East Lancashire Hospitals
NHS Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

Personal

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East Lancashire Hospitals NHS Trust

TRUST BOARD MEETING (OPEN SESSION)

9 JANUARY 2019, 13.00

SEMINAR ROOM 6, ROYAL BLACKBURN HOSPITAL

AGENDA

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

OPENING MATTERS				
TB/2019/001	**Chairman's Welcome**	Chairman	v	
TB/2019/002	**Open Forum** To consider questions from the public	Chairman	v	
TB/2019/003	**Apologies** To note apologies.	Chairman	v	
TB/2019/004	**Declaration of Interest Report** To note the directors register of interests and note any new declarations from Directors.	Chairman	d✓	Information/ Approval
TB/2019/005	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 14 November 2018.	Chairman	d✓	Approval
TB/2019/006	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2019/007	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2019/008	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2019/009	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information
QUALITY AND SAFETY				
TB/2019/010	**Patient Story** To receive and consider the learning from a patient story.	Director of Nursing	p	Information/ Assurance
TB/2019/011	**Neuro-rehabilitation Services**	Directorate Lead	p✓	Information/ Assurance
TB/2019/012	**Electronic Patient Referral System**	Director of Operations	d✓	Information/ Assurance
TB/2019/013	**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

Agenda

TB/2019/014	**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/2019/015	**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/2019/016	**Planning Day 2019/20 Themes**	Chief Executive/ Director of Service Development	d✓	Information/ Assurance
TB/2019/017	**Equality, Diversity and Inclusion**	Director of HR&OD	d✓	Information/ Assurance
TB/2019/018	**Culture and Leadership Update**	Director of HR&OD	p✓	Information/ Assurance
	ACCOUNTABILITY AND PERFORMANCE			
TB/2019/019	**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/2019/020	**Finance and Performance Committee Update Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information/ Assurance
TB/2019/021	**Quality Committee Update Report** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information/ Assurance
TB/2019/022	**Trust Charitable Fund Reporting** **a) Trust Charitable Funds Update Report** **b) Charity Annual Accounts** (*Board is meeting as Corporate Trustee for this item)*	Committee Chair Director of Finance	d✓ d✓	Information/ Assurance Decision
TB/2019/023	**Trust Board Part Two Information Report** To note the matters considered by the Committee in discharging its duties	Chairman	d✓	Information
	FOR INFORMATION			
TB/2019/024	**Any Other Business** To discuss any urgent items of business.	Chairman	v	

TB/2019/025	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2019/026	**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/2019/027	**Date and Time of Next Meeting** Wednesday 13 March 2019, 1.00pm, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.	Chairman	v	

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 4

9 January 2019

Purpose Information
Approval

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. The presented Directors' Register of Interest will be included in the Trust's Annual Report.

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.

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

(4) Directors' Register of Interests

Directors Register of Interests

There are no company directorships or other significant interests held by directors which may conflict with their management responsibilities other than those disclosed below.

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 19.06.2018) • 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 • Honorary Fellow at University of Central Lancashire	21.09.2018
Patricia Anderson Non-Executive Director	• Accountable Officer at Wigan Borough CCG (until 31.05.2018). • Public Sector Director on One Partnership (LIFTCO) (January 2015 until 31.05.2018) • Spouse is a recently retired Consultant Psychiatrist formerly employed at Mersey Care NHS Trust	19.09.2018
John Bannister Director of Operations	Positive Nil Declaration.	07.03.2018

Name and Title	Interest Declared	Date last updated
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).	23.02.2018
Martin Hodgson Director of Service Development	Positive Nil Declaration.	23.02.2018
Christine Hughes Director of Communications and Engagement	Positive Nil Declaration.	23.02.2018
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 at Nursing & Midwifery Council (NMC) - Independent Contractor. • 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).	28.03.2018

Name and Title	Interest Declared	Date last updated
	• Relative (brother-in-law) is a Mental Health Nurse.	
Kevin Moynes Director of Human Resources & Organisational Development	• Spouse is a very senior manager at Health Education England. • Governor of Nelson and Colne College (until 01.02.2018).	05.03.2018
Christine Pearson Director of Nursing	• Spouse is the Head of Medicines Optimisation, at Heywood, Middleton & Rochdale Clinical Commissioning Group	23.02.2018
Damian Riley Executive 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. • Spouse is a locum GP and may undertake work in local GP practices. There is potential for bias affecting relationships and interactions with CCGs and commissioners of primary care. • Spouse may undertake work in PWE practices, and ELHT has a financial commitment to PWE consortium.	19.10.2018
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	05.03.2018

Name and Title	Interest Declared	Date last updated
	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 with Pennine Acute Hospitals Trust based at the Royal Oldham hospital. • Member of the Law Society.	
Professor Michael Thomas Associate Non-Executive Director	• Vice-Chancellor of UCLAN (to 30.11.2018).	01.12.2018
Michael Wedgeworth Associate Non-Executive Director	• Honorary Canon of Blackburn Cathedral in 2003 • Assistant Priest at Blackburn Cathedral since 1995. • 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	23.02.2018

Name and Title	Interest Declared	Date last updated
	Integrated Care Organisation Board).	
David Wharfe Non-Executive Director	• Positive Nil Declaration. • Trustee of Pendleside Hospice (from June 2018)	26.09.2018
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. • Chair of Blackburn Cathedral Finance Committee	15.11.2018

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary, 7 December 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 5

9 January 2019

Purpose Action

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

Summary: The minutes of the previous Trust Board meeting held on 14 November 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

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 2.30PM, 14 NOVEMBER 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
Miss N Malik	Non-Executive Director/ Vice Chair	
Mr K Moynes	Director of HR and OD	Non-voting
Mrs C Pearson	Director of Nursing	
Dr D Riley	Medical Director	
Mr R Slater	Non-Executive Director	
Professor M Thomas	Non-Executive Director	
Mr M Wedgeworth	Associate Non-Executive Director	Non-voting
Mr D Wharfe	Non-Executive Director/Vice Chair	
Mr J Wood	Director of Finance	

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Associate Director of Corporate Governance/ Company Secretary	
Miss K Ingham	Company Secretarial Assistant	Minutes
Mr B Butler	Lancashire Telegraph	Observer
Mr D Byrne	Corporate Governance Officer	Observer

APOLOGIES

Mrs P Anderson	Non-Executive Director
Mr R Smyth	Non-Executive Director

TB/2018/108 CHAIRMAN'S WELCOME

Professor Fairhurst welcomed the Directors and members of the public to the meeting; particularly Mr Dan Byrne the newly appointed Corporate Governance Officer who will be

working within the Company Secretariat.

TB/2018/109 OPEN FORUM

There were no questions or queries raised by members of the public.

TB/2018/110 APOLOGIES

Apologies were received as recorded above.

TB/2018/111 DECLARATIONS OF INTEREST

There were no declarations of interest reported.

TB/2018/112 MINUTES OF THE PREVIOUS MEETING

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

RESOLVED: The minutes of the meeting held on 12 September 2018 were approved as a true and accurate record

TB/2018/113 MATTERS ARISING

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

TB/2018/114 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.

TB/2018/080: Open Forum – Mr Bannister reported that the changes to the signage at the Burnley General Teaching Hospital site would take place upon completion of the current developments.

TB/2018/085: Action Matrix – Mrs Pearson confirmed that the Trust was currently in negotiations with the Nursing Directorate at UCLAN and NHS England to determine whether it is possible to include a cohort of nurses from Kosovo on the Global Learners' Programme or the Earn, Learn and Return programme. Directors noted that discussions will also need to be held with the Kosovan Government in order for them to agree to release the nurses.

TB/2018/094: Culture and Leadership – Mr Moynes confirmed that a slide deck has been developed and has been discussed with the Executive Team, the system leaders across the Integrated Care System (ICS) and a range of other internal forums.

TB/2018/106: Board Performance and Reflection – Mrs Pearson reported that there would be an open session of the Patient Panel on 12 December 2018 with a formal launch planned for January 2019.

RESOLVED: **The position of the action matrix was noted.**

Mrs Pearson to provide an update on the Patient Panel open session and launch of the Panel.

TB/2018/115 CHAIRMAN'S REPORT

Professor Fairhurst reported that Professor Mike Thomas had been acknowledged as a leading light for compassionate leadership by the Women of the Future organisation. She went on to report that since the last meeting the Trust had held its Annual General Meeting, which culminated in the final NHS70 tea party.

Professor Fairhurst confirmed that she had taken the opportunity to visit one of the GP practices that the Trust runs as part of the PWE partnership. She commented that the visit was interesting and demonstrated the enthusiasm of the GP partners within the practice to work with us. Directors noted that since the partnership took over the running of the practice, the patient list size has grown.

Professor Fairhurst reported that the Board had recently taken part in an export readiness workshop by Healthcare UK, which is part of the Department of Trade. There was recognition that the NHS is a global brand and it has a significant role to play as an exporter of services.

Directors noted that Sir Keith Pearson, Chair of Health Education England had recently visited the Trust and was complimentary about the innovative work that is taking place within the Trust, particularly the work around developing a workforce of the future. One of the presentations given on the day of the visit focused on the fulfilment of corporate social responsibility and highlighted the stark health inequalities of the population. It showcased some of the work the Trust is undertaking with local schools and colleges, local Department of Work and Pensions, the Prince's Trust, and Lancashire County Council's services for looked after children.

Professor Fairhurst reported that Professor Iqbal Singh had recently organised an international conference of the Centre of Excellence for Safety for Older People, which was well attended and included a number of poster presentations from ELHT staff.

Directors noted that the Trust's inaugural Nursing and Allied Health Professionals (AHP) conference took place earlier in the month and provided a good indication of the joint

working that the Trust is doing in this domain.

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

TB/2018/116 **CHIEF EXECUTIVE'S REPORT**

Mr McGee presented his report to Directors and highlighted the revised format of the report and the additional content included, particularly the media coverage report.

Mr McGee went on to provide an overview of some of the national items contained within the report, including the launch of the NHS Winter Campaign, information relating to the NHS from the Autumn Budget, and zero tolerance of abuse towards staff.

Directors noted the appointment of Mrs Michelle Brown to the role of Associate Director of Improvement for the Trust and the Integrated Care Partnership (ICP). Mr McGee reported that the Trust's Neonatal Intensive Care Unit had opened the 'Forget Me Not' suite for bereaved parents. The suite has been developed in partnership with the Trust and parents and families.

Dr Riley confirmed that the Respiratory Ambulatory Care Unit opened on 14 September 2018. He provided a brief overview of the way that the unit works and the benefits that it will have for the flow through the emergency care pathway.

Mr McGee confirmed that the Trust's stroke service had been rated as 'A' in its most recent Sentinel Stroke National Audit Programme (SSNAP) assessment. He went on to draw the Directors' attention to the new media update section which provided an overview of the work that has gone on since the last meeting. Directors noted that the vast majority of the media coverage relating to the Trust was positive in nature, despite the tendency of the press to focus on negative coverage.

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

TB/2018/117 **PATIENT STORY**

Mrs Pearson introduced Mrs Pollard and her husband and confirmed that Mrs Pollard would be sharing her experience of being a patient following a stroke earlier in the year.

Mrs Pollard confirmed that she and her husband had both spent in excess of 30 years as employees of the NHS. She reported that on 29 April 2018 following an intracranial haemorrhage she was admitted to the Emergency Department. Upon admission she was gravely ill and was taken into the resuscitation area to be stabilised. From there she went for a scan, where immediate feedback was given to her husband and care team regarding her condition. Mr Pollard reported that the nursing and medical staff were excellent in terms of

the care provided to his wife and spent a great amount of time allaying his fears.

Mrs Pollard reported that following stabilisation she was moved to ward B2 for four days and from there she was transferred to Preston for surgery. Upon her return to the Trust to commence rehabilitation the care she received continued to be good and communication between the two organisations seemed to be effective and efficient. The only negative thing Mrs Pollard reported was that the rehabilitation bed she was admitted to did not feel like a rehabilitation bed, as there was no active physiotherapy input from the start of her admission. She was then transferred to Rakehead, where the rehabilitation was intense and of a high quality. Mrs Pollard spent a total of seven weeks in hospital and, upon discharge, was regularly seen by the community rehabilitation team.

Mrs Pearson commented that the Trust had recently had an improved SSNAP rating and that the Trust had made significant progress in recent months in relation to the stroke pathway. She thanked Mrs Pollard and her husband for sharing their story with the Board.

Mr McGee commented that it was pleasing to hear that the communication between the two Trusts was good.Mr Bannister stated that it is important for the Board to recognise how immediate the effects of stroke are and just how wide ranging the impact can be.

Mrs Pollard commented that the only negative experience her family had was when her son had been asked to leave the ward at visiting time when there were more than five people around her bed, which in itself is not an issue, but the manner in which he was asked to leave could have been improved. Mrs Pearson thanked Mrs Pollard for her feedback and assured her that it has been taken on board.

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

TB/2018/118 CORPORATE RISK REGISTER

Dr Riley referred Directors to the previously circulated report and confirmed that the format of the report had been revised in line with the discussions held at the last meeting. He went on to confirm that the risks contained within the document had been revised and reworded, with the risk relating to constitutional standards being broken into three separate risks, namely, focusing on cancer targets, referral to treatment (RTT), and emergency flow/four hour standards. Directors noted that the risks had been aligned to the strategic risks contained within the Board Assurance Framework (BAF).

Professor Fairhurst suggested that the revised document enabled the Board to gain better and more informed assurance regarding the work being undertaken to mitigate and manage the risks.

Mr Hodgson reported that the Trust had received the quarter two performance information relating to the Hepatitis C CQUIN and the risk on the register would be reviewed again in light of this new information.

RESOLVED: **Directors were assured by the data presented and approved the CRR in its revised format.**

TB/2018/119 BOARD ASSURANCE FRAMEWORK

Dr Riley presented the report and highlighted the changes to the document since the last Board meeting in September (see pages 68 to 75 of the November 2018 Board papers).

Mr McGee commented that for the document to be useful to the Board it needed to become a truly live document and asked how often it was reviewed. Dr Riley confirmed that the document was reviewed by the Executive Directors on a monthly basis and also presented to the Quality Committee (at each meeting) and Finance and Performance Committee (alternate meetings) for review and discussion. Dr Riley went on to suggest that future iterations of the document include a differentiation between internal and external sources of assurance and also include the Vital Signs programme work that is taking place within the Trust.

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

Future iterations of the document to include a differentiation between internal and external sources of assurance in addition to the Vital Signs work that is taking place in the Trust

TB/2018/120 SERIOUS INCIDENTS REQUIRING INVESTIGATION REPORT

Dr Riley referred Directors to the previously circulated report, highlighting those incidents which had occurred and required reporting on the Strategic Executive Information System (StEIS) and those incidents occurring in the Trust which did not meet the criteria. The latter, however were of sufficient importance to trigger internal review processes. Directors noted that, unless otherwise stated all internal rapid reviews were undertaken within 48 hours of an incident being reported.

Dr Riley went on to highlight the focused work which the Trust has been undertaking in relation to falls. He confirmed that, over a three year period, the number of falls had reduced significantly, but, the number of patients suffering a fractured neck of femur as a result of a fall had not changed significantly.

Dr Riley referred Directors to the final part of the report which gave an overview of an external Level 3 Investigation Report into the care and death of a patient in 2015. He confirmed that the Trust undertook an internal investigation following the incident. This took several months and made recommendations based on the findings. Following presentation of the internal investigation report and findings, the family remained aggrieved and sought an external investigation. He confirmed that the full external investigation report had now been received and the findings were summarised in the report. Directors noted that the majority of the findings in the report mirrored those contained within the internal investigation report and a task and finish group had been set up to ensure actions were implemented and embedded. The group will continue to meet over the coming year and progress will be reported through the Quality Committee.

RESOLVED: Directors received the report and noted its content.

TB/2018/121 FLU VACCINATIONS PROGRAMME 2018/19

Mr Moynes presented the report and highlighted the work being undertaken to vaccinate staff against flu. He confirmed that the Trust achieved the highest rate of flu vaccinations in the country in 2017 (92.3%) and good progress was already being seen in the 2018 campaign, with 60% of the workforce already having been vaccinated.

Miss Malik commented that the percentage of staff having received the vaccination in 2017 was impressive and asked whether there had been any work carried out to dispel any rumours about the side effects or the cultural/ethical reasons for refusing the vaccination. Dr Riley reported that there had been a number of staff who had refused the vaccination in the previous year, due to the vaccine being developed in egg embryos.

In response to Mr McGee's question, Mr Moynes confirmed that the uptake of the vaccination for healthcare workers was high, but there had not been any work carried out to correlate the staff who had received the vaccine with those members of staff who had been absent from work due to sickness. Sickness rates for the post vaccination period in 2017 were between 6% and 7%.

Professor Fairhurst suggested that the high uptake of the vaccination was evidence of the Health and Wellbeing Strategy working.

In response to Miss Malik's question, Dr Riley confirmed that the Trust had an obligation to ensure that patient-facing staff were immune to a range of diseases, such as measles, hepatitis and chicken pox.

RESOLVED: Directors received the report and noted its contents.

TB/2018/122 **LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE SYSTEM (ICS) MEMORANDUM OF UNDERSTANDING (MoU)**

Mr McGee presented the document to Directors and confirmed that the Memorandum of Understanding (MoU) had been presented to all the Trusts/organisations that were part of the Integrated Care System (ICS). He provided a brief overview of the document and the obligations that it set out for partner organisations. Directors agreed to approve the MoU on the basis that the ICS works with the Trust/organisations to firm up the governance arrangements and that an agreement is reached regarding the allocation of capital across the area.

RESOLVED: **Directors discussed and approved the Memorandum of Understanding, on the basis that the ICS works with the Trust/organisations to firm up the governance arrangements and that agreement is reached regarding the allocation of capital across the area.**

TB/2018/123 **INTEGRATED PERFORMANCE REPORT**

Mr McGee introduced the report to the Directors and confirmed that the report related to the period to the end of September, with the exception of the cancer standards which are reported to the end of August 2018. He commented that the Trust continued to perform well overall, particularly in relation to infection prevention and control indicators. Directors noted that the Trust continues to work towards improving performance in areas of pressure, particularly the emergency care pathway and the four hour standard.

a) Performance

Mr Bannister reported that of the 16,088 attendances at the Emergency Department in the month, 13,055 were seen within the required four hours. The month end performance was 81.2%. Directors noted that there had been 19 breaches of the 12 hour trolley wait, all of which were patients awaiting assessment of admission to mental health services. Mr Bannister reported that the average time for ambulance handovers to the Trust was 21 minutes against the standard time of 15 minutes. Work is taking place with North West Ambulance Service (NWAS) to improve the performance against this indicator. Mr Bannister went on to confirm that the referral to treatment (RTT) incomplete standard was 92.1% for the month and there were no patients who waited in excess of 52 weeks for surgery. There

were 73 operations cancelled on the day during the reporting month, with all being rebooked within the required 28 days.

Mr Bannister reported that the Trust had failed to achieve the cancer 62 day standard for the reporting month of August (82.4%). He also confirmed that the breast symptomatic two week standard was below target at 86.8%, but the GP 2 week and 31 day standards were achieved. Directors noted that there had been 4.5 breaches of the 104 day standard, which equated to seven patients.

Despite the previously reported improvements in relation to delayed transfers of care (DTOC), the position deteriorated in the month. The performance reported at the end of the reporting period was 3.9%, which is in excess of the 3.5% threshold and equated to 32 lost bed days in the month of September 2018.

In response to Mr Wedgeworth's question regarding the DTOC position against peers in the area and the North West as a whole, Mr McGee suggested that there were particular issues for the Lancashire Trusts, including mental health services, which impact on the transfers of care. He went on to confirm that there was a difference in the ways in which transfers of care are counted across Trusts, with this Trust taking a strict view of what is and is not classed as a delayed transfer of care.

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

b) Quality

Dr Riley reported that there had been one case of Clostridium Difficile (C-Diff) identified in the reporting month which brings the Trust to two cases above the year to date trajectory. There were no cases of MRSA identified in the month and gram negative/Urinary Tract Infections remain at acceptable levels.

Directors noted that the Trust's performance against the hospital standardised mortality ratio (HSMR) and the Summary Hospital Mortality Indicator (SHMI) remain good.

Professor Fairhurst commented that it was worth noting that the Trust has come a long way in relation to the performance against the mortality indicators since the Keogh Review. The Board should recognise the work that has been carried out, particularly by Dr Stanley and the clinical and coding teams.

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

c) Workforce

Mr Moynes reported that the response rate to the staff survey currently stood at 35%. The survey closes in three weeks' time. He confirmed that the appraisal rates for staff on Agenda for Change contracts are at 84%, which is below the expected threshold and 97% of staff have completed corporate induction. Directors noted that the only core skills module which was below the required compliance level was Information Governance at 93%, against a compliance threshold of 95%. Mr Moynes confirmed that the vacancy rate had reduced to 7.8%. The staff sickness rate had improved slightly and stands at 5.03%, although this remains higher than the percentage for the same period in 2017. The Health and Wellbeing team are undertaking a number of initiatives to support staff welfare and improve sickness rates.

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 the month, although there had been a slight improvement in comparison with August 2018. There were two red flag incidents which occurred in the Outpatient department in the month and a further three in the Family Care Division, none of which were noted to have had a detrimental effect on patient care.

Directors noted the scores relating to the Friends and Family Test and that there had been an increase in the number of patients who would recommend the Trust as a place to receive treatment.

Mrs Pearson stated that the Trust received 37 complaints in September, which is the lowest number of complaints received since she commenced employment with the Trust in 2014.

Professor Fairhurst acknowledged the work that has taken place to reduce the number of complaints received to such low levels.

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

e) Finance

Mr Wood reported that the Trust remained on track to achieve the financial control total at the end of the 2018/19 financial year; however, a significant risk remained in relation to the financial position, which requires mitigation for the remainder of the year.

Directors noted that the cash balance of the Trust was £9,000,000, which related to the drawdown of cash for the Phase Eight work at the Burnley General Teaching Hospital site.

Mr Barnes commented that the Finance and Performance Committee had sought further assurance in relation to the risks to the financial position in the remaining half of the year.

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

TB/2018/124 EMERGENCY PREPAREDNESS RESILIENCE REPORT (EPRP)

Mr Bannister reminded Directors of the discussions undertaken at the last meeting regarding the report and presented it for information. He confirmed that the certificate declaring full compliance had been submitted by the required deadline of 30 September. He referred Directors to appendix B: Annual EPRP Work Plan for the Trust 2018/2019, which will ensure that the Trust maintains full compliance in the coming year.

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

TB/2018/125 ELHT&ME UPDATE REPORT

This item was considered with the Board acting as the Corporate Trustee for the ELHT&Me charity.

Mrs Hughes referred Directors to the previously circulated document and provided a summary of the progress of the Charity since it was relaunched as ELHT&Me in 2016. She highlighted the three main strategic objectives, which were noted to be: make the charity more recognisable; make it easier for people to donate to the charity; and make it easier for people to fundraise for the charity. Directors noted that the objectives were being met and that a revised strategy would be developed in the coming year. It was anticipated that the strategy would be revised in March 2019. Mrs Hughes requested that the Board members, acting as the Corporate Trustee, note the progress made to date and continue to act as ambassadors for the charity.

Mr Barnes commented that as Chair of the Trust Charitable Funds Committee he had seen good progress being made in the last year, particularly given the limited resources available.

Miss Malik commented that it was impressive that the charity was almost half way to achieving its target of £1,000,000, since the appeal was launched in February 2018. She went on to ask what the next fundraising target would be for the charity following the achievement of the £1,000,000 goal. Mrs Hughes suggested that the time to take stock and set a new challenge would be around March 2019 and there was an interest in targeting

commercial giving with local and national businesses.

Mr Wood welcomed the report and the enthusiasm that had been generated in relation to the charity.

Directors considered the recommendations within the report and approved them as the Corporate Trustee.

RESOLVED: Directors approved the recommendations in the report as the Corporate Trustee for the charity.

TB/2018/126 AUDIT COMMITTEE UPDATE REPORT

Mr Wharfe presented the report on behalf of Mr Smyth and confirmed that the Committee had received a number of internal audit reports. He went on to report that in advance of the main Audit Committee in October, the Committee members had met with a number of the Executive Directors to undertake a deep dive into BAF risk 2 (workforce) and 5 (constitutional standards), the discussion and decisions made were reflected in the report presented to the Board.

RESOLVED: Directors received the report and noted its contents.

TB/2018/117 FINANCE AND PERFORMANCE COMMITTEE UPDATE REPORT

Mr Wharfe presented the report and highlighted the discussions that had taken place at the meeting. He confirmed that the Committee had spent some time debating the financial control total and the likelihood of meeting it for the current financial year. The Committee also considered the medical staffing costs. Mr Wharfe highlighted the increased levels of income from the Commissioners based on the increased activity and case mix currently being experienced within the Trust. Directors noted that the Committee had received detailed financial presentations from the Family Care and the Surgical and Anaesthetic Services Divisions which had helped the Committee to gain greater understanding of their challenges and plans to meet the required Divisional financial out-turn positon at the end of the financial year.

RESOLVED: Directors received the report and noted its content.

TB/2018/128 QUALITY COMMITTEE UPDATE REPORT

Ms Malik presented the report on behalf of Mrs Anderson and commented that the majority of discussions undertaken throughout the course of today's meeting in relation to quality and safety had been discussed by the Quality Committee. She highlighted the summary of the

Director of Infection Prevention and Control Annual Report which had been discussed at a recent Quality Committee meeting.

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

TB/2018/129 **REMUNERATION COMMITTEE INFORMATION REPORT**

The report was presented to the Board for information.

TB/2018/130 **TRUST BOARD PART TWO INFORMATION REPORT**

The report was presented to the Board for information.

TB/2018/131 **ANY OTHER BUSINESS**

There were no matters of business raised under this item.

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

TB/2018/132 **OPEN FORUM**

There were no questions or comments from members of the public.

TB/2018/133 **BOARD PERFORMANCE AND REFLECTION**

Professor Fairhurst invited comments and observations about the meeting from the Directors. The Directors agreed that the agenda items that had been discussed covered a wide range of the activities undertaken by the Trust. Miss Malik commented that the Patient Story had been particularly touching. Mr Slater commented that the revised Chief Executive's Report was greatly improved; particularly the section pertaining to media reports and it went some way to demonstrating the reach of the Trust's message.

In relation to the Patient Story, Professor Thomas asked how the Board could check back to see if the actions highlighted in this and previous stories had been implemented. Mrs Pearson confirmed that the Trust produced a collection of patient stories on an annual basis, all of which were discussed through the various Divisions. Any resultant actions are fed back through the particular care pathway and on occasion through the Quality Committee.

R**ESOLVED:** **Directors noted the feedback provided.**

TB/2018/134 **DATE AND TIME OF NEXT MEETING**

The next Trust Board meeting will take place on Wednesday 9 January 2019, 13:00, Seminar Room 6, Learning Centre, Royal Blackburn Teaching Hospital.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 7

9 January 2019

Purpose Information

Title	Action Matrix
Author	Miss K Ingham, Corporate Governance Manager/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 their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2018/114: Action Matrix	*Board Performance and Reflection:* Mrs Pearson to provide an update on the open session and launch of the Patient Panel	Director of Nursing	January 2019	Verbal Report
TB/2018/119: Board Assurance Framework	Future iterations of the document to include a differentiation between internal and external sources of assurance in addition to the Vital Signs work that is taking place in the Trust	Medical Director	January 2018	Agenda Item January 2019
TB/2018/122 Lancashire and South Cumbria Integrated Care System Memorandum of Understanding	Directors discussed and approved the Memorandum of Understanding, on the basis that the ICS works with the Trust/organisations to firm up the governance arrangements and that agreement is reached regarding the allocation of capital across the area.	Chief Executive	January 2019	Verbal Report

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 9

9 January 2019

Purpose Information

Title	Chief Executive's Report
Author	Mrs E-L Cooke, Senior Communications Manager
Executive sponsor	Mr K McGee, Chief Executive

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

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

Report linkages

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

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

CEO Report

January 2019

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

One - National Headlines

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

Health Secretary launches prevention vision

Matt Hancock, Health Secretary, published is vision of transforming with the document 'Prevention is better than cure', which builds on the work already undertaken in areas such as childhood obesity and social prescribing. It shifts the focus to primary and community care services. Prevention will be at the heart of the NHS long-term plan. It will look at new technologies and shift the focus from treating single acute illnesses to promoting the health of the whole individual. The statement is to be followed by a green paper this year, setting out a first draft of the government's plans.

Funding announced for Primary and Community services

The government set out a major new investment in primary and community healthcare, worth £3.5bn a year in real terms by 2023/4, to build on the existing NHS budget for these services. It was announced that more patients will be cared for at home and in their community to avoid them going into or staying in hospital unnecessarily. This will be achieved through community-based 24/7 rapid response teams and dedicated support for care home residents. This pledge forms a key part of the long-term plan for the NHS which is the biggest ever cash boost for the health service.

NHS long-term plan

The delayed long-term plan, which was announced in March 2018, will now be published in January 2019.

Universal electronic prescriptions ever closer

NHS Digital has launched a pilot that could see more than 95% of GP prescriptions processed electronically, saving the NHS precious time and money. Eight GP practices across England have been piloting Phase 4 of the Electronic Prescription Services during 2018, further practices will follow in 2019. If the pilot is successful, the new functionality will be made available to all GP practices in England.

New chair of Health Education England

Sir David Behan has been appointed as the new chair of Health Education England (HEE). The Department of Health and Social Care announced that the former chief executive of the CQC will chair HEE for three years, beginning 1 December 2018. Sir Behan stepped down from his role at the CQC in July after six years leading the regulator. Ian Trenholm has now taken up the position as its new chief executive.

Addendum to NHS Improvement subsidiaries guidance

NHS Improvement (NHSI) published an addendum to the transactions guidance outlining a new framework that changes the way subsidiaries are reported to and approved. The guidance will require all proposals to create subsidiary companies to be reported to NHS Improvement by Trusts. NHSI will then review those wholly owned subsidiary proposals which identify 'significant risk'. The guidance will require Trusts to prove that they have engaged with staff, put plans in place to comply with any consultation requirements and have a workforce strategy. If a Trust does not receive approval, it must delay establishing the subsidiary while it addresses the risks highlighted by NHSI.

Proposed changes to the English language test

The Nursing and Midwifery Council (NMC) have agreed for changes to the requirements for overseas nurses and midwives taking the International English Language Test System (IELTS). Following the change nurses and midwives will still be required to achieve a minimum overall level of 7 in the test. However, a level 6.5 in writing will be accepted alongside a level 7 in reading, listening and speaking. The changes, which came into effect on 5 December, are in line with the NMC's commitment to better, safer care and will ensure that only those nurses and midwives with the right skills, knowledge and command of English are able to work in the UK.

HSIB publish full investigation report

A full investigation, conducted by Healthcare Safety Investigation Branch (HSIB), has been published focusing on the provision of care to patients who present at emergency departments with mental health problems. This was instigated by the tragic death of a woman who, having presented to her GP, ambulance service and the emergency department of her local hospital, subsequently took her own life. The full report and summary, including recommendations can be read here.

Q2 figures show response to growing pressures

NHS Improvement (NHSI) has published its latest report on the Performance of the NHS provider sector covering June to September 2018, which reflects a very difficult summer for Trusts and their staff. The figures show that hospitals admitted nearly 1,000 more emergency patients a day and treated nearly 2,000 more a day within the four-hour target compared with the same time last year. Vacancies for doctors and nurses still stand at over 100,000. These statistics are against a backdrop of a forecasted deficit of £558 million by the end of March for the provider sector. NHSI argues that the long-term plan for the NHS will signal a reset on performance over the next five years.

Seven regional directors named by NHSE and NHSI

NHS Improvement (NHSI) has announced the joint directors of the new NHS England (NHSE) and Improvement regional teams. Three of the seven new directors are former NHS Trust chief executives. The new NHS executive group is set to hold its first meeting in January 2019, with the new national and regional directors expected to formally lead their integrated directorates by April 2019.

The regional directors have been named as follows:

- **South West:** Elizabeth O'Mahony, currently NHSI's chief financial officer.
- **South East:** Anne Eden, already joint NHSE and I regional director for the South East.
- **Midlands:** Dale Bywater, currently NHSI's regional director for the Midlands and East.
- **East of England**: Ann Radmore, currently Kingston Hospital Foundation Trust chief executive.
- **North West**: Bill McCarthy, currently deputy vice chancellor at Bradford University and chair of Bradford Teaching Hospital Foundation Trust and a former NHS England and Department of Health executive director.

- **North East and Yorkshire:** Richard Barker, currently NHSE's director for the North of England.
- **London**: Sir David Sloman, currently Royal Free London Foundation Trust.

Among the current NHSE and NHSI regional directors Paul Watson (NHSE in the Midlands and East), Jennifer Howells (both organisations in the South West), Steve Russell (NHSI in London) and Lyn Simpson (NHSI in the North) are leaving, while Jane Cummings (NHSE in London) is retiring.

Collaborative commissioning at system level

A joint report from NHS Providers and NHS Clinical Commissioners finds that although progress is at an early stage, the relationship between commissioners and providers is on the brink of significant change. Commissioners are beginning to take a more strategic approach, commissioning for outcomes across larger population footprints, with Trusts taking on or supporting activities previously undertaken by clinical commissioning groups (CCGs) such as developing pathways and service specifications.

Driving forward system working: a snapshot of early progress in collaborative commissioning is based on interviews with leaders from CCGs, NHS Trusts, national policy makers and think tanks and explores the changing relationship between commissioners and providers in the context of system working.

Plan to provide more support for veterans

A new dedicated crisis service will provide intensive support to scores of the most vulnerable former armed forces men and women battling alcohol, drugs and mental health problems. The £10 million of investment will provide specialist health support when needed to the 2.6 million veterans living in the UK.

Proposal to halve avoidable patient harm

Proposals have been revealed on how the NHS will safeguard it is the safest healthcare system in the word. The commitment includes a proposal for some of the most important types of avoidable harm to patients to be halved over the next five years in areas such as medication errors and Never Events. This would be alongside developing a 'just culture' for the NHS where

frontline staff are supported to speak up when errors occur. The proposals have been set out as part of a public consultation in order to inform the development of an NHS-wide strategy. This will be delivered together with the NHS Long Term Plan during 2019.

Two - Pennine Lancashire Headlines

Important updates and information reflecting work being carried out by the integrated health and care partnership for Pennine Lancashire

Together a Healthier Future

Pennine Lancashire's 'Together a Healthier Future' is one of five Integrated Care Partnerships (ICP) which make up the Lancashire and South Cumbria Shadow Integrated Care System (formerly Sustainability and Transformation Partnership) area.

The key focus of Together a Healthier Future is the development and articulation of a New Model of Care and an Integrated Health and Care Partnership for Pennine Lancashire. A number of management portfolios for Pennine Lancashire ICP have been agreed, with the intention that existing staff within Pennine take up leadership of these portfolios alongside their substantive roles.

The development and establishment of this management and leadership capacity is intended to drive forward and realise the ambitions for Pennine and:

- Build sufficient management and leadership capacity to ensure the successful delivery of the agreed priorities for Pennine Lancashire
- Empower management colleagues to lead the continuing development of the Integrated Health and Care Partnership
- Mainstream the Pennine Way so that partnership working becomes 'the way we do things around here'
- Provide a level of stability for partner organisations to ensure the ability to continue to deliver the business in a time of change.

These leads are now confirmed as follows:

- Delivery EL Local Community Partnership: Alex Walker
- Delivery BwD Local Integrated Care Partnership: Roger Parr

- Delivery Urgent, Acute and Planned Care: Tony McDonald
- Workforce and OD: Kevin Moynes
- Digital: Paul Fleming
- Nursing: Chris Pearson
- Quality and Safety: Kathryn Lord
- Strategy, Planning and Performance: Martin Hodgson
- Communications: Christine Hughes
- Finance and Estates: Finance and Investment Group will be redeveloped to fulfil this role
- Prevention: To be confirmed
- Mental Health: To be confirmed

Mental Health stakeholder briefing

This year has seen a significant increase in the demand for mental health services across Lancashire and South Cumbria. A stakeholder briefing has been produced to explain how the NHS, local government and other organisations have partnered together to take action in addressing the situation.

National Record Locator Service

The National Record Locator Service will enable triage personnel such as mental health nurses and paramedics, who are called to patients in distress, to find out whether they have a mental health crisis plan in place. This will enable them to transport the patient to a more appropriate care setting as indicated in the crisis plan, rather than A&E. This will not only improve patient safety and mental health outcomes, but it will also reduce duplicate care costs (within A&E and mental health services) and improve staff safety.

The North West, North East, Yorkshire and London Ambulance Services are in the first phase. They will be working with their local mental health Trusts; Cumbria Partnership NHS FT, Humber NHS FT, South London and Maudsley NHS FT, Lancashire Care NHS FT and Cheshire and Wirral Partnership NHS FT. A wider roll out is planned throughout 2019.

NHS Careers - Explore the Roles

ELHT's Work Place Education Team held their second health and social care careers fair this year. Following on from the well-attended first event at Blackburn College at the start of the

year, Colne College was chosen as the second venue. The event was another great success, showcasing the variety of careers throughout the health and social care economy. Pupils from schools and colleges from across East Lancashire were invited to attend providing them with opportunities to chat with specialists and professionals representing different areas of health and social care. Pupils were also informed of alternatives to traditional university degree programmes, such as apprenticeships.

Home First Awards Nomination

The Trusts Home First service was shortlisted for the category 'Improved Partnerships between Health and Local Government' at the recent HSJ Awards ceremony. Working with Blackburn with Darwen Borough Council and Lancashire County Council, the service works with people to find the best way to support their healthcare needs and help them to be as independent as possible. The team ensure a person receives the right support for now and in the future. Although the team did not lift the winning trophy, the work they are undertaking is priceless for our patients and their families. A case study of the service can be read here.

Three - ELHT Headlines

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

Use of the Trust Seal

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

- On 5 December 2018 the seal was applied to the Settlement and Variation Agreement between ELHT, Consort HealthCare Ltd and Engie Services Ltd. The Chief Executive and the Director of Finance were the signatories.

Winter escalation unit opens

The 24 bedded unit located on Ward 19 at the Burnley Teaching hospital site, was officially opened on 16 November by John Bannister, Director of Operations, followed by a patient tea party on 29 November hosted by Christine Pearson, Director of Nursing.

The unit will be operational throughout the winter months to assist with the challenges that the colder weather brings. Patients will benefit from being cared for in an environment that promotes independence and routine whilst being involved in the final arrangements for returning home. The environment has been specifically designed to enhance healing, promote independence, encourage rehabilitation and improve motivation for the next step in a person's recovery. Patients are encouraged to be dressed in their own clothes and fully participate in achieving their goals for that day. This could include using the dining areas as opposed to eating at the bedside. Television, music and a range of activities are available in the communal areas supported by the staff, volunteers and family members.

Award wins and nominations

There is no doubt that our success at the recent Health Service Journal Award event was down to a huge amount of hard work and determination by the whole Trust. Winning the category for 'Creating a Supportive Staff Culture' was proof positive that the Engage to Make a Difference project has achieved its goal – to create a culture where staff can communicate their worries without fear and to provide regular and consistent information about the direction of the organisation. This was further supported by the nomination of Director of HR&OD, Kevin Moynes, for HR Director of the Year in the Personnel Today Awards. Kevin was shortlisted in a strong field of private and public sector HR Directors.

Honorary Doctorate for Professor Fairhurst

It was with great pride that Professor Eileen Fairhurst MBE, Chair of ELHT, received an Honorary Doctorate. The tribute was to acknowledge the significant contribution Professor Fairhurst has made to the development of the University's School of Medicine and her academic achievements in the field of health and wellbeing.

Professor Fairhurst joined hundreds of undergraduates, postgraduates and doctorate students on the stage at Preston's Guild Hall on 11 December. Throughout the four winter graduation ceremonies, more than 1,600 students collected their awards in front of family and friends.

Progress visit for £15.5 million Burnley hospital development

VIPs from partnership organisations, MPs from Rossendale and Darwen, Burnley and Pendle were welcomed along with former Burnley MP Gordon Birtwistle, to spend time meeting staff and touring the Phase 8 construction site. The new development, which is half way through

construction, will boast a state of the art ophthalmology centre, outpatients department and maxillo facial facilities.

Christmas arrives at ELHT

It has been a very busy run up to Christmas this year. Special thanks go to members of the public, volunteers, staff and VIP visitors who have gone the extra mile to spread joy and happiness to our patients. The Trust played host to a range of activities to lift people's spirits. These include visits from the Mayor of Blackburn, Accrington Stanley, Blackburn Rovers and Burnley football clubs, a number of local primary schools, Blackburn Hawks ice hockey team, and many local businesses. We also held our first Christmas Market stalls, with local schools and voluntary groups providing choirs to sing Christmas carols.

Charity Christmas Raffle

This year also saw the very first ELHT&Me Christmas raffle. With three big prizes up for grabs: £1000 cash, £500 Love to Shop vouchers and a family Blackburn Rovers day, it really was worth being part of. The raffle was drawn on 19 December with three lucky winners being contacted on the day. The prizes were very kindly donated – Engie providing the £1000 cash – meaning every penny raised goes directly towards providing an enhanced patient experience.

SPEC Panels

Since the last Trust Board meeting in November 2018 there have been five SPEC Panels as part of the Nursing Assessment Performance Framework. All five wards were successful at the panel stage and have been put forward to the Board for silver ward status. The wards are:

1. Marsden Ward, Pendle Community Hospital
2. Coronary Care Unit, Royal Blackburn Teaching Hospital
3. Critical Care Unit, Royal Blackburn Teaching Hospital
4. Ward C5, Royal Blackburn Teaching Hospital

Four – Communications and Engagement

A summary of the external communications and engagement activity.

Communications and Engagement

Monthly Media Update

During November ELHT has…

- Opened a new escalation unit, Ward 19
- Launched a multi-agency breastfeeding campaign
- Held a careers fair at Nelson College
- Launched the STAR Awards
- Held a Phase 8 progress tour for MPs
- Launched a new test for bowel cancer

Staff Engagement wins a prestigious HSJ Award for creating a supportive staff culture

Press and Media Relations

42 ↑ Mentions in all media

20 ↑ Media enquiries handled

11 ↑ Media releases issued this month

90% → of stories were positive or neutral

Top Stories

- Choose well this winter
- First double operation carried out using the surgical robot
- Ongoing complaints fall to record low
- HSJ Award winners

The monthly media net score (positive minus negative) **+ 34**

Website

Our website got **76,822** page views by **28,118** people

The most viewed webpage was – Working for us

Social media and digital

Followers on social media

9,069

5,490

1,014

40,164
Avg Weekly Facebook Reach

162,000
Twitter Impressions

84%
Facebook page responsiveness

818
Twitter mentions

The most talked about issues on our social networks

- STAR Awards launched
- Keep A&E free for emergencies
- Mental Health in winter
- Recruitment opportunities

- HSJ Awards
- Staff Survey
- Winter health messages
- Recruitment opportunities

Posts of the month

Surgeons first combined surgical robotic procedure

11,751 People reached

3,425 Engagements

#squadgoals

Top Tweet earned 660 impressions

If you're heading out this weekend we hope you have a fabulous night. Look after your squad, don't overdo it and try to get a taxi home together to make sure you are all safe #squadgoals

1 3

Facebook review rating

4.5

Other activity

- Weekly staff bulletin
- Team Brief meetings and video
- Our Trust Your News
- Supporting events with photography
- Supporting ELHT&Me

Safe | Personal | Effective

If you would like any further information about this report please email communications@elht.nhs.uk.

Five - Chief Executive's Meetings

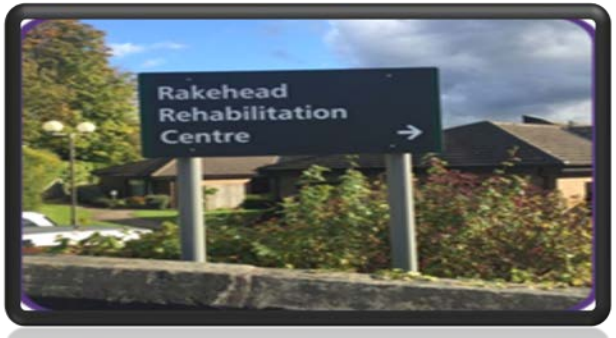
Below are a summary of the meetings the Chief Executive has chaired or attended.

December 2018 Meetings

Date	Meeting
3 December	Team Brief Accrington and Clitheroe
3 December	NHSI Quarterly Review Meeting
3 December	Hospital Christmas Carol Concert, Bridgewater Hall
4 December	Trust Planning Day
4 December	Engaging Managers Event
4 December	Chairman/CEO introductory meeting with County Councillor Geoff Driver and CEO Angie Ridgewell
5/7 December	HFMA Annual Conference
10 December	Chairman/CEO introductory meeting with Chairman/CEO of Airdale
10 December	Ward Clerk Development Programme, Burnley General
12 December	Visit to the Darwen Integrated Neighbourhood Team
12 December	Serve Staff Christmas Lunch
12 December	Board Development Session
13 December	Partnership Delivery Group/Practice Coaching Training
13 December	Back to the floor Night visit to the Integrated Community Team
14 December	Chairman/CEO meeting with Stephen Barnes and Dennis Medoros
14 December	Prince's Trust Celebrations Event
14 December	Presentation at Warrington and Halton Hospitals Trust Board
18 December	Rainbows Christmas Party
18 December	Chairman/CEO meeting
19 December	Accountable Health and Care Partnership Leaders Forum
20 December	Trust CEOs and CCG AOs Briefing Session in London

January 2018 Meetings

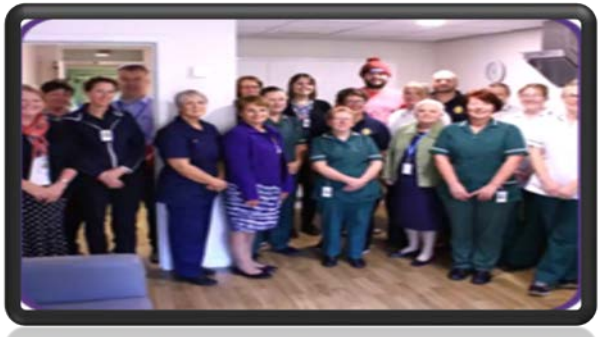
Date	Meeting
4 January	Lancashire and South Cumbria Provider Board
7 January	Introductory meeting with David Blacklock, CEO of Healthwatch Lancashire
8 January	Chairman/CEO meeting
9 January	Trust Board
10 January	A&E Delivery Board
10 January	Partnership Deliver Board
11 January	Visit to the Integrated Neighbourhood Team BwD
11 January	Report Out Session
14 January	Vital Signs Programme Review
14 January	NHS Winter Plan meeting with NWAS
14 January	Meeting with Mick Cartledge CEO Burnley Borough Council
15 January	Chairman/CEO meeting
16 January	Integrated Care System Board
17/18 January	CEO Development Network
21 January	Vital Signs Transformation Guiding Board - London
22 January	Chairman/CEO meeting with Peter Mileham from the Rosemere Cancer Foundation
23 January	Partnership Leaders Forum
28 January	Finance and Performance Committee
29 January	Chairman/CEO meeting
29 January	Burnley Borough Council Policy Board
30 January	Operational Delivery Board
31 January	Diagnostic Project Group



East Lancashire Hospitals
NHS Trust

Item 11

Neuro- Rehabilitation Service – an Integrated Patient Journey



Safe | Personal | Effective

Our Journey


Where we were
• Challenges around access/LOS
• Consultant cover
• Limited examples of integrated working
Where we are now
• Sustained good access and appropriate LOS
• Developing the workforce
• Building on good practice
Our vision, our future
• Enhanced community based provision
• Research/UCLAN
• Fully utilising the workforce capability/new ways of working

Safe
Personal
Effective

The Neuro-Rehab pathway includes:

Outpatient services

Community Neuro-rehab team (CNRT)

Inpatient Neuro-rehab unit (17 bedded unit & 1 flat)

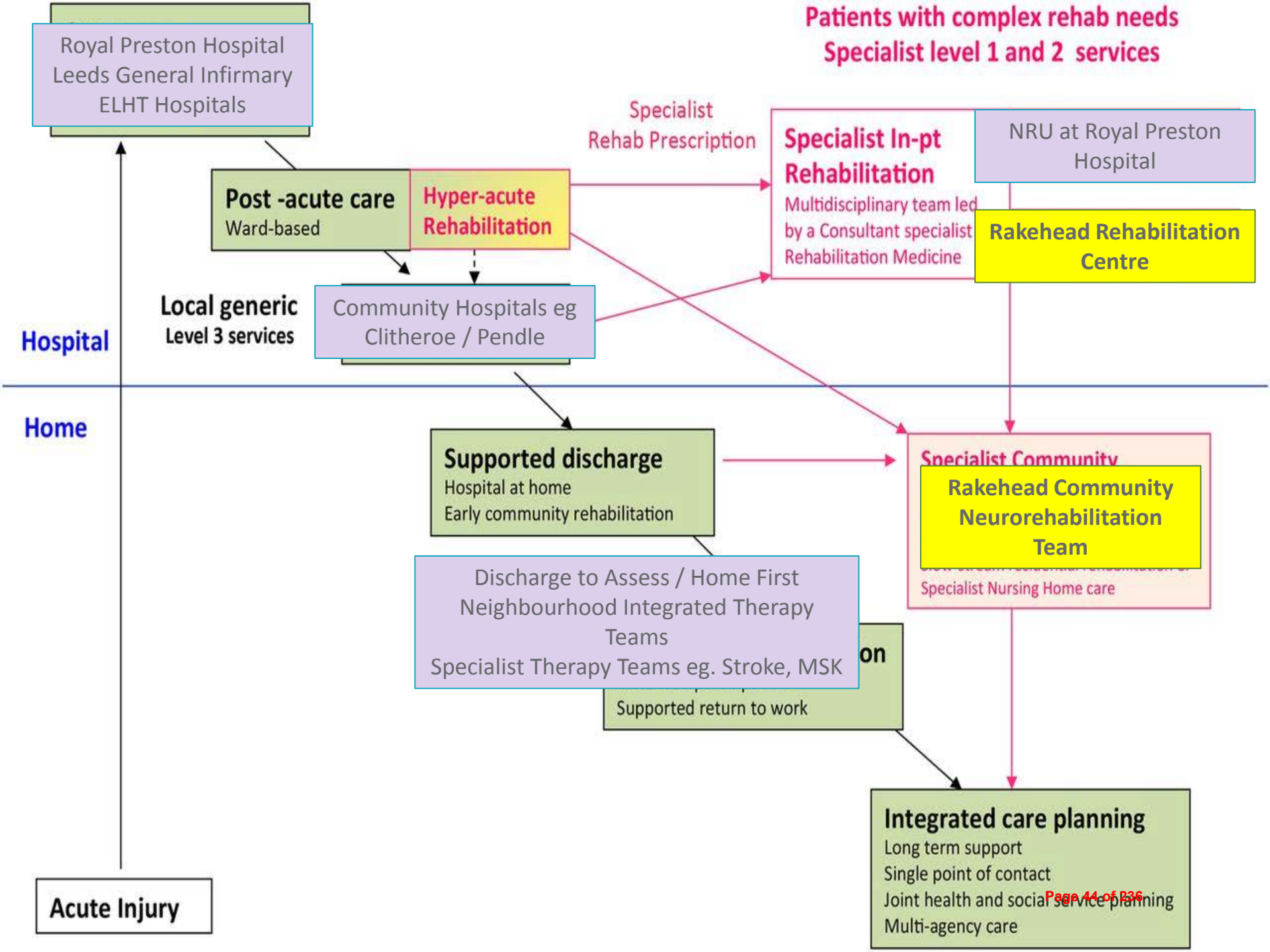
Where we are based:

Rakehead Rehab Centre - inpatient unit and community team office

Outpatient clinics held at Burnley General and Royal Blackburn

Who we are:

Specialist, highly skilled staff: Rehab Nurses, Rehab Consultant, Physiotherapists, Occupational Therapists, Neuro-psychologist, HCAs, Speech and Language Therapists, Rehab Assistants, Therapy Trainee Assistants, Technical Instructors, Neuro-Rehab Coordinator, AHP Lead.


Patients with complex rehab needs
Specialist level 1 and 2 services
Royal Preston Hospital
Leeds General Infirmary
ELHT Hospitals
Specialist
Rehab Prescription
Specialist In-pt Rehabilitation
Multidisciplinary team led by a Consultant specialist Rehabilitation Medicine
NRU at Royal Preston Hospital
Rakehead Rehabilitation Centre
Post -acute care
Ward-based
Hyper-acute Rehabilitation
Local generic
Level 3 services
Community Hospitals eg Clitheroe / Pendle
Hospital
Home
Supported discharge
Hospital at home
Early community rehabilitation
Specialist Community
Rakehead Community Neurorehabilitation Team
Specialist Nursing Home care
Discharge to Assess / Home First
Neighbourhood Integrated Therapy Teams
Specialist Therapy Teams eg. Stroke, MSK
Supported return to work
Integrated care planning
Long term support
Single point of contact
Joint health and social service planning
Multi-agency care
Acute Injury

Typical Patient Journey

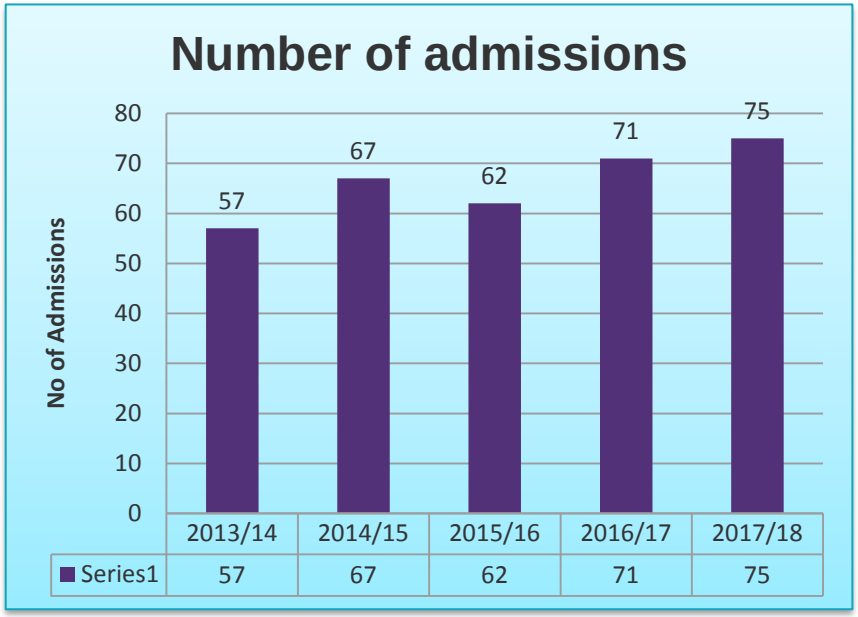
24hrs Admission Assessment	Assessment Discharge planning Goals set	2 -3 weeks Case Review	4 weeks Treatment Cycle Goals reviewed weekly	Multi-disciplinary Case Review	Discharged to appropriate place of care – supported by integrated team of medical/nursing & therapy staff

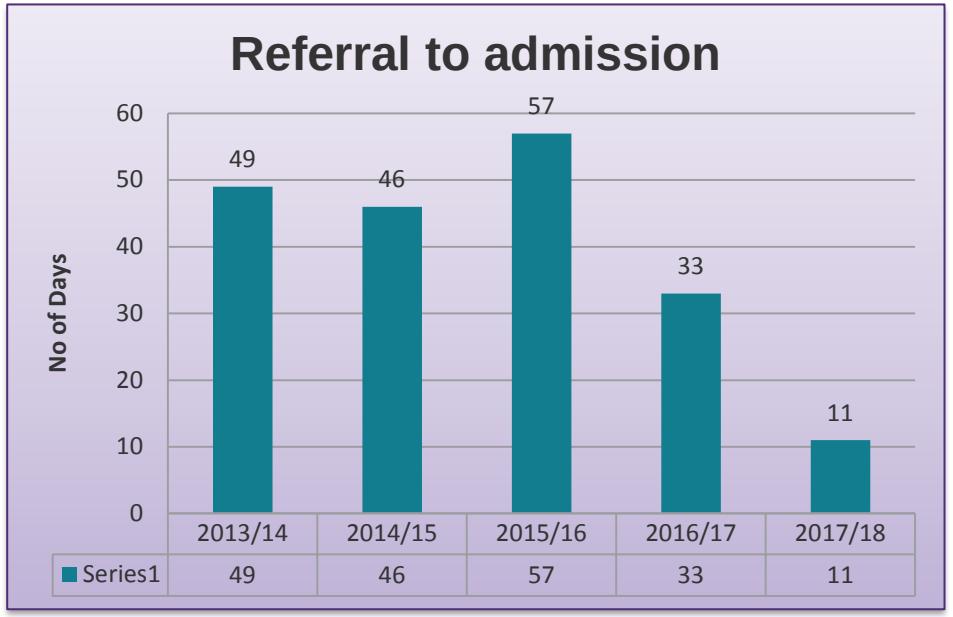
Safe | Personal | Effective

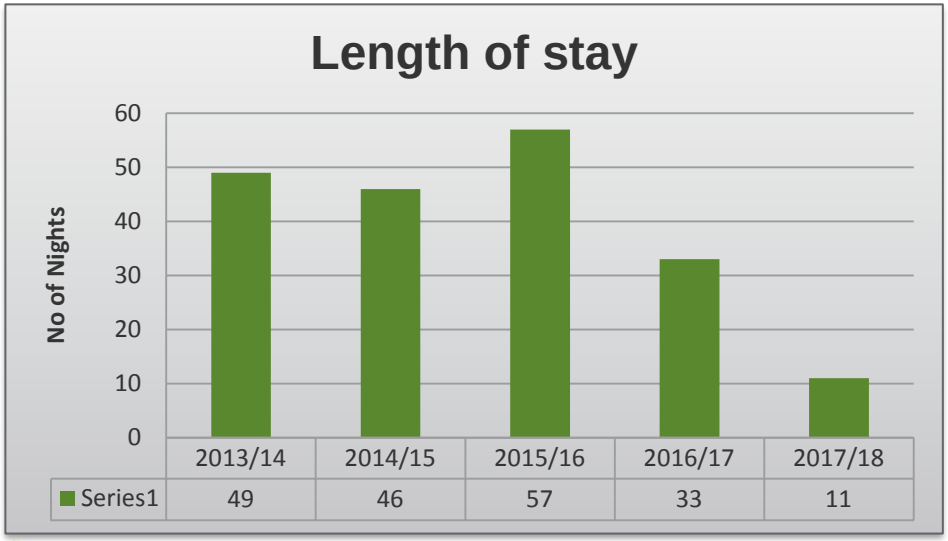
Our journey to integration

Safe | Personal | Effective

UK ROC data

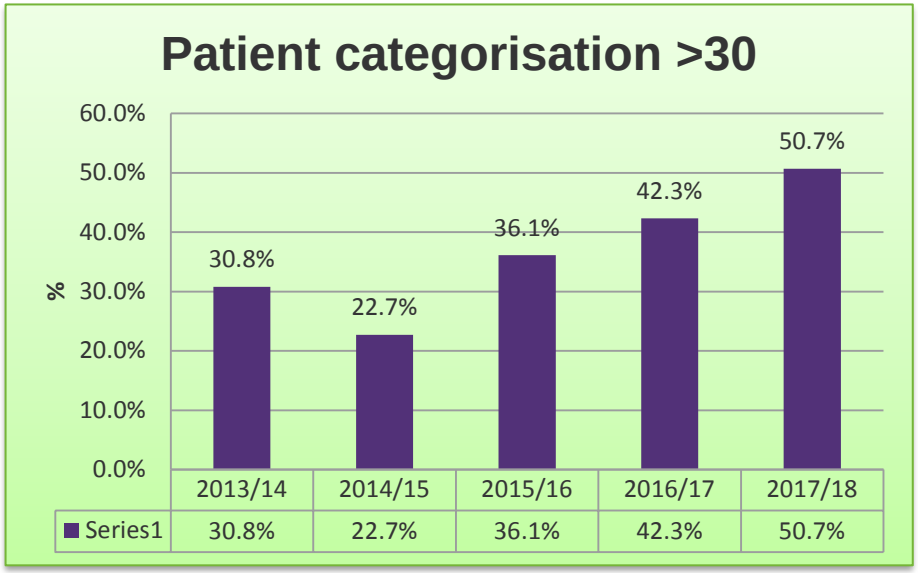


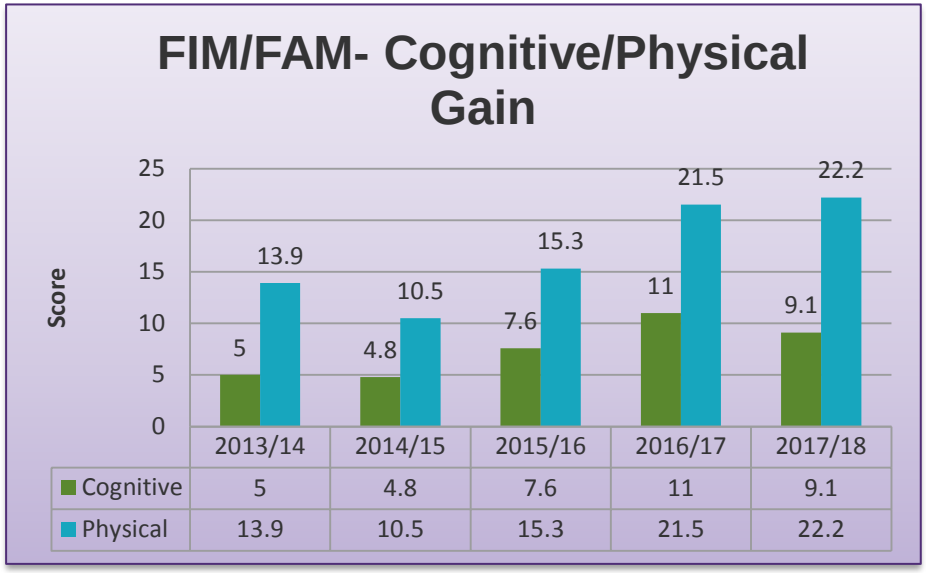


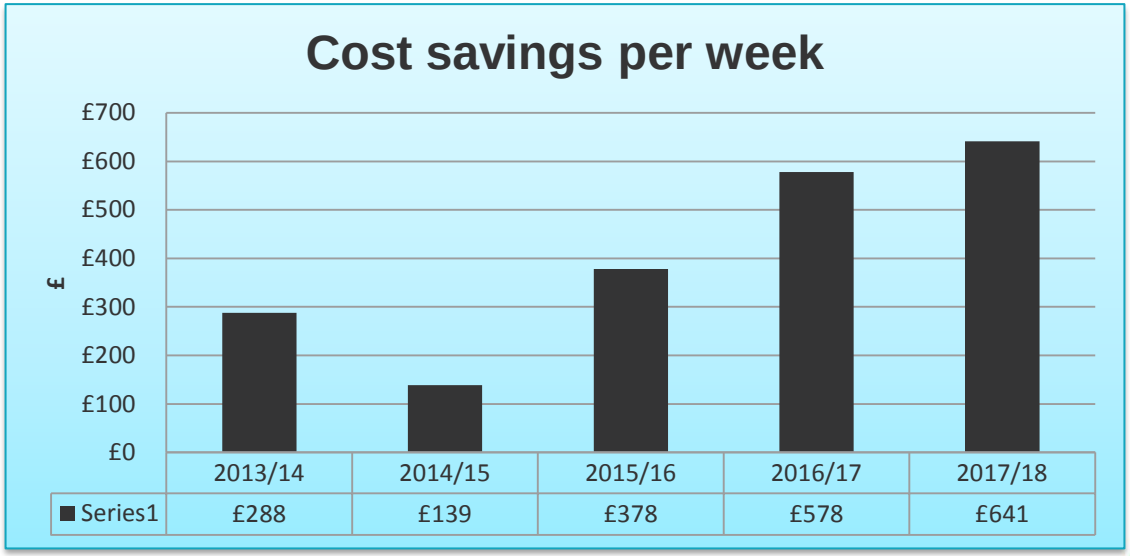


Safe | Personal | Effective

UK ROC Data


Patient categorisation >30
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
%
30.8%
22.7%
36.1%
42.3%
50.7%
2013/14 2014/15 2015/16 2016/17 2017/18
Series1 30.8% 22.7% 36.1% 42.3% 50.7%


FIM/FAM- Cognitive/Physical Gain
25
20
15
10
5
0
Score
5
13.9
4.8
10.5
7.6
15.3
11
21.5
9.1
22.2
2013/14 2014/15 2015/16 2016/17 2017/18
Cognitive 5 4.8 7.6 11 9.1
Physical 13.9 10.5 15.3 21.5 22.2


Cost savings per week
£700
£600
£500
£400
£300
£200
£100
£0
£
2013/14 2014/15 2015/16 2016/17 2017/18
Series1 £288 £139 £378 £578 £641

Challenges

Commissioning – Pennine Lancs and Lancs/South Cumbria network

End to end pathway workforce capacity

Provision of 24/7 rehabilitation

Spasticity and Neuropsychology services

Continuous Improvement Work

Patient experience	Estates	MDT clinic/ outpatients	Specialist equipment	Share 2 Care Integrated Report
Hospital Passports	Website	Assistant practitioner workforce	Spasticity management	Test for change
Pathway	Band 5/6 competencies	BRSM standards action plan	Induction	Slings/slide sheets
Rehab assistant role	Goal Planning	Integrated MDT working	Best practice networking	Research/links with UCLAN

Patient Experience

100% of patients felt they knew what they had to do as part of their rehabilitation

Really professional service from all Therapists- they inspired my confidence and progress

100% of patients felt they were supported and able to talk to their Therapist when they needed to

Always treated with dignity, patience and respect. Went above and beyond to help, care and provide

100% of patients were seen promptly

A fantastic team who did everything right!

100% of patients felt they were involved in setting their rehab goals alongside their Therapist

A good team of people working well together, with combined effort and as a final result help people to go home more capable that when they arrive

100% of patients felt they were treated with dignity and respect

Safe | Personal | Effective

East Lancashire Hospitals
NHS Trust

TRUST BOARD REPORT

Item 12

9 January 2019

Purpose Information
Monitoring

Title	Electronic Patient Referral System
Author	Mrs S Elliston, Directorate Manager (Centralised Outpatients and Administration Services)
Executive sponsor	Mr J Bannister, Director of Operations

Summary: This paper is to update the board on the completion of the project for the switch off to paper referrals for first consultant led appointments. It will identify changes the key processes, risks, benefits and current utilisation of the project.

Recommendation: To note the success and approve the closure of the project.

Report linkages

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

Impact

Legal – changes to standard NHS contract	Yes	Financial – non-payment of first outpatient appoint if processes and escalation not followed	Yes

Equality	No	Confidentiality	No

Executive Summary

1. Changes made to the 2018/19 NHS standard contract, means from the 1st October 2018, all GP referrals to first consultant led outpatient appointments have to be made through the Electronic Referral System (e-RS). Any referral not made through the e-RS system and not appropriately escalated to the relevant Clinical Commissioning Group (CCG's); the Trust will not be paid for the Out Patient activity.
2. Switch off was in 2 stages, 2 week waits (potential cancer referrals) switched on the 1st May and all other referrals on the 31st July 2018. Utilisation figures can be found in Appendix 1. Since the contractual change, 2 referrals have been received and accepted outside of e-RS. However, neither could have been electronically received and the relevant CCG has approved payment.
3. The programme has now been successfully completed and the board is recommended to note this success and approve the closure of the project.

Introduction

4. Changes made to the 2018/19 NHS standard contract, meant that from the 1st October 2018, all GP referrals to first consultant led outpatient appointments have to be made through the Electronic Referral System (e-RS). Any referral not made through the e-RS system, is not on the agreed exclusion list or has not been escalated to the relevant CCG; the Trust will not be paid for the Out Patient activity. E-RS allows the patient to make and agree their outpatient appointment directly with their GP or know what the next step in their care will be. The system offers a full audit trail of the referral, so GP's are able to see where patients are in the initial stages of their pathway.
5. Pennine Lancashire agreed a switch off date of the 31st July 2018. This allowed for a period of review of the systems and processes to ensure safe, personal and effective care. Collaborative working between ELHT and the CCG's since January '18 took place to prepare for this change and to ensure that we are fully paperless by the July deadline.

Changes to the 2018/19 NHS standard contract

6. "With effect from 1 October 2018, subject to the provisions of NHS e-Referral Guidance:

a) 6.2A.1 the Provider need not accept (and will not be paid for any first outpatient attendance resulting from) Referrals by GPs to Consultant-led acute outpatient Services made other than through the NHS e-Referral Service;

b) 6.2A.2 the Provider must implement a process through which the non-acceptance of a Referral under this Service Condition 6.2A will, in every case, be communicated without delay to the Service User's GP, so that the GP can take appropriate action; and

c) 6.2A.3 each Commissioner must ensure that GPs within its area are made aware of this process".

Project Plan

7. A comprehensive project plan has been in place since January 2018 and has been overseen by the e-RS programme board. The board is a collaborative of Trust and CCG members and is chaired by John Bannister as the responsible officer.

8. The project plan implemented a number of key stages including a full review of the Trusts Directory of Services, distribution of smart cards and computer access, training of staff and joint communication strategy.

9. At the latest programme board on the 17th October, a full review of the project plan and utilisation was undertaken. The outcome from the board was that all possible actions had been successfully completed. However, there was 1 connecting project, the electronic transfer of the referral into the Trusts clinical patient portal, which would progress outside of the programme, and this is being over seen by the trusts e-Health board.

10. Utilisation of the e-RS system can be found in appendix 1, leading upto the contractual requirement. Since this, 2 referrals have been received and accepted outside of e-RS. However, neither could have been electronically received and the relevant CCG has approved payment.

Financial Impact

11. NHS Digital (NHSD) are developing an authentication report for the CCG's which will check the unique booking reference number (UBRN) and will identify any anomalies. These can then be checked against the exclusion or escalation lists. If there are still anomalies then this would be queried with the Trust and payment for the outpatient activity withheld. In August 2018, there were 45 of the 6,718 referrals which were received by the Trust, however, they were subsequently redirected and submitted via

e-RS. In September, 6 out of 6,011 referrals were registered on the Trust administration system without being submitted via e-RS. This would amount to approx. £720 of income. In October we received 2 but due to the nature of the referral they could not have been made via e-RS and agreement was sought from the CCG for payment. There is now a daily report which highlights any breaches in compliance and are escalated and managed as required.

12. It is not envisaged that e-RS will have the financial impact on income as first anticipated.

Appropriate Slot Issue (ASI's)

13. The availability of adequate capacity for GP's to directly refer patients into the Trust continues to be challenging. To facilitate this, the forward planning of additional ad hoc clinics is vital to reducing the number of patients who leave their GP surgery without an appointment date. To support this operation teams have been requested to provide minimum notice periods for these clinics, 2 weeks for 2 week wait and 4 weeks for routine clinics. However, there continues to be a number of patients across the specialities where the patient has not got their outpatient appointment booked on leaving the GP's surgery.

Risks

14. To the Trust's 2WW cancer standard. Some patients will have the ability cancel and rebook their appointment independently and this could be in excess of the 14 day standard. To mitigate this risk, we continue to work with GP's to ensure that the urgency of their referral is communicated to patients and to encourage them to attend their appointment. Monitoring of cancelled 2WW appointments is also undertaken by the booking centre and contact made with them to rebook their appointment within the timescales.
15. Financial loss of income. Where referrals are not made through e-RS, the Trust will not be paid for this activity. During October there were 2 referrals where this could have applied. Therefore this is minimal.
16. Patient choice. Patients may choose to be treated at neighbouring Trusts if their waiting times are less, however conversely this might attract patients into the Trust.

Benefits

17. Patients will have a choice of appointment date and time and will be able to take control of their care. This should result in better patient experience and a fall in the "Did not attend" rates within the Trust, as the patient will have committed to their appointment date.
18. Having a digital transfer of the information will streamline the initial outpatient booking phase of patients' pathways, secure processing of clinical information and there will be an auditable trail of the referrals. This leads to a more cost efficient service.

The future

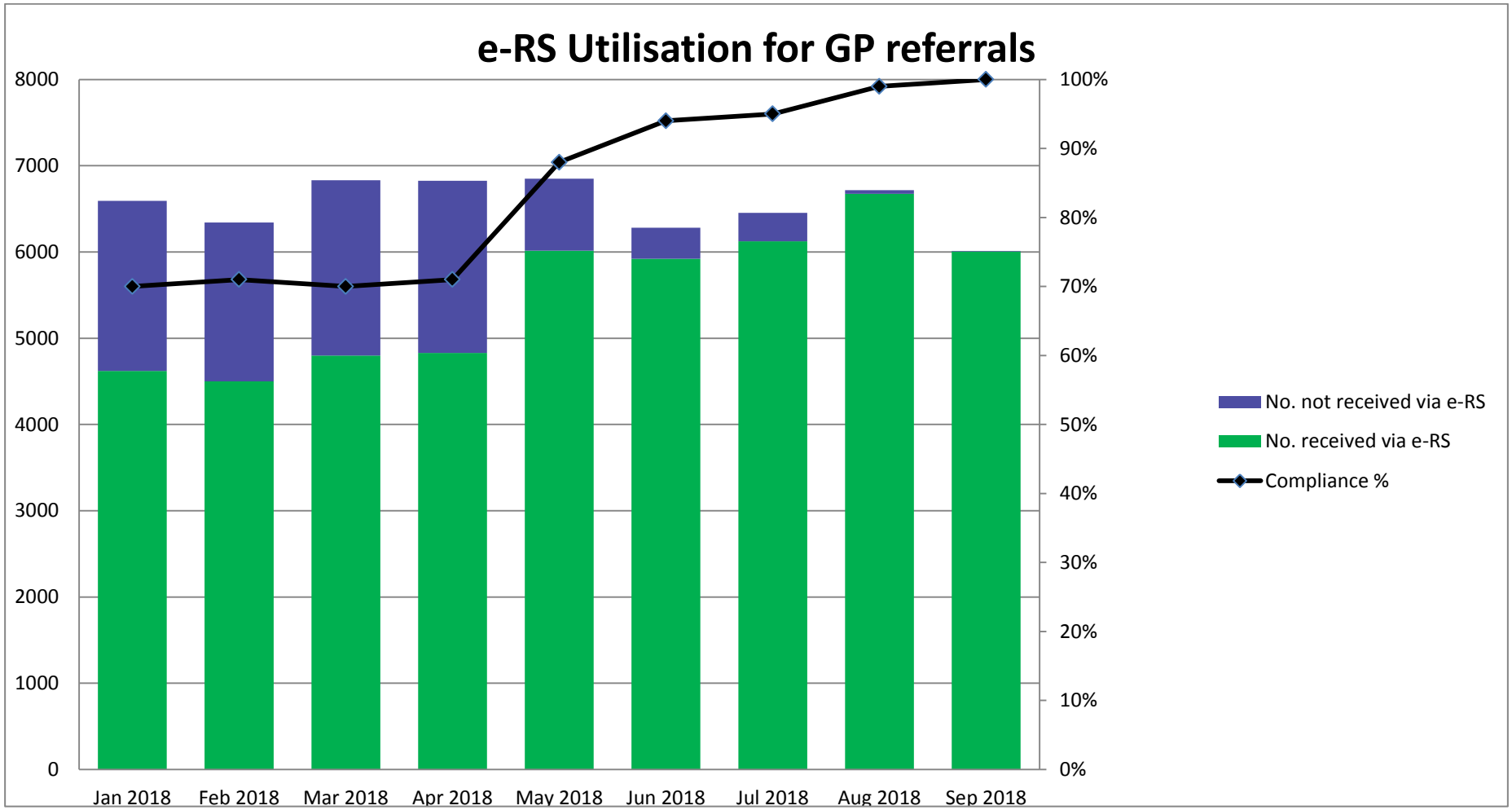
19. GP's have expressed a wish for all referrals to be made through e-RS and have provided a "wish list" of progression. Over the coming months, we will work towards moving all referrals where possible to e-RS. This will be governed by either the scheduled care board or the continuation of the e-RS programme board.

Conclusion

20. The project plan has been completed and the Trust declared to have switched off to paper referrals on the 31st July. Processes have been reviewed and tested to support the flow of patients to their first consultant appointment.
21. Any outstanding actions have been appropriately allocated to other review meetings to manage to completion.
22. The board is therefore recommended to note this success and approve the closure of the project.

Sue Elliston, Directorate Manager, November 2018

Appendix 1:


e-RS Utilisation for GP referrals
8000
7000
6000
5000
4000
3000
2000
1000
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Aug 2018
Sep 2018
No. not received via e-RS
No. received via e-RS
Compliance %

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 13

9 January 2019

Purpose Information

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

Summary: The report presents an overview of the Corporate Risk Register (CRR) and risks which have been recommended by Divisions/Corporate areas to the RAM for approval and inclusion onto the CRR.

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 their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to 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) as well as the Trust-wide Risk Register (TWRR). The changes recommended by the RAM and Patient Safety Risk Assurance Committee (PSRAC) to the CRR 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`s Corporate and Trust-wide risk registers.
2. There are currently 11 live risks on the CRR which are shown in table 1.

Table 1: The Corporate Risk Register

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
7067	Aggregated Risk - Failure to obtain timely MH treatment impacts adversely on patient care, safety and quality	15
1810	Failure to adequately manage the Emergency Capacity *and* Flow system.	15
5790	Aggregated risk – Failure to adequately recruit to substantive medical posts may adversely impact on patient care and finance.	15
5791	Aggregated Risk - Failure to adequately recruit to substantive nursing & midwifery posts may adversely impact on patient care and finance.	15
7513	Aggregated Risk - Radiology capacity issues would impact on inpatient flow, Referral to Treatment (RTT) and Patient Experience'.	15
7583	Loss of facility for Level 3 Containment in pathology	15
7008	Failure to comply with the 62 day cancer waiting time.	15
7552	Risk that PACS downtime occurs and brings delay to patient pathways or delays in operating theatre activity.	15
4353	Potential loss of images (OCT and FFA) if equipment should fail or be stolen	15

Risk	Title	Current Score
7330	Aggregated risk – Inability to identify, track & monitor the cohorts of women and newborns who require and have screening due to lack of an end-to-end IT System for Maternity.	15

3. The following new risks were discussed at the last RAM meeting on 7 December 2018 with the view of approving them for inclusion onto the CRR (table 2):

Table 2: New Risks added onto the CRR since last RAM meeting:

Risk	Title	Current Score
4353	Potential loss of images (OCT and FFA) if equipment should fail or be stolen	15
7330	Aggregated risk – Inability to identify, track & monitor the cohorts of women and newborns who require and have screening due to lack of an end-to-end IT System for Maternity.	15

Risks being presented for approval for closure:

4. No risk was presented and approved for closure.

Corporate Risk Register (Appendix 1):

5. Details of the current Corporate Risk Register could be found in appendix 1, whilst appendix 2 provides a one page representation of all risks on the CRR by showing their current score. Appendix 3 on the other hand, provides a summary of all the aggregated/linked risks on the CRR.

Conclusion

6. Members are asked to gain confidence and note the assurance 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, East Lancashire Hospitals NHS Trust, December, 2018

	Appendix 1: The Corporate Risk Register – Current Risks				
Title:	Aggregated Risk – Failure to meet internal and external financial targets in year will adversely impact the Continuity of Service Risk Rating				
Trust-wide/ Divisional	Trust-wide				
Identified in BAF Risk ID	BAF/04	Title	The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework.		
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- (15) 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) - (10)
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		Where are the gaps in control:	Individual acting outside control environment in place	

	and procedures • Delegated authority limits at appropriate levels • Training for budget holders • Availability of guidance and policies on Trust intranet • Monthly reconciliation • 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 – 27/09/2018			
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. – Ongoing			

Title:	Aggregated Risk - Failure to obtain timely Mental Health treatment impacts adversely on patient care, safety and quality.				
Trust-wide/ Divisional	Trust-wide (More than one Division)				
Identified in BAF Risk IDs	BAF/03	Titles	Lack of effective engagement within partnership organisations (ICS and ICP) results in failure to work together causing detrimental effect on the health and wellbeing of our communities.		
	BAF/05		The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).		
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:	Jonathan Smith	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) (5083 – Linked to 7582 - Failure to have a robust system to assess and manage patients with mental health needs - 15).
What is the Hazard:	ELHT is not a specialist provider or equipped to provide inpatient mental health services. However, patients with mental health need do present to the Trust and they may require both physical and mental health assessments, treatment and referral to specialist services. Due to lack of specialist knowledge, this may		What are the risks associated with the Hazard:	• Breach of statutory targets • Impact on other patient care due to resource use and patients and/or carers perceptions • Risk of harm to other patients • Impact on staffing (medical and nursing) to monitor/ manage patients with MH needs • Patient deterioration, or failure to Safeguard	

	cause deterioration of the patient. Staff generally do not have training in physical interventions and restraint.		• Risk of patient harm to themselves
What controls are in place:	• Frequent meetings to minimise risk between senior LCFT managers, specialist and urgent care commissioners 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. Ring fenced assessment beds within LCFT bed base (x1Male, x1Female). In Family Care ongoing liaison with ELCAS and Commissioners • 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	Where are the gaps in control:	• Unplanned demand • ELCAS only commissioned to provide weekday service • Limited appropriately trained agency staff available
What assurances are in place:	• Appropriate management structures in place to monitor and manage performance • Appropriate monitoring and escalation processes in place to highlight and	What are the gaps in assurance:	Other agency capacity and availability of s136 facilities

	mitigate risks • Ongoing monitoring of patient feedback through a variety of sources • Escalation of adverse incidents through internal and external governance processes • Review of performance by Executive Team members on a weekly basis • Monthly Performance Report to Trust Board • Appropriate escalation and management policies and procedures are in place and regularly reviewed • Joint working with external partners on pathways and design improvements • 12 hour breach monitoring • Cluster reviews of 12 hour breaches undertaken. Presented at A and E Delivery board and SIRI (if required) • Every 12 hour breach is incident reported and has a timeline undertaken to identify themes for shared learning • Themes from timelines/cluster reviews are discussed weekly with commissioners, NHS England and LCFT • SOP in place for management of high risk patients (recently reviewed and up-dated)		

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. – Ongoing • New procedures to be introduced for creating a safe environment to cohort high risk mental health patients – 27/09/2018

Title:	Aggregated Risk: Failure to adequately manage the Emergency Capacity *and* Flow system.				
Trust-wide/ Divisional	Trust-wide				
Identified in BAF Risk ID	BAF/05	Title	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).		
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:	908 - The inability to provide performance and patient care due to low medical staffing levels within the ED department – (12) 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 - (8)
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, sepsis six, and access to early senior review for trauma patients). • 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	• Daily staff capacity assessment		Where are the	Trust has no control over the number of attendees	

controls are in place:	• Daily Consultant ward rounds • Opening of Ambulatory Emergency Care Unit for Acute Medicine including frailty patients and rapid chest pain assessment. • Review of the use of the old Ambulatory Emergency Care for Surgery in progress. • Pennine Lancashire and ELHT Winter Plans approved by Pennine Lancashire A&E Delivery Board and ELHT Operational Delivery Board to support safety and timely care and movement of patients. • Introduction of ED & UCC Trigger Tools and Escalation arrangements including actions cards for relevant roles and services linked to Trust Resilience and Escalation Policy and Procedures. • 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 • Introduction of Full Capacity Protocol • Refined 2 hourly patient flow meetings	gaps in control:	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	What are the gaps in assurance:	None identified

	Performance Report • Weekly reporting at Exec Team • System Oversight by Pennine Lancashire A+E Delivery Board		

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 - Ongoing • Review the impact of the newly introduced Full Capacity Protocol and refined patient flow meetings – 01/09/2016 • Development of Ambulatory and Emergency Care Unit and new pathways – 01/09/2019
Notes: • Mitigating actions are deployed on a daily basis at an operational level to reduce the risk to patient care – Ongoing

Title:	Aggregated risk – Failure to adequately recruit to substantive medical posts may adversely impact on patient care and Finance.				
Trust-wide/ Divisional	Trust-wide				
Identified in BAF Risk IDs	BAF/02	Titles	Recruitment and workforce planning fail to deliver the Trust objectives.		
	BAF/04		The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework.		
	BAF/05		The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations.		
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 - (9), 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		What are the risks associated with the	• Escalating costs for locums • Breach of agency cap	

	cost to the Trust	Hazard:	• 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 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	What are the gaps in assurance:	None identified.
Actions to be carried out			
• Per individual linked risks – 10/07/2017 • Ongoing recruitment and innovative packages offered- Ongoing • Workforce transformation and new models of skill mix – Ongoing • On-going pressure to reduce locum rates – Ongoing			
• All requests to exceed capped rates to be approved by medical directorate on a case by case basis – Ongoing			

Title:	Aggregated risk –Failure to adequately recruit to substantive nursing posts may adversely impact on patient care and Finance.				
Trust-wide/ Divisional	Trust-wide				
Identified in BAF Risk IDs	BAF/02	Titles	Recruitment and workforce planning fail to deliver the Trust objectives.		
	BAF/04		The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework.		
	BAF/O5		The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations		
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:	Julie Molyneaux	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 • Daily review of acuity and dependency to staffing levels • Recording and reporting of planned to		Where are the gaps in control:	• Unplanned short notice leave and sickness. • Non elective activity impacting on associated staffing • Break downs in discharge planning • Individuals acting outside control environment		

	actual staffing levels and Care Hours per Patient Day (CHPPD) • E-rostering KPI's • Ongoing recruitment campaigns • Overseas recruitment as appropriate • Establishment of internal staff bank arrangements • Senior nursing staff authorisation of agency usage • Monthly financial reporting		
What assurances are in place:	• Daily staffing teleconference with Divisional Director of Nursing • 6 monthly formal audit of staffing needs to acuity of patients • Formal review of nursing and midwifery establishments annually more often if required • Exercise of professional judgment on a daily basis to allocate staff appropriately, alongside Safe Care acuity data • Monthly integrated performance report contains staffing data containing planned to actual nurse staffing levels and CHPPD 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"- 03/09/2018 • Non-Medical Bank and Agency Group - Ongoing			
• Risk mitigation action plans are appended to each of the linked risks and are reviewed by the Divisions on an ongoing basis with assurances being provided to Divisional meetings – Ongoing			

Title:	Aggregated Risk - Radiology capacity issues would impact on inpatient flow, Referral to Treatment (RTT), Cancer and Patient Experience				
Trust-wide/ Divisional	Divisional				
Identified in BAF Risk ID	BAF/05	Title	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).		
ID	7513	Current Status	Live Risk Register – all risks accepted	Opened	30/08/17
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 5 Consequence: 2 Total: 10
`Risk Handler:	Moira Rawcliffe	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),
What is the Hazard:	• Increased Radiology report turnaround times.		What are the risks associated with the Hazard:	Due to delayed reporting of scans/ images this is having a negative impact on the following for SAS Division: • 1. Patient experience • 2.Delays in the RTT pathway • 3.Financial risk • 4.Delays to Cancer Pathway • 5.Impact on Performance targets	
What controls are in place:	1. Weekly Performance meetings to review report turnaround times. 2. Daily PTL statistics to all modality leads to target long waiters. 3. Capacity Lists offered for reporting when required. 4. Outsourcing of reporting. 5. Locum Radiologists recruited.		Where are the gaps in control:	None identified	

	6. Actively recruiