigger B2 of the CQUIN for 2017/2018 failed due to not achieving the run rate and cost of treatments issued.		What are the risks associated with the Hazard:	Financial - Penalty for not achieving the CQUIN, loss of incentive (partnership working and governance, plus 1.6% of overall CQUIN) Financial - lack of treatment may incur increased incidence of liver disease and the effects. Clinical - lack of HCV antiviral provision for patients with HCV across the network - having to give slots away to other ODN's. Reputation - ELHT is the hub for the ODN and failure to achieve the CQUIN may result in the ODN being lost to a larger Trust.	
What controls are in place:	ODN set up with weekly meetings for approval of treatments across Lancashire networks. Minute meetings and clinical treatment decisions for all organisations.		Where are the gaps in control:	Workforces gaps, project manager, case finder/band 3 further nursing support – No funding secured for posts Strategic support for Triggers required	

	Clinical registry of patients initiated and live. Run rate divided across network according to population served. Specialist pharmacist Medical support with deputy and 24 hour support. Experienced specialist nurses across the network. Temporary post of MDT-ODN co-ordinator for help with collation of statistics.		across the network with other partners. Memorandum of Understanding requires partnership sign-off, signed by ELHT Partnership organisations not hitting the run rates Letter received from NHSE identified insufficient staffing and lack of robust memorandum of understanding Hepatology nurse of long term sick
What assurances are in place:	PSRAC Reporting	What are the gaps in assurance:	
Actions to be carried out			
Ongoing discussions with partner organisations. Work towards completion of Peer review Action Plan Work towards completion of Peer review Action Plan			

New Risks for RAM and PSRAC for review and approval prior Quality Committee and inclusion onto the Corporate Risk Register					
Title:	Vascular Centre Status				
ID	6664	Current Status	Live Risk Register – all risks accepted	Opened	07/03/2016
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 3 Consequence: 5 Total: 15	Target Rating:	Likelihood: 2 Consequence: 2 Total: 4
Risk Handler:	Nikita Pickard	Risk Owner:	Robert Salaman	Linked to Risks:	N/A
What is the Hazard:	The hazard is that we will lose our status as vascular centre and the service attached to it which has an income plan of approx. £7.9million, 55WTE staff and will have a detrimental impact on care provided in other sub specialties such as, but not limited to, Interventional Radiology, General Surgery, Diabetes and Urology which may impact the recruitment to these specialties.		What are the risks associated with the Hazard:	The risk is that the service specification requirements to be a vascular centre is not met resulting in the decommissioning of the service. These requirements are: - minimum number of carotids and AAA repairs - 6 Interventional Radiologists and an associated 24/7 on call rota - Activity to sustain 6 vascular surgeons and an associated 24/7 on call rota.	
What controls are in place:	Active review of current capacity Expansion of peripheral clinics Targeted capacity at in demand areas Project group to be initiated regarding a hybrid theatre build. Action plan to roll out one stop vascular scanning facilities		Where are the gaps in control:	Commissioning decisions are hard to influence and the market in this area is currently dominated by Preston. Interventional radiologists are hard to recruit.		

	Review of consultant job plans Strategic working where possible with local neighbours Work on going to improve position as a vascular centre.		
What assurances are in place:		What are the gaps in assurance:	
Actions to be carried out			
Micromanagement of arterial work and monitoring through Directorate meetings Task and finish group around join working of radiology and vascular surgery chaired by Dr Riley			

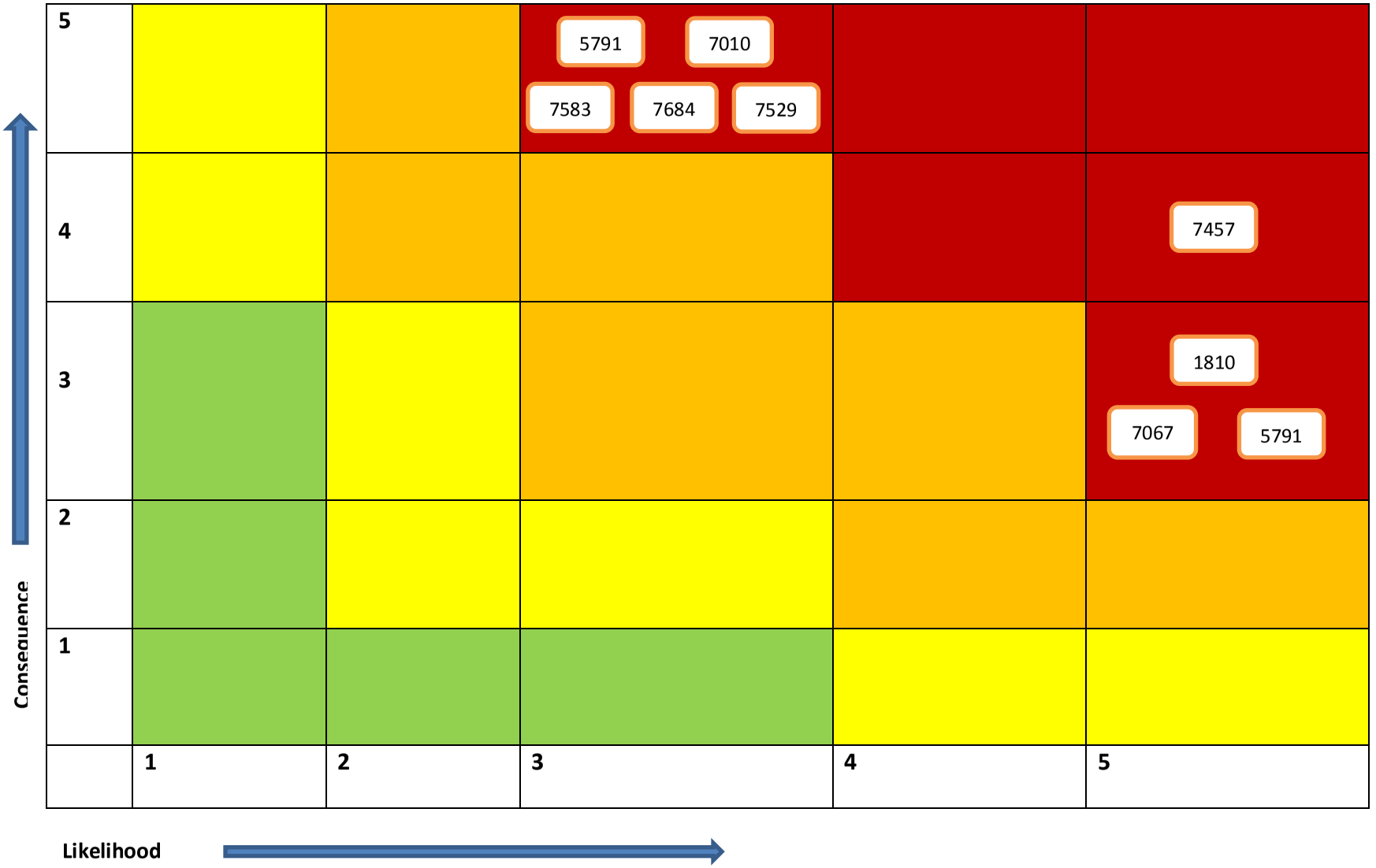
New Risks for RAM and PSRAC for review and approval prior Quality Committee and inclusion onto the Corporate Risk Register					
Title:	• Potential breach of Patient data, loss of / or reduced income and failure to identify and monitor safeguarding concerns in a timely manner • Inadequate Safeguarding Information Recorded in Maternity Notes.				
ID	7330 and 7123	Current Status	Live Risk Register – all risks accepted	Opened	29/01/2018
Initial Rating	Likelihood: 5 Consequence: 4 Total: 20	Current Rating:	Likelihood: 5 Consequence: 4 Total: 20	Target Rating:	Likelihood: Consequence: Total:
Risk Handler:	Adele Morton	Risk Owner:	Angela O'Toole	Linked to Risks:	N/A
What is the Hazard:	There is not one complete patient record to support clinical care from the moment of booking to the postnatal discharge date Inability to identify the cohort of women, foetus' and babies who require screening in the antenatal and postnatal period. Potential for abnormal screening tests not to be followed up / acted upon as midwives working in community do not have access to the ICE system. Impacts on resources and staff time managing these gaps. Potential for litigation. Loss of / reduced income due to using paper sheets for coding purposes. Inability to collate the maternity dataset information that		What are the risks associated with the Hazard:	ELHT uses the maternity IT system Athena /Guardian for intrapartum and postnatal care. There is no currently no end to end maternity system in use at ELHT that allows a seamless information flow Inability to meet the National screening targets. Abnormal screening results not identified and acted upon. Serious safeguarding concerns not acted upon and managed in a timely manner potentially leading to a serious case review.		

	is required nationally. Potential for adverse media coverage. Safeguarding risk as midwives working in the community unable to file notes in patient records in a timely manner. Midwives working in community do not have access to the full patient record and have limited information in relation to the woman's medical / obstetric and social history. Potential for safeguarding concerns to be missed or plans not updated. Lack of robust system for handover of care to GP's and Health Visitors, stop smoking service etc. at present these are paper based systems. Failure to meet national targets to improve health and wellbeing for women, babies and children such as the national target for the reduction of women smoking due to paper based referral systems. Risk of information being lost or stolen whilst staff carrying around patient records whilst in the community setting. Risk of information governance / general data protection breach.		Potential for fines for breaching information governance / general data protection rules. Poor patient experience. Potential loss of income to the organisation due to a paper based coding system for payment within maternity systems. Potential fines for not meeting national targets / KPI's. Potential to be identified as outliers nationally in national reports for example the National Maternal Perinatal Audit / National Neonatal Audit.
What controls are in place:	Dedicated clinic for quadruple screening. Coding Clerks/Assistant business manager have various processes in place to ensure that the maternity tariff is captured. This includes ensuring that 'co-morbidity' from uplifted antenatal tariffs flow through to ensure uplift in postnatal tariff Collation of data to reduce gaps in data collection from various IT systems which is time consuming. Review of processes when incidents occur. Review of monitoring systems and data collection systems to ensure ELHT Maternity Services report locally and	Where are the gaps in control:	

	nationally all data that is able to be captured. Midwives and Maternity Support Workers manually input data in a variety of ways. Midwives able to view GP EMIS in certain settings in order to look at the medical history of women. Paper based diaries in place to record when investigations have been undertaken to ensure they are followed up and acted upon. Excel spread sheets developed and utilised to manage women with abnormal antenatal and newborn screening results		
What assurances are in place:	Risk assessment to be reviewed every 3 months at Divisional Management Board and progress against the actions overall risk discussed and escalated through the Risk Assurance Meeting. Risk assessment to be monitored via the Risk Assurance Meeting once accepted on to the Trust Risk Register.	What are the gaps in assurance:	
Actions to be carried out			
To work with IM&T to develop and implement an end to end maternity system To review and identify gaps in data submission To continue to monitor processes in division in relation to record keeping To work alongside IM&T in the procurement of an end to end maternity system			

Appendix 2: One page representation of the Corporate Risk Register as at 2 August 2018 showing risk IDs and their current scores: (9 Risks in total)

East Lancashire Hospitals NHS Trust



Safe | Personal | Effective

Retain 30 years
Destroy in conjunction with National Archive Instructions
V:\Corporate Governance\Corporate Meetings\TRUST BOARD\2018\06 September\Part 2\(090) NEW - Corporate Risk Register Report July - 2018 V2 KI.docx

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 91

12 September 2018

Purpose Approval

Title	Board Assurance Framework (BAF)
Author	Mrs A Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary
Executive sponsor	Dr D Riley, Medical Director

Summary: The Executive Directors have revised the BAF and examined the controls and assurances, together with any gaps, to establish whether they have changed. They considered whether they risks are still relevant or have they altered and updated the BAF, including any milestones and timelines as appropriate.

The BAF has now been presented to the Audit Committee on 14 August 2018 where further revisions were requested. A further session of the Audit Committee has been arranged for the 1 October 2018 to carry out some further in-depth review of particular BAF risks.

The document presented to the Board includes the revisions requested by the Audit Committee in addition to the usual review of the risks by the Executive Directors.

Recommendation: The Board is asked to discuss the revised BAF, including the controls, potential sources of assurance, gaps and actions to address and mitigate these and approve the document.

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: Audit Committee, Executive Directors (August 2018).

(91) Board Assurance Framework

1. The Board Assurance Framework (BAF) brings together in one document all of the relevant information on the risks to the Trust's strategic objectives. By regularly reviewing it, the Trust is in a position to identify whether the BAF remains fit for purpose and whether it provides the Board with real confidence that it is having a thorough oversight of the strategic risks.
2. The effective application of assurance processes in producing and maintaining the BAF is enabling the Board to consider the process of securing the necessary assurance using formal procedures that promote good governance and accountability, whilst gaining a clear and comprehensive understanding of the risks faced by the Trust in pursuing its strategic objectives.
3. The BAF informs the Board about the types of assurance currently obtained, so consideration can be given whether they are effective and efficient and enables the Board to identify areas where the existing controls might be failing and the risks that are more likely to occur as a consequence. The BAF also gives the Board the ability to better focus the existing assurance resources.
4. Following the last review, the Board is asked to discuss and approve the proposed changes to the BAF and the risk scores set out below:

Risk 1: Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives.

5. There is a **proposed increase to the risk score**, moving it from 16 **to 20** based on the increased likelihood of the risk materialising (likelihood **5** x consequence **4**), due to the SRCP schemes not delivering the anticipated savings for the current period.
6. The following key controls have been included:
   a) The programme is monitored through the Improvement Practice Office who report to the Operational Delivery Board and the Finance and Performance Committee.
   b) All schemes are aligned to the Trust's clinical, financial and operational strategies.
   c) The Trust has been selected to be in the first cohort of the new NHSI Lean programme (Vital Signs) and are working with the NHSI Lean Team to develop a single improvement methodology across Pennine Lancashire - 'the Pennine Way'.

7. Potential sources of assurance have been updated and the following information has been included:
   a) Monthly report demonstrating progress against key targets reported to the Finance & Performance Committee.
   b) The Lean Programme (Vital Signs) overall linking to the workforce transformation.
   c) Agreed transition to one Pennine Lancashire team, one transformation plan and one improvement methodology - allowing all schemes to gain traction and improve delivery.
   d) Several senior ELHT clinicians attending Care Professional Board workshops
   e) Model Hospital and GIRFT
   f) Gaps in control have been revised to include the opportunities to link transformation objectives to appraisals.
8. Gaps in assurance now include:
   a) Model Hospital and associated processes are still developing.
   b) Early planning of improvement events and flexible approaches to enable the release of clinicians for improvement activities.
   c) Not delivering the percentage increase regarding the Productivity and Efficiency transformation that we aspire to. Internal changes are needed; and external efficiencies require Pennine Lancashire whole system working.
   d) Risks associated with the high concentration of efficiency schemes being scheduled to release savings in the second half of the year, the potential impact which winter pressures may have on this work and the number of non-recurrent schemes in the plan.
9. The actions planned and updates have been revised to include:
   a) Performance Assurance Framework due for review in quarter 2 will be presented to the Finance and Performance Committee on 24 September 2018
   b) Care Professionals Board held a workshop with a wider audience in August 2018 to create plans for a Pennine Lancashire Professional Executive Committee, bringing together relevant professionals to support the Pennine Lancashire transformation.
   c) Divisions attending Finance and Performance Committee from September 2018 onwards to provide assurance on the delivery of SRCP.

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

10. The **risk score remains 12** (likelihood 3 x consequence 4).
11. The potential sources of assurance have been updated to include the linking of the Lean Programme (Vital Signs) to workforce transformation.
12. Gaps in assurance now include the inability to control external factors (Brexit, visas etc).
13. Actions and updates have been updated to include:
    a) 23 nurses have been sourced via the Global Learners Programme.
    b) A large scale HCA recruitment exercise is complete, resulting in over 100 appointments. HCA bank shift requests have reduced by 1,500 per month as a result, thus adding further stability and flexibility to our support workforce.
    c) A Senior Medical Staffing Performance Review Group has now been established and will take responsibility for reviewing all consultant job plans, consultant vacancies etc. adding further rigor on our appropriate use of resource.
    d) The National WRES Lead is visiting the Trust on 8 October 2018 and arrangements are being made for the visit.
    e) The Trust is working with ICP partners to undertake systematic and integrated workforce transformation linked to the NHSI Lean improvement programme. We are working across the ICS to develop a mobility agreement to assist with the movement of staff across the region. A Recruitment and Selection Strategy is being developed to underpin a system wide approach to recruitment.
    f) The 12 hour shift project is now complete, reducing the number of nursing shift patterns to fewer than 10 (from 250+) allowing for greater resource flexibility to cover gaps and reduce agency usage.

Risk 3: Alignment of partnership organisations and resources required (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP and other providers) could impact adversely on our ability to become an outstanding acute provider.

14. The **risk score remains 12** (likelihood 3 x consequence 4).
15. There is a proposal to revise the strategic risk to the following: **Lack of effective engagement within the partnership organisations (ICS and ICP) results in failure to work together causing a detrimental effect on the health and wellbeing of our communities.**

16. There is also a proposal to revise the first consequence of the risk materialising from **Failure to work together consistently as partner organisations in an Integrated Care System and Integrated Care Partnership (ICS and ICP)** to: **Failure to engage leadership and wider stakeholder groups**
17. The potential sources of assurance have been reviewed and the following points have been included:
    a) The Trust is hosting the Providers Programme Director for the ICS Provider Board who is reporting to the Chief Executive of ELHT. Director of Service Development leading on the construction of the work programme with the Directors of Strategy from all the providers.
    b) Vital Signs is a system wide programme across Pennine Lancashire.
    c) Posts for Portfolio Holders at ICP level are in development.
18. The gaps in control section now includes the need to build trust and confidence and agree a collaborative approach to service provision.
19. Gaps in assurance includes reference to the unknown impact of recent changes in senior leadership in partner organisations.
20. The actions planned and updates section had been reviewed and now includes the following updates:
    a) East Lancashire CCG extended the Community Services contract by 12 months allowing for the principles of the new clinical model at ICP level to be developed.
    b) Good co-production on developing clinical model across the ICS for CAMHS services was presented to the Commissioners on 6 August, outcome awaited.

Risk 4: The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework

21. The **risk score remains at 20** (likelihood 5 x consequence 4).
22. The potential sources of assurance section now includes:
    a) The setting of financial objectives in senior management appraisals.
    b) Budget setting
    c) Financial Forecasts
    d) Briefings on risk
    e) Pipeline of schemes to reduce cost.
23. The gaps in control have been updated with the following:
    a) Inadequate funding assumptions applied by external bodies (pay awards).

b) Hidden costs of additional regulatory requirements, these have been highlighted to NHSI by the Trust.

c) Cost shunting by public sector partners increasingly managed through ICS and ICP.

d) Failure to meet Provider Sustainability Fund requirements.

e) Agency and locum sign off with escalation of cost.

24. The actions section has been updated to include the reporting of agency and locum sign off with escalation of cost, total hours booked and average pay per hour to the Finance and Performance Committee from September 2018 as part of the Financial Performance Report.

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

25. There is a **proposed change to the risk score**, moving from 12 **to 16** based on the increased likelihood of the risk materialising (likelihood 4 x consequence 4), due to the challenges with the 4 hour standards and the 62 day cancer standard.

26. Key controls have been updated to include:

a) Quality and safety compliance assessed by each division and assurance through the Divisional Quality and Safety Boards (DQSB) reporting into the Quality Committee Sub-Committees.

b) Nursing Assessment Performance Framework reporting through to the Quality Committee and involvement of NEDs on the SPEC Panels and Board approval for the award of SPEC awards.

c) A&E Delivery Board with Emergency Care Pathway assurance feeding into it.

d) System-wide Scheduled Care Board with elective pathway assurance feeding into it.

e) Weekly Medical Staffing Review - Nursing and Midwifery staffing review feeding into the annual professional judgement review for all wards.

27. Potential sources of assurance have been updated to include:

a) Staffing escalation process for nursing including forecast gaps in staffing and senior decision making. Standard Operating Procedure (SOP) developed and monitoring through Nursing and Midwifery Leaders' Forum. IPR reporting to the ODB and at Board/Committee level.

b) Recovery plans in relation to the risks around some of the national trajectories addressed through the Emergency Care Pathway Transformation programme, Scheduled Care Programme, Cancer Improvement Action Plan. Regular monitoring by the Executive Team and ODB.

c) Weekly monitoring of complaints and reporting to the Patient Experience Committee and End of Life Care Group

d) Nurse staffing review as part of the IPR. Staff Care Allocate and daily monitoring of allocation for staff and three times daily matrons meetings to monitor. Audit carried out by MIAA for nurse staffing received significant assurance.

e) operational monitoring through the Nursing and Midwifery Leaders' Forum monthly, receiving assurance from the Assistant Director of Nursing and NAPF team and monitoring by matrons at ward level where they carry out mini-NAPFs on a weekly basis to keep up the improvement work.

28. Gaps in control have been updated to include the insufficient capacity to deliver comprehensive seven day services across all areas.

29. Gaps in assurance have been updated to include:

a) Gaps in assurance from the medical staffing perspective. E-Rostering inability to fill all vacant shifts/short term sickness or non-attendance.

b) Delivery of the cancer target (Care 62 day wait) and 4 hour standard.

30. The actions have been updated to include the following:

a) Review of the complaints element of the Patient Experience Strategy has been launched and a user friendly version will be ready for publication by the end of September 2018.

b) Implementation of an objective to reduce the percentage of wards rated as red following NAPF assessment visits by 50% reduction by the end of March 2019.

c) Redesign emergency care workforce plan carried out as planned and agreed with NHSI, awaiting response.

d) The development of a mental health decision unit has been delayed by external partners (originally due to be functioning by the end of July 2018). The Trust continues to work with external partners to enable delivery and further update will be available by November 2018.

e) The Cancer Improvement Action Plan sets out the trajectory to improve performance by the end of Quarter 3.

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance, 30 August 2018.

Our Strategic Objectives

1. **Put safety at the heart of everything we do**
2. **Invest in and develop our workforce**
3. **Work with key stakeholders to develop effective partnerships**
4. **Encourage innovation and pathway reform and deliver best practice**

Reference Number: BAF/01

Responsible Director(s): Director of Finance and Medical Director

Aligned to Strategic Objectives: 1, 2, 3 and 4.

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

Consequences of the Risk Materialising:
1. Ability to deliver against the constitutional standards and organisational delivery would be adversely affected
2. Mismatch between demand and capacity will result in inability to balance elective versus emergency care
3. Inability to provide financial assurance to the Board
4. Reduced ability to integrate primary and secondary care
5. Reduced ability to have the right workforce planning

Key Controls *What controls/ systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**				**Gaps in Control** *Where we are failing to put controls/ systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/ systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	**Q2**	**Q3**	**Q4**			
The transformation programme has been set for 2018-19 for the Trust, covering following themes: 1. Emergency care pathway 2. Model ward 3. Productivity & Efficiency 4. Community 5. Support services 6. SRCP The Trust is working across the Pennine Lancashire footprint a single transformation plan. 'the Pennine Way'. This will offer benefits in terms of sharing resources and joint savings and quality plans. The programme is monitored through the Improvement Practice Office who report to the Operational Delivery Board and the Finance and Performance Committee. All schemes are aligned to our clinical, financial and operational strategy. Trust has been selected to be in the 1st cohort of the new NHSI Lean programme and are working with the NHSI Lean team to develop a single improvement methodology across Pennine Lancashire.	Monthly report demonstrating progress against key targets reported to the Finance & Performance Committee. The Lean Programme (Vital Signs) overall linking to the workforce transformation. ELHT represented on the Pennine Lancashire Finance and Investment Group. Divisional plans linked to the operational and transformational plans. Agreed pathway developments part of the transformation plan. Clinical Effectiveness Committee acting as a governance mechanism for the agreement of internal pathways. ELHT continues to have provider to provider discussion (e.g. GP federations) with the aim of refining clinical pathways Trust SRCP and transformation plans for 2018-19 developed and linking into local delivery plans. Direct link between the Trust programme and the Pennine Lancashire Local Delivery Plan. Internally, divisional transformation leads embedded into the programme. Agreed transition to one Pennine Lancs team, one transformation plan and one improvement methodology - allowing all schemes to gain traction and improve delivery. LDP system level aiming to prioritise health improvements that can deliver beneficial outcomes more quickly. Several senior ELHT clinicians attending Care Professional Board workshops Medial Director of the Trust appointed as the Professional Lead for the Pennine Lancashire ICP influencing the collaborative work on transformation. Good track record of successfully bidding for tenders in the last 12 months. The emergency care pathway is a good example of collaborative working and should be used as a blueprint for other system working moving away from organisational boundaries. The Performance Assurance Framework Model Hospital and GIRFT	15	10	16	5x4	16	20			Capacity for delivery of transformation programme. Capacity and resilience building in relation to the service redesign is in early phase. Workforce issues/senior clinical and managerial staff ability to balance the operational and strategic requirements/demands. Opportunities to link transformation objectives to appraisals.	Assurance in place about the process, but assurance about the delivery and benefits is still work in progress at this stage. Dependency on stakeholders to deliver key pieces of transformation. Linking between clinical effectiveness and the transformation programme needs to be developed. The need to explore the interdependencies between BAF risks 1 and 3 and the system transformation in areas such as community services and the emergency care pathway. Exploring the opportunities in a changing leadership at collaborative level and linking into the new system executive roles. Winning tenders creates a risk of reaching a point where services cannot be maintained due to the lack of relevant/appropriate infrastructure. This has the potential to affect all risks identified in the BAF. Practical application and delivery of the transformation plan together with resourcing needs to be addressed in the near future . Model Hospital and associated processes still developing. Early planning of improvement events and flexible approach to enable the release of clinicians for improvement activities. Not delivering the percentage increase regarding the productivity and Efficiency transformation that we aspire to. Internal changes are needed, external efficiencies require Pennine Lancashire whole system working. Risks associated with the high concentration of efficiency schemes being scheduled to release savings in the second half of the year, the potential impact which winter pressures may have on this work and the number of non-recurrent schemes in the plan.	Using the Financial Assurance Board meetings and our membership of Pennine Lancashire to influence delivery of transformation. The Provider Programme Director for the STP is in place and the Providers' Operational Board meets on a monthly basis. Performance Assurance Framework due for review in quarter 2 will be presented to the Finance and Performance Committee on 24 September 2018 Care Professional Board held a workshop with a wider audience in August 2018 to create plans for a Pennine Lancashire Professional Executive Committee, bringing together relevant professionals to support the Pennine Lancashire transformation. Divisions attending Finance and Performance Committee from September 2018 onwards to provide assurance on the delivery of SRCP.

Reference Number: BAF/02

Responsible Director(s): Director of HR and OD

Aligned to Strategic Objectives: 2, 3 and 4.

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

Consequences of the Risk Materialising:
1. Gaps on rotas impacting adversely on ability to deliver safe, personal and effective care
2. Negative impact on financial position through high use of agency staff

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**				**Gaps in Control** *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	Q2	Q3	Q4			
Workforce Transformation strategy in place and associated Divisional and Trust-wide plans monitored through the Workforce Transformation Board. Divisional Workforce Plans aligned to Business & Financial Plans, Divisional Performance Meetings, Reports to Finance & Performance Committee. Recruitment strategy and plans linked to Workforce Plans. Trust Workforce Controls group in place to review all vacancies and support the Workforce Transformation strategy. One Workforce Planning Methodology across Pennine Lancashire. Joint SRO at Pennine Lancashire LDP level. Workforce planning at STP level, e.g. Apprenticeships, recruitment and retention initiatives, collaborative medical banks and talent management.	On-going monitoring of vacancies and bank/agency usage at Trust Operational Delivery Board via Trust performance report. Performance measures, time limited focus groups with action plans, board and committee reports, regulatory and inspection agencies, stakeholders, internal audit. WRES action plan with timelines in place. Regular reporting to the Board on progress. Work with the Fanshawe Report. Ongoing monitoring of workforce diversity through the re-establishment of the Diversity and Inclusion Steering Group and Trust Operational Delivery Board. Workforce Control Group regularly reports to the Executive on workforce control measures and indicators. Dashboard developed. Annual report to the Quality Committee. Medical and Non-Medical Agency Group in place. Dashboard giving overview of bank/agency usage presented to the Executive team meeting monthly. The Performance Assurance Framework Lean Programme (Vital Signs) overall linking into workforce transformation.	16	10	12	3x4	12	12			National recruitment shortages, capacity for delivery of transformation programmes, financial restrictions. Reduction of CPD monies from HEE (could be off-set by the apprenticeship levy). Implications of Brexit on the workforce - uncertainty/ workforce are yet to be determined.	Assurances in place in the IPR, Safer Staffing Report and Quality Dashboard. Assurance through the HR governance processes. Inability to control external factors (Brexit, visas etc)	Currently there are a further 126 external nurses in the recruitment pipeline due to start with the Trust been now and March 2019. 23 nurses have been sourced via the global learners programme. A large scale HCA recruitment exercise is complete resulting in over 100 appointments. HCA bank shift requests have reduced by 1500 per month as a result. Adding further stability and flexibility to our support workforce. A Senior Medical Staffing Performance Review Group has now been established and will take responsibility for reviewing all consultant job plans, consultant vacancies etc. adding further rigor on our appropriate use of resource. The Culture and Leadership programme update report was presented at Trust board in March and a Culture and Leadership Programme presentation took place at the Pennine Lancashire Workforce Group in April. The Culture and Leadership Change Team have met on a number of occasions and stage 1 (diagnostics) of the programme is due to close in September with a presentation to Board on the 12 September. Significant progress made with WRES action plan. The NHS National Workforce Race Equality Standard (WRES) 2017 data analysis report December 2017 demonstrated continued improvement and ELHT are highlighted as better than average in Indicator 6: a decrease in the overall percentage of staff experiencing harassment, bullying or abuse from other colleagues. Review of internal data in January demonstrates further improvements in WRES indicators 1, 2 and 3. Work continues with Diversity by Design to pilot joint selection process. 2018/19 plan to review the Trust Equality and Diversity Strategy and to develop plans to address issues related to all protected characteristics. The national WRES lead is visiting the Trust on the 8th October and arrangements are being made for this equality and diversity event. The Workforce Transformation Strategy addresses the future workforce supply pipeline, opportunities to up skill current staff, introducing new competencies, e.g. Physicians Associates and Associate Nurses and establishing new ways of working. The 2018-19 Business Planning approach includes a Workforce Planning and Transformation return from each Division which will inform the Trusts and Pennine Lancashire Transformation and Workforce priorities. We are now working with ICP partners to undertake systematic and integrated workforce transformation linked to the NHSi LEAN improvement programme. We are working across the ICS to develop a mobility agreement to assist with the movement of staff across the region. A Recruitment and Selection Strategy is being developed to underpin a system wide approach to recruitment. The 12 hour shift project is now complete, reducing the number of nursing shift patterns to fewer than 10 (from 250+) allowing for greater resource flexibility to cover gaps and reduce agency usage.

Reference Number: BAF/03

Responsible Director(s): Chief Executive, Director of Finance, Director of Service Development and Medical Director

Aligned to Strategic Objectives: 3 and 4

Strategic Risk: Lack of effective engagement within the partnership organisations (ICS and ICP) results in failure to work together causing a detrimental effect on the health and wellbeing of our communities.

Consequences of the Risk Materialising:
1. Failure to engage leadership and wider stakeholder groups
2. Failure to secure key services for Pennine Lancashire.
3. Failure to maximise our potential as a provider of key specialist services (Stroke etc.) across the STP footprint.
4. Delay in the speed of implementing integrated solutions and planning public engagement due to less effective partnerships.
5. Capability and capacity to deliver their component of the partnership working and deliver their own statutory obligations could cause a transfer of risks from partners to the Trust.

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**				**Gaps in Control** *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	Q2	Q3	Q4			
Pennine Lancashire Senior Leaders' Forum meets to discuss strategy. Engagement by senior leaders in wider transformation programmes. Regular Board updates and decisions on key actions. Strengthen links between internal transformation and external change processes. Care Professional Group (changing to become Professional Executive Committee) has ELHT representation. At Pennine Lancashire level health improvement priorities agreed (HIMPs). HIMPs reporting to the Care Professionals Board. Number of senior clinicians involved with ICS work groups. System Leaders Forum. ICS Finance Group. Defined gateway process sponsored by NHS Improvement and supported by the Good Governance Institute (GGI) in relation to supporting NLAG, ICP Finance and Investment Group. The ELHT Chief Executive is the senior responsible officer (SRO) for the Pennine Lancashire Transformation Programme, sits on the Senior Leaders Forum and sits on the ICS Programme Board. The Trust's Medical Director is the professional lead for the Pennine Lancashire ICP. Vital Signs Programme ensures the ICP as a system is having a significant participation as part of the Lean Programme.	Verbal and written updates, where appropriate Board approvals will be established and permissions will be provided by the Board to let Executives to progress the generation of ideas and options with external stakeholders. The Pennine Lancashire and ICS Cases for Change have been published. Pennine Lancashire resource in post working on developing models of care against specific improvement priorities (paediatrics, respiratory and frailty). Health and Wellbeing Improvement Partnerships (HIMPs) at Pennine Lancashire level reviewed around the health improvement priorities and the majority are relatively well established with minor changes need to link into the new structures. ICS governance oversight forms part of the Audit Committee standing agenda for 2018/19. Fostering good relationships with GP practices and Federations e.g. service pilots and as a result of tenders and general dialogue. Pennine Lancashire Memorandum of Understanding agreed by stakeholders. ELHT Chief Executive chairing the ICS Providers' Forum. Programme Director in post - foundations of the work programme started to be designed. Component business cases at Pennine Lancashire level forming a draft overarching ICP plan. Plan on a page for the ICP being worked on connecting to the Plan on a page for ELHT that was presented to the Commissioners. Structures in place for the Out of Hospital stream with the Trust significantly contributing to the workstream. CEO of ELHT and Accountable Officer of East Lancashire CCG jointly chairing the Pennine Lancashire ICP Programme. Potential gains in strengthened reputation with regulators and across the ICS footprint with regular reporting to the Board via the Finance and Performance Committee on progress, milestones and risks linked to the gateway process. ICS architecture on clinical services is developing (eg pathology, stroke and frailty). Positive feedback from service reviews (stroke and endoscopy). Pennine Lancashire Delivery Group has ELHT representation and is chaired by the Trust's Chief Executive. Patient experience strategy envisages good patient and public involvement to support collaborative transformation. Clinical leadership through the Care Professionals Board (changing to become Professional Executive Committee) at ICP level giving consistent message about the importance of working as a system. A&E Delivey Board Hosting the Providers Programme Director for the ICS Provider Board who reports to the Chief Executive of ELHT. Director of Service Development leading on the construction of the work programme with the Directors of Strategy from all the providers. Vital Signs is a system wide programme across Pennine Lancashire. Posts for Portfolio Holders at ICP level are in development.	16	12	12	3x4	12	12			System leaders agreed a process to develop the governance system across Pennine Lancashire; however this is still in development ICS System Management model is in early stages of development. Decision making process for Pennine Lancashire system will need agreement. Priorities of the individual organisations and those of the system not being aligned/agreed. There is a need for consistent leadership across the system. Building trust and confidence and agreeing collaborative approaches to service provision	Timeline for consultation with public - uncertainty about the detail of the consultation for the component business case at ICP level. Lack of unified approach in relation to procurement by Commissioners. Priorities of CCGs starting to be aligned with priorities for pathway redesign (e.g. stroke) but this work is still in the early phases. Future role of NHSE/NHSI merged teams to be determined. Creation of single teams for care functions to deliver the transformation agenda at system level. Ensuring consistent capacity to work externally as well as internally by building system collaboration into the leadership roles and having good joined leadership programmes. Adequate assurance mechanism that the service integration plans are on track together with the rigour of governance arrangements/lack of delegation from the sovereign bodies to the system. it is unclear what the impact of the hanges in senior leadership in partner organisations will be.	Regular updates provided to Board and the Audit Committee. Standing agenda item at Execs and Trust Board. Pennine Lancashire project solution design phase completed and case for change published. Across the ICS footprint the Medical Directors of the four Trusts agreed to focus on urology, vascular services, stroke, emergency department, interventional radiology and gastrointestinal bleed, and neonatology. At ICS level all providers met to formulate work programme - 3 categories of services agreed a) services that are fragile now b) services where there is no immediate risk but possible in the not too distant future c) services that need to be managed across the whole footprint. Agreement on the way of taking this forward to be agreed. Pennine Lancashire Delivery Group established and meting regularly Regular ICS Programme Board happening with CEO attendance. Pennine Lancashire ICP component business case prepared and consultation in progress. Focus on developing at LDP level wider deliverables. Mitigation in place for creating single teams across the system, eg, 'one workforce' with timelines for implementation. East Lancashire CCG extended the Community Services contract by 12 months allowing for the principles of the new clinical model at ICP level to be developed. Good co-production on developing clinical model across the ICS for CAMHS services was presented to the Commissioners on 6 August, outcome awaited.

Reference Number: BAF/04

Responsible Director(s): Director of Finance

Aligned to Strategic Objectives: 3 and 4.

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

Consequences of the Risk Materialising:
1. Inability to invest and maintain the estate
2. Potential negative impact on safety and quality/increased risk of harm
3. Financial Special Measures
4. Inability to pay suppliers/supply disruption
5. Increased cost of borrowing

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**				**Gaps in Control** *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	**Q2**	**Q3**	**Q4**			
Budgetary controls (income & expenditure) in place including virement authorisation, workforce control, monthly performance meetings and variance analysis. Measures to mitigate financial risk overseen by Finance and Performance Committee.	Monthly reporting to Finance and Performance reports and the Board to reflect financial position. Separate reporting available to support assurances on the transformation programme. Regular Performance Review meetings between Executives and Divisions. Financial objective included in individual appraisals. Setting of financial objectives in senior management appraisals. Budget setting Financial Forecasts Briefings on risk Pipeline of schemes to reduce cost. Model hospital data. Performance Assurance Framework	16	12	20	5x4	20	20			Additional workforce controls to remain in place. Policies and procedures may require amendments where they are no longer fit for purpose. Controls around transformation schemes and SRCP to be monitored by the PMO and the Finance Department with Division to be held to account via the PMO. Gaps in control regarding funding for A&E and STF funding - recovery plan underway. Weaknesses in rostering controls. Weaknesses in discretionary non-pay spend Deterioration in the underlying financial position requiring additional transformation schemes in 2018/19. SRCP being delivered non-recurrently. Officers operating outside the scheme of delegation. Inadequate funding assumptions applied by external bodies (pay awards) Hidden costs of additional regulatory requirements - highlighted with NHSI Cost shunting of public sector partners increasingly managed through ICS and ICP Failure to meet Provider Sustainability Fund requirements Agency and locum sign off with escalation of cost	Utilise the internal audit programme to test for assurance on core controls, SRCP and transformation plans. External audit view on value for money. Review of divisional governance processes. Understanding the changes in income services (NHS and private). Weaknesses in appraisals and accountability framework. The Performance and Accountability Framework will require review and approval in 2018.	Regular updates to Board and Finance and Performance Committee Actions and risk relating to the achievement of 'incentivised funding' (e.g. Provider Sustainability Funding) will be routinely reviewed. Risks in relation to the impact of the changes to CQUIN and Provider Sustainability Funding arrangements to the end of 2018/19 are being managed and reporting to the Quality Committee and Finance and Performance Committee. Performance Assurance Framework due for review in quarter 2. Report rates through to Finance and Performance Committee Agency and locum sign off with escalation of cost, total hours booked and average per hour will be reported to the Finance and Performance Committee from September 2018 as part of the Financial Performance Report.

Reference Number: BAF/05

Responsible Director(s): Director of Operations, Director of Nursing and Medical Director

Aligned to Strategic Objectives: 1, 3 and 4.

Strategic Risk: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil the regulatory requirements defined in the NHS Constitution and relevant legislation.

Consequences of the Risk Materialising:
1. Poor patient experience.
2. Increased regulatory intervention, including the risk of being placed in special measures.
3. Risk to income if four hour standard is not met.
4. Risks to safety.
5. Risk of not being able to deliver seven day services.

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**				**Gaps in Control** *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	Q2	Q3	Q4			
Divisional business plans Monthly divisional performance meetings feeding into the ODB and Finance and Performance Committee Weekly operational performance meeting covering RTT, cancer, 4 hour performance and holding list management. Engagement meetings with CQC CQC Steering Group in place Quality and safety compliance assessed by each division and assurance through the Divisional Quality and Safety Boards (DQSB) reporting into the Quality Committee Sub-Committees. Divisional assurance boards feeding into the operational sub-committees and the Quality Committee. Nursing Assessment Performance Framework reporting through to the Quality Committee and involvement of NEDs on the SPEC Panels and Board approval for the award of SPEC awards. A&E Delivery Board with Emergency Care Pathway assurance feeding into it. System-wide Scheduled Care Board with elective pathway assurance feeding into it. Daily nurse staffing review using safe care/allocate Nursing and Midwifery. Weekly Medical Staffing Review - Nursing and Midwifery staffing review feeding into the annual professional judgement review for all wards. Operational flow meetings at 08.30, 12.30, 15.30, 18.00 and 19.30	IPR reporting to the ODB and at Board/Committee level. Regular deep dive into the IPR through Finance and Performance Committee. System wide approach to Emergency Care Pathway, as part of monthly A&E Delivery Board supported operationally by the A&E Delivery Group Regular reporting from the divisions into the operational sub-committees and the Quality Committee. Alignment with national priorities through the quality and safety governance mechanisms. Trust rated 'Good' by CQC. ED performance and four hour improvement action plan aligned with the NHSI Rapid Improvement Collaborative and agreed by NHS England. Performance monitoring provided through the Emergency Care Pathway Programme Board (progress reporting) as part of the transformation programme governance. Silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments continues. Eight Silver Accreditation of a ward approved by the Trust Board with further three awaiting approval. Increased number of assessments under the framework planned all inpatient wards completed in ICG and SAS. Work started on Family Care and Community Services and a plan is in place for 2018/19. Significant reduction in the number of complaints upheld by the Ombudsman. Comprehensive system for addressing complaints. PLACE assessments - percentage improved in all areas and monitoring continues. Annual PLACE report presented to the Quality Committee for assurance. Nursing and Midwifery Leaders' Forum also monitor. Patient Experience Committee receive minutes of the PLACE Steering Group. NAPF Team also monitors environmental issues linking to PLACE Assessments. Positive responses to Friends and Family Test and patient surveys with improvement areas identified. Monitoring at ward level, local divisions prepare monthly patient experience action plans that feed into the Patient Experience Committee that reports to the Quality Committee. Monitoring monthly by the Nursing and Midwifery Leaders' Forum. CQC Task and Finish Group meets regularly and is chaired by the Director of Nursing and includes representation by all the Clinical Divisions. Mini CQC visits regularly carried out and focussing on all areas with regular reporting back to the Quality Committee. Reduction in use of nursing bank and agency staff continues, revisiting the specialing policy with further reduction in spend. Delivery of RTT and most cancer standards. Staffing escalation process for nursing including forecast gaps in staffing and senior decision making. Standard Operating Procedure (SOP) developed and monitoring through Nursing and Midwifery Leaders' Forum. Patient Safety Walkrounds Delayed Transfers of Care have been reduced to below 3% and target achieved in the last quarter. Positive response and results from the most recent National Staff Survey. The Performance Assurance Framework System-wide approach to elective care pathway through the System Scheduled Care Board, supported operationally by the Access and Choice Committee . Recovery plans in relation to the risks around some of the national trajectories addressed through the Emergency Care Pathway Transformation programme, Scheduled Care Programme, Cancer Improvement Action Plan. Regular monitoring by Execuive Team and ODB. Weekly monitoring of complaints and reporting to the Patient Experience Committee and End of Life Care Group Nurse staffing review as part of the IPR. Staff Care Allocate and daily monitoring of allocation for staff and three times daily matrons meetings to monitor. Audit carried out by MIAA for nurse staffing received significant assurance. NAPF - operational monitoring through the Nursing and Midwifery Leaders' Forum monthly, recieving assurance from the Assistant Director of Nursing and NAPF team and monitoring by matrons at ward level where they carry out mini-NAPFs on a weekly basis to keep up the improvement work.	15	9	12	4x4	12	16			Restrictions in the supply of medical, nursing, midwifery and other staff groups to meet demand. Risk of mental health providers not being able to ensure sufficient assessment and treatment capacity. Restrictions in the primary care system to ensure sufficient capacity. Insufficient capacity to deliver comprehensive seven day services across all areas.	Staffing gaps on rotas. Gaps in assurance from the medical staffing perspective. E-Rostering inability to fill all vacant shifts/short term sickness or non-attendance. Challenges to the delivery of the four hour standard Extended waiting times for mental health patients. Continued non-elective activity is placing pressure on the elective care and the RTT standard. Delivery of the cancer target (Care 62 day wait) and 4 hour standard. Wards and departments overdue for refurbishment due to the lack of decant facilities. Nursing Assessment Performance Framework post funded for a further 12 months and will need to be re-considered for permanent funding.	Reduction on overall number of complaints, 50+ and 40+ days continues. Review of the complaints element of the Patient Experience Strategy has been launched and we are developing a user friendly version for publication by the end of September 2018. Emergency care pathway section plan in place and is monitored monthly through the ECP Programme Board. Board receives regular SRCP and transformation updates. Plans for estates and staffing changes are in place so that the four hour target can be achieved at 90% by end of September 2018 and 95% by the end of March 2019. Nursing Assessment and Performance Framework assessments are continuing. Eight Silver Accreditation of a ward approved by the Trust Board. Further inspections planned for a number of wards awaiting third assessment following two green assessments. Work is planned within the NAPF team to develop the process to incorporate non-nursing areas, such as pharmacy. Objective is for a 50% reduction in all red wards by the end of March 2019. Continuing to recruit registered nurses and working with Health Education England with the Global Learning Programme and aiming to recruit 20 international registered nurses. Offers have been made will arrive in the Trust in approx 40 weeks. Continuing to recruit for substantive medical posts within ED and Urgent Care. A further cohort of Trainee Nurse Associates (TNA's) commenced in the Trust. First cohort of 13 are due to qualify in March 2019. Redesign emergency care workforce plan carried out as planned and agreed with NHSI, awaiting response. The Trust is developing a full business case regarding the emergency care pathway and is anticipated to be ready for presentation and sign off in late 2018. Care 24 implementation commenced in April 2018 and will run until March 2019. Development of mental health decision unit planned by July 2018 had been delayed by external partners. The Trust continues to work with external partners to enable delivery and further update by November 2018. Performance Assurance Framework due for review in quarter 2. Revised document to be presented to the Finance and Performance Committee at the end of September. Develop escalation facilities in Victoria wing at BGTH by October 2018, convert ward C3 to allow use as a decant ward in the next financial year (after Easter 2019). The Cancer Improvement Action Plan sets out the trajectory to improve performance by the end of Quarter 3.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 92

12 September 2018

Purpose Information
Monitoring

Title	Serious Incidents Requiring Investigation Report
Author	Mrs R Jones , Patient Safety Manager
Executive sponsor	Dr D Riley, Medical Director

Summary: This report provides a summary of the Serious incidents and Duty of Candour requirements that have occurred within the Trust in June and July 2018

Recommendation: Members are asked to receive the report, note the contents and discuss the findings and learning

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objective Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes/No	Financial	Yes/No
Equality	Yes/No	Confidentiality	Yes/No

Contents:

Part 1: Overview of serious incidents requiring investigation (SIRI) reported 5 - 6

- Summary
- Table providing breakdown of incidents

Part 2: Non STEIS SIRIs reported 7

- Summary
- Table providing breakdown of incidents

Duty of candour 8

- Table providing details of breached Duty of candour

Part 3: ID Me Campaign 9 – 18

- Background
- “Right person. Right time, every time"
- Appendices

Executive Summary

Trust has reported 16 strategic executive information system incidents in June and July 2018:

- All duty of candours have been served in appropriate cases
- Root Cause Analysis (RCA) Investigations are in progress with nominated leads

Trust has requested 9 internal root cause analysis investigations within the Divisions:

- All duty of candours have been served in appropriate cases
- Root cause analysis investigations are in progress

Update on ID me campaign, what is being done and going forward.

Part 1: Overview of SIRIs reported since last Board report

Strategic executive information system* (STEIS) – *serious incidents requiring investigations reported in June and July 2018

1. There have been 16 serious incidents requiring investigation which have been reported through Strategic Executive Information System (STEIS). Each incident has had a rapid review undertaken and a copy has been sent to the commissioner and regulatory bodies. The Assistant Director of Quality and Safety has commissioned a root cause analysis investigation for each incident and on completion these will be presented to the serious investigation requiring investigation (SIRI) panel. The table on the following pages provides details of these incidents:

	eIR1	Division	Incident reported	Category/Allegation	Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of harm	Next steps
1	eIR1146605	ICG	08/06/18	Pressure ulcer	Y	Y	Pressure ulcer steering group	Moderate	RCA to SIRI
2	eIR1147581	ICG	27/06/18	Fracture neck of femur	Y	Y	Falls steering group	Severe / Major	RCA to SIRI

	eIR1	Division	Incident reported	Category/Allegation	Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of harm	Next steps
3	eIR1148141	SAS	06/07/18	Fracture neck of femur	Y	Y	Falls steering group	Severe / Major	RCA to SIRI
4	eIR1141799	SAS	06/03/18	Delay in diagnosis / treatment	Y	Y	Cluster review to be undertaken	Moderate	RCA to SIRI
5	eIR1148099	ICG	06/07/18	Fracture neck of femur	Y	Y	Falls steering group	Severe / Major	RCA to SIRI
6	eIR1145382	SAS	15/05/18	Delay in diagnosis / treatment	Y	Y	Cluster review to be undertaken	Severe / Major	RCA to SIRI
7	eIR1146895	FC	14/06/18	Pressure ulcer	Y	Y	Pressure ulcer steering group	Moderate	RCA to SIRI
8	eIR1148980	SAS	21/07/18	Fracture neck of femur	Y	Y	Falls steering group	Severe / Major	RCA to SIRI
9	eIR1139281	ICG	18/01/18	Infection control incident - CDiff	N	Y	Infection control steering harms reduction programmes	Low / Minor	RCA to SIRI
10	eIR1146986	DCS	15/06/18	Delay in diagnosis / treatment	Y	Y	Cluster review to be undertaken	Severe / Major	RCA to SIRI
11	eIR1131652	SAS	31/08/17	Delay in diagnosis / treatment	Y	Y	Cluster review to be undertaken	Moderate	RCA to SIRI
12	eIR1149207	ICG	26/07/18	Violence and aggression	Y	Y	Staff and patients fully supported by ELHT	Moderate	RCA to SIRI

	eIR1	Division	Incident reported	Category/Allegation	Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of harm	Next steps
13	eIR1134533	ICG	22/10/17	Unexpected deterioration	Y	Y	Deteriorating patient steering group project	Death / Catastrophic	RCA to SIRI
14	eIR1147531	FC	26/06/18	Unexpected deterioration	Y	Y	Each baby counts project	Moderate	RCA to SIRI
15	eIR1147491	ICG	25/06/18	Fracture neck of femur	Y	Y	Falls steering group project	Severe / Major	RCA to SIRI
16	eIR1146952	ICG	15/06/18	Unexpected deterioration	Y	Y	Deteriorating patient steering group project	Death / Catastrophic	RCA to SIRI

Part 2: **Overview of DSIRGs reported since last Board report**

Non-strategic executive information system – serious incidents requiring investigations reported in June and July 2018

2. There were 9 non-strategic executive information system incidents deemed to be serious incidents requiring investigation. A rapid review has been undertaken where further information was required and duty of candour completed on all moderate and above incidents in line with trust policy. A full root cause analysis investigations have been requested and once complete will be presented to each divisional serious investigation review group (DSIRG) panel.

	eIR1	Division	Incident reported	Category/Allegation	Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of Harm	Next steps
1	eIR1145184	SAS	11/05/18	Communication problem that could have caused delay in treatment	N	Y	Re-emphasis on SBAR process/handover	No harm - Impact prevented	RCA to DSIRG
2	eIR1145997	ICG	27/05/18	Unwitnessed fall – Fracture	Y	N	Falls steering group in place	Moderate (Not STEIS reportable)	RCA to DSIRG
3	eIR1147596	FC	27/06/18	Concerns raised by family around the care received	N	N	Investigation initiated.	No harm - Impact not prevented	RCA to DSIRG
4	eIR1145870	ICG	24/05/18	Information governance breach – Handover sheet	N	N	Scored against ICO toolkit – not reportable – investigation initiated within division	No harm - Impact not prevented	RCA to DSIRG
5	eIR1146184	SAS	31/05/18	Equipment failure	N	Y	Reported to MHRA	No harm - Impact not prevented	RCA to DSIRG
6	eIR1147961	SAS	04/07/18	Medication error	N	N	Medicine management Steering Group in place	Low / Minor	RCA to DSIRG

	eIR1	Division	Incident reported	Category/Allegation	Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of Harm	Next steps
7	eIR1148872	FC	19/07/18	Delay in treatment	Y	N	Investigation initiated	Moderate	RCA to DSIRG
8	eIR1147298	ICG	21/06/18	Discharge – planning failure	N	N	Investigation initiated	No harm - Impact not prevented	RCA to DSIRG
9	eIR1141463	SAS	27/02/18	Medication error	N	Y	Medication error Harms reduction programme ongoing	Low/Minor	RCA to DSIRG

Duty of Candour

3. Duty of candour is a legal and regulatory requirement following the visit from CQC and reviewed at its Well Led Framework. The Trust has put measures in place for the delivery of duty of candour and education has been delivered.

4. Of the above reported incidents Duty of candour has been delivered where applicable with one incident that breached the 10 working day target, details as below:

EiR1	Date of incident reported	Date Duty of Candour Commenced	Date Duty of Candour completed	Incident date	Division	Reason for breach
eIR1145382	15/05/18	15/05/18	06/07/18	02/05/18	SAS	Duty of candour was delivered at patient's appointment in July, this was due to be delivered in June but patient was unable to attend appointment due to illness and other scheduled appointments.

Part 3 – ID Me Campaign

Summary

5. The Trust has recently identified a number of incidents relating to patient wristbands not being in place and/or patients being taken for the wrong investigation. In April 2018 the Trust launched the **ID Me** campaign to raise awareness with staff:
   - The importance all patients have a wristband in place on admission from ED and whilst an inpatient on any of the wards within the Trust.
   - Staff must check the wristbands before administering medication and before the start of any investigation to ensure the correct patient, every time.
6. An action plan has been developed and owned by the Director of Communications and Engagement (see appendix A) and due to be completed by September 2018. Posters and stickers have been designed, distributed and displayed on every ward and in every patient area (See appendix B) across the Trust and the campaign was promoted via a number of different communication systems:
   - the chief execs blog,
   - all staff user emails,
   - team brief,
   - message of the day,
   - staff newsletter.
7. As part of a further quality and safety check an audit has been completed on 47 patient transfer checklists in July 2018 across Integrated Care and Surgical Acute

wards at the Royal Blackburn Hospital site. Out of the 47 patients 34 (72% compliance) had a checklist in the notes or had had a nurse escort with them, one had no RXR number on the form and one had no porters signature.

8. In July 2018 internal key stakeholders formed a focus group "Right patient, right time, every time" to identify all ongoing projects around the identification and transfer of patient care across the Trust, to help ensure 100% of patients receive Safe, Personal and Effective care. The focus group met for the first time 23rd July 2018 and agreed the key aims of the group, developed and approved an action plan. Going forward the focus group will meet monthly to monitor improvement work and make further recommendations if required. (See appendix C for driver diagram and appendix D for action plan). Jonathan Smith, Assistant Director of Nursing, Interim in ED and Andrew Taylor, Patient Services Manager has been nominated as project leads. The project will be added to the harms reduction programme which will provide assurance into Patient Safety and Risk Committee on a bimonthly basis.

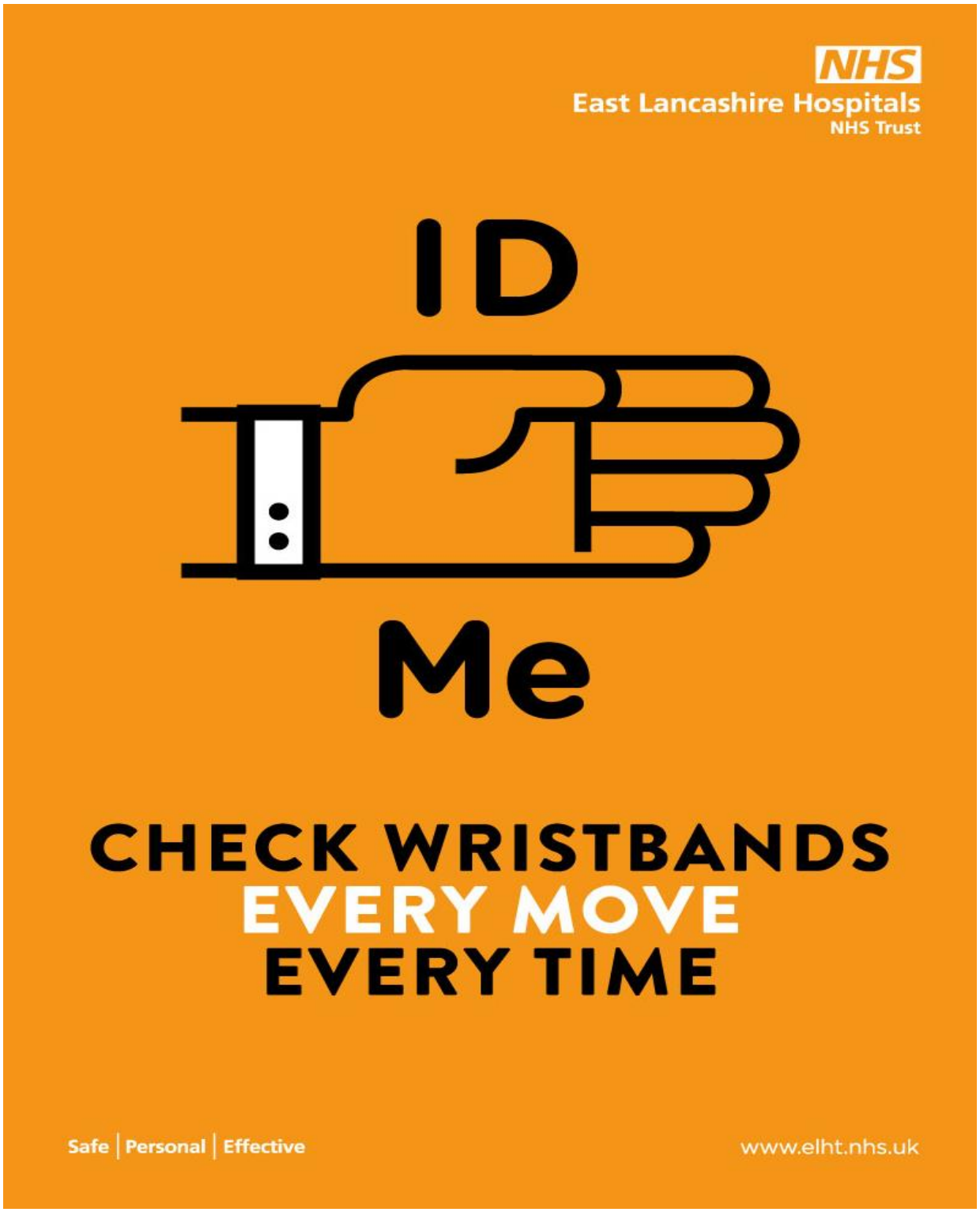
Appendix A: Project/Action Plan for ID Me Campaign 2018

Key Actions	Lead	Progress	RAG	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Develop and produce materials for distribution across the Trust	CH	Stickers 76mm diameter x 6 kinds 10,000 stickers total A4 posters x 4 types 200 of each 800 total A3 posters x 4 types x 100 of each 400 total Distributed across all five sites, in all wards, waiting and clinical areas as well as corridors where appropriate. (A small supply of stock is held in the Communications Office)														
All User Email	CH	March Launch of campaign and call to action														
CEO Blog	CH	23/03 Completed														
Team Brief Update of reported patient harms	SD	27/04 Completed 01/06 Completed 29/06 Completed														

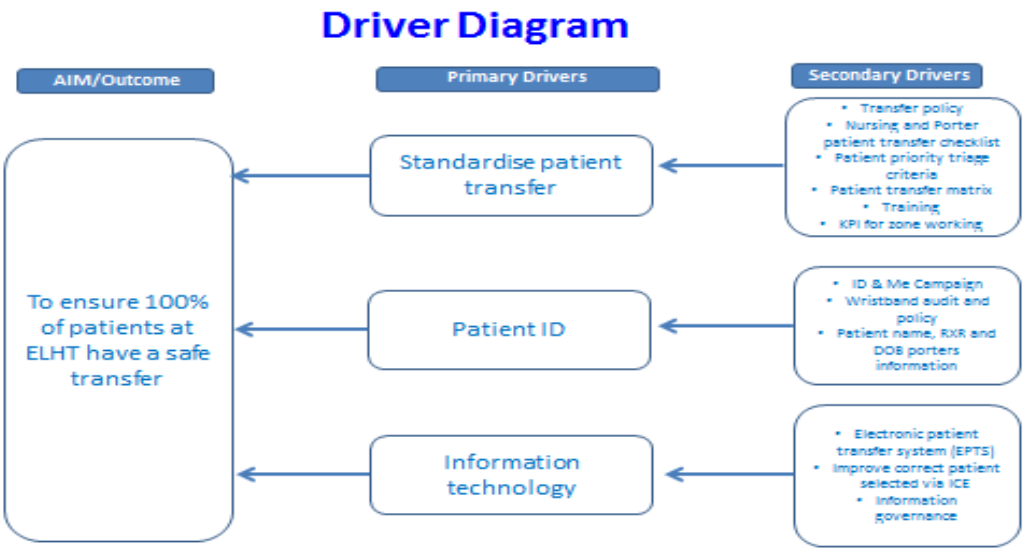
		27/07 31/08 28/08	Completed															
Team Brief Awareness of campaign	SD	27/04 01/06	Completed Completed															
MOTD	ELC	19/04 30/05 06/06 16/08 14/09 17/10 15/11 13/12	Completed Completed Completed Booked Booked Booked Booked Booked															
Newsletter	SW	April Edition	Completed															
Share to Care	CA	June Edition	Completed															
Trust's Welcome Handbook Provided to all inpatients	ELC	June Hard copies distributed throughout the Trust.																
OLI Homepage	ELC	April May June July	Completed Completed Completed Completed															

Appendix B – Stickers for ID Me campaign

Appendix B (Continued) Poster for ID Me campaign



Appendix C: Driver Diagram "Right person, right time, every time"



Appendix D: action plan "Right person, right time, every time"

Action Number	Description	Lead/Action Status	Due Date/ Evidence
Update			
1	Standardise patient transfer forms on all wards and Oli. **Update: V3 transfer of care form needs to be embedded on to all wards, VT/HC to visit wards to ensure the correct form is in place – this is to take place on 4th September 2018**	HC & VT	September 2018
2	**New Action:** LA to chase up with Heather Coleman, Andrew Costello and Wayne Gibson re the results of the *Wristband and Transfer Audit and standardised Transfer Form template.*	LA	September 2018
3	Communication to the Trust to standardise practice for use of the Transfer Form. **Update:** *RJ informed the group that she and VT are still awaiting the results from the Wristband and Transfer Audit.*	RJ & VT	September 2018 1.Transfer of care form approved at policy council August 2018 – communication to be sent out w/c 10/09/2018 due to form at the printers/roll out to all wards
4	Standardise oxygen bottles – raise this issue at Deteriorating Patient Steering Group. **Update:** *No update available – carry over to next month's meeting.*	HC	September 2018

5	Develop a patient priority scoring system. Link in with Clinical Site Managers and Bed Management Teams. Linking KPI for patient service assistants / zone working. **Update:** *TR reported that he is awaiting the launch of the new Patient Service in September, in order to set these KPI's.*	Lesley Gaw, JS & TR	September 2018
6	Discuss the information governance issue of using patient information over the Porters communication system with Salem Badat. **Update:** *TR reported that firstly not being allowed to give out patient information i.e. Name, RXR, DOB etc…over the Porters communication system was incorrect. Salem had stated that the risk of the patient receiving the incorrect procedure/investigation outweighs the risk of information governance. Therefore patient details as above can be given over the radio from the helpdesk to the Porters. CH raised concerns over using the patients NHS number, as this can be used more than a patient RXR, as the patient RXR number is only local to the hospital.* *TR reiterated that in order to ensure that the Portering Team are collecting the Right Patient, Right Time, Every Time that the right information will need to be given to the helpdesk from the wards, in order for this to be disseminated to the Porters correctly.*	TR	03/08/2018 1.Porters now using RXR reference to identify patients as well as DOB and name
7	**New Action:** TR to feedback re the use of patient details over the Porters communication system.	TR	September 2018
8	**New Action:** RJ & VT to monitor whether this 'Test of Change' has an effect on the number of patient incidents.	RJ & VT	September 2018
9	KPI planning for new patient service assistants following the start of Phase 1 zone working in September 2018. **Update:** *TR reported he is awaiting the launch of the new Patient Service in September in order to set KPI's.*	TR	September 2018
10	Look at the potential use of EPTS (Bed Board) to improve the referral process and traceability of patient information. Discuss with Jane Dean to see how the Acute Care Team implemented this. **Update:** *RJ reported that a meeting had taken place between herself, HC, VT and KP on 31.07.18 to discuss this. KP to give update as part of today's Agenda.*	VT, RJ & HC	06/08/2018 1.EPTS looked at but the process would

			be too long. Agreed at meeting Transfer of care form to be used and signed at each point of care.
11	Invite EPTS Lead to the next *Right Patient, Right Time, Every Time Meeting to discuss Action 10.*	V Taylor	03/08/2018
12	Inform the Medical Directorate re issue of the wrong patient being requested on ICE. Pull number of related incidents reported. **Update:** *RJ reported that VT had emailed Moira Rawcliffe (Interim Radiology Directorate Manager) for this data to evidence that this is an issue.*	V Taylor	03/08/2018 1.RJ to run report in VT absence and liaise with ICG/DCS 30/08/2018
13	Beds left on corridors not having the correct documentation. **Update:** *KA informed the group that unfortunately this was an on-going issue, as recently as today, and contributed to delays.* *RJ reiterated that the updated Decontamination Policy need disseminating back to the floor within the Divisions and that a MOTD had been booked for 09.08.18 to raise awareness of the updates to this policy. It will also feature in the weekly Trust News Bulletin.*	HC	September 2018 1.2 forms identified in use – VT working with infection control to standardise
14	**New Action:** Leslie Gaw and Jonathan Smith to meet to discuss potential ways in which to enable the Helpdesk to triage/prioritise jobs in terms of Routine & Urgent.	Lesley Gaw & JS	September 2018
15	**New Action:** Quality Improvement Facilitators should shadow/observe patient journeys with the Portering Team for a day.	VT & LA	September 2018

16	**New Action:** VT to organise the next meeting for a month's time and Bi-weekly thereafter.	VT	September 2018
17	**New Action:** VT to confirm the Chair, Aim and Terms of Reference for this group. Leads are Andy Taylor and Jonathan Smith Aim- To ensure all patients at ELHT have a safe, personal & effective transfer.	VT	September 2018
18	**New Action:** LA to check which version of the Transfer Policy is on OLI.	LA	September 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 93

12 September 2018

Purpose Information
Action

Title	2018-2021 Staff Health and Wellbeing Strategy
Author	Mrs L Barnes, Head of Staff Health Wellbeing & Engagement
Executive sponsor	Mr K Moynes, Director of Human Resources and Organisational Development

Summary: Board members are asked to note the progress made over the last 3 years with staff health and wellbeing in the organisation. Members are asked to review the new 2018-2021 Staff Health and Wellbeing Strategy and supporting staff health and wellbeing outcomes and metrics.

Recommendation: Directors are also asked to approve and support the outlined new strategy.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objective Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by: Quality Committee (July 2018)

Executive summary

1. The new 2018-2021 Staff Health and Wellbeing Strategy was discussed and approved at the 25th July Quality committee. The agreed next step was approval at Trust board. A brief summary of the strategy is detailed below. The full report can be viewed here and the Strategy can be viewed here.
2. Members are asked to review and approve the strategy and supporting appendices.

Introduction

3. This strategy follows on from the 2014-2017 Staff Health and Wellbeing Strategy and is aligned to the wider Lancashire Health and Wellbeing Strategy and the NHS Workforce Health and Wellbeing Framework.
4. The strategy is a reflection of the advances the Trust has made in improving staff health and wellbeing and our desire to continue this journey to ensure that our Trust evolves from a good to outstanding place to work. We intend to implement strategies for compassionate and inclusive leadership which result in a culture that delivers high quality, continuously improving compassionate care.
5. The new strategy provides cost effective interventions, guidance and information to give our staff the impetus and support to take control and responsibility for their health and wellbeing.

Our key activities and achievements

6. It is important to reflect on the impact of the 2014-2017 Staff Health and Wellbeing Strategy. Figure two on page 5 of the strategy document details key activities and achievements delivered due to the 2014-2017 strategy.
7. NHS England measure the progress NHS Trusts are making with staff health and wellbeing via the NHS Staff health and wellbeing CQUIN. The CQUIN outlined three areas where NHS England would like providers to make progress in improving their health and wellbeing offer to staff.
8. Information from the staff health and wellbeing CQUIN 1a data provided by the staff survey co-ordination centre highlights that improvements across all metrics have been demonstrated during the 3 year strategy period.
   a) ELHT are now in the best 20% of Acute Trusts for taking positive action on health and wellbeing.

b) ELHT are above average for minimising musculoskeletal problems as a result of work activities when compared with all Acute Trusts in 2017.

c) ELHT are in the best 20% of Acute Trusts for minimising work related stress.

9. CQUIN indicator 1b has demonstrated significant improvements over the last three years. Extensive changes have been made to improve healthy food for staff, visitors and patients. Examples of actions taken are:

a) A reduction in the percentage of high fat/sugar/salt products displayed.

b) An increase in healthier alternatives.

c) Avoidance of overt promotion of unhealthy food and drink.

10. CQUIN indicator 1c demonstrates an outstanding performance in improving the uptake of Flu vaccinations for ELHT front line healthcare workers. At the end of the 2017/18 Flu campaign ELHT:

a) Over performed by 22.3% against the national target.

b) Are the best Trust in the country for Flu vaccination uptake.

11. All of the above demonstrate that implementing the 2014-2017 staff health and wellbeing strategy along with other key strategies has influenced the direction of travel and improvements seen across the Trust.

Recommendations

12. It is recommended that the board note the progress made over the last 3 years and review and approve the 2018-2021 staff health and wellbeing strategy.

Conclusion

13. The strategy aims to empower all staff to have a positive staff experience and view the Trust as an outstanding place to work, where all staff thrive at ELHT.

14. The strategy will enable significant improvements for the health and wellbeing of the workforce and in turn shape the health of the organisation, along with promoting and enhancing the wider health and wellbeing of all we come into contact with, thereby influencing the health and wellbeing of the population we serve.

Next steps

15. Following approval at Trust-board the strategy will be widely disseminated across the Trust.

Lee Barnes, Head of Staff Health Wellbeing and Engagement

East Lancashire Hospitals NHS
NHS Trust

Phase 1- Discovery Findings

Safe | Personal | Effective

Why is this important to us?

Leadership, particularly compassionate, inclusive leadership is the key to creating cultures that enable organisations to:

- Deliver high quality care and value for money while supporting a healthy and engaged workforce.
- Enable staff to show compassion, to speak up, to continuously improve and create an environment where there is no bullying, where there is learning, quality.
    - *This is reflected in several recent reports and reviews (e.g. the Rose review, the report of the Mid-Staffordshire NHS Foundation Trust Inquiry and the Berwick review)*
- Help boards receive assurance on the 'culture and capability' domain of the well-led framework and improve results in governance reviews.

Intended Benefits - Our Culture and Leadership Programme

- Every person at ELHT, at every level and in every role can flourish and deliver their best for patients – continuously improving, high quality, safe, compassionate care.
- Everyone working at ELHT and across the system is healthy, happy and passionately engaged in improving the lives of people in their communities and are commitment to providing high quality of care.
- Everyone counts, at all levels, feels inspired and empowered to lead positive change, to constantly learn, and to continuously improve health and care for the population of Pennine Lancashire.
- It is easy to feel compassion for others, because every person working in the system is treated with respect and dignity and feels appreciation, compassion and support from their leaders and colleagues – especially during times of stress or difficulty.
- As a result staff health and wellbeing is improved
- No matter where in the system we work, we work together for patients and the population we serve.

What is the culture and leadership programme?

The culture and leadership programme consists of three phases to develop and implement strategies for compassionate leadership which result in cultures that **deliver high quality, continuously improving, compassionate care.**

NHS Improvement

The King's Fund

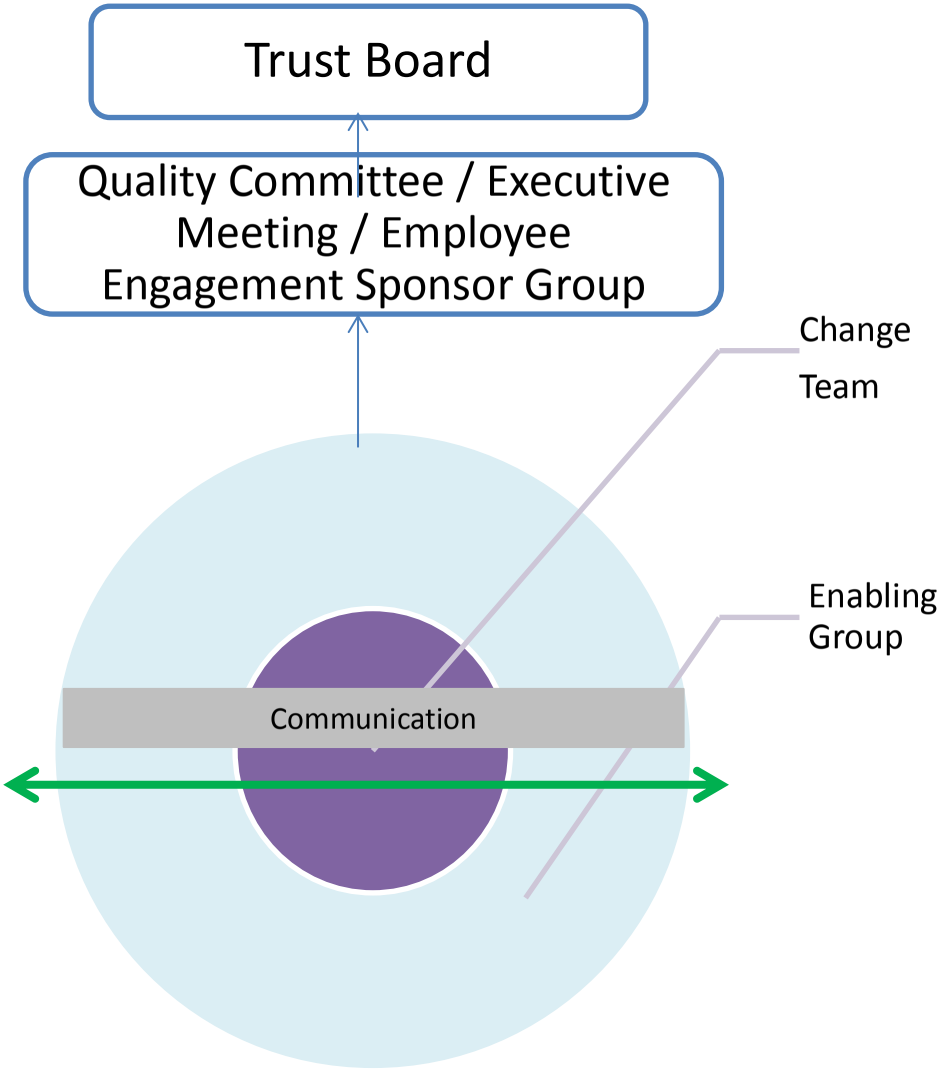
Center for Creative Leadership

The resources supporting the programme were originally developed by:

- **NHS Improvement**
- **The King's Fund**
- **Centre for Creative Leadership & tested by three trusts**

Given the evidence, we believe this programme will benefit our organisation, by **helping improve the health and wellbeing of our staff** and leading to **better outcomes for patients**.

Culture and Leadership Programme
Oversight and Governance Structure



Enabling Group (meets monthly)

- Oversight of the programme plan, key milestones and Trust wide interdependies
- Responsible for the design and delivery of the overall programme
- Key decision making group for the overall programme delivery
- Oversight and ownership of the resource plan and budget
- Design and oversight of the communications plan, development of key messages
- Change champions driving both the programme and essential behaviours
- Regular reporting to Trust Board, Executive and Employee Engagement Sponsor Group (EESG) on the overall programme
- Shape the role of the change team

Change Team- 42 people (meets monthly)

- Fundamental to the success of the programme.
- A collection of individuals who have volunteered their time to make a difference for themselves and their colleagues by looking at their organisation's culture and how they would like it to be.
- Is someone who has their line manager's support to protect your time and your ability to do the tasks you have volunteered for.
- An MDT from across our organisation – championing a compassionate and inclusive leadership approach.
- All team members are expected to:
  - disseminate learning & influence within the organisation.
  - demonstrate commitment to exploring ideas & assumptions about the culture at ELHT.
  - be committed to this work & to involving others.
  - be resourceful & dynamic.
  - use this work to support personal & professional development.

East Lancashire Hospitals NHS
NHS Trust

Culture and Leadership Programme
Discovery Phase Diagnostic Tools

Culture and outcomes dashboard
High level understanding of culture and related outcomes

Culture focus groups
Understand individuals' experience of current organisational culture

Board interviews
Understand the board's approach to supporting effective organisational culture

Leadership workforce analysis
Understand the organisation's needs on leadership workforce capacity

Leadership behaviours surveys
Understand staff and stakeholder views on behaviours of your organisation's staff and leaders as a whole

Patient experience
Understand patients' experience of culture

Synthesis: Bring together the results of the diagnostic resources

Compassionate Leadership

Leadership behaviours		Cultural elements
Facilitating shared agreement about direction, priorities and objectives	Encouraging pride, positivity and identity in the team / organisation	**Vision and values** Constant commitment to quality of care
Ensuring effective performance	Ensuring necessary resources are available and used well	**Goals and performance** Effective, efficient, high quality performance
Modelling support & compassion	Valuing diversity and fairness	**Support and compassion** Support, compassion & inclusion for all patients and staff
Enabling learning and innovation	Helping people to grow and lead	**Learning and innovation** Continuous learning, quality improvement and innovation
Building cohesive and effective team working	Building partnerships between teams, departments, and organisations	**Team work** Enthusiastic cooperation, team working & support within & across orgs.

"Leadership of all, by all and for all."

Culture and outcomes dashboard

High level understanding of culture and related outcomes

The NHS Improvement Culture and Outcomes Template was completed

Data was taken from:

- Staff survey results
- Trust Board Reports
- Culture and Leadership Focus groups (Vision and Values)

Overall the dashboard for ELHT shows an organisation which is performing well in relation to the metrics used, and is generally above the national average for NHS Trusts in most areas. However none of the twelve areas assessed scored as 'outstanding'

Culture focus groups

Understand individuals' experience of current organisational culture

- 23 focus groups were held during 13 sessions at Blackburn, Burnley and Pendle.
- Over 200 staff members were involved.
- All divisions were represented, a good cross section of clinical and non-clinical staff from a wide range of grades and work areas, with the exception of medical staff.
- The questions used were designed by NHS Improvement and intended to elicit responses about the five key elements of a high quality care culture, and the strength of collective and compassionate leadership

The key themes that emerged focus on leadership and management, relationships and behaviour, consistency, and personal empowerment.

Board interviews

Understand the board's approach to supporting effective organisational culture

- ELHT Culture and Leadership change team used a set of 14 questions exploring board views on and behaviour in relation to culture and leadership.
- One-hour semi-structured interviews
- Board members were asked to give their perception of the overall performance of the board.
- Of a total of 15 board members, 12 completed the interviews (80% response rate).

Key themes included a view that the Trust was on an improvement journey and in a period of transition. The board are proud of the organisation and the continuing development of the board and the organisation as a whole. The board is ambitious and has an aspiration for ELHT to be the best organisation it can be. Areas for specific focused development are leadership and management, equality, diversity and inclusion, ELHTs approach to appraisal, objective setting and performance management, the design of board development, ELHTs approach to Team development.

Leadership workforce analysis

Understand the organisation's needs on leadership workforce capacity

- Completed by the Education Directorate to analyse and understand the:
  - Current state of key leadership roles
  - Future state of key leadership roles
  - Gaps in key leadership roles
  - Organisational design and workforce
  - Policies and procedures

Key themes are workforce capability planning, training needs assessments and talent management, equality diversity and inclusion, recruitment processes and learning and development.

Leadership behaviours surveys

Understand staff and stakeholder views on behaviours of your organisation's staff and leaders as a whole

The Leadership Behaviours Survey was open to all staff from 20th July for three weeks. There were 808 responses (10% of staff)

From a staff perspective ELHT is most positively seen in terms of support and compassion and vision and values and learning and innovation.

The main perceived areas for improvement are teamwork, goals and performance.

Patient experience

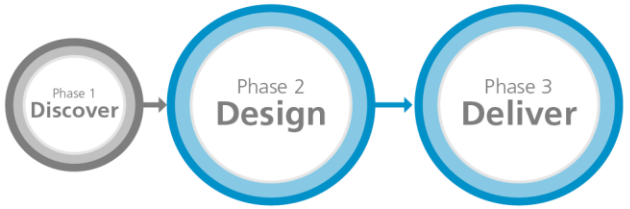
Understand patients' experience of culture

- Completed by the ELHT Patient Experience Team.
- Data was from the from the friends and family survey and also from 264 complaints / compliments received between November 2017 and April 2018, which were themed as below:

Theme	Compliments	Complaints
Vision and Values	19	15
Goals and Performance	4	115
Support and Compassion	50	41
Learning and Innovation	12	0
Teamwork	1	7

Next steps phase 2 Design

Based on the findings of phase 1, we will design and develop interventions that build on our strengths and address development areas. These will be scoped as part of the design phase so that we can develop our Leadership Strategy.



1. Vision and values

- Communications, listening
- Leadership development
- Patient/service user involvement and stakeholder engagement
- Values-based recruitment

2. Goals and performance

- Performance management
- Information/knowledge management
- Business planning, organisation development
- Management training

3. Support and compassion

- Reduced hierarchy/command and control
- Communications strategy
- Engagement strategy
- Health and wellbeing strategy

4. Learning and innovation

- Quality improvement systems, support systems for innovation and QI
- QI training
- Empowering and enabling staff
- Quality strategy
- Leadership training

5. Teamwork

- Board Development
- Team assessments
- Team based working, inter team working
- Reduced layers of hierarchy
- Leadership coaching for team leaders

Any Questions…

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 95

12 September 2018

Purpose Monitoring

Title	Integrated Performance Report (April - July 2018)
Author	Mr M Johnson, Associate Director of Performance and Informatics
Executive sponsor	Mr J Bannister, Director of Operations

Summary: This paper presents the corporate performance data at July 2018

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objective Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Legal	Legal	Legal
Equality	Equality	Equality	Equality

Board of Directors, Update

Corporate Report

Executive Overview Summary

No never events reported during July. A total of six incidents were reported to StEIS during the period.

One clostridium difficile infection was detected during July, taking the year to date total to 10 which is above the annual trajectory. No MRSA infections in July, one year to date.

Nursing and midwifery staffing in July 2018 was extremely challenging. 9 areas fell below an 80% average fill rate for registered nurses on day shifts.

HSMR remains 'better than expected' and the SHMI is 'as expected'.

The 4 hour target performance has deteriorated in July and remains below the 95% threshold. The proportion of delayed discharges has increased but remains below the 3.5% threshold.

The HAS compliance improved during July above threshold. The average ambulance handover time increased during July.

There were 37 mental health breaches of the 12 hour trolley wait standard in July.

The Referral to Treatment (RTT) target was again achieved at 92.5% above the 92% standard. There were no breaches of the 52wk standard at the end of July.

The cancer 2wk wait and 2wk breast targets were not met during June. The 62 day target was also not met during July. All other targets were met.

The 6wk diagnostic target was met in July and the number of operations cancelled on the day has reduced again in July and there were no breaches of the 28 day standard.

Sickness rates have increased in July to 4.8% which is higher than last year (4.3%).

The vacancy rate increased to 8.8% in July, above threshold and above last year (7.0%).

Compliance against the Information Governance Toolkit has improved and is above threshold. All other areas of core skills training are above threshold.

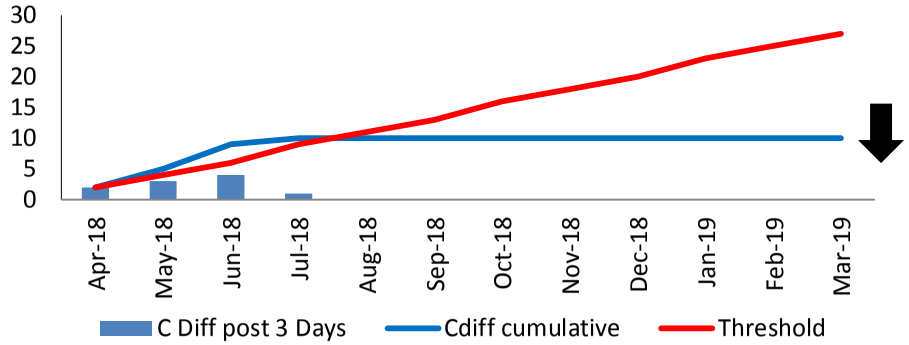
The Trust has agreed a revised underlying control total for 2018/19 of a £15.798million deficit, which has been met for the first four months of 2018/19, with a deficit of £5.837million reported, and a £4.615million deficit after Provider Sustainability Funding (PSF) of £1.221million.

Introduction

This report presents an update on the performance for April - July 2018 and follows the NHS Improvement Single Oversight Framework. The narrative provides details on specific indicators under the five areas; Safe, Caring, Effective, Responsive, Well Led.

SAFE

C Difficile

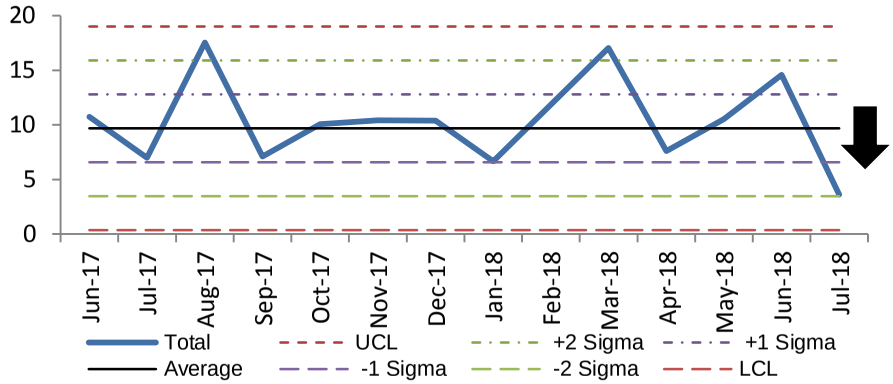


There were no MRSA infections reported in July. Year to date there has been 1 case attributed to ELHT.

There was one Clostridium difficile toxin positive isolates identified in the laboratory in July which were post 3 days of admission.

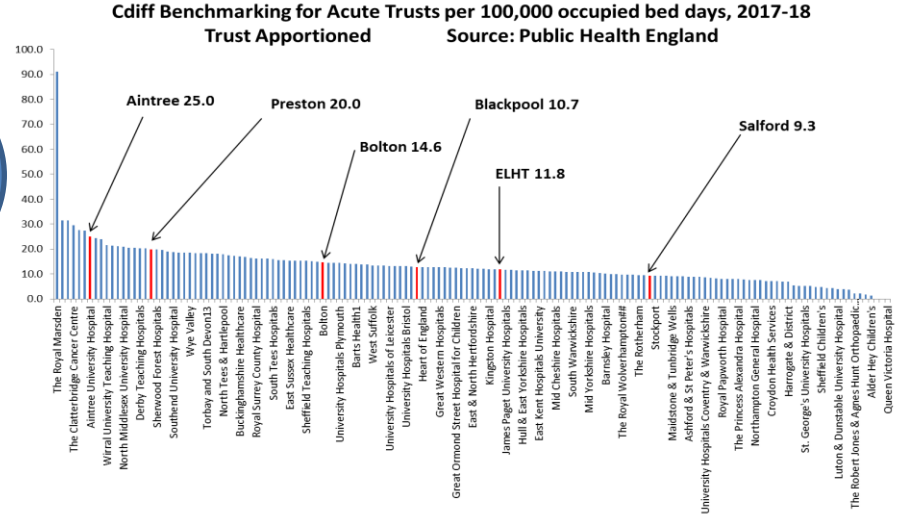
The year to date cumulative figure is 10 against the trust target of 27. The detailed infection control report will be reviewed through the Quality Committee.

C Difficile per 100,000 occupied bed days



The rate of infection per 100,000 bed days decreased in July to 3.6, below average.

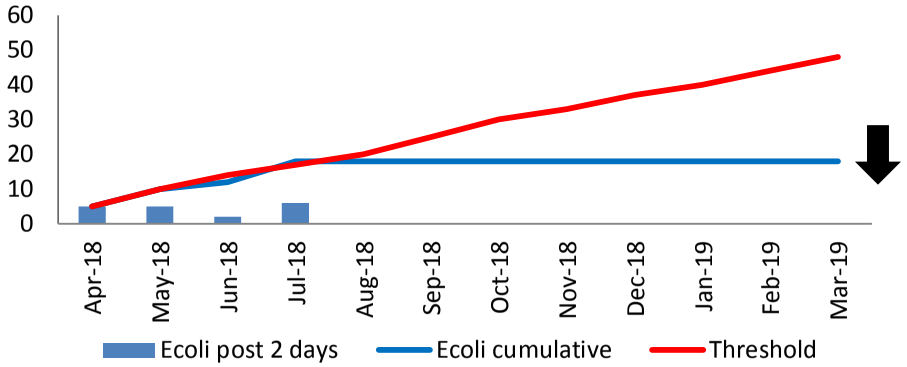
C Difficile benchmarking



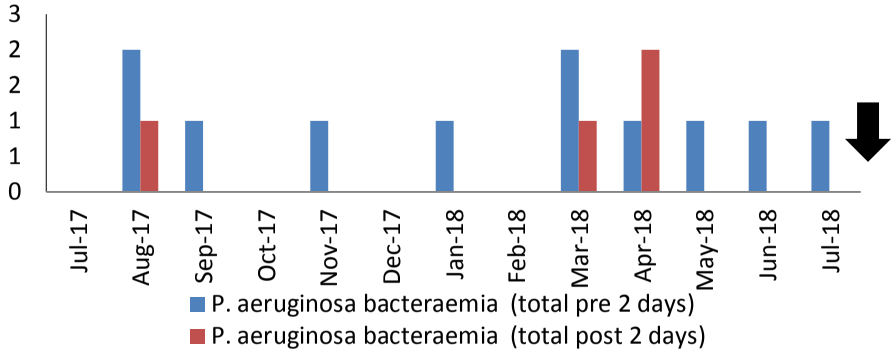
ELHT ranked 71st out of 151 trusts in 2017-18 with 11.8 clostridium infections per 100,000 bed days. The best performing trust had 0 and the worst performer had 91 infections per 100,000 bed days.

SAFE

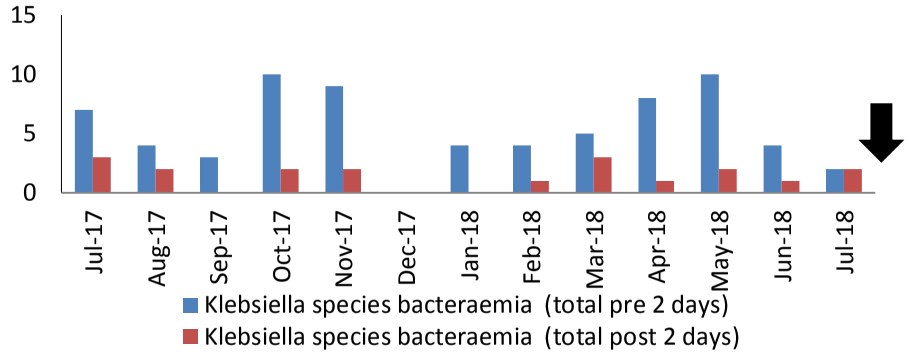
E. Coli



P.aeruginosa



Klebsiella



In response to Lord O'Neill's challenge to strengthen Infection Prevention and Control (IPC), the Secretary of State for Health has launched an important ambition to reduce Gram-negative Blood stream infections (BSIs) by 50% by 2021.

One of the first priorities is reducing E.coli BSI which account for 55% of all BSI nationally. In 2017/18, the Trust achieved the target 10% reduction.

This year we should have no more than 48 E. coli bacteraemia.

There were six E.coli bacteraemia detected in July, which is above the monthly threshold.

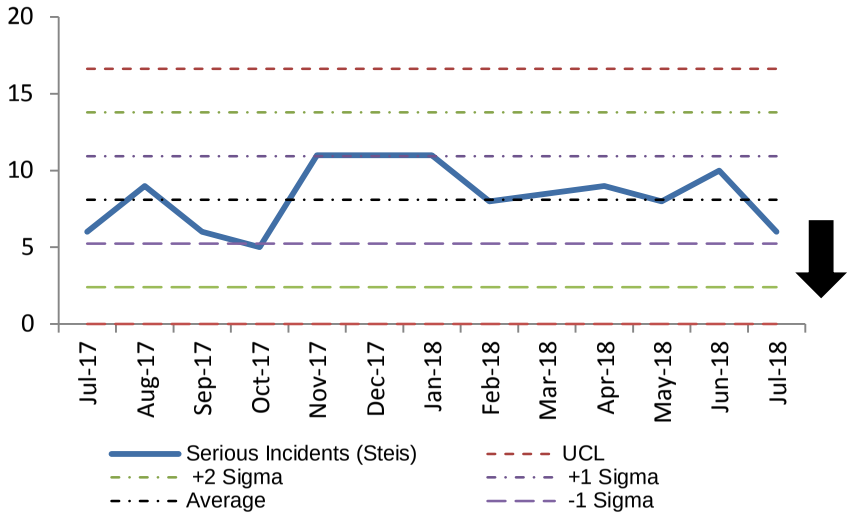
From April 2017, NHS Trusts must report cases of bloodstream infections due to *Klebsiella species* and *Pseudomonas aeruginosa* to Public Health England.

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

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

SAFE

Serious Incidents

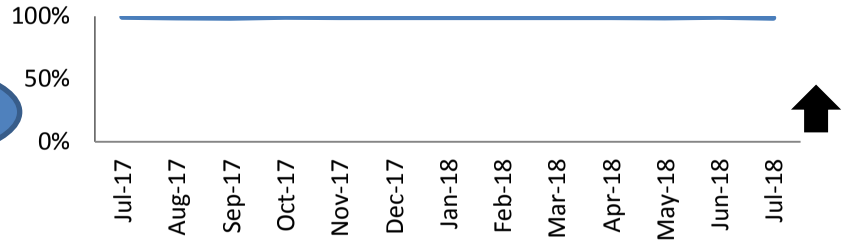


There were no never events reported in July.

The Trust unverified position for incidents reported to the Strategic Executive Information System (StEIS) in July was six incidents. These incidents were categorised as follows:

StEIS Category	No. Incidents in July
Slips Trips and Falls	3
Diagnostic	1
Adverse Media Incident	1
Treatment delay	1

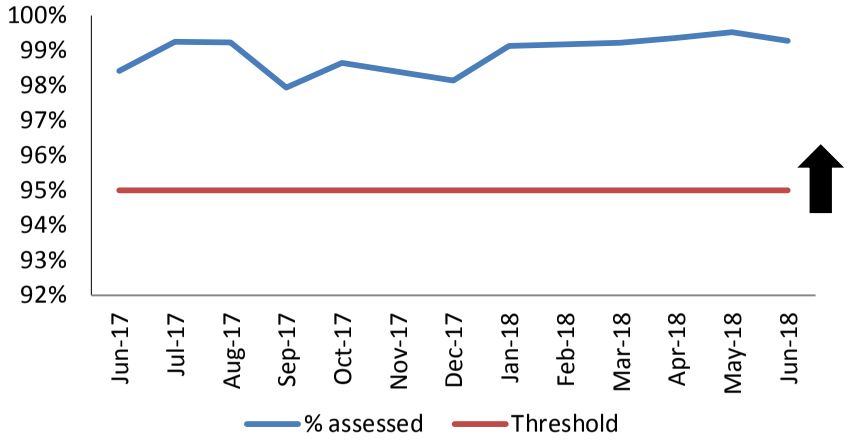
% Harm Free



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

The Trust remains consistent with the percentage of patients with harm free care at 98.9% for July using the National safety thermometer tool.

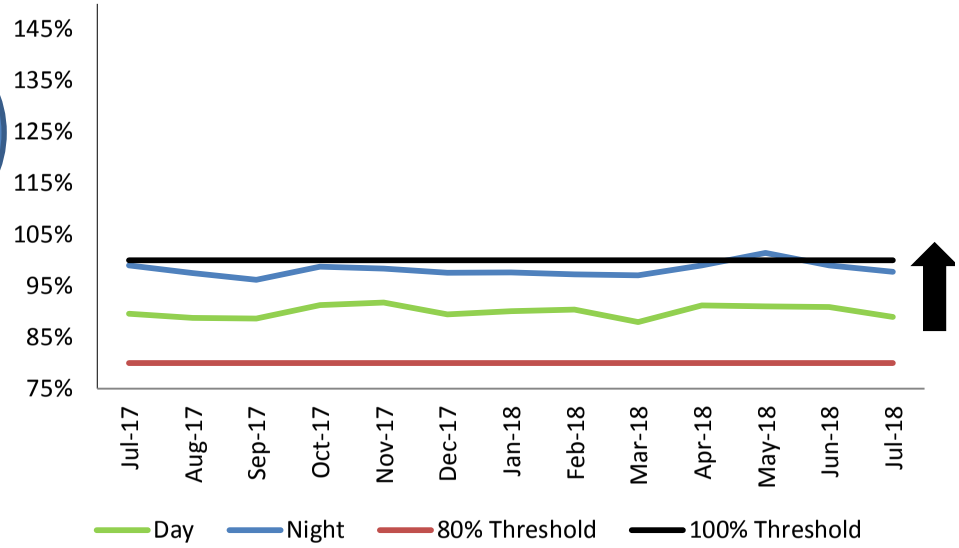
VTE assessment



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

Pressure Ulcers	Hospital Aquired	Community Aquired
Grade 2	2	0
Grade 3	0	0
Grade 4	0	0

Registered Nurses/ Midwives



Nursing and midwifery staffing in July 2018 was extremely challenging. 9 areas fell below an 80% average fill rate for registered nurses on day shifts. Within the family care division 1 area fell below the 80% average fill rate for registered midwives on night duty.

The causative factors remain as in previous months, compounded by escalation areas being opened, pressures within the emergency department, school holiday period, vacancies and sickness. Registered nurse allocation on arrival shifts continue to prove difficult to fill for the reasons previously discussed

Of the 9 areas below the 80% for registered nurses on day shifts, all were due to co-ordinator unavailability which is in addition to agreed staffing levels.

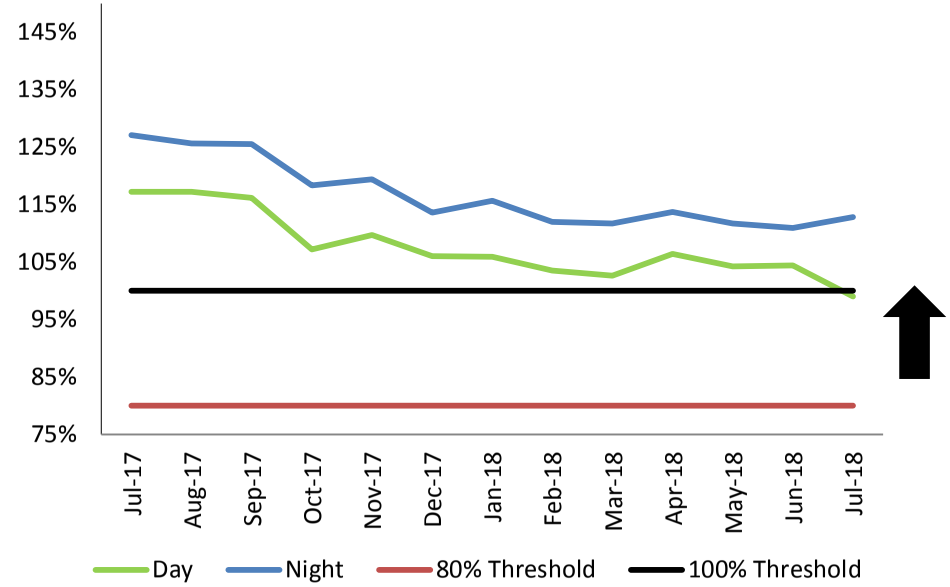
Night Shifts Registered Midwives

• Blackburn Birth Centre

The situation remains as in previous months and Blackburn Birth Centre is still experiencing difficulty staffing to the planned requirements on night duty, to mitigate this, activity is reduced when required.

It should be noted that actual and planned staffing does not denote acuity, dependency, the amount of women in labour or bed occupancy. The divisions consistently risk asses and flex staffing resources to ensure safety is maintained. Of the staffing DATIX incidents reported the divisions have given assurance that no harm has been identified as a consequence of staffing.

Care Staff



Average Fill Rate

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
Month	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff
Jul-18	89.0%	99.0%	97.8%	112.8%	26513	8.77	9	1	1	0

There were no red flag incidents reported in the month of July for general nurse staffing. The divisional directors of nursing have been asked to reiterate the importance of staff entering red flag staffing incidents should they have concerns.

Actions taken:

- Extra allocation on arrival shifts continue to be booked. These have incrementally been increased
- Safe staffing conference at 10 am followed up with meetings through out the day where required to ensure safe staffing, with contingencies agreed for weekends and out of hours.
- Extra health care assistant shifts are utilised to support registered nurse gaps if required
- On going active recruitment.
- The Trust has engaged with Health Education England (HEE) to work collaboratively with the Global Learners Programme. 25 offers of employment have recently been given, with approximately 4 registered nurses due to arrive in the next few months and another 5 awaiting their decision letter from the NMC
- The Trust has agreed to recruit a further 20 trainee nursing associates.
- The staffing templates will change over the coming months to reflect the roll out of the 12 hour shift pattern, some differences may be noticed in respect of actual and planned hours as a consequence, potentially from August/September

Family Care

Maternity

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Staffed to full Establishment	01:29.9	01:28.8	01:29.9	01:28.7	01:30.0	01:29	01:28.7	01:28.6	01:29	01:28.2	01:28.7	01:29.2
Excluding mat leave and vacancies	01:30.6		01:31.1	01:30.1	01:31.1	01:30.2	1:29.9 9.21wte on maternity leave	1:29.84	01:30	01:29.3	01:29.9	01:30.8
With gaps filled through ELHT Midwife staff bank	01:29.3		01:29.8	01:29.2	01:30.1	01:28.3	01:28.7	01:28.5	01:28.4	01:28.5	01:28.8	01:29.4
	Bank usage 9.11 WTE		Bank usage 9.10 WTE		Bank usage 6.43 WTE	Bank usage 10.04 WTE		Bank usage 9.59 WTE	Bank usage 10.4 WTE	Bank usage 6.35 WTE	Bank Usage 7.9 WTE	Bank Usage 9.5 WTE

The staffing figures do not reflect how many women were in labour or acuity of areas.
The midwife to birth ratio should be 1:28

Red Flag Staffing Events
On reviewing Datix 16 incidents were reported overall as Red Flag events in Family Care Division in July.
Of the 16 incidents reported all of them occurred within Maternity Services.
Of these 16 incidents reported within Maternity Services 7 have been excluded as they related to outpatient services.
The incidents were reported under the following category and sub-categories:

Maternity Services - 9
- 3 maternity / obstetrics - missed or delayed care. *1 X No harm, impact prevented. 2 X No harm, impact not prevented.*
- 4 staffing issue – staff shortage midwives. *No harm, impact prevented*.
- 1 staffing issue – staff shortage other. *No harm, impact prevented*.
- 1 staffing issue – unable to carry out intentional rounding. *No harm, impact prevented*

For the remaining incidents, **No harm** was caused.
There was appropriate escalation and implementation of the escalation policy when acuity and activity was high. Workload was prioritised and staff moved to the areas with the highest workload. All area leads, shift co-ordinators were informed of plans and communication was excellent throughout.

Maternity

Maternity services have experienced high activity in the month of July which has proved challenging with 10.73 WTE band 5/6 midwives off sick, 8.35 WTE on maternity leave and 4 WTE vacancies. Therefore despite trying to fill gaps with midwife bank shifts the midwife to birth ratio achieved for this month was 1:29.4 against a target of 1:28. In September there are approx. 13 WTE midwives commencing in post. Due to sickness, vacancies and redeployment of midwives to Lancashire Womens and Newborn to maintain safe staffing levels, Blackburn Birth Centre on some nights has fallen below the 80% shift fill rates. When this happens the intrapartum activity is reduced and women are diverted to the Burnley Birth Centre to maintain safety.

Where the midwife staffing levels are not at the maximum levels, staff are rotated dependent on acuity and services diverted to other areas of maternity to maintain safety at all times. This is completed formally as part of safety huddles within a 24 hour period with interim or point prevalent huddles if required. Acuity and activity are assessed four times daily with a multi professional team being part of the safety huddles on Central Birth Suite, the huddles assess the whole picture across maternity services at ELHT and staff with relevant skills and competencies are moved accordingly to ensure safe staffing throughout the services.

NICU

No exceptions to report. Nurse staffing levels for the acuity are monitored throughout the day and if acuity changes shift are put out to bank and agency to fill the gaps to ensure safe staffing and where necessary the unit closed to external admissions to maintain safety. There has been a steady decrease in the amount of agency nurses to cover gaps in staffing.

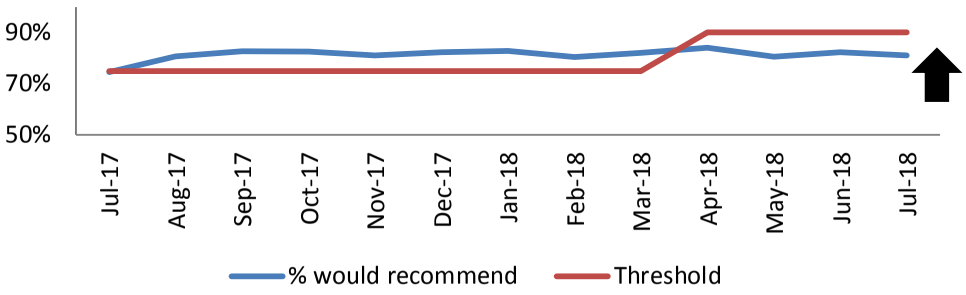
Paediatrics

The children's ward has had a high level of sickness which has meant that on some shifts the actual staffing is lower than the planned. However due to some estates work that has been undertaken on the ward beds have been closed and this has therefore balanced out the staffing. Activity and acuity are closely monitored and recorded 3 times throughout the day on safe staffing.

Please see Appendix 2 for UNIFY data and nurse sensitive indicator report

CARING

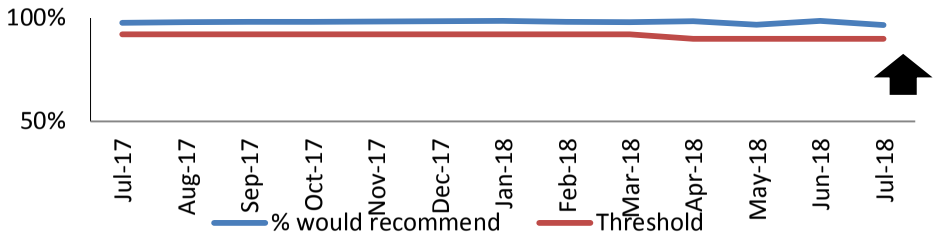
Friends & Family A&E



These metrics reflect national measurement methodology, which measures the proportion of patients that would recommend the Trust to friends and family. The threshold has been revised to 90% from April 2018.

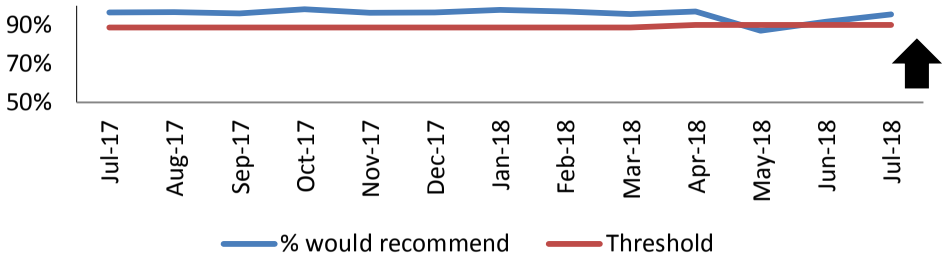
The proportion that would recommend A&E to friends and family has decreased in July to 81.1% with a response rate of 19.7%

Friends & Family Inpatient



The proportion that would recommend inpatient services has remained high at 96.6% in July. The response rate was 48.6%

Friends & Family Community

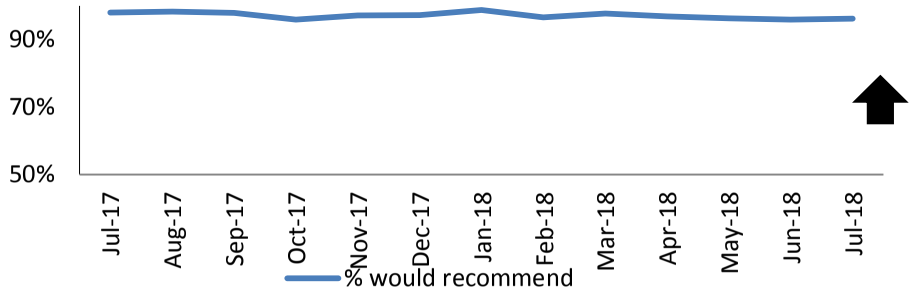


Community services would be recommended by 95.5% in July.

Maternity services would be recommended by 96.2% in July.

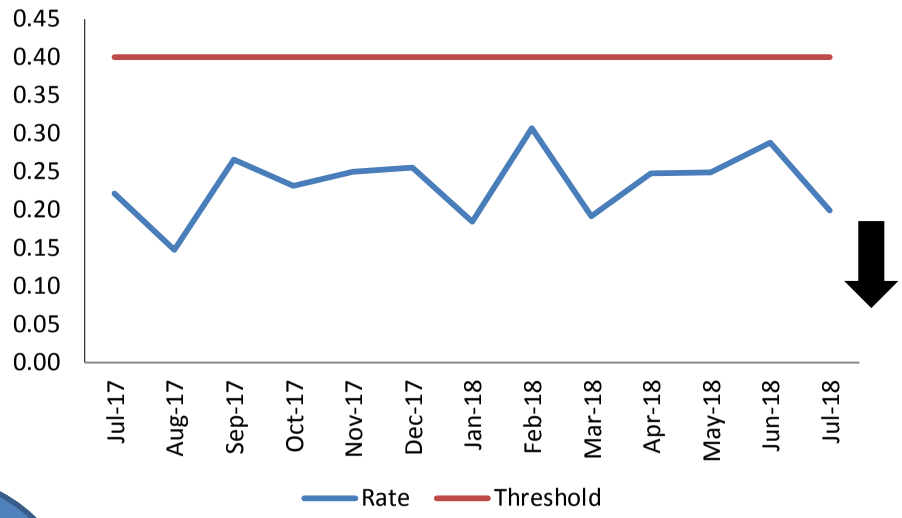
Volunteer support is now available for inputting responses and matrons are alerted to areas with low response rates.

Friends & Family Maternity



CARING

Complaints per 1000 contacts



The Trust opened 22 new formal complaints in July. The number of complaints closed was 30.

ELHT is targeted to achieve a threshold of at or less than 0.4 formal complaints per 1,000 patient contacts – made up of inpatient, outpatient and community contacts. The Trust on average has approximately 116,000 patient contacts per calendar month.

For July the number of complaints received is shown as 0.20 Per 1,000 patient contacts.

Patient Experience

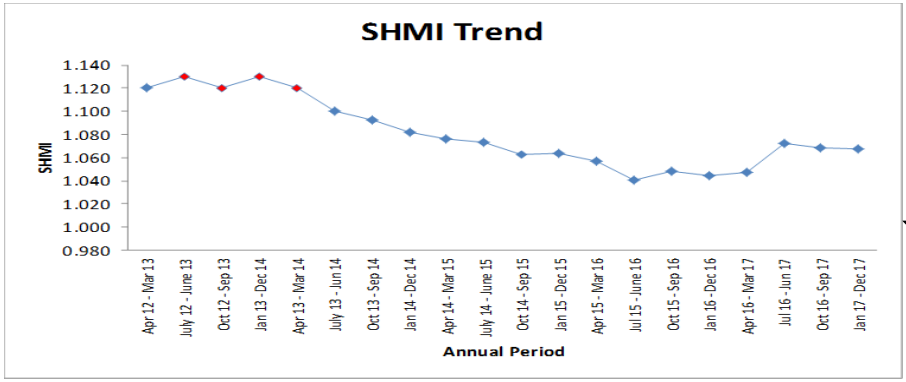
From 1st May 2018 the Trust has been working with Healthcare Communications Envoy to provide the Friends and Family Test (FFT) and survey services via one system.

All local surveys have now been created and staff are inputting completed surveys onto the Envoy system.

Competency score performance linked to each survey will require configuration and Envoy have raised a system enhancement request to undertake this task. Until competencies and scoring are added to each survey, competency score data is not available.

Envoy will provide updates on this functionality to the Patient Experience Team.

SHMI Published Trend



The latest Trust SHMI value as reported by the Health and Social Care Information Centre and Care Quality Commission for the period January 17 to December 17 has improved slightly to 1.067 and is still within expected levels, as published in July 2018.

Dr Foster Indicative HSMR rolling 12

	DFI Rebased on latest month Apr 17 – Mar 18 (Risk model December 17)
TOTAL	90.2 (CI 85.8 – 94.7)
Weekday	89.8 (CI 84.8 – 95.2)
Weekend	91.1 (CI 82.4 – 100.4)
Deaths in Low Risk Diagnosis Groups	43.5 (CI 19.9 – 82.7)

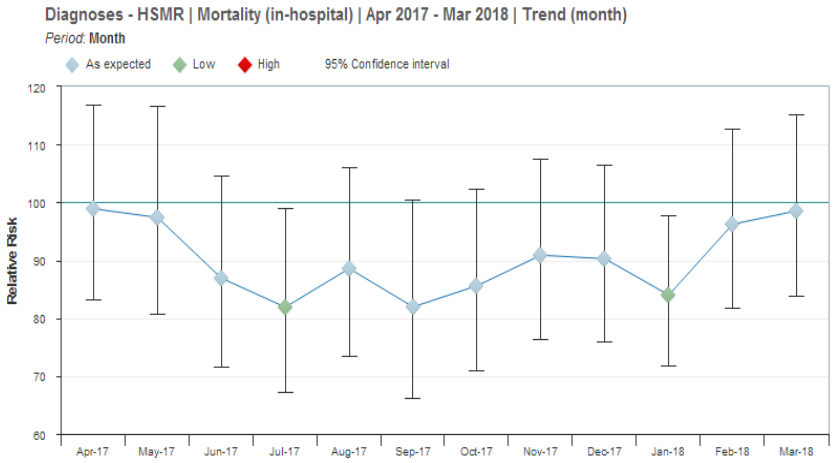
The latest indicative 12 month rolling HSMR (April 17 – March 18) is reported as 'significantly better than expected' at 90.2 against the monthly rebased risk model.

The weekday HSMR is also 'significantly better than expected'

All HSMR groups are now either 'as expected' or 'better than expected'.

There are currently three SHMI groups with significantly high relative risk scores. These are being investigated through the mortality steering group and each have a nominated clinical lead and an associated action plan.

Dr. Foster Indicative HSMR monthly Trend



Two learning disability deaths were reviewed through the Learning Disability Mortality Review Panel in July. All cases have been reported to the LeDeR National Programme. The LDMR Panel continue to meet on a monthly basis as required to review cases.

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

Structured Judgement Review Summary

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

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

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

	Month of Death											
Stage 1	pre Oct 17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	TOTAL
Deaths requiring SJR (Stage 1)	39	50	37	29	33	28	30	27	24	23	27	347
Allocated for review	39	50	37	28	29	17	8	8	7	3	6	232
SJR Complete	38	43	23	23	16	7	4	7	3	2	1	167
1 - Very Poor Care	1	0	0	1	0	0	0	0	0	0	0	2
2 - Poor Care	7	4	4	2	4	0	0	0	0	1	0	22
3 - Adequate Care	12	14	7	9	3	2	2	1	0	0	0	50
4 - Good Care	16	21	10	9	9	5	2	6	2	1	1	82
5 - Excellent Care	2	4	2	2	0	0	0	0	1	0	0	11
Stage 2												
Deaths requiring SJR (Stage 2)	8	4	4	3	4	0	0	0	0	1	0	24
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	0	1	1	0	0	0	0	0	0	0	5
Allocated for review	5	4	2	2	4	0	0	0	0	1	0	18
SJR-2 Complete	5	4	2	2	2	0	0	0	0	0	0	15
1 - Very Poor Care	1	0	0	0	1	0	0	0	0	0	0	2
2 - Poor Care	3	1	1	1	0	0	0	0	0	0	0	6
3 - Adequate Care	1	3	1	1	1	0	0	0	0	0	0	7
4 - Good Care	0	0	0	0	0	0	0	0	0	0	0	0
5 - Excellent Care	0	0	0	0	0	0	0	0	0	0	0	0

	pre Oct 17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Total
stage 1 requiring allocation	0	0	0	1	4	11	22	19	17	20	21	115
stage 1 requiring completion	1	7	14	5	13	10	4	1	4	1	5	65
Backlog	1	7	14	6	17	21	26	20	21	21	26	180
stage 2 requiring allocation	0	0	1	0	0	0	0	0	0	0	0	1
stage 2 requiring completion	0	0	0	0	2	0	0	0	0	1	0	3
Backlog	0	0	1	0	2	0	0	0	0	1	0	4

Commissioning for Quality and Innovation

EFFECTIVE

in 2018/19 the Trust is participating in the following 5 national CQUIN schemes as agreed with the CSU in 2017/18:

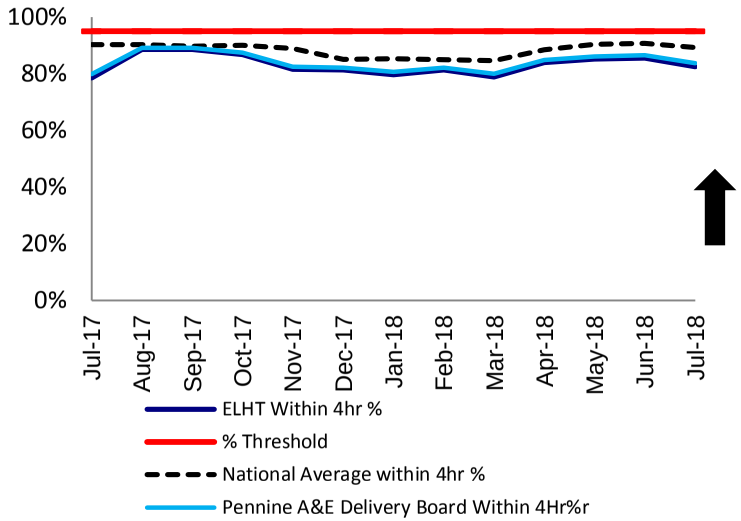
1. NHS Staff Health and Wellbeing
2. Reducing the impact of serious infections
3. Improving services for people with mental health needs who present to A & E
4. Preventing ill health by risky behaviours (2018/2019 only).
5. Personalised care/support planning

Clinical Effectiveness Committee will seek assurance that schemes are in progress and on track for delivery with timescales.

CQUIN Scheme		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Q1	Q2	Q3	Q4
national	**NHS STAFF HEALTH & WELLBEING** - Flu Vaccine Uptake	**75%**																
national	**SEPSIS PART A- IDENTIFICATION**- TOTAL %	**90.0%**	**100.0%**	**100.0%**	**100.0%**										**100%**			
national	**SEPSIS PART B - ANTIBIOTIC ADMINISTRATION - TOTAL %**	**90.0%**	**90.4%**	**93.4%**	**90.6%**										**91.5%**			
national	**SEPSIS PART C - ANTIBIOTIC REVIEW -** % Prescriptions Reviewed within 72 Hrs	**Q1 25% Q2 50% Q3 75% Q4 90%**	**100%**	**100%**	**100%**										**100%**			
national	**REDUCTION IN ANTIBIOTIC CONSUMPTION- PART D**- Total antiobiotic consumption per 1000 admissions	***4944.0***																
national	-Antibiotic % Reduction on 2016 baseline	***-2.0%***																
national	- Total consumption of carbapenem per 1000 admissions	***31.9***																
national	-Carbapenam % Reduction on 2016 baseline	***-3.0%***																
national	- Increase proportion of antiobiotic usage within the Access group of the AWaRe category	**>=55%**																

RESPONSIVE

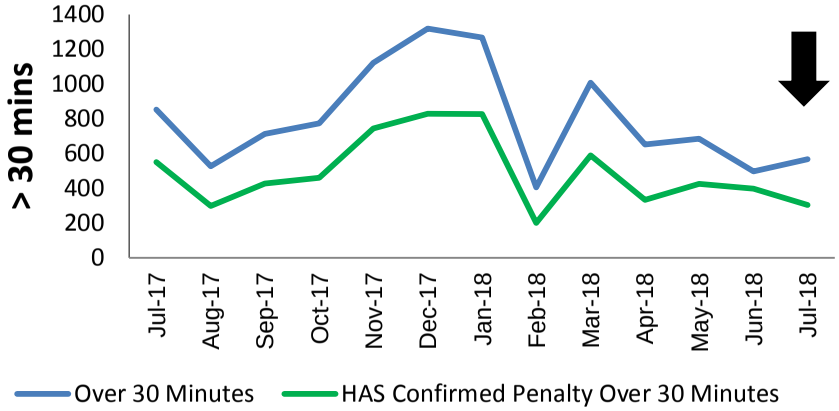
A&E 4 hour standard % performance



Overall performance against the ELHT Accident and Emergency four hour standard deteriorated in July to 82.5%, which remains below the 95% threshold. The performance against the Pennine A&E Delivery Board four hour standard has also deteriorated to 83.8% in July.

The number of attendances during July was 17,668 and of these 14,805 were treated and left the department within 4 hours. (Pennine A&E Delivery Board)

Ambulance Handovers



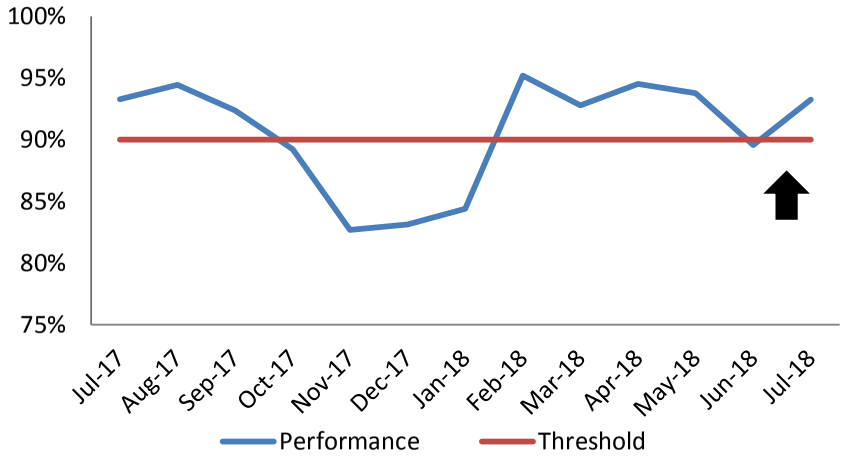
The national performance deteriorated to 89.3% in July (All types) with 18 out of 134 reporting trusts with type 1 departments achieving the 95% standard.

There were 37 reported breaches of the 12 hour trolley wait standard from decision to admit during July. All were mental health breaches. Rapid review timelines are completed in accordance with the NHS England Framework and a root cause analysis will be undertaken.

The number of handovers over 30 minutes increased to 568 for July compared with 497 for June. The average handover time has increased in July to 19:30 minutes from 18:41 minutes in June.

The validated NWAS penalty figures are reported as at July as;- 161 missing timestamps, 250 handover breaches (30-60 mins) and 55 handover breaches (>60 mins).

HAS Compliance

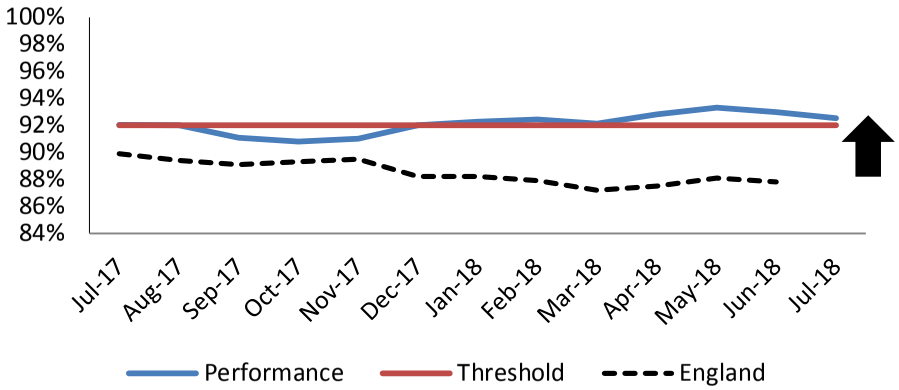


The ambulance handover compliance indicator measures the compliance with PIN entry on completion of patient handover. This improved and was achieved at 93.3% in July, which is below the 90% threshold.

The full action plan is monitored through the Finance & Performance Committee & the A&E Delivery Board.

RESPONSIVE

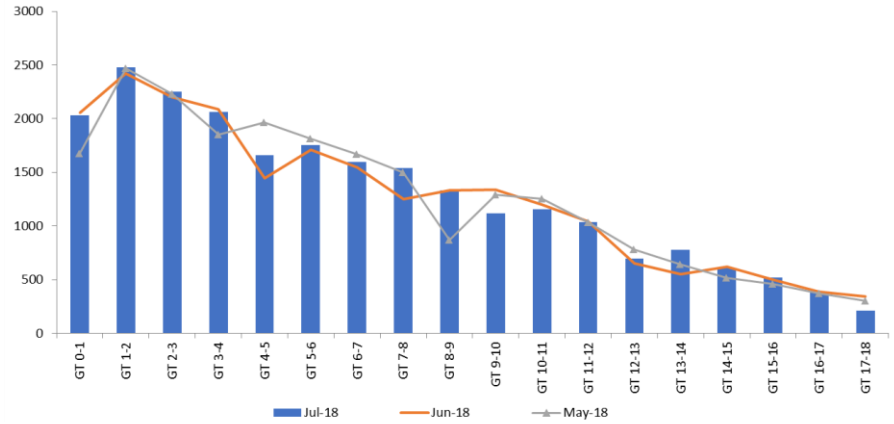
RTT Ongoing



The 18 week referral to treatment (RTT) % ongoing position was achieved in July with 92.5% patients, waiting less than 18 weeks to start treatment at month end.

There were no patients waiting over 52 weeks at the end of July.

RTT Ongoing 0-18 Weeks



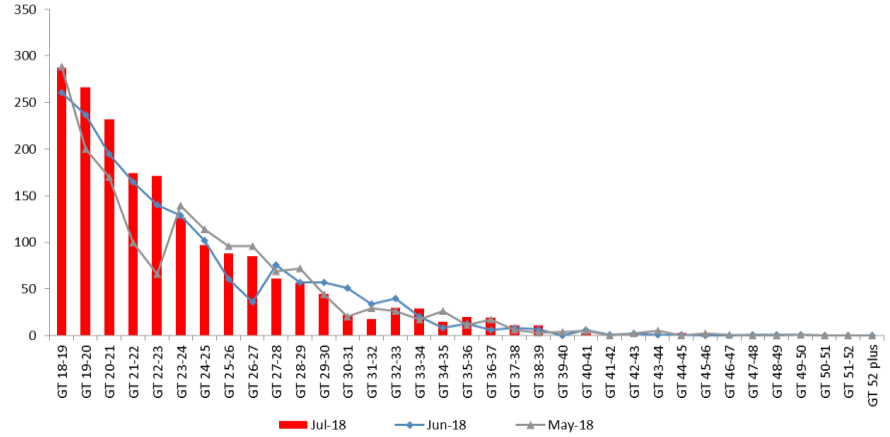
The total number of on-going pathways has increased in July to 25,086 from 24,418 in June.

There has been an increase in patients waiting over 18 weeks at the end of July to 1877 from 1717 in June.

The median wait has remained at 6.4 weeks in July from 6.4 weeks in June.

Although no longer a national target, the proportion of admitted and non-admitted patients is included on the scorecard for information.

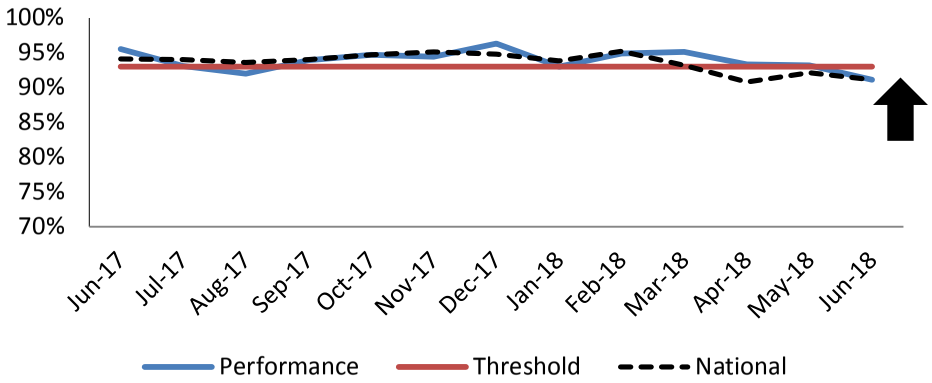
RTT Over 18 weeks



The latest published figures from NHS England show continued failure of the ongoing standard nationally (reported 1 month behind), with 87.8% of patients waiting less than 18 weeks to start treatment in June, compared with 88.1% in May.

RESPONSIVE

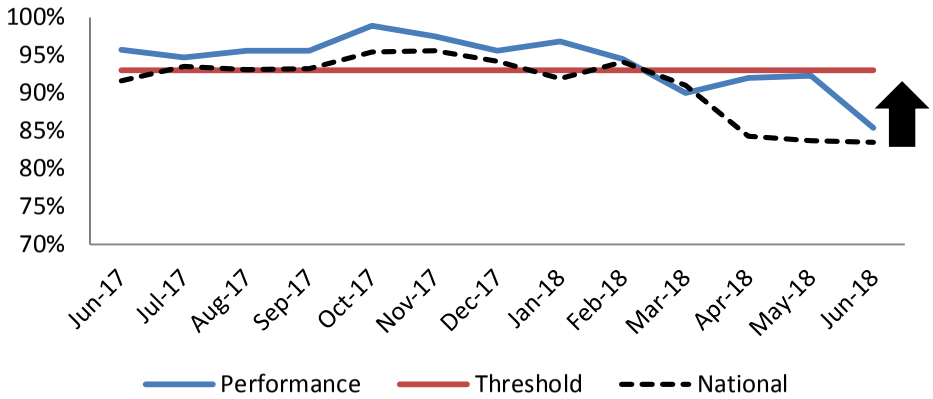
Cancer 2 Week



The cancer 2 week wait for GP referrals standard was not achieved in June at 91.1%, below the 93% standard and as a result, the quarter 1 performance also fell below the standard at 92.5%

National performance has also been below the standard in quarter 1.

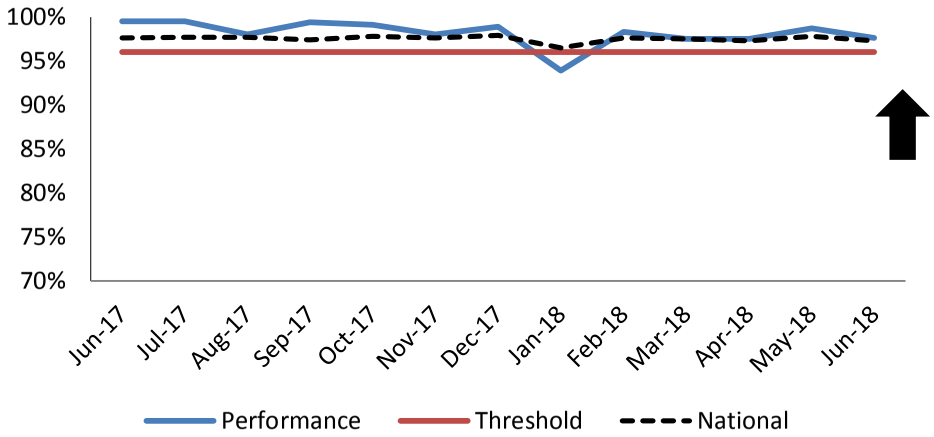
Cancer 2 Week - breast



The 2 week breast symptomatic standard was not achieved in June at 85.4%, below the 93% standard and the quarter 1 performance was also not met at 89.8%

National performance has also been below the standard in quarter 1.

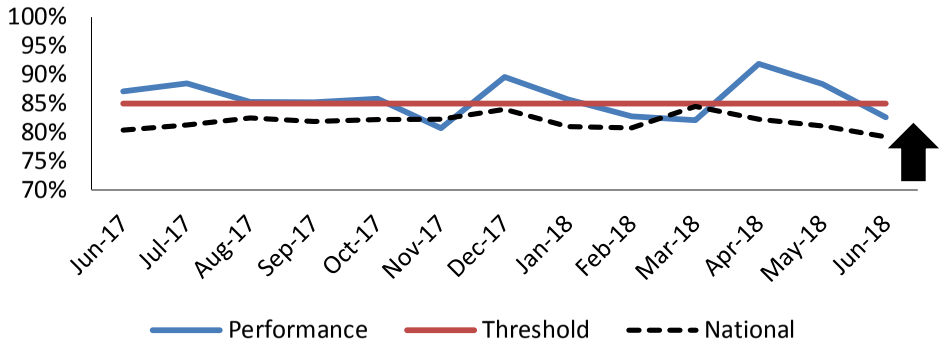
Cancer 31 day



The 31 day target was achieved in June at 97.6%, above the 96% standard and the quarter 1 standard has also been achieved at 97.9%

RESPONSIVE

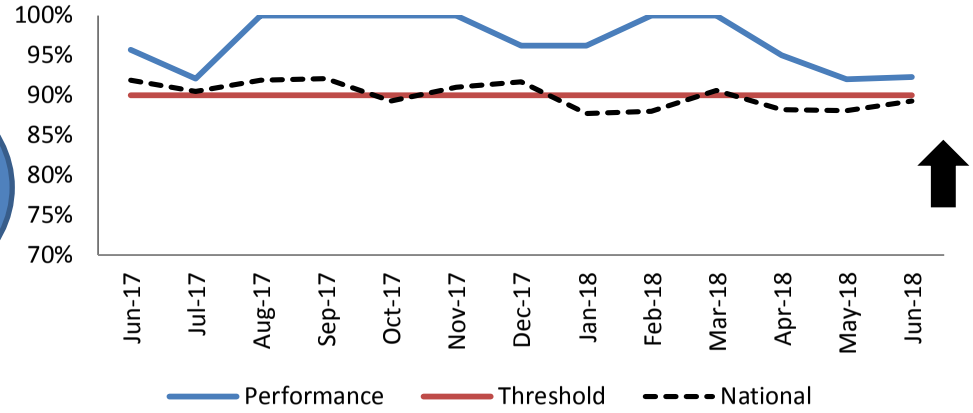
62 Day Cancer



62 day performance was not achieved in June at 82.6%, below the 85% threshold. However the quarter 1 performance was achieved at 87.5%

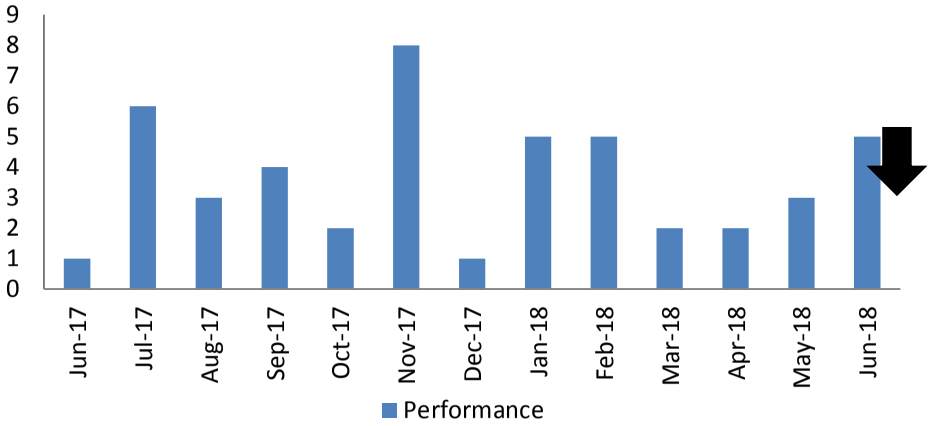
National performance has been consistently below the standard.

62 Day Screening



The 62 day screening standard continued to be achieved in June at 92.3% and quarter 1 was also met at 92.9%

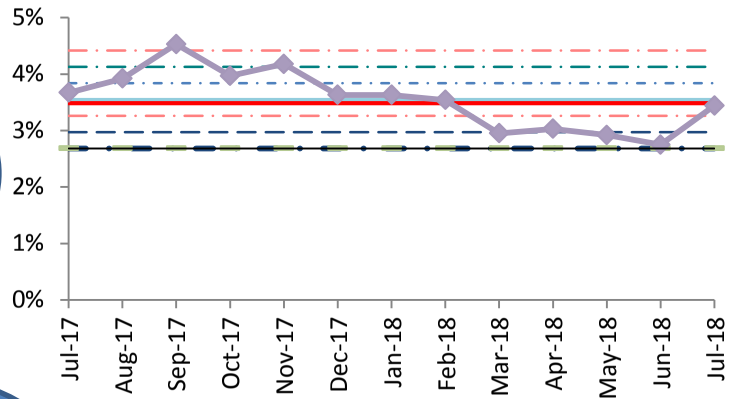
Cancer Patients Treated > Day 104



There were 5 patients (4 breaches allocated to the Trust) treated after day 104 in June and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the Consultants involved in the pathway as required.

RESPONSIVE

Delayed Discharges per 1000 bed days

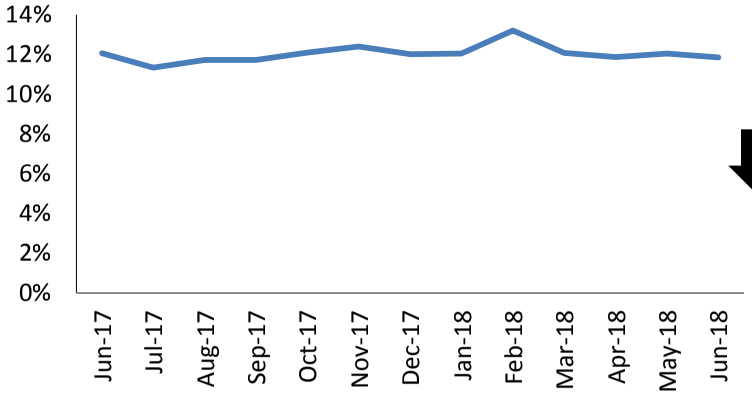


The proportion of delays reported against the delayed transfers of care standard has increased during July to 3.4% which remains under the threshold of 3.5%.

This equates to an average of 28 beds lost per day in July. The top three reasons for the bed days lost due to delayed discharge are; Awaiting completion of assessment' (25%) 'Patient or Family Choice' (26%), 'Awaiting public funding' (19%). The achievement of this target is multi-factorial, linked to complex discharge processes involving ELHT and partners.

There is a full action plan which is monitored through the Finance & Performance Committee.

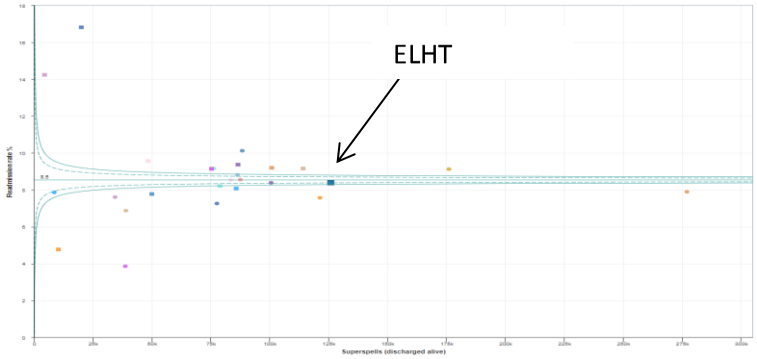
Emergency Readmissions



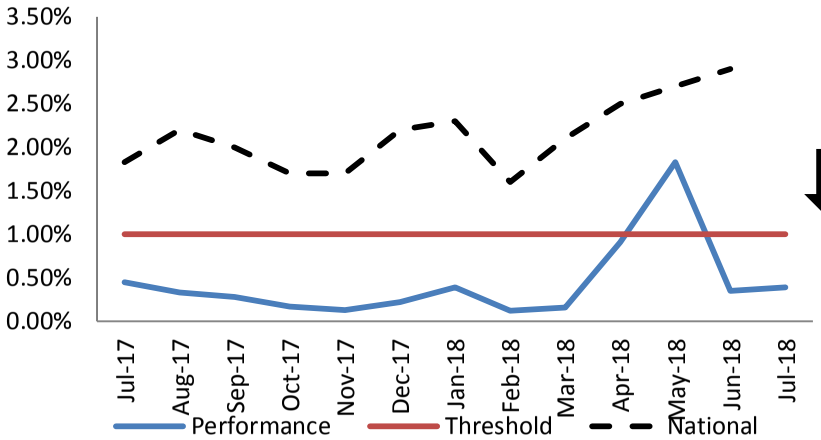
The emergency readmission rate has decreased to 11.9% in June 2018 (reported 1 month behind) compared to 12.1% in June 2017.

Dr Foster benchmarking shows ELHT have a similar rate to the North West average and are not an outlier.

Readmissions within 30 days vs North West - Dr Foster
December 2016 - November 2017



Diagnostic Waits



In July 0.4% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is within the 1% threshold. Nationally, the performance is failing the 1% target and has deteriorated to 2.9% in June (reported 1 month behind), compared with 2.7% in May.

RESPONSIVE

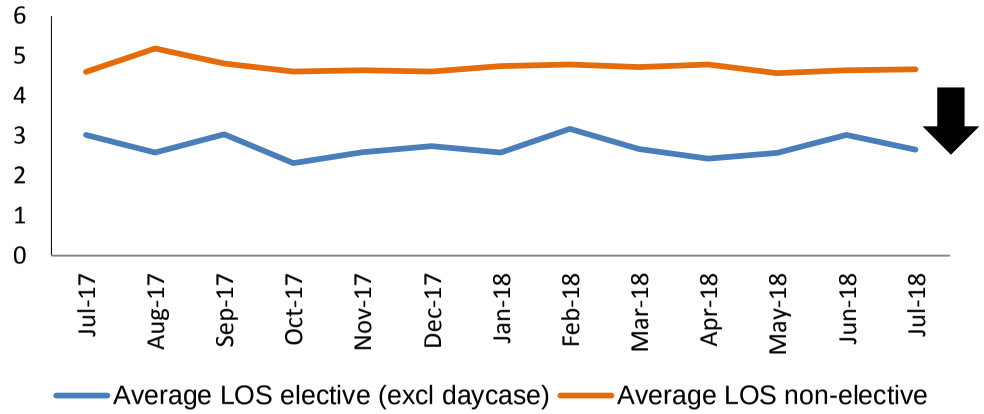
Average Length of Stay Benchmarking

Dr Foster Benchmarking April 17 - March 18

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	60,869	10,082	50,787	3.4	2.7	-0.7
Emergency	53,794	53,794	0	4.9	4.9	0.0
Maternity/ Birth	13,654	13,654	0	2.2	2.3	0.2
Transfer	202	202	0	10.3	23.8	13.4

Dr Foster benchmarking shows the Trust length of stay to be as expected for non-elective and below expected when compared to national case mix adjusted, for elective patients.

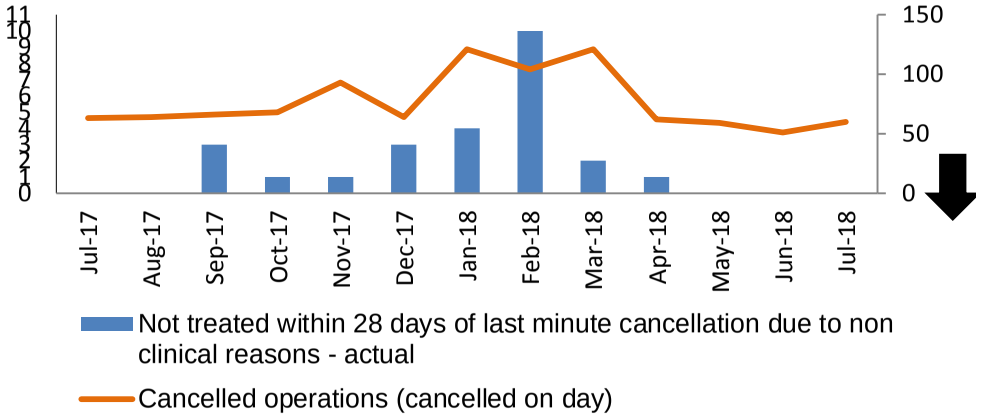
Average Length of Stay



The Trust non elective average length of stay increased to 4.7 days in July, compared to 4.6 in June.

The elective length of stay (excluding day case) has decreased to 2.7 days in July from 3.0 days in June.

Operations cancelled on day - 28 day standard

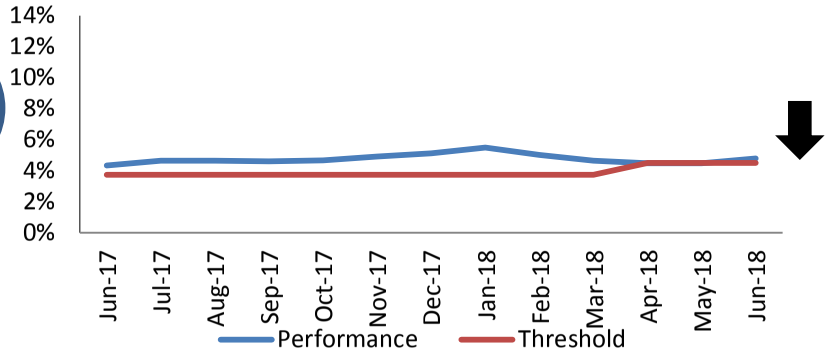


There were 60 operations cancelled on the day of operation in July. There were 0 'on the day' cancelled operations not rebooked within 28 days in June.

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

WELL LED

Sickness

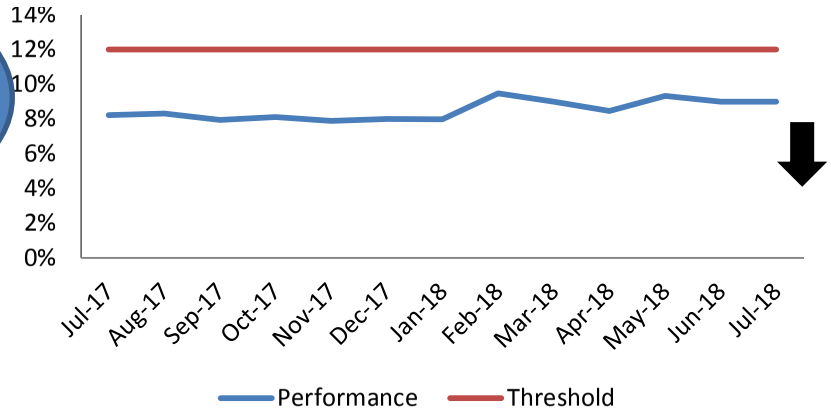


The sickness absence rate has increased from 4.49% in May to 4.79% in June 2018. The current rate is slightly higher than the previous year (4.34%).

High sickness rates are a financial risk as bank and agency expenditure increases to cover shifts. Long term sickness attributed to anxiety/stress and musculoskeletal problems continue to be the main reasons for sickness absence.

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

Turnover Rate

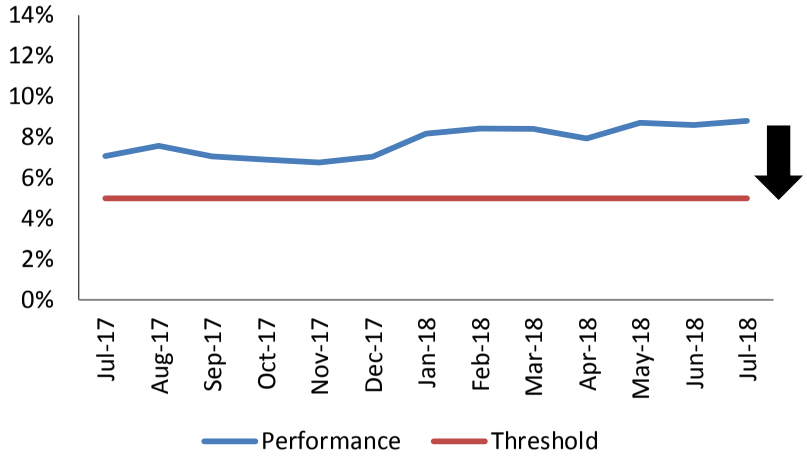


The trust turnover rate has remained at 9% in July and the vacancy rate has increased slightly to 8.8% in July from 8.6% in June.

Overall the Trust is now employing 7263 FTE staff in total. This is a net increase of 21 FTE from the previous month. The number of nurses in post at July 2018 stood at 2273 FTE which is 12 lower than last month and a net increase of 224 FTE since 1st April 2013.

As at 30 July 2018 there are a further 87 external/R&R nurses in the recruitment pipeline. Scheduled to start between now and March 2019 and 46 changing posts internally. These figures include our 2 first overseas nurses through the HEE Global Learners Programme (GLP). In addition to this we have a further 24 GLP candidates not included in these figures as yet who are currently going through the overseas registration process

Vacancy Rate



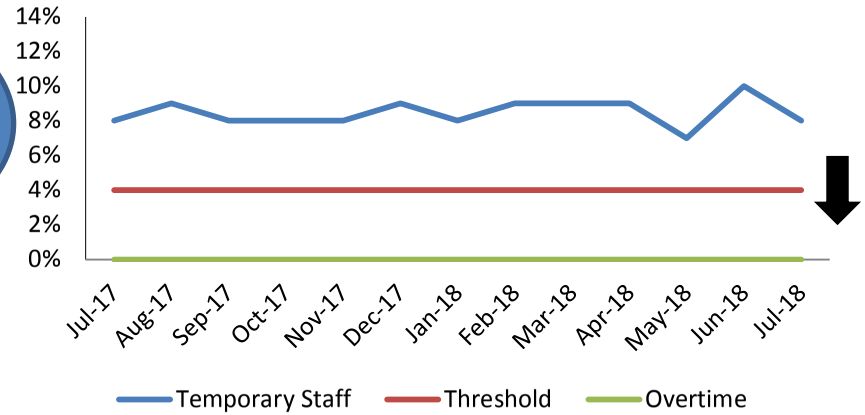
The vacancy rate for nurses now stands at 10.12% (256 FTE)

As of August 2018 there are 96 FTE Medical Posts vacant of which 45 posts have been offered and awaiting pre-employment checks or confirmation of start dates to be agreed.

The vacancy rates for doctors now stands at 7.6% (47 FTE).

WELL LED

Temporary costs and overtime as % total pay bill



In 2017/18 East Lancashire Hospitals NHS Trust spent £27.4m on temporary staffing for the year. This represented 8% of the overall pay bill. (9% 2016/17;8% 2015/16; 9% 2014/15; 8% 2013/4; 5.5% 2012/13).

For the year ending 2017/18 the Trust spent £27,459,459 (£12,832,971 agency; £14,626,488 bank).

In July 2018 the Trust spent £2,400,228 on bank and agency. This was more than in July 2017 (£2,162,111) and more than in June 2018 (£2,357,176).

In April to July 2018 £9.9million was spent on temporary staff. £3.8million expenditure on agency staff and £6.1million expenditure on bank staff.

Appraisals, Consultant & Other Medical

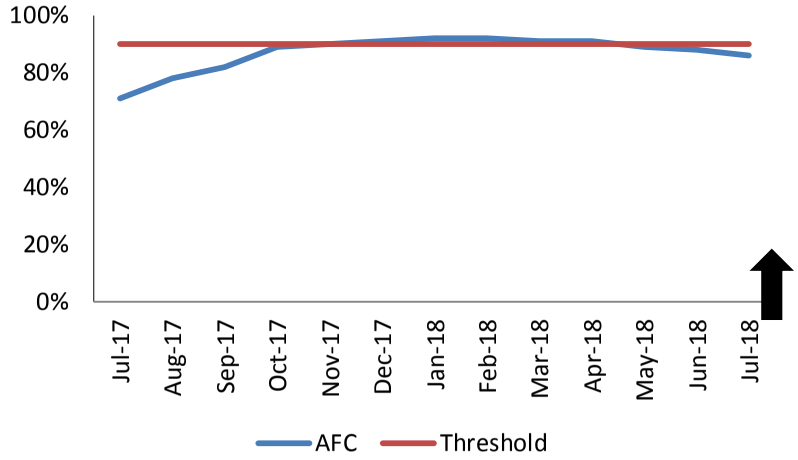
Consultant and Other Medical appraisal data is not available for the month of July, but will be updated from September.

At the 31st July 2018 there are 701 vacancies.

Wte staff worked (7,947wte)was 194wte less than is funded substantively (8,141wte).

Pay costs are £2.4million above budgeted establishment primarily due to premium rates paid for agency staff.

Appraisals AFC



The AFC appraisal rates continue to be reported as a rolling 12 month figure and remains below threshold at 86% in July.

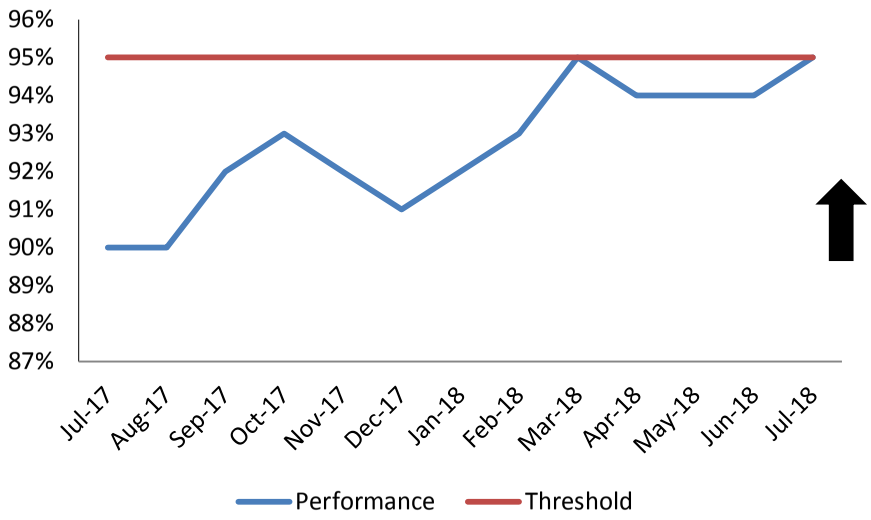
There has been a range of Trust wide actions to support compliance which are on-going. These actions are monitored through the Finance & Performance Committee.

WELL LED

Job Plans

Information Governance Toolkit

Core Skills Training % Compliance



	Target	Compliance at end July
Basic Life Support	90%	91%
Conflict Resolution Training Level 1	90%	98%
Equality, Diversity and Human Rights	90%	98%
Fire Safety	90%	98%
Health, Safety and Welfare Level 1	90%	99%
Infection Prevention	90%	98%
Information Governance	95%	95%
Prevent Healthwrap	90%	96%
Safeguarding Adults	90%	97%
Safeguarding Children	90%	97%
Safer Handling Theory	90%	97%

All job plans with the exception of Trauma & Orthopaedics, have been reviewed, at 1st or 2nd sign off stage and will be completed by 16th September.

Confirm and Challenge meetings will be held with Divisional Directors during October and November 2018, to sign off job plans within their directorates, chaired by the Deputy Medical Director .

Trauma and Orthopaedics requested an extension to the job plan sign off process, due to undertaking a departmental review and have been granted authorisation to roll over existing job plans from 2017/18.

Information governance toolkit compliance has improved to 95% in June, in line with the 95% threshold.

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

All of the eleven areas are currently at or above threshold for training compliance rates.

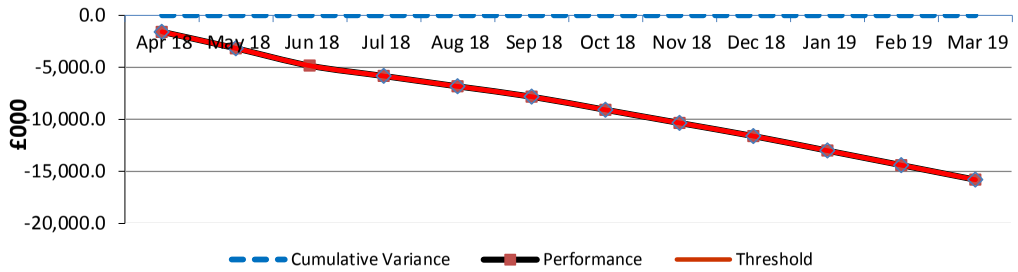
Divisional actions plans to address non-compliance are in place and are being monitored through divisional meetings. Furthermore, a range of Trust-wide measures to support staff to be fully compliant are in place. These include facilitated e-Learning sessions, bespoke training for wards and departments, cascade training and the availability of real-time compliance reporting to assist managers monitor compliance.

WELL LED

Finance & Use of Resource metrics

Area	Metric	Actual YTD Performance	Actual YTD Score	Forecast outturn Performance	Forecast outturn Score
Financial sustainability	Capital service capacity	0.7	4	1.0	4
	Liquidity (days)	(8.4)	3	(9.1)	3
Financial efficiency	I&E margin	(2.6%)	4	(1.8%)	4
Financial control	Distance from financial plan	(0.1%)	2	(0.2%)	2
	Agency spend	5.6%	2	0.0%	1
Total			3		3

Adjusted financial performance (deficit) *



* - excludes PSF allocation

The Trust has agreed a revised underlying control total of a £15.798million deficit

The acceptance of the control total allows the Trust access to a Provider Sustainability Fund (PSF) of up to £8.050million.

Access to the £8.050million is reliant on 30% achievement of the 4 hour target and 70% achievement of the underlying control total.

At month 4, the Trust is reporting an underlying position of a £5.837million deficit in line with the financial plan, and a £4.615million deficit after Provider Sustainability Funding (PSF) of £1.221million.

The Safely Releasing Cost Programme (SRCP) is £18.0million for 2018-19. £5.2million has been identified to date of which £4.4million is recurrent.

The Better Payment Practice Code (BPPC) targets continues to be achieved across all four areas, both in month and for the year to date.

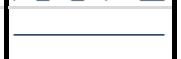
The 'Finance and use of resources metrics score' has moved back to 3 for the financial year from 2 in the previous month, primarily due to the earlier than expected repayment of the £2.75million revenue support loan taken out in June. 1 being the best level of performance and 4 being in financial special measures.

The cash balance at 31 July 2018 was £10.0million, an increase of £5.1million in month.

Efficiency Savings

Division	Target	Green	Amber	Red	Total	(Over) / Under Identified	Total Green Schemes	Non Rec	Rec	Identified
		£000's	£000's	£000's	£000's	£000's	%	£000's	£000's	£000's
Integrated Care Group	3,154	1,626	80	1,874	3,580	(426)	45%	32	1,594	1,626
SAS	3,720	261	1,586	117	1,964	1,756	13%	51	210	261
Family Care	2,423	310	91	0	401	2,022	77%	214	96	310
DCS	1,103	1,203	302	0	1,505	(402)	80%	38	1,165	1,203
Estates & Facilities	1,440	719	49	0	768	672	94%	60	659	719
Corporate Services	536	148	175	0	323	213	46%	0	148	148
Cross divisional	0	0	0	5,982	5,982	(5,982)	0%	0	0	0
Targetted Transformation	5,624	894	500	2,084	3,479	2,145	26%	400	494	894
Total	**18,000**	**5,161**	**2,783**	**10,057**	**18,001**	**(1)**	**0**	795	4,366	5,161

APPENDIX 1

Safe		Threshold 18/19	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Monthly Sparkline
M64	CDIFF	27	3	2	5	2	3	3	3	2	3	5	2	3	4	1	
M64.1	Cdiff Cumulative from April	27	9	11	16	18	21	24	27	29	32	37	2	5	9	10	
M65	MRSA	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	
M124	E-Coli (post 2 days)	48	8	0	6	4	6	2	3	3	4	3	5	5	2	6	
M154	P. aeruginosa bacteraemia (total pre 2 days)		1	0	2	1	0	1	0	1	0	2	1	1	1	1	
M155	P. aeruginosa bacteraemia (total post 2 days)	4	0	0	1	0	0	0	1	0	0	1	2	0	0	0	
M156	Klebsiella species bacteraemia (total pre 2 days)		6	7	4	3	10	9	5	4	4	5	8	10	4	2	
M157	Klebsiella species bacteraemia (total post 2 days)	16	0	3	2	0	2	2	3	0	1	3	1	2	1	2	
M66	Never Event Incidence	0	0	1	0	0	2	0	0	1	0	1	1	0	0	0	
M67	Medication errors causing serious harm (Steis reported date)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C28	Percentage of Harm Free Care	92%	98.7%	99.7%	99.1%	98.8%	99.5%	99.4%	99.0%	99.3%	99.3%	99.6%	99.3%	99.2%	99.6%	98.9%	
M68	Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	98.4%	99.3%	99.2%	97.9%	98.6%	98.9%	98.1%	99.1%	99.3%	99.2%	99.4%	99.5%	99.3%		
M69	Serious Incidents (Steis)		7	6	9	6	5	11	7	11	8	6	9	8	10	6	
M70	CAS Alerts - non compliance	0	0	0	0	2	0	3	2	2	0	0	2	0	0	0	
M146	Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80%	96%	90%	89%	89%	91%	92%	90%	90%	90%	88%	91%	91%	91%	89%	
M147	Safer Staffing -Day-Average fill rate - care staff (%)	80%	114%	117%	117%	116%	107%	110%	106%	106%	104%	103%	106%	104%	104%	99%	
M148	Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80%	99%	99%	98%	96%	99%	98%	98%	98%	97%	97%	99%	101%	99%	98%	

M149	Safer Staffing -Night-Average fill rate - care staff (%)	80%	127%	127%	126%	126%	118%	119%	114%	116%	112%	112%	114%	112%	111%	113%	
M150	Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80%	0	2	5	6	4	4	5	12	10	7	12	5	5	8	9	
M151	Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80%	0	1	0	0	1	1	0	1	0	0	1	0	0	0	1	
M152	Safer Staffing - Day -Average fill rate - care staff- number of wards <80%	0	0	1	1	0	1	1	1	1	1	1	0	1	1	1	
M153	Safer Staffing - Night -Average fill rate - care staff- number of wards <80%	0	1	1	1	1	1	1	1	1	1	1	1	1	1	0	

Caring

		Threshold 18/19	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Monthly Sparkline
C38	Inpatient Friends and Family - % who would recommend	90%	98.0%	97.7%	97.9%	98.2%	98.2%	98.3%	98.5%	98.6%	98.1%	97.9%	98.5%	96.8%	98.7%	96.6%	
C31	NHS England Inpatients response rate from Friends and Family Test		43.1%	49.5%	48.3%	51.2%	49.8%	47.7%	51.6%	48.6%	45.7%	47.8%	49.3%	36.2%	41.5%	48.6%	
C40	Maternity Friends and Family - % who would recommend	90%	98.9%	98.0%	98.3%	98.0%	96.0%	97.2%	97.2%	98.8%	96.6%	97.7%	96.8%	96.3%	95.9%	96.2%	
C42	A&E Friends and Family - % who would recommend	90%	78.1%	74.6%	80.6%	82.7%	82.5%	81.1%	82.3%	82.8%	80.4%	82.1%	84.1%	80.5%	82.3%	81.1%	
C32	NHS England A&E response rate from Friends and Family Test		16.8%	18.6%	17.4%	15.8%	20.3%	19.5%	20.3%	20.1%	20.9%	22.4%	23.1%	17.1%	20.8%	19.7%	
C44	Community Friends and Family - % who would recommend	90%	95.8%	96.5%	96.6%	95.9%	98.1%	96.3%	96.4%	97.7%	96.9%	95.6%	97.0%	87.1%	91.7%	95.5%	
C15	Complaints – rate per 1000 contacts	0.4	0.3	0.2	0.1	0.3	0.2	0.2	0.3	0.2	0.3	0.2	0.2	0.2	0.3	0.2	
M52	Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Effective

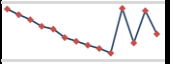
		Threshold 18/19	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Monthly Sparkline
M73	Deaths in Low Risk Categories - relative risk	Outlier	90.4	83.9	85.0	81.6	67.1	59.1	46.3	47.3	52.4	43.5					
M74	Hospital Standardised Mortality Ratio - Weekday (DFI Indicative)	Outlier	95.5	94.9	93.3	92.0	89.0	89.8	88.8	90.4	88.5	89.8					
M75	Hospital Standardised Mortality Ratio - Weekend (DFI Indicative)	Outlier	97.2	95.9	96.2	95.0	96.2	94.2	93.9	93.2	91.1	91.1					
M54	Hospital Standardised Mortality Ratio (DFI Indicative)	Outlier	95.9	95.2	94.1	92.8	90.8	90.9	90.1	91.1	89.1	90.2					
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Outlier	1.07														
M159	Stillbirths	<5	3	4	2	2	2	5	4	3	2	4	3	1	4	2	
M160	Stillbirths - Improvements in care that impacted on the outcome		0	1	0	0	0	0	0	0	0	1					
M89	CQUIN schemes at risk	0	0														

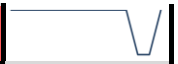
Responsive

		Threshold 18/19	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Monthly Sparkline
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95%	83.6%	78.5%	88.6%	88.6%	86.9%	81.6%	81.3%	79.6%	81.4%	78.9%	84.0%	85.3%	85.6%	82.5%	
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95%	84.7%	80.0%	89.2%	89.2%	87.5%	82.5%	82.1%	80.7%	82.2%	80.1%	84.9%	86.1%	86.6%	83.8%	
M62	12 hour trolley waits in A&E	0	13	7	7	1	2	4	4	5	12	23	9	3	34	37	
M81	HAS Compliance	90%	94.16%	93.28%	94.46%	92.37%	89.24%	82.68%	83.12%	84.40%	95.21%	92.79%	94.53%	93.79%	89.57%	93.26%	
M82	Handovers > 30 mins ALL	0	626	854	528	714	775	1122	1319	1267	405	1008	652	685	497	568	
M82.6	Handovers > 30 mins ALL (NWAS Confirmed Penalty)	0	378	552	299	428	461	745	829	827	201	589	334	426	399	305	
C1	RTT admitted: percentage within 18 weeks	N/A	71.4%	70.9%	68.6%	69.5%	64.8%	65.3%	79.0%	72.2%	72.2%	73.1%	69.7%	71.9%	71.6%	73.0%	
C3	RTT non- admitted pathways: percentage within 18 weeks	N/A	92.2%	91.8%	94.6%	90.8%	89.4%	89.0%	90.0%	90.7%	92.4%	92.1%	90.6%	93.5%	93.2%	92.4%	
C4	RTT waiting times Incomplete pathways	92%	92.4%	92.0%	92.0%	91.1%	90.8%	91.0%	92.0%	92.3%	92.4%	92.1%	92.8%	93.3%	93.0%	92.5%	

C37.1	RTT 52 Weeks (Ongoing)	0	1	2	0	0	1	3	3	0	0	0	0	0	0	0	
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1%	0.7%	0.5%	0.3%	0.3%	0.2%	0.1%	0.2%	0.4%	0.1%	0.2%	0.9%	1.8%	0.4%	0.4%	
C18	Cancer - Treatment within 62 days of referral from GP	85%	87.1%	88.5%	85.3%	85.2%	85.8%	80.7%	89.6%	85.7%	82.8%	82.1%	91.9%	88.4%	82.6%		
C19	Cancer - Treatment within 62 days of referral from screening	90%	95.7%	92.1%	100.0%	100.0%	100.0%	100.0%	96.2%	96.2%	100.0%	100.0%	95.0%	92.0%	92.3%		
C20	Cancer - Treatment within 31 days of decision to treat	96%	99.5%	99.5%	98.0%	99.4%	99.1%	98.0%	98.9%	93.9%	98.3%	97.5%	97.5%	98.7%	97.6%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98%	98.7%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94%	95.5%	97.9%	92.9%	97.9%	97.6%	100.0%	95.0%	94.8%	91.2%	96.0%	89.2%	97.5%	92.7%		
C24	Cancer - seen within 14 days of urgent GP referral	93%	95.5%	93.1%	92.0%	93.9%	94.7%	94.4%	96.3%	93.0%	94.9%	95.1%	93.3%	93.2%	91.1%		
C25	Cancer - breast symptoms seen within 14 days of GP referral	93%	95.7%	94.7%	95.6%	95.6%	98.9%	97.5%	95.6%	96.8%	94.5%	90.0%	92.0%	92.3%	85.4%		
C36	Cancer 62 Day Consultant Upgrade	85%	96.8%	91.2%	90.0%	86.4%	93.2%	88.9%	88.5%	89.4%	95.8%	92.3%	90.0%	90.4%	96.3%		
C25.1	Cancer - Patients treated > day 104		1	6	3	4	2	8	1	5	5	2	2	3	5		
M9	Urgent operations cancelled for 2nd time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	1	0	0	3	1	1	3	4	10	2	1	0	0	0	
M138	Cancelled operations (cancelled on day)		66	63	64	66	68	93	64	121	104	121	62	59	51	60	
M55	Proportion of delayed discharges attributable to the NHS	3.5%	4.8%	3.7%	3.9%	4.5%	4.0%	4.2%	3.6%	3.6%	3.5%	3.0%	3.0%	2.9%	2.8%	3.4%	
C16	Emergency re-admissions within 30 days		12.1%	11.4%	11.7%	11.7%	12.1%	12.4%	12.0%	12.1%	13.2%	12.1%	11.9%	12.1%	11.9%	9.5%	
M90	Average LOS elective (excl daycase)		3.1	3.0	2.6	3.0	2.3	2.6	2.7	2.6	3.2	2.7	2.4	2.6	3.0	2.7	
M91	Average LOS non-elective		4.8	4.6	5.2	4.8	4.6	4.6	4.6	4.8	4.8	4.7	4.8	4.6	4.6	4.7	

Well led

		Threshold 18/19	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Monthly Sparkline
M77	Trust turnover rate	12%	8.3%	8.2%	8.3%	8.0%	8.1%	7.9%	8.0%	8.0%	9.5%	9.0%	8.5%	9.3%	9.0%	9.0%	
M78	Trust level total sickness rate	4.5%	4.3%	4.7%	4.7%	4.6%	4.7%	4.9%	5.1%	5.5%	5.0%	4.6%	4.5%	4.5%	4.8%		
M79	Total Trust vacancy rate	5%	7.2%	7.1%	7.6%	7.1%	6.9%	6.8%	7.0%	8.2%	8.4%	8.4%	7.9%	8.7%	8.6%	8.8%	
M80.3	Appraisal (AFC)	90%	66.0%	71.0%	78.0%	82.0%	89.0%	90.0%	91.0%	92.0%	92.0%	91.0%	91.0%	89.0%	88.0%	86.0%	
M80.3	Appraisal (Consultant)	90%	86.0%	87.0%	90.0%	88.0%	93.0%	94.0%	95.0%	93.0%	95.0%	97.0%	97.0%				
M80.4	Appraisal (Other Medical)	90%	90.0%	97.0%	91.0%	94.0%	95.0%	95.0%	95.0%	96.0%	95.0%	98.0%	98.0%				
M80.2	Safeguarding Children	90%	90.0%	93.0%	94.0%	95.0%	95.0%	95.0%	95.0%	95.0%	96.0%	96.0%	96.0%	96.0%	96.0%	97.0%	
M80.2	Information Governance Toolkit Compliance	95%	90.0%	90.0%	90.0%	92.0%	93.0%	92.0%	91.0%	92.0%	93.0%	95.0%	94.0%	94.0%	94.0%	95.0%	
F8	Temporary costs as % of total paybill	4%	8%	8%	9%	8%	8%	8%	9%	8%	9%	9%	9%	7%	10%	8%	
F9	Overtime as % of total paybill	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
F1	Adjusted financial performance (deficit) including PSF (£M)	(7.7)	(0.2)	(0.3)	(0.3)	(1.3)	(1.7)	(2.1)	(2.5)	(3.0)	(3.4)	(2.7)	(1.6)	(3.2)	(3.6)	(4.6)	
F1.1	Adjusted financial performance (deficit) excluding PSF (£M)	(15.8)													(4.8)	(5.8)	
F2	SRCP Achieved % (green schemes only)	100.0%	32%	34%	40%	46%	53%	54%	77%	79%	80%	107%	8%	17%	18%	29%	
F3	Liquidity days	>(14.0)	(5.5)	(6.2)	(6.7)	(7.5)	(7.8)	(8.8)	(9.2)	(9.6)	(10.0)	(10.5)	(5.4)	(9.4)	(5.7)	(8.4)	
F4	Capital spend v plan	85%	32%	41%	46%	55%	57%	68%	77%	88%	73%	95%	38%	81%	67%	61%	
F16	Finance & Use of Resources (UoR) metric - overall	3	2	2	2	3	3	3	3	3	3	3	3	3	2	3	
F17	Finance and UoR metric - liquidity	4	3	3	3	3	3	3	3	3	3	3	4	4	2	3	
F18	Finance and UoR metric - capital service capacity	4	2	2	2	3	3	3	3	3	3	3	2	3	4	4	
F19	Finance and UoR metric - I&E margin	4	3	3	3	3	3	3	3	3	3	3	4	4	4	4	
F20	Finance and UoR metric - distance from financial plan	4	1	1	1	2	2	2	2	2	2	2	4	1	1	2	

F21 Finance and UoR metric - agency spend	1	2	2	2	2	2	2	2	2	2	2	2	1	1	2	
F12 BPPC Non NHS No of Invoices	95%	96.3%	95.7%	95.7%	95.8%	96.0%	95.5%	95.7%	95.3%	95.4%	95.0%	95.2%	96.3%	96.5%	96.2%	
F13 BPPC Non NHS Value of Invoices	95%	96.0%	95.1%	95.0%	95.2%	95.4%	95.3%	95.4%	94.9%	95.1%	95.1%	96.9%	95.6%	96.1%	96.5%	
F14 BPPC NHS No of Invoices	95%	95.1%	95.2%	95.0%	95.0%	95.0%	95.1%	95.3%	94.0%	92.4%	95.6%	96.6%	97.3%	97.8%	98.1%	
F15 BPPC NHS Value of Invoices	95%	98.2%	97.6%	97.9%	97.9%	97.9%	98.0%	98.0%	97.7%	97.5%	98.2%	99.3%	99.5%	99.4%	99.3%	

Safe Staffing (Rota Fill Rates and CHPPD) Collection

Organisation : RXR East Lancashire Hospitals Trust
Month : Jul-18

Trust Website where staffing information is available

http://www.elht.nhs.uk/safe-staffing-data.htm

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
					midwives/nurses		Care Staff		midwives/nurses		Care Staff									
Site code	Hospital Site name	Ward Name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Nurses & Midwives	Care staff	Overall
RXR60	ACCRINGTON VICTORIA HOSPITAL - RXR60	Ward 2	314 - REHABILITATION		1,116	864	744	1,086	744	744	744	936	77.4%	146.0%	100.0%	125.8%	531	3.03	3.81	6.84
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Acute Stroke Unit (ASU)	300 - GENERAL MEDICINE		1,860	1,554	1,488	1,368	1,116	1,128	1,116	1,056	83.5%	91.9%	101.1%	94.6%	634	4.23	3.82	8.05
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B18	320 - CARDIOLOGY		1,860	1,518	1,116	1,092	744	1,032	744	744	81.6%	97.8%	138.7%	100.0%	757	3.37	2.43	5.79
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B20	100 - GENERAL SURGERY		1,612	1,398	806	1,151	682	682	682	990	86.7%	142.7%	100.0%	145.2%	519	4.01	4.12	8.13
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B22	110 - TRAUMA & ORTHOPAEDICS		1,612	1,359	2,418	2,308	682	682	1,705	1,628	84.3%	95.4%	100.0%	95.5%	608	3.36	6.47	9.83
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B24	110 - TRAUMA & ORTHOPAEDICS		1,612	1,365	1,209	1,255	682	682	682	781	84.7%	103.8%	100.0%	114.5%	645	3.17	3.16	6.33
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B4	430 - GERIATRIC MEDICINE		1,488	1,212	2,232	2,046	744	744	1,488	1,464	81.5%	91.7%	100.0%	98.4%	736	2.66	4.77	7.43
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Blackburn Birth Centre	501 - OBSTETRICS		1,009	968	489	480	1,000	688	1,075	1,075	96.0%	98.2%	68.8%	100.0%	17	97.43	91.47	188.90
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C1	300 - GENERAL MEDICINE		1,488	1,248	1,488	1,158	744	756	1,116	1,128	83.9%	77.8%	101.6%	101.1%	586	3.42	3.90	7.32
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C10	300 - GENERAL MEDICINE		1,488	1,146	1,488	1,572	744	780	1,116	1,224	77.0%	105.6%	104.8%	109.7%	678	2.84	4.12	6.96
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C11	300 - GENERAL MEDICINE		1,488	1,212	1,488	1,452	744	732	744	1,116	81.5%	97.6%	98.4%	150.0%	673	2.89	3.82	6.70
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14A	100 - GENERAL SURGERY		1,860	1,842	1,116	1,080	744	744	372	456	99.0%	96.8%	100.0%	122.6%	487	5.31	3.15	8.46
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14B	100 - GENERAL SURGERY		1,860	1,776	1,116	1,038	744	744	372	420	95.5%	93.0%	100.0%	112.9%	469	5.37	3.11	8.48
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18A	100 - GENERAL SURGERY		1,860	1,830	1,116	1,140	744	744	372	516	98.4%	102.2%	100.0%	138.7%	485	5.31	3.41	8.72
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18B	100 - GENERAL SURGERY		1,860	1,818	1,116	1,326	744	744	372	672	97.7%	118.8%	100.0%	180.6%	507	5.05	3.94	8.99
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C2	301 - GASTROENTEROLOGY	MEDICINE	1,488	1,194	1,488	1,230	1,116	1,116	1,116	1,044	80.2%	82.7%	100.0%	93.5%	732	3.16	3.11	6.26
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C22	101 - UROLOGY	120 - ENT	2,418	2,223	1,612	1,931	1,023	1,100	1,364	1,518	91.9%	119.8%	107.5%	111.3%	978	3.40	3.53	6.92
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C3	300 - GENERAL MEDICINE		1,236	1,170	1,440	1,356	996	1,056	1,080	1,296	94.7%	94.2%	106.0%	120.0%	659	3.38	4.02	7.40
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C4	301 - GASTROENTEROLOGY	MEDICINE	1,440	1,116	1,440	1,200	1,080	984	1,080	1,068	77.5%	83.3%	91.1%	98.9%	708	2.97	3.20	6.17
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C5	430 - GERIATRIC MEDICINE		1,116	840	1,488	1,464	744	744	1,116	1,284	75.3%	98.4%	100.0%	115.1%	427	3.71	6.44	10.15
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C6	340 - RESPIRATORY MEDICINE	MEDICINE	1,488	1,212	1,116	1,116	1,116	1,104	744	780	81.5%	100.0%	98.9%	104.8%	712	3.25	2.66	5.92
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C7	340 - RESPIRATORY MEDICINE	MEDICINE	1,488	1,158	1,116	1,206	744	804	744	960	77.8%	108.1%	108.1%	129.0%	645	3.04	3.36	6.40
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C8	340 - RESPIRATORY MEDICINE	MEDICINE	1,860	1,560	1,488	1,284	1,116	1,104	744	792	83.9%	86.3%	98.9%	106.5%	542	4.92	3.83	8.75
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C9	300 - GENERAL MEDICINE		1,488	1,224	1,488	1,392	744	768	744	1,092	82.3%	93.5%	103.2%	146.8%	683	2.92	3.64	6.55
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Children's Unit	420 - PAEDIATRICS		4,650	4,030	1,116	954	3,581	3,219	326	431	86.7%	85.5%	89.9%	132.3%	659	11.00	2.10	13.10
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Coronary Care Unit (CCU)	320 - CARDIOLOGY		1,488	1,254	744	678	1,116	1,116	-	-	84.3%	91.1%	100.0%	0.0%	246	9.63	2.76	12.39
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Critical Care Unit	192 - CRITICAL CARE MEDICINE		6,656	6,656	988	884	5,632	5,390	352	231	100.0%	89.5%	95.7%	65.6%	553	21.78	2.02	23.80
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D1	300 - GENERAL MEDICINE		1,488	1,230	1,116	1,182	744	744	744	1,020	82.7%	105.9%	100.0%	137.1%	593	3.33	3.71	7.04
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D3	300 - GENERAL MEDICINE		1,488	1,146	1,116	1,176	744	756	744	1,008	77.0%	105.4%	101.6%	135.5%	608	3.13	3.59	6.72
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUA)	300 - GENERAL MEDICINE		3,720	3,396	2,232	2,424	3,348	3,000	1,488	1,488	91.3%	108.6%	89.6%	100.0%	1192	5.37	3.28	8.65
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUB)	300 - GENERAL MEDICINE		3,348	3,126	2,604	2,568	2,616	2,904	1,488	1,476	93.4%	98.6%	111.0%	99.2%	1118	5.39	3.62	9.01
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Neonatal Intensive Care Unit	420 - PAEDIATRICS		4,836	4,637	360	342	4,464	4,056	-	132	95.9%	95.0%	90.9%	13200.0%	734	11.84	0.65	12.49
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Surgical Triage Unit	100 - GENERAL SURGERY		1,612	1,593	806	897	1,023	1,012	341	671	98.8%	111.3%	98.9%	196.8%	427	6.10	3.67	9.77
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Antenatal Ward	501 - OBSTETRICS		1,488	1,560	744	732	1,116	1,118	744	720	104.8%	98.4%	100.2%	96.8%	105	25.50	13.83	39.33
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Burnley Birth Centre	501 - OBSTETRICS		1,395	1,325	372	357	1,116	1,032	372	372	95.0%	96.0%	92.5%	100.0%	69	34.16	10.57	44.72
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Central Birth Suite	501 - OBSTETRICS		3,720	3,386	744	744	3,720	3,516	744	744	91.0%	100.0%	94.5%	100.0%	251	27.50	5.93	33.43
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Gynaecology and Breast Care Ward	502 - GYNAECOLOGY		1,056	1,052	552	546	794	788	326	326	99.6%	98.9%	99.2%	100.0%	264	6.97	3.30	10.27
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Postnatal Ward	501 - OBSTETRICS		2,418	2,430	1,248	1,272	2,232	2,220	1,488	1,488	100.5%	101.9%	99.5%	100.0%	731	6.36	3.78	10.14
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Rakehead	314 - REHABILITATION		1,116	798	1,860	1,518	744	744	744	816	71.5%	81.6%	100.0%	109.7%	399	3.86	5.85	9.71
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 15	110 - TRAUMA & ORTHOPAEDICS		1,352	1,131	962	858	682	671	561	594	83.7%	89.2%	98.4%	105.9%	381	4.73	3.81	8.54
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 16	300 - GENERAL MEDICINE		1,710	1,326	1,488	1,578	744	744	1,116	1,512	77.5%	106.0%	100.0%	135.5%	740	2.80	4.18	6.97
RXR70	CLITHEROE COMMUNITY HOSPITAL - RXR70	Ribblesdale	314 - REHABILITATION		1,860	1,536	1,488	1,662	1,116	1,116	1,488	1,668	82.6%	111.7%	100.0%	112.1%	914	2.90	3.64	6.54
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Hartley	314 - REHABILITATION		1,488	1,152	1,116	1,104	744	744	744	744	77.4%	98.9%	100.0%	100.0%	705	2.69	2.62	5.31
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Marsden	314 - REHABILITATION		1,302	1,212	1,860	1,728	744	744	744	1,008	93.1%	92.9%	100.0%	135.5%	733	2.67	3.73	6.40
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Reedyford	314 - REHABILITATION		1,302	1,212	1,116	1,248	744	744	744	960	93.1%	111.8%	100.0%	129.0%	673	2.91	3.28	6.19
		Total			87,588	77,994	56,738	56,181	58,044	56,783	36,729	41,448	89.05%	99.02%	97.83%	112.85%	26513	5.08	3.68	8.77

Ward Staff Summary - Jul 2018

Executed on: 23/08/2018 at: 2:12:13 PM

Division: All 3 Available Divisions Selected
Directorate: All 17 Available Directorates Selected
Site: All 5 Available Hospital Sites Selected
This report is based on the 45 wards which submitted data for the monthly Safer Staffing return

R: ≥ ±10% | A: ≥ ±5% | G: < ±5% | R: > 0 | G: = 0 | R:≥ 5% | G:< 5% | R:≥ 3.75% | G:< 3.75%

Site	Cost Centre Code	Ward	Day Shift						Night Shift						Pressure Ulcers Acquired			Falls with Harm (Mod & Above)	Infections Acquired		Vacancies WTE (RegN/M + HCA)*		Sickness/Absence RegN/M + HCA)*	
			Registered Nurses / Midwives			Care Staff			Registered Nurses / Midwives			Care Staff												
			Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	G2	G3	G4		C Diff	MRSA	WTE Vacant	% Vacant	WTE Days	% Abs Rate
EC: Surgical & Anaes Services																								
EC02: General Surg Services																								
RBH	5142	Ward C14A	1,860	1,842	99.03%	1,116	1,080	96.77%	744	744	100.00%	372	456	122.58%	0	0	0	0	0	0	3.13	13.01%	33.28	5.15%
	5143	Ward C18A	1,860	1,830	98.39%	1,116	1,140	102.15%	744	744	100.00%	372	516	138.71%	0	0	0	0	0	0	2.45	10.19%	56.80	8.48%
	5144	Surgical Triage Unit	1,612.00	1,592.50	98.79%	806.00	897.00	111.29%	1,023	1,012	98.92%	341.00	671.00	196.77%	0	0	0	0	0	0	10.42	28.09%	70.80	8.56%
	5145	Ward C14B	1,860	1,776	95.48%	1,116	1,038	93.01%	744	744	100.00%	372	420	112.90%	0	0	0	0	0	0	4.62	19.21%	100.88	16.75%
	5146	Ward C18B	1,860	1,818	97.74%	1,116	1,326	118.82%	744	744	100.00%	372	672	180.65%	0	0	0	0	0	0	5.85	24.17%	14.60	2.57%
EC03: Urology																								
RBH	5128	Ward C22	2,418	2,223	91.94%	1,612.00	1,930.50	119.76%	1,023	1,100	107.53%	1,364.00	1,518.00	111.29%	0	0	0	0	0	0	-2.44	-11.15%	72.00	9.55%
EC04: Orthopaedic Services																								
BGH	4393	Ward 15	1,352	1,131.00	83.65%	962.00	858.00	89.19%	682.00	671.00	98.39%	561.00	594.00	105.88%	0	0	0	1	0	0	2.06	5.92%	74.32	7.32%
RBH	5366	Ward B24	1,612.00	1,365.00	84.68%	1,209	1,254.50	103.76%	682.00	682.00	100.00%	682.00	781.00	114.52%	0	0	0	0	0	0	6.66	21.31%	92.20	12.09%
	5367	Ward B22	1,612.00	1,358.50	84.27%	2,418	2,307.50	95.43%	682.00	682.00	100.00%	1,705.00	1,628	95.48%	0	0	0	0	0	0	4.59	9.84%	64.19	5.13%
EC05: Head & Neck																								
RBH	5119	Ward B20 Max Fac	1,612.00	1,397.50	86.69%	806.00	1,150.50	142.74%	682.00	682.00	100.00%	682.00	990.00	145.16%	0	0	0	0	0	0	0.58	2.11%	7.91	0.95%
EC09: Anaesth & Critical Care																								
RBH	5362	Elht Critical Care	6,656.00	6,656.00	100.00%	988.00	884	89.47%	5,632	5,390	95.70%	352.00	231.00	65.63%	1	0	0	0	0	0	14.92	12.08%	150.15	4.46%
ED: Family Care																								
ED07: General Paediatrics																								
RBH	5210	Inpatient	4,650	4,030	86.67%	1,116	954	85.48%	3,580.50	3,218.50	89.89%	325.50	430.50	132.26%	0	0	0	0	0	0	5.25	6.33%	152.52	6.35%
ED08: Gynae Nursing																								
BGH	4169	Gynae And Breast Care Ward	1,056	1,052.25	99.64%	552	546	98.91%	794	787.50	99.18%	325.50	325.50	100.00%	0	0	0	0	0	0	2.84	10.11%	21.16	2.70%
ED09: Obstetrics																								
BGH	4165	Birth Suite	3,720	3,386	91.02%	744	744	100.00%	3,720	3,516	94.52%	744	744	100.00%	0	0	0	0	0	0	-0.49	-0.71%	116.44	5.36%
	4192	Burnley Birth Centre	1,395	1,325	94.98%	372	357	95.97%	1,116	1,032	92.47%	372	372	100.00%	0	0	0	0	0	0	2.13	4.77%	22.56	1.73%
	4200	Antenatal Ward 12	1,488	1,560	104.84%	744	732	98.39%	1,116	1,118	100.18%	744	720	96.77%	0	0	0	0	0	0	-1.44	-4.66%	56.71	5.56%
	4203	Postnatal Ward 10	2,418	2,430	100.50%	1,248	1,272	101.92%	2,232	2,220	99.46%	1,488	1,488	100.00%	0	0	0	0	0	0	-0.92	-1.63%	117.28	6.53%
RBH	5256	Blackburn Birth Centre	1,009	968.25	95.96%	489	480	98.16%	999.75	688	68.82%	1,075	1,075	100.00%	0	0	0	0	0	0	5.23	11.03%	98.60	7.65%
ED15: Neonates																								
RBH	4215	Nicu	4,836	4,637	95.89%	360	342	95.00%	4,464	4,056	90.86%	0	132	-	0	0	0	0	0	0	0.44	0.53%	108.19	4.20%
EH: Integrated Care Group																								
EH05: Business Support Unit																								
RBH	6078	Ward C3	1,236	1,170	94.66%	1,440	1,356	94.17%	996	1,056	106.02%	1,080	1,296	120.00%	0	0	0	0	0	0	26.46	61.68%	48.72	8.69%

For any queries regarding this report please contact the information department information@elht.nhs.uk
Report Location: /Operational Reports/Ward Scorecard Monthly Trend/Ward Staff Summary

** Vacancies and Sickness metrics include the Staff Groups 'Nursing and Midwifery Registered' & 'Additional Clinical Services' only.*

Ward Staff Summary - Jul 2018

Executed on: 23/08/2018 at: 2:12:13 PM

Division: All 3 Available Divisions Selected
Directorate: All 17 Available Directorates Selected
Site: All 5 Available Hospital Sites Selected
This report is based on the 45 wards which submitted data for the monthly Safer Staffing return

R: ≥ ±10% | A: ≥ ±5% | G: < ±5% | R: > 0 | G: = 0 | R:≥ 5% | G:< 5% | R:≥ 3.75% | G:< 3.75%

Site	Cost Centre Code	Ward	Day Shift						Night Shift						Pressure Ulcers Acquired			Falls with Harm (Mod & Above)	Infections Acquired		Vacancies WTE (RegN/M + HCA)*		Sickness/Absence RegN/M + HCA)*	
			Registered Nurses / Midwives			Care Staff			Registered Nurses / Midwives			Care Staff												
			Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	G2	G3	G4		C Diff	MRSA	WTE Vacant	% Vacant	WTE Days	% Abs Rate
EH15: Acute Medicine																								
RBH	5058	AMU A	3,720	3,396	91.29%	2,232	2,424	108.60%	3,348	3,000	89.61%	1,488	1,488	100.00%	0	0	0	0	0	0	7.98	9.74%	59.90	2.57%
	6092	AMU B	3,348	3,126	93.37%	2,604	2,568	98.62%	2,616	2,904	111.01%	1,488	1,476	99.19%	0	0	0	0	0	0	11.64	14.22%	58.04	2.62%
EH20: Respiratory																								
RBH	5063	Ward C6	1,488	1,212	81.45%	1,116	1,116	100.00%	1,116	1,104	98.92%	744	780	104.84%	0	0	0	0	1	0	8.22	24.92%	56.48	7.70%
	5064	Ward C8	1,860	1,560	83.87%	1,488	1,284	86.29%	1,116	1,104	98.92%	744	792	106.45%	0	0	0	0	0	0	7.88	20.56%	36.52	3.93%
	6027	Ward C7	1,488	1,158	77.82%	1,116	1,206	108.06%	744	804	108.06%	744	960	129.03%	0	0	0	0	0	0	5.38	17.21%	63.96	7.97%
EH25: Cardiology																								
RBH	5095	Coronary Care	1,488	1,254	84.27%	744	678	91.13%	1,116	1,116	100.00%	0	0	-	0	0	0	0	0	0	-0.37	-1.49%	30.68	4.01%
	5097	Ward B18	1,860	1,518	81.61%	1,116	1,092	97.85%	744	1,032	138.71%	744	744	100.00%	0	0	0	0	0	0	-0.50	-1.52%	37.00	3.56%
EH30: Gastroenterlogy																								
RBH	5050	Ward C2	1,488	1,194	80.24%	1,488	1,230	82.66%	1,116	1,116	100.00%	1,116	1,044	93.55%	0	0	0	0	0	0	9.77	27.34%	41.84	5.13%
	5062	Ward C4	1,440	1,116	77.50%	1,440	1,200	83.33%	1,080	984	91.11%	1,080	1,068	98.89%	0	0	0	0	0	0	16.26	44.55%	50.20	8.02%
	6103	Ward C11	1,488	1,212	81.45%	1,488	1,452	97.58%	744	732	98.39%	744	1,116	150.00%	0	0	0	0	0	0	3.30	9.24%	45.52	4.74%
	6106	C1 (Gastro)	1,488	1,248	83.87%	1,488	1,158	77.82%	744	756	101.61%	1,116	1,128	101.08%	0	0	0	0	0	0	10.71	32.45%	49.32	7.30%
EH35: Mfop & Complex Needs																								
BGH	4613	Rakehead Nursing Staff	1,116	798	71.51%	1,860	1,518	81.61%	744	744	100.00%	744	816	109.68%	0	0	0	0	0	0	6.70	20.31%	36.08	4.42%
	6094	Ward 16 Sept 13	1,710	1,326	77.54%	1,488	1,578	106.05%	744	744	100.00%	1,116	1,512	135.48%	0	0	0	0	0	0	3.79	9.20%	99.36	8.82%
PCH	4581	Marsden Ward	1,302	1,212	93.09%	1,860	1,728	92.90%	744	744	100.00%	744	1,008	135.48%	0	0	0	0	0	0	6.05	16.93%	52.96	5.75%
	4582	Reedyford Ward	1,302	1,212	93.09%	1,116	1,248	111.83%	744	744	100.00%	744	960	129.03%	0	0	0	0	0	0	2.11	7.22%	80.96	9.63%
	4583	Hartley Ward	1,488	1,152	77.42%	1,116	1,104	98.92%	744	744	100.00%	744	744	100.00%	0	0	0	0	0	0	5.46	17.65%	41.00	5.20%
RBH	5023	Ward D1	1,488	1,230	82.66%	1,116	1,182	105.91%	744	744	100.00%	744	1,020	137.10%	0	0	0	1	0	0	8.17	26.65%	75.28	10.78%
	5036	Acute Stroke Unit (B2)	1,860	1,554	83.55%	1,488	1,368	91.94%	1,116	1,128	101.08%	1,116	1,056	94.62%	0	0	0	0	0	0	12.45	26.67%	45.56	4.29%
	5037	Ward B4	1,488	1,212	81.45%	2,232	2,046	91.67%	744	744	100.00%	1,488	1,464	98.39%	0	0	0	0	0	0	10.25	23.33%	144.44	13.83%
	5048	Ward C10	1,488	1,146	77.02%	1,488	1,572	105.65%	744	780	104.84%	1,116	1,224	109.68%	0	0	0	0	0	0	10.17	27.53%	78.92	9.99%
	6096	Ward C5	1,116	840	75.27%	1,488	1,464	98.39%	744	744	100.00%	1,116	1,284	115.05%	0	0	0	0	0	0	9.34	28.31%	31.49	4.29%
	6105	Ward C9	1,488	1,224	82.26%	1,488	1,392	93.55%	744	768	103.23%	744	1,092	146.77%	0	0	0	0	0	0	9.09	25.44%	110.64	13.18%
EH4: Speciality Medicine																								
RBH	5040	Ward D3	1,488	1,146	77.02%	1,116	1,176	105.38%	744	756	101.61%	744	1,008	135.48%	0	0	0	0	0	0	5.13	17.30%	28.72	3.85%
EH7: Comm In Patient Care																								
AVH	R133	Avch Ward 2	1,116	864	77.42%	744	1,086	145.97%	744	744	100.00%	744	936	125.81%	0	0	0	0	0	0	3.29	13.84%	56.80	8.94%
CLI	R141	Ribblesdale Ward	1,860	1,536	82.58%	1,488	1,662	111.69%	1,116	1,116	100.00%	1,488	1,668	112.10%	0	0	0	0	0	0	-0.63	-1.43%	152.64	11.27%
Total for 45 wards shown					**89.05%**			**99.02%**			**97.83%**			**112.85%**	**1**	**0**	**0**	**2**	**1**	**0**	**263.98**	**14.16%**	**3,043.62**	**6.15%**

For any queries regarding this report please contact the information department information@elht.nhs.uk
Report Location: /Operational Reports/Ward Scorecard Monthly Trend/Ward Staff Summary

** Vacancies and Sickness metrics include the Staff Groups 'Nursing and Midwifery Registered' & 'Additional Clinical Services' only.*

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

12 September 2018

Item 97

Purpose Information
Monitoring

Title	Annual Board Report Medical Appraisal and Revalidation 2017/2018
Author	Mrs C Schram, Deputy Medical Director
Executive sponsor	Dr D Riley, Medical Director

Summary: Annual Board Report Medical Appraisal and Revalidation 2017/2018

Recommendation: The Board is asked to review and approve the report for submission to NHS England.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objective The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: Quality Committee (July 2018)

Executive summary

1. This is the seventh annual report on doctors' appraisal to come to the Board, the fifth since Revalidation was introduced in 2012. This year, 2017.2018, was Year 5 of Revalidation, during which 59 doctors had a revalidation recommendation made at ELHT.
2. At the time of writing there are 473 doctors with a prescribed connection to ELHT as their Designated Body (DB). These are Consultants, SAS doctors and Clinical Fellows. This number changes over the year as doctors start and leave. Doctors in training have a prescribed connection with the North West Deanery and consequently do not form part of this report.
3. The first revalidation cycle of 5 years finished on 31.03.2018. Appraisal and Revalidation is now well embedded at ELHT. This report details the performance and governance in place for medical revalidation and appraisal.

Purpose of the Paper

4. This report provides assurance to the Board that statutory requirements for Medical Appraisal and Revalidation of these doctors are being met. This allows the 'Compliance Statement' (see

5. Appendix 1) to be signed off by the Board. NHS England requires the Compliance Statement to be submitted by 28.09.2018.

Governance Arrangements

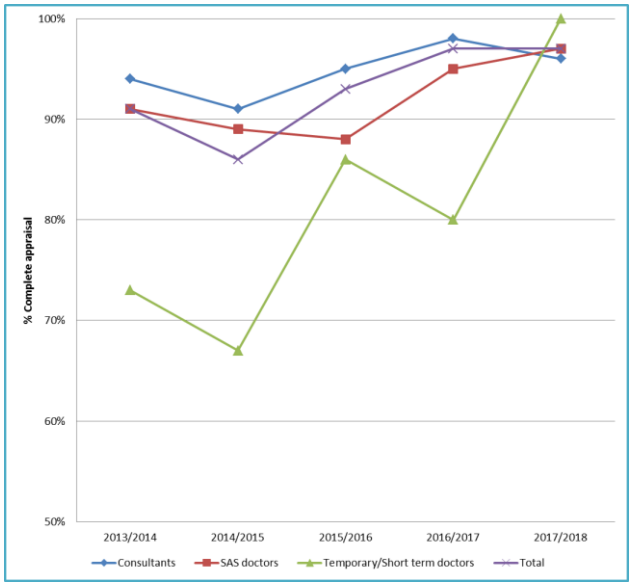
6. The Responsible Officer (RO) is accountable to the Chief Executive and the Trust Board for implementing and managing the appraisal and revalidation process including appraisal outcomes. The organisational structures and responsibilities for medical appraisal and revalidation are described in detail in ELHT Trust policy HR46v3 which is currently under review (Review date June 2018). This policy covers roles and responsibilities, the organisation and governance of appraisal and revalidation as well as the process, inputs and outputs of the appraisal itself.
7. There are currently 79 appraisers at ELHT, who appraise between 2 and 10 appraisees each. All newly appointed appraisers go through a competency assessed appraiser training programme before starting in their role as appraisers. Appraisees are allocated an appraiser for three years, after which a new appraiser is allocated for 3 years.
8. On-going training and support to appraisers is through appraiser network evenings, and direct support from the Appraisal Lead and Appraisal Administrator. Appraisee support is provided on an individual level as necessary, with full resources available for support on MyL2P, the web based appraisal and revalidation system we use.
9. With appraisal now firmly embedded, we have moved away from the time consuming formal quality assurance (QA) of every appraisal, to formal QA of 20% of appraisals, using a validated national QA review tool (PROGRESS). New appraisers have 3 appraisals QA'd and need to achieve a top score on 3 before sampling commences.
10. As it is now becoming more common for appraisers to appraise someone outside their own specialty (as accepted by GMC and NHS England), we have developed a 'Guideline for Specialty Specific Appraisals'. Whilst the GMC is clear about the six types of supporting information with documented reflection a doctor must provide at appraisal (CPD, Quality Improvement, Significant Events, Patient Feedback, Colleague Feedback, Complaints and Compliments), the specific information that a doctor will bring will vary. This will depend not only on the specific nature of the doctor's work, but also on the requirements of specialty and/or professional organisations, e.g. royal colleges, and on local agreements.

11. The guideline clarifies what is expected as supporting information for doctors and helps standardise the approach to cross specialty appraisals.

Performance Data

12. The Annual Organisational Audit (Appendix 2: Annual Organisational Audit) was submitted to NHS England in May 2018. In summary, table 1 summarises the position of medical appraisal on 31.03.2018. Chart two shows complete appraisal rates for the first revalidation cycle 2012-2017.

Doctors	No. prescribed connections	Completed appraisal 2017.2018	Approved incomplete/missed appraisal 2017.2018	Unapproved incomplete/missed appraisal 2017.2018	Total	% completed appraisal 2017/2018	% completed appraisal 2016/2017 national acute trusts*	% completed ELHT appraisal 2016.2017	% completed ELHT appraisal 2015.2016	% completed ELHT appraisal 2014.2015	% completed ELHT appraisal 2013/2014
Consultants	281	271	10	0	281	96%	94%	98%	95%	91%	94%
SAS doctors	134	130	4	0	134	97%	87%	95%	88%	89%	91%
Temporary/short term doctors	20	20		0	20	100%	80%	80%	86%	67%	73%
Other with prescribed connection	2	2		0	2	100%					
Total	437	423	14	0	437	97%	90%	97%	93%	86%	91%

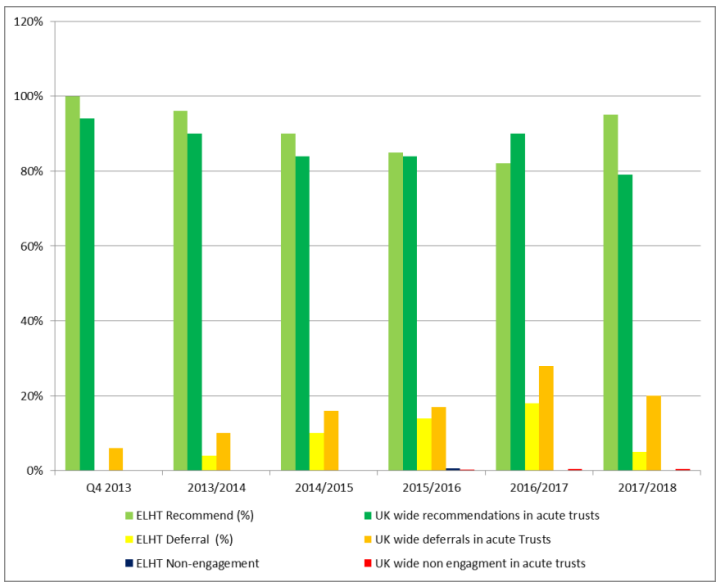


13. The reasons for approved incomplete/missed appraisals in 2017/2018 are summarised in table 2.

New to UK and first job in UK (appraisal date was within first 3 months of job)	1
Health factors including maternity	8
Sabbatical Career Break	1
Holidays/Diary difficulty in scheduling appointment	2
Delay with sign off of complete appraisal	2

14. Between 1.04.2017 and 31.03.2018, fifty-nine recommendations regarding revalidation were made to the GMC. The table and graph below shows the trends for recommendations in the first revalidation cycle completed (2012-2018) for ELHT and national acute trusts.

Year	Cohort	No. of Recommendations	Recommend (%)	Deferral (%)	Non-engagement	Deferrals UK wide acute Trusts
Year 0: 2013	Clinical Leaders	30	30 (100%)	0	0	6%
Year 1: 2013.2014	Senior Doctors	85	82 (96%)	3 (4%)	0	10%
Year 2: 2014.2015	Mainly Consultants	127	109 (90%)	12 (10%)	0	16%
Year 3: 2015.2016	All	127	108 (85%)	18 (14%)	1 (0.7%)	17%
Year 4: 2016.2017	All	17	14 (82%)	3 (18)%	0	28%
Year 5: 2017/2018	All	59	56 (95%)	3 (5%)	0	20%



15. In 2017.2018 all recommendations were made on time and were approved by the GMC. 95% were recommendations to revalidate, and three were to defer. All deferrals were for reasons of insufficient supporting information. All had a positive recommendation made for revalidation at the end of their deferral period.

16. There were no non-engagement recommendations; however, in two cases a 'Rev 6' form was requested and sent out. This is a letter of concern from the GMC to inform

a doctor that they are not sufficiently engaging with local processes and are not meeting the requirements for revalidation. In one of these two cases a 'Rev 9' form was required, which is when the GMC brings a doctor's revalidation date forward, after they have not complied with a Rev 6, to allow the Responsible Officer to make a recommendation of non-engagement if necessary. Fortunately, in our case, with a lot of support, the Doctor did finally comply with appraisal and revalidation requirements. (In 2017/2018 eighty-five doctors in the UK had a recommendation of non-engagement made, which leads to automatic removal from the GMC register).

Recruitment and engagement background checks

17. ROs have an overseeing role in ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed

18. Vacancies for Medical Staff are advertised through TRAC, the Trust recruitment system that is built around the NHS Employment Check Standards (gold standard). The system prompts the administrator for certain checks throughout the process. This includes checks for identity (passport) and qualifications. As TRAC will not allow the administrator to progress with the recruitment if the documentation is not provided, no candidate can be employed without the correct documentation being received: This includes obtaining a reference from the doctor's last employer and previous employment, recruitment medical, verification of qualifications, registration with the General Medical Council and license to practise, a disclosure and Barring Service check and an identity check.

19. It is a statutory requirement for the Responsible officer to ensure that all doctors have appropriate English language skills to do their jobs. Language skills are checked at ELHT as follows:

		Country of Origin	
		EU	Non-EU
Employment route	Substantive or fixed term appointment	At interview*	IELTS***
	Agency Locum	Via Agency**	IELTS

*Any member of interview panel (especially so following phone interviews) can flag concern which must be checked by supervisor at start of attachment

**Will only use agencies which follow our framework

***International English Language Testing System – GMC registration requirement is a minimum overall score of 7.5

20. There is a standardised process in place within our organisation for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's Responsible Officer and other Responsible Officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work.

Locum Doctors

21. When employing a doctor from an agency ELHT does not go outside of the Agency Framework. The agencies on the Framework are bound by the same employment checks, however, the medical staffing team double check all documentation received from the agency in the format of a compliancy check pack. This is held centrally on the Locum Inbox.

22. Additional processes have been put in place to ensure locum doctors, particularly those new to the NHS, have appropriate skills and knowledge to provide a safe and effective serviced. E.g.:

a) Doctors who are new to the GMC register have an approved practice setting (APS) restriction on their registration until their first revalidation. This means that they cannot practise unless they have a prescribed connection to a designated body. If a doctor has an APS restriction, our employment services will ensure the doctor has an RO connection before adding them to a locum bank or issuing a zero hours contract.

b) A locum induction pack is now provided to all locum doctors: this pack includes matters ranging from where to get something to eat and logins for IT programs to how to raise concerns and ELHT values and behaviours. It has been designed to be readable and compact, signposting to where further information can be found.

c) Identity checks for all short term locum doctors have been strengthened.

d) The RO/DMD must be informed before employment of any doctor who has not worked in the NHS before, so that appropriate supervision can be put in place before commencement of their post. This includes a CAST (Clinical Activity Support Team) assessment prior to starting on the wards.

Monitoring performance, Responding to Concerns and Remediation

23. ELHT HR policy 039 (v4) details the processes to be followed for the investigation, monitoring and response to concerns about a doctor's practice. The policy was reviewed last year, and following consultation with the LNC, a number of changes made regarding responsibilities, responding to claims, and conduct of hearings.

24. HR policy 66 v1.2 sets out the approach and processes for remediation and was reviewed in February 2018.

25. An audit of 'doctors in difficulty', doctors about whom there are capability, conduct, health (or a mixture) concerns, is included in

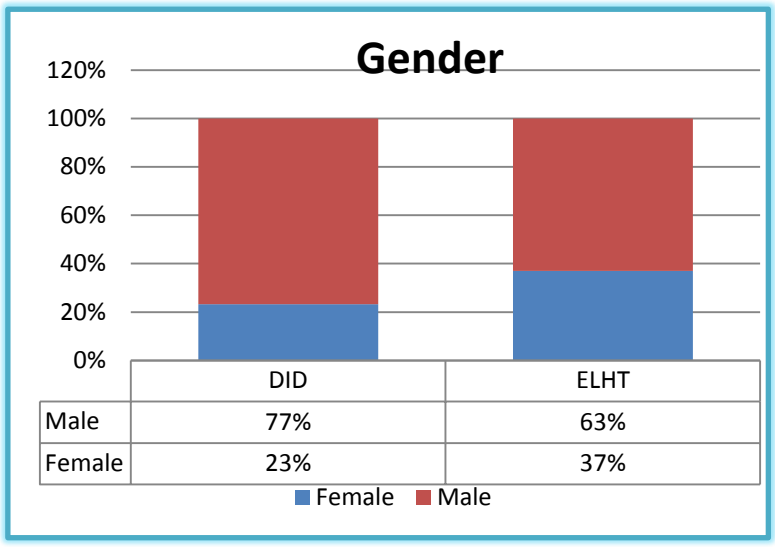
Appendix 3: Audit Doctors in DifficultyAppendix 2: Annual Organisational Audit

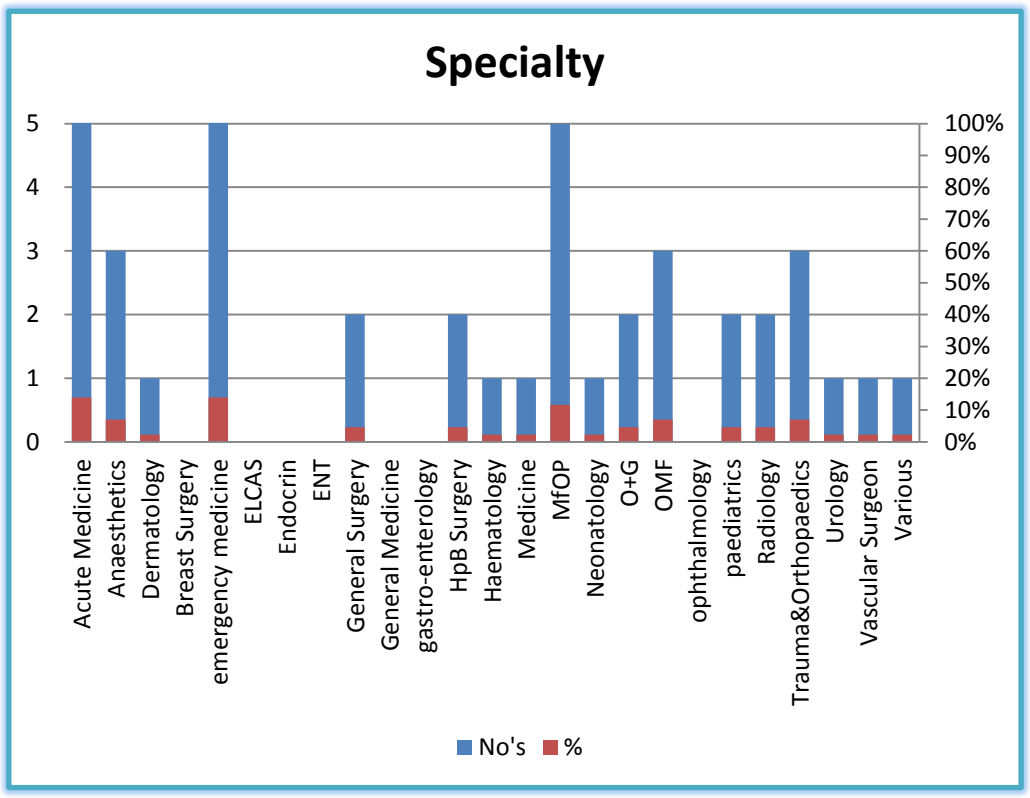
East Lancashire Hospice_Aoa_2017-1

Appendix 3: Audit Doctors in Difficulty

Audit Methodology: Analysis of 2017-2018 data on Doctors in Difficulty database: 43 cases

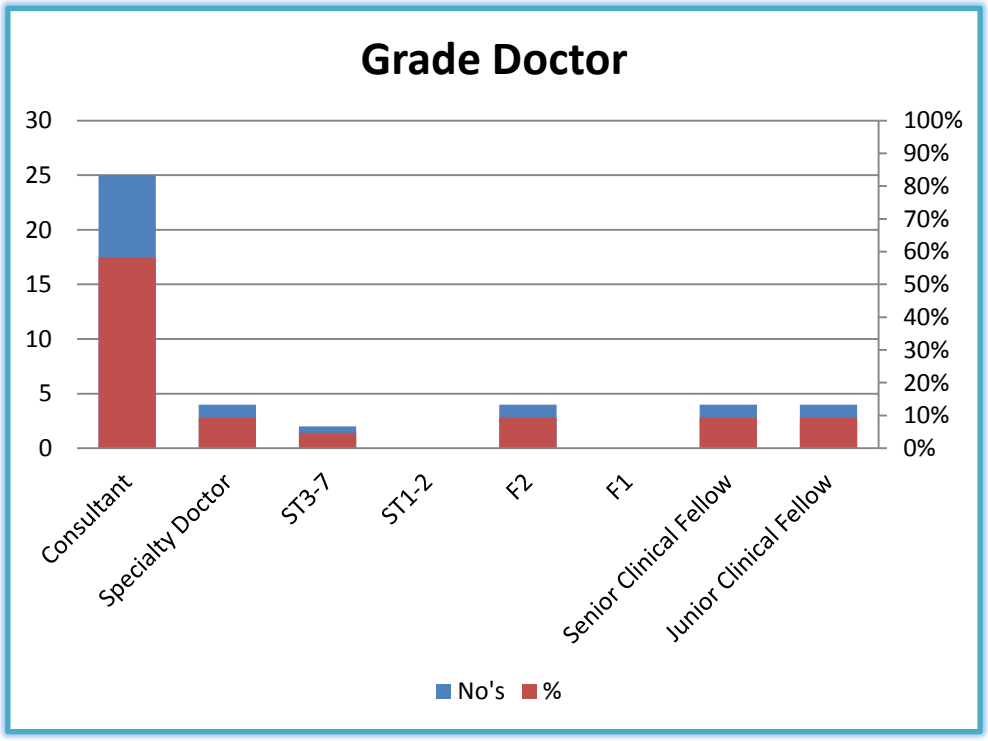
Data:

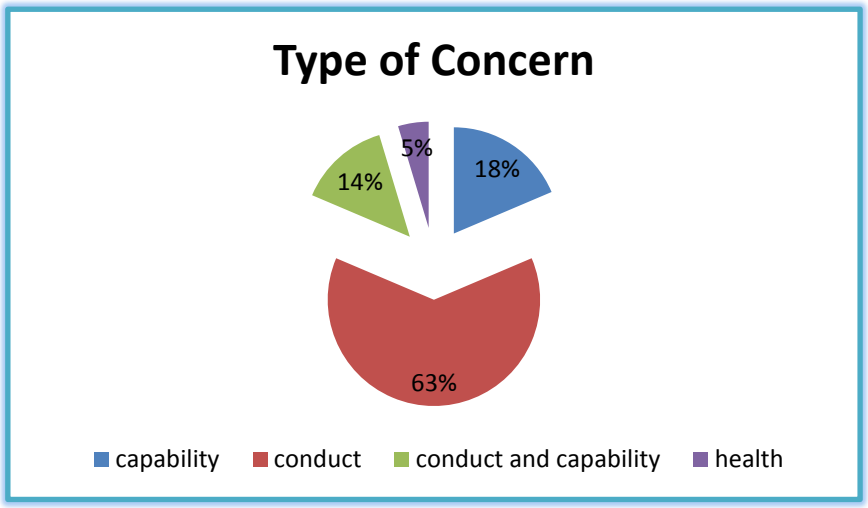


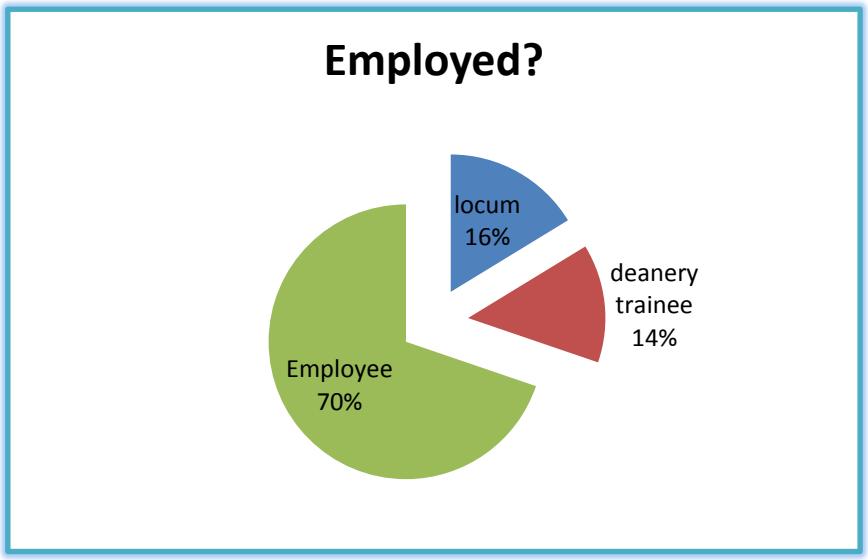


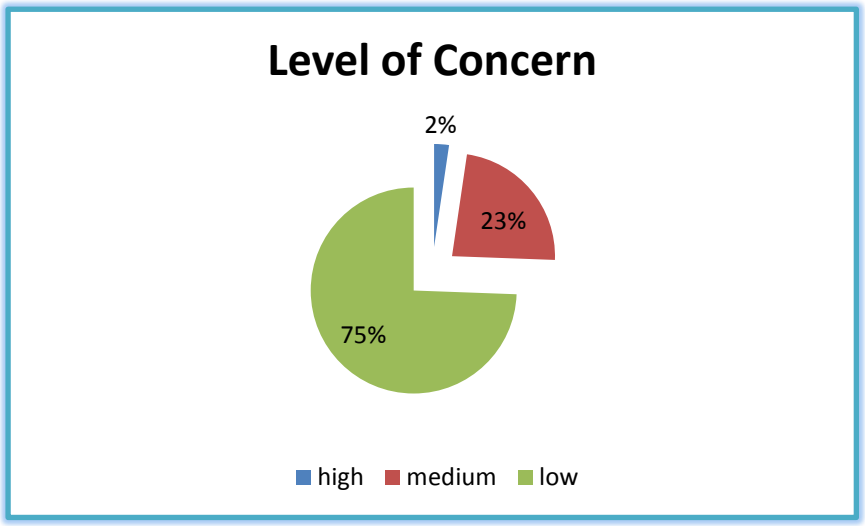
Ethnicity	DID no's	DID %	ELHT %
White - British	14	33%	35%
White - Any other White background	7	16%	10%
Mixed - White & Black African		0%	0%
Mixed - White & Asian		0%	1%
Mixed - Any other mixed background		0%	1%
Asian or Asian British - Indian	6	14%	20%

Asian or Asian British - Pakistani	5	12%	13%
Asian or Asian British - Bangladeshi	1	2%	1%
Asian or Asian British - Any other Asian background	3	7%	5%
Black or Black British - Caribbean		0%	0%
Black or Black British - African	1	2%	3%
Black or Black British - Any other Black background		0%	1%
Chinese		0%	2%
Any Other Ethnic Group	3	7%	3%
Not stated	3	7%	




Type of Concern
5%
18%
14%
63%
capability
conduct
conduct and capability
health


Employed?
locum
16%
deanery
trainee
14%
Employee
70%



26. . In 2017/2018 there were 43 such cases, overseen by the 'Doctor in Difficulty' group, which meets monthly, chaired by the Deputy Medical Director, Professional Standards. Minutes of those meetings go to the named Non-executive Director for doctors in difficulty.

Opportunities and Risks

27. Whilst appraisal and revalidation for medical staff is well established at ELHT, it is of note that Sir Keith Pearson completed an independent review of medical revalidation in January 2017. He made 18 recommendations, including driving up the quality and consistency of appraisal and ensuring the process is properly resourced, as well as exploring ways to make it easier for doctors to pull together and reflect on supporting information for their appraisal. While highlighting the significant progress made and the benefits realised, Sir Pearson notes the concerns of some doctors that appraisal and revalidation is becoming increasingly burdensome, and he recommends a review of supporting information. This should clarify what is mandatory for revalidation, versus what royal colleges and/ or organisations are recommending or mandating for their own (equally valid but separate) purposes. The GMC and royal colleges are reviewing their guidance in the light of these recommendations. ELHT will review its own guidance when the colleges and GMC have provided new guidance.
28. Locally, our appraisal administrator, Lynda Calverley, retired in April 2018. Lynda has been a tremendous support in establishing systems and processes, as well as providing advice to doctors during her years in this post, and we thank her for that.
29. This provided an opportunity to review the existing arrangements for the administration of medical appraisal and revalidation. The decision was taken to move

the post from the Post Graduate Medical Centre into the Learning Hub, and align it to the team managing nurses revalidation. Whilst recognising the many differences between the revalidation systems of doctors and nurses, there is an opportunity to learn from, and support each other. There is still a dedicated medical appraisal and revalidation administrator, who is now supported by a business manager with other members of the team, providing cross cover. The change has led to a period of familiarisation with the systems, but ultimately it is felt the whole will be stronger.

Recommendations

30. The Board is asked to:

a) Receive this annual report and note that it will be shared, along with the annual audit, with the higher level Responsible Officer at NHS England.

b) Approve the 'statement of compliance' (appendix 1) confirming that the organisation, as a designated body, is in compliance with the regulations.

Appendix 1 Designated Body Statement of Compliance

The Board of * has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Dr Damian Riley

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Yes, see Annual Report 2017.2018

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: Yes, see Annual Report 2017.2018

4. Medical appraisers participate in on going performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: Yes, see Annual Report 2017.2018

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes, see Annual Report 2017.2018

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments: Yes, see Annual Report 2017.2018

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments: Yes, ELHT policy HR 39

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

   Comments: Yes, ELHT policy HR 46

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Comments: Yes, see Annual Report 2017.2018

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes, see Annual Report 2017.2018

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _
[chief executive or chairman of ELHT Board

Date: _ _ _ _ _ _ _ _ _ _ _

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

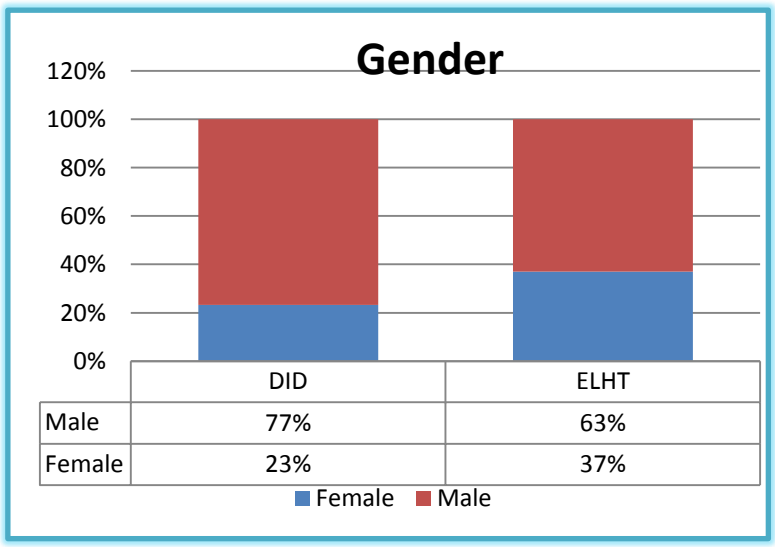
Appendix 2: Annual Organisational Audit

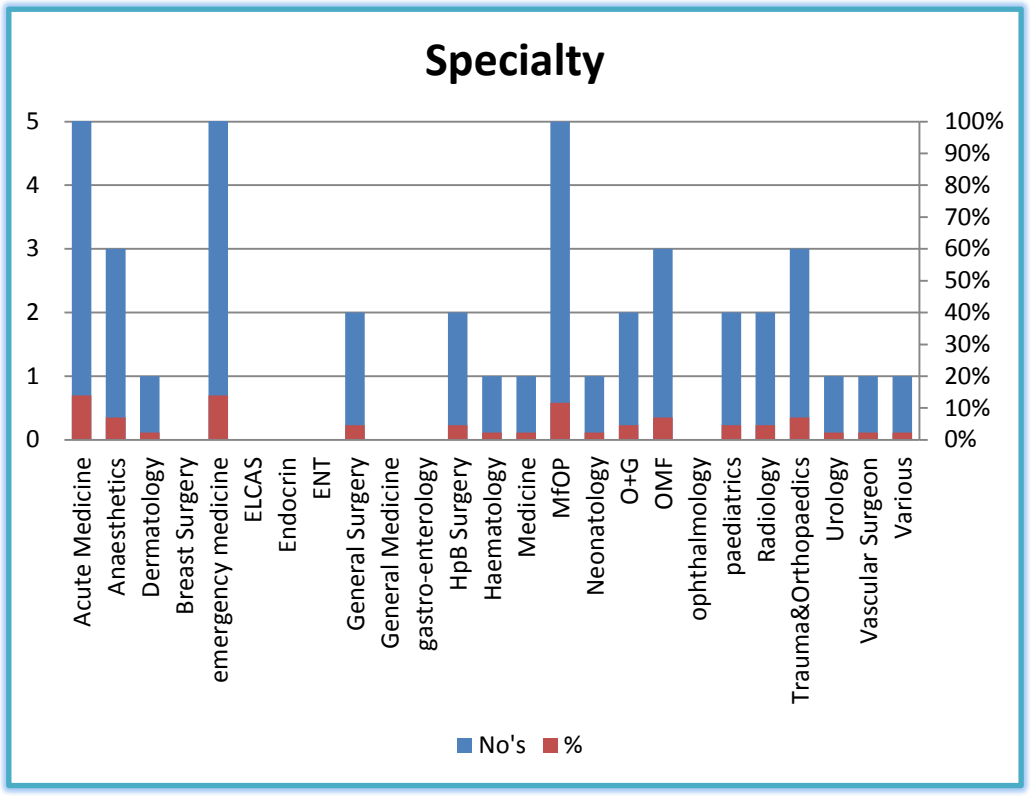
East Lancashire Hospice_Aoa_2017-1

Appendix 3: Audit Doctors in Difficulty

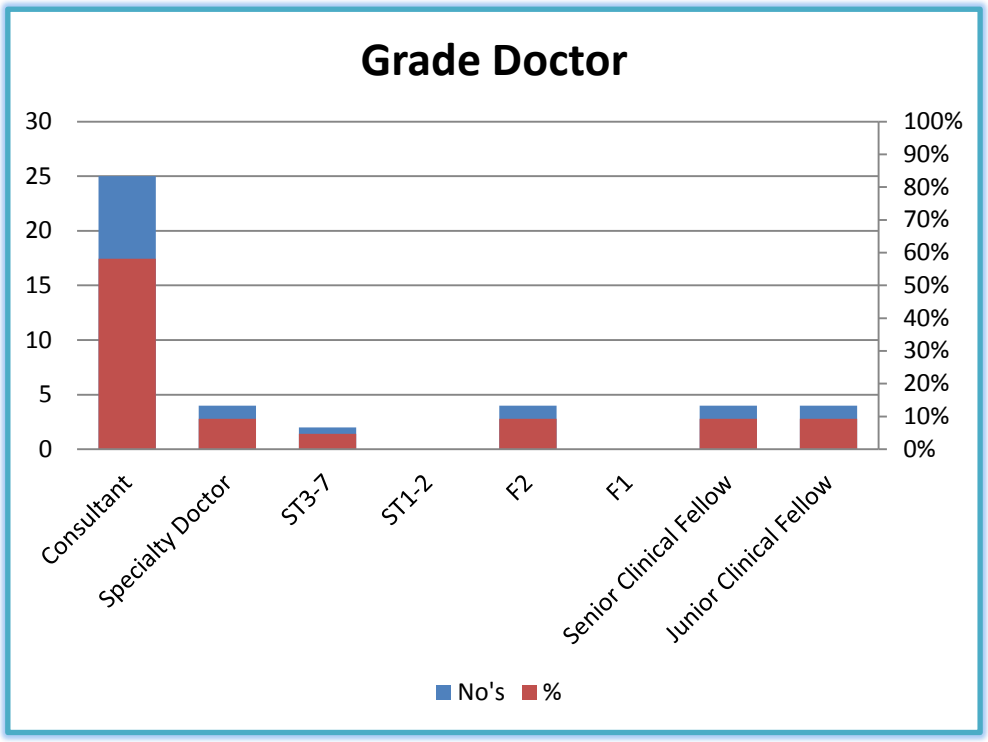
Audit Methodology: Analysis of 2017-2018 data on Doctors in Difficulty database: 43 cases

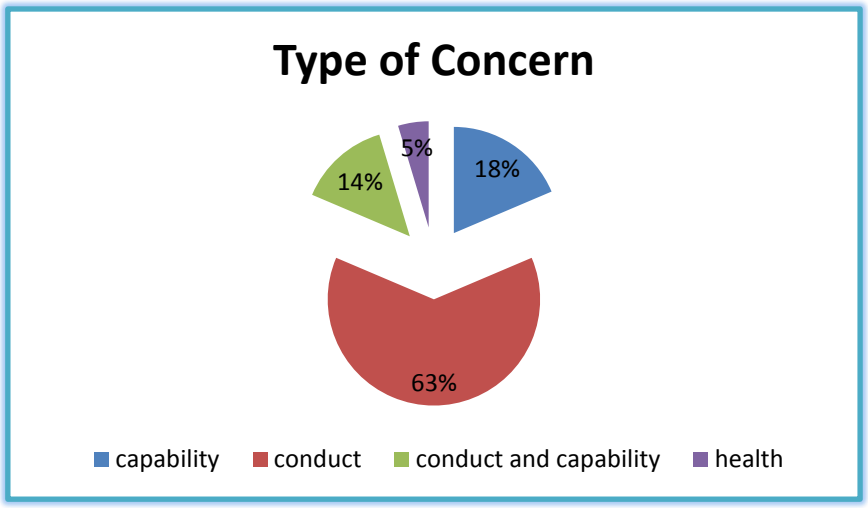
Data:

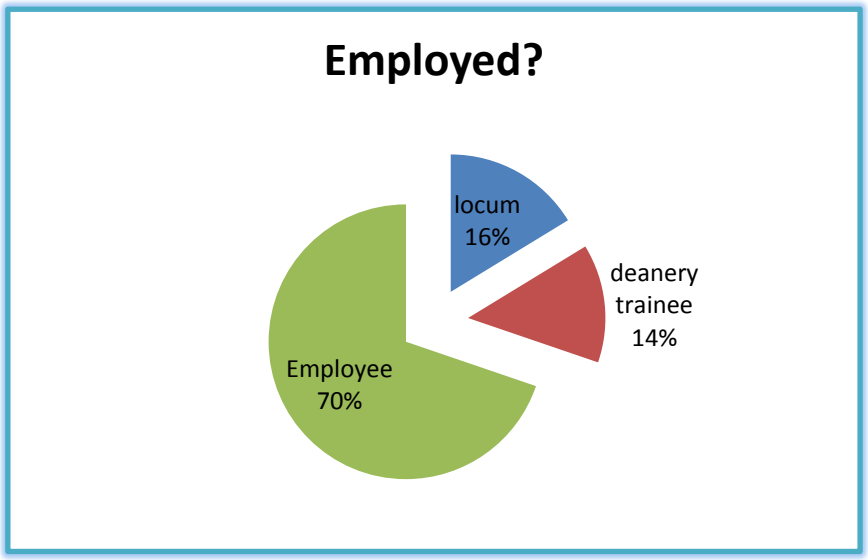


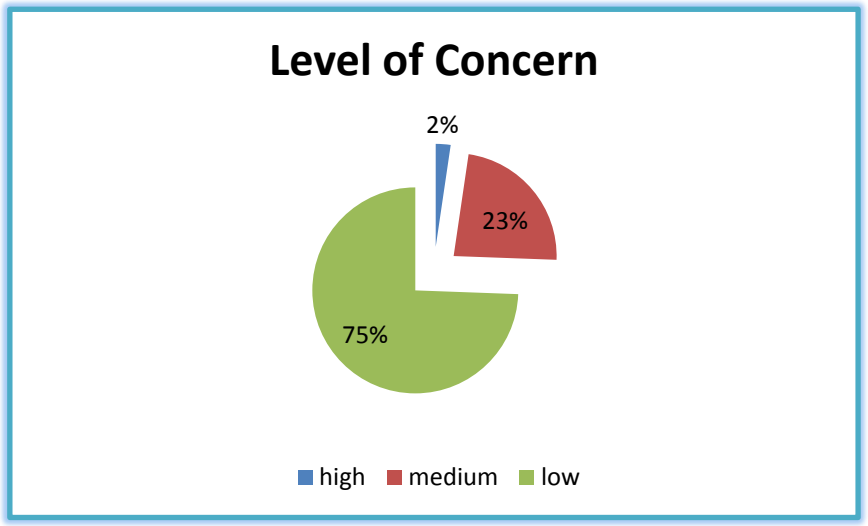


Ethnicity	DID no's	DID %	ELHT %
White - British	14	33%	35%
White - Any other White background	7	16%	10%
Mixed - White & Black African		0%	0%
Mixed - White & Asian		0%	1%
Mixed - Any other mixed background		0%	1%
Asian or Asian British - Indian	6	14%	20%
Asian or Asian British - Pakistani	5	12%	13%
Asian or Asian British - Bangladeshi	1	2%	1%
Asian or Asian British - Any other Asian background	3	7%	5%
Black or Black British - Caribbean		0%	0%
Black or Black British - African	1	2%	3%
Black or Black British - Any other Black background		0%	1%
Chinese		0%	2%
Any Other Ethnic Group	3	7%	3%
Not stated	3	7%	


Grade Doctor
30
25
20
15
10
5
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Consultant
Specialty Doctor
ST3-7
ST1-2
F2
F1
Senior Clinical Fellow
Junior Clinical Fellow
No's
%


Type of Concern
5%
18%
14%
63%
capability
conduct
conduct and capability
health


Employed?
locum
16%
deanery
trainee
14%
Employee
70%


Level of Concern
2%
23%
75%
high
medium
low

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 98

12 September 2018

Purpose Information Assurance

Title	Audit Committee Update Report
Author	Miss K Ingham, Assistant Company Secretary
Executive sponsor	Mr R Smyth, Non-Executive Director, Committee Chair

Summary: The report sets out the matters discussed and decisions made at the Audit Committee meeting held on 2 July 2018 and the Committee's meeting to review the Board Assurance Framework (BAF) on 14 August 2018.

Recommendation: The Board is asked to note the content of the report..

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Recruitment and workforce planning fail to deliver the Trust objective Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Audit Committee Update

At the meeting of the Audit Committee held on 2 July 2018 members considered the following matters:

1. The internal audit reports listed below were presented to the Committee:
   a) Duty of Candour - **Limited Assurance**
   b) Divisional Risk Registers – **Limited Assurance**
   c) Staff Lottery - Significant Assurance
   d) Key Financial Systems - Significant Assurance
   e) Information Governance Assurance – Significant Assurance
   f) Cancer Referrals - High Assurance
   g) Managing Conflicts of Interest - Partially Compliant (no assurance rating required)
   h) Assurance Framework Review – Meets Requirements (no assurance rating required)
2. The Committee received the management response updates in relation to the following areas:
   a) Duty of Candour
      i. It was noted that the audit had highlighted the need to ensure ongoing regular training for staff; better use of the Trust's Datix risk reporting system; and the need to dovetail the Duty of Candour policy with the Trust's Open and Honest Policy.
      ii. Members received an overview of the actions that had been undertaken to date and those still to be completed to address the recommendations made in the report.
   b) Divisional Risk Registers
      i. Members noted that the actions being undertaken to address the recommendations in the report, particularly the review of the membership and reporting lines of the Risk Assurance Meeting; and the complete review of the Trust's Risk Management Strategy.
      ii. The Committee members shared their concern at the challenging timescales for completion of the remaining actions.
      iii. It was agreed that a further progress report would be presented to the next meeting of the Committee in October 2018.

c) Bank and Agency Staff Review

i. Members noted that there had been a total of seven recommendations from the report, two being of high priority with a further five being rated as medium priority.

ii. The Committee noted that the Temporary Staffing policy would be revised by the end of October 2018 following a review of the process for booking temporary and locum staff.

iii. Members noted the potential gap in assurance relating to the scheduling of temporary and locum staff out of normal office hours and at weekends. They sought further information regarding the retrospective checks that are in place and their outcomes in these instances.

d) External Audit Mortality Review Report

i. Members noted that the audit report had identified five recommendations; two of which related to pathways of care; two relating to the need to adequately reflect care provided to documentation; and one relating to the recording of changes.

3. The Committee received the Anti-Fraud Service Progress Report and noted the progress being made in relation to the referrals and investigations that were currently underway. The Committee were also informed of the recent proactive detection exercise that took place in relation to overseas visitors and were pleased to note that no fraud had been identified as a result.

4. Members received the Anti-Fraud Service annual report and noted the process undertaken regarding the annual declaration and submission to the NHS Counter Fraud Authority (NHS CFA). Committee members noted that the Trust had been subject to an inspection by NHS CFA in May 2018 and received an overview of the results of the inspection. Members noted that an update on actions from the inspection would be provided to subsequent meetings of the Committee and that NHS CFA had requested that minutes of future Committee meetings be submitted once approved by the Committee as evidence of monitoring.

5. The Committee received the progress report from external auditors and noted that work would be commencing on the 2018/19 work plan, including the work on the Trust's charitable fund accounts.

6. Following a review of the Trust's Standing Financial Instructions (SFIs) in March 2018 and subsequent investigations regarding section 9.1.4 of the document that

relates to the approval of the remuneration and conditions of service for staff not covered by either Agenda for Change or the Remuneration Committee, the Audit Committee recommended that the section of the document be amended to the following text: *"The Remuneration Committee will receive a report by the Chief Executive on the remuneration and conditions of service for those employees who are not Executive Directors or employed under the terms of Agenda for Change"*. The Board ratified the revised section 9.1.4 it for inclusion in the SFIs at the Board meeting in July 2018. Since the meeting of the Board in July the document has been updated to reflect the aforementioned changes and has been re-issued to staff through the Trust's intranet site.

7. The Committee also received an update on IMT Asset Management, salary overpayments (with the full report being presented to the Committee in October 2018, the Annual Audit Letter, and the External Audit Report on the Quality Account 2017/18.

At the meeting of the Audit Committee held on 14 August 2018 to review the Board Assurance Framework (BAF) members considered the following matters:

1. In light of the focus on effective partnership working across the Integrated Care partnership (ICP) and Integrated Care System (ICS) the Committee members felt that there was a need to revise the description of BAF risk three. The proposed revised wording is as follows: "Lack of effective engagement and leadership with partnership organisations, Pennine Lancashire Integrated Care partnership (ICP) and Lancashire and South Cumbria Integrated Care System (ICS) may result in a detrimental impact on the health and wellbeing of our communities".
2. Potential sources of assurance for all risks on the BAF would benefit from additional narrative to explain/evidence the assurance required.
3. The Committee agreed that the Executive Directors assigned as Responsible Directors for risks would be asked to attend the Audit Committee, or suitable alternative session for detailed discussions on specific BAF risks.
4. The Committee members asked that the actions contained within the document should be clarified and be borne out by evidence.
5. Members requested that additional evidence be submitted for informational purposes where relevant.

6. It was agreed that a meeting would be arranged to carry out a detailed review of BAF risks 2 (workforce) and 5 (constitutional standards).
7. The Committee requested that the responsible director for each risk be reviewed and revised as appropriate.

Kea Ingham, Assistant Company Secretary, 4 September 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 99

12 September 2018

Purpose Information Assurance

Title	Finance and Performance Committee Update Report
Author	Miss K Ingham, Assistant Company Secretary
Executive sponsor	Mr D Wharfe, Non-Executive Director

Summary: The report sets out the matters discussed and decisions made at the Finance and Performance Committee meeting held on 25 June and 30 July 2018.

The Board is asked to note the content of the report.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Finance and Performance Committee Update Report

At the meeting of the Finance and Performance Committee held on 25 June 2018 members considered the following matters:

1. The Committee received the Integrated Performance Report, including an overview of the financial position for the month of May 2018. Members noted the Trust's performance against the four hour standard in the month remained below the 95% target at 86.1% and received an overview of the work that was taking place to improve performance. There were three breaches of the 12 hour trolley wait standard in the month, with all three being patients requiring assessment or treatment by mental health service providers.
2. The Committee received a detailed finance report for the month of May 2018 and noted that the Trust had now signed up to the revised control total, thus allowing access to lower rates of borrowing and the ability to bid for capital monies in the year. Members noted that there had been a need to draw down some cash as the Trust had not received Sustainability and Transformation funds from the previous financial year.
3. The Committee received the Sustaining Safe, Personal and Effective Care 2018/19 report and noted that the majority of savings were forecast for release in the final half of the financial year, with 40% of the total savings being planned for quarter four (January 2019 to March 2019). Non-Executive Director members raised their concerns in relation to the risk that this posed to the overall financial position of the Trust in the current year.
4. In addition to the regular Sustaining Safe, Personal and Effective Care Report, the Committee also received an update on the work that the Trust was doing to become a lean organisation and the work being undertaken across the ICP to embed lean as at a system level. Members noted the most significant risk to the lean work was ensuring adequate buy-in from senior leaders across the ICP and maintaining the momentum of embedding the lean culture.
5. Committee members received an update regarding the Trust's newly formed Education Directorate and noted the complexities around funding of education, particularly in relation to medical placements. Members also noted that medical students from Manchester University would no longer be placed at the Trust; however students from UCLan and Lancaster University medical schools would be

placed at the Trust. It was agreed that a further update would be provided to the Committee in November 2018.

6. The Committee were presented with a proposed revised terms of reference which detailed a change to the membership of the Committee. Members discussed the proposal for the Director of HR and OD to no longer be a formal member of the committee and have a Deputy Director of HR and OD attend instead. The members agreed that this was an appropriate request and would not have a detrimental effect on the quoracy or effectiveness of the Committee. Following presentation of this matter to the Trust Board in July 2018, the revised terms of reference were agreed and approved by the Board.
7. The Committee received an update report on tenders; an update on the procurement cluster; the Committee specific Board Assurance Framework for review; and the minutes of the Contract and Data Quality Board for information.

At the meeting of the Finance and Performance Committee held on 30 July 2018 members considered the following matters:

8. The Committee received the Integrated Performance Report, including an overview of the current financial position to the end of June 2018. The members noted that all cancer standards were met for the month of May 2018 with the exception of the two week breast symptomatic standard which was missed at 92.3. There had been 34 patients who had endured 12 hour breaches, all of which were noted to be patients awaiting assessment or admission by mental health services.
9. Members received the Financial Performance Report and Sustaining Safe, Personal and Effective Care 2018/19 Report. Committee members noted that the Financial Performance Report was broadly in line with the forecast position. The Committee notes that that the Trust was eligible for Provider Sustainability Funds (PSF) of £8,050,000 across the year, and was in lien to receive £1,200,000 of the funds associated with the quarter one performance. The Committee noted that the main concern in relation to the achievement of the financial year end position related to the delivery of SRCP schemes. Non-Executive Director members sought additional assurance in relation to the delivery of these schemes and asked that over-programming of schemes for 2019/20 was carried out. It was agreed that the Divisions would be invited to attend future meetings to provide an update on their

performance towards achievement of their SRCP targets and highlight any challenges/blockers.

10. The Committee received the Electronic Patient Record Business Case on behalf of the Board and were asked, following detailed discussions to recommend to the Chairman of the Trust that the Board approve the submission of the business case to NHSI in line with the required timeframes. The Committee were apprised of the process; the five stage model; and provided with overviews of the component parts of the business case, including: strategic, economic, commercial, financial and management cases. The members noted that potential savings were in the region of 25% (£28,900,000 cash releasing) over a ten year period after optimism bias had been accounted for; although it was acknowledged that any savings would not be seen until at least the third year due to the need to run dual systems in the first two years. The majority of cash releasing benefits would be in relation to staff efficiencies and displaced IT Costs.

11. The Committee received the Trust's response to the Use of Resources request from the CQC for information and noted the areas where the Trust had running costs that compared favourably with the national average.

12. The Committee also received updates on tenders and the revision of the Performance and Accountability Framework. In addition the Trust received the minutes of the Contract and Data Quality Committee.

Kea Ingham, Assistant Company Secretary, 4 September 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 100

12 September 2018

Purpose Information
Assurance

Title	Quality Committee Update Report
Author	Miss K Ingham, Assistant Company Secretary
Executive sponsor	Ms N Malik, Committee Chair

Summary: The report sets out the summary of the papers considered and discussions held at its meeting on 25 July 2018.

Recommendation: The Board is asked to note the report.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objective The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Quality Committee Update

At the meeting of the Quality Committee held on 25 July 2018 members considered the following matters:

1. The Committee members agreed to include an additional standing item on the agenda titles 'Patient Safety' where individuals could raise patient safety issues that had not been included in the papers presented to the Committee. Members raised the ongoing issues around timely assessment and treatment of patients with mental health needs by the mental health care provider and the impact that this has on the emergency care pathway.
2. The Committee received the Serious Investigations Requiring Investigation (SIRI) report and discussed the information relating to duty of candour, particularly the actions being undertaken as a result of the recent internal audit report. Members noted that the Open and Honest policy had been updated to include references to the Duty of Candour policy and would be formally ratified at the next Policy Council meeting.
3. Members noted that the Trust would receive the CQC Well-Led inspection in late September 2018 and that unannounced CQC inspections will take place in the intervening time.
4. The Committee received the annual update in relation to the Nursing and Midwifery Strategy and discussed the benefits and constraints of incorporating the Strategy into the overarching Clinical Strategy in the future and it was agreed that the two strategies should be aligned.
5. The Committee received a report relating to the Nursing Assessment Performance Framework, it was confirmed that in addition to the six 'silver' wards there were a further two wards that were awaiting Board approval for 'Silver Ward Status and another that was eligible to present to SPEC panel later in the year.
6. The Committee received the report of the Director of Infection Prevention and Control (DIPC). The report included the progress made to date in relation to managing and reducing infections such as MRSA, Clostridium Difficile and E-Coli. Members noted that the Trust had achieved a substantial reduction in hospital onset E-Coli blood stream infections (a reduction in excess of 10%). The report also highlighted the work being carried out in relation to antibiotic stewardship.

7. The Committee spent some, time discussing the evaluation of the Trust's Winter Plan 2017/18 and the learning that could be taken from it and incorporated in the forthcoming plan.

8. The Committee received a detailed report concerning cancer performance, particularly around the inconsistency in achievement of the 62 day cancer standard. It was noted that the main issues related to patient choice, complex patient pathways and capacity issues which affected the ability to deliver scheduled surgery. The Committee were provided with an overview of the work that was being undertaken to rectify the issues and mitigate any potential risks to patients.

9. Members received the Quality Dashboard and an overview of current quality performance indicators. They were particularly interested in the information presented regarding clostridium difficile (C-Diff) cases identified within the Trust and the work that was being undertaken to improve performance against the four hour standard.

10. The Committee also received the draft Health and Wellbeing Strategy for information and comment prior to presentation at the Trust Board in September 2018. In addition, the Committee received the Annual Report relating to Medical Appraisal and Revalidation for review prior to presentation and sign off by the Trust Board in September 2018. The Committee received the Medicines Management Annual Report for information ; Corporate Risk Register; and Summary Reports from the following Sub-Committee Meetings:

    a) Patient Safety and Risk Assurance Committee (May 2018)
    b) Infection Prevention and Control Committee (May and June 2018)
    c) Health and Safety Committee (June 2018)
    d) Internal Safeguarding Board (May 2018)
    e) Patient Experience Committee (June 2018)
    f) Clinical Effectiveness Committee (June 2018)
    g) Trust Education Board (June 2018)

Kea Ingham, Assistant Company Secretary, 4 September 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 101

12 September 2018

Purpose Information
Assurance

Title	Trust Charitable Funds Committee Update Report
Author	Miss K Ingham, Assistant Company Secretary
Executive sponsor	Mr S Barnes, Non-Executive Director

Summary: The report sets out the matters discussed and decisions made at the Trust Charitable Funds Committee meetings held on 30 July 2018.

Recommendation: The Board is asked to note the content of the report.

Report linkages

Related strategic aim and corporate objective	NA
Related to key risks identified on assurance framework	NA

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

(101) Trust Charitable Funds Committee Update Report

Trust Charitable Funds Committee Update

At the meeting of the Trust Charitable Funds Committee held on 30 July 2018 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.

1. The Committee received a brief update from the ELHT&Me Strategy Session that was held on 11 June and noted that an ELHT&Me Strategy document would be developed for presentation to the Trust Board and would include the promotion of the charity to corporate entities.
2. The Committee received notification that the Trust had received £71,755 from Novartis towards an Optus camera costing £81,455, the remaining £9,245 being met by the Ophthalmology Service general charitable fund. There were no requests for funds in excess of £20,000.
3. The Committee members received further information regarding the potential purchase of a mobile MRI scanner and it was confirmed that this option was no longer viable. Therefore the Committee agreed to support the raising of funds for the purchase of a relocatable MRI scanner.
4. The Committee were updated on the work of the Fundraising Manager. Within the report there was a summary of the various fundraising activities that were to be undertaken in conjunction with the 70th anniversary of the NHS. The Committee members noted the ongoing work to nurture and further develop relationships with the Trust's various community hospital groups
5. The Committee also received the Investment Performance Report; Fund Performance and Utilisation Report; and the minutes of the Staff Lottery Committee.

Kea Ingham, Assistant Company Secretary, 4 September 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 102

12 September 2018

Purpose Information

Title	Remuneration Committee Information Report
Author	Miss K Ingham, Assistant Company Secretary
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The list of matters discussed at the Remuneration Committee held on 11 July 2018 are presented for Board members' information.

Recommendation: This paper is brought to the Board for information.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objective Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No

Equality	No	Confidentiality	No

Remuneration Committee Information Report

1. At the meeting of the Remuneration Committee held on 11 July 2018 members considered the following matter:

   a) Chief Executive's Annual Appraisal

Kea Ingham, Assistant Company Secretary, 4 September 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 103

12 September 2018

Purpose Information

Title	Trust Board Part Two Information Report
Author	Miss K Ingham, Assistant Company Secretary
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The report details the agenda items discussed in Part 2 of the Board meetings held on 11 July 2018.

As requested by the Board it can be confirmed that, in preparing this report the external context has been taken into account, such as regulatory requirements placed on NHS providers. Other elements such as local needs, trends and engagement with stakeholders would not be applicable in this instance.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objective Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Trust Board Part Two Information Report

1. At the meeting of the Trust Board on 11 July 2018, the following matters were discussed in private:
   a) Round Table Discussion: Community Neighbourhood Services
   b) Round Table Discussion: Model Hospital
   c) Round Table Discussion: Update on ICS/ICP Developments
   d) Sustaining Safe, Personal and Effective Care 2018/19 Update Report
   e) Tender Update
   f) Royal Blackburn Teaching Hospital Phase 6 Full Business Case
   g) Serious Untoward Incident Report
   h) Doctors with Restrictions
2. The matters discussed were private and confidential and/or identified individuals and/or were commercially sensitive at this time and so the decision was taken that these items should not be discussed in the public domain. As these items progress, reports will be presented to Part 1 of Board Meetings at the appropriate time.

Kea Ingham, Assistant Company Secretary, 4 September 2018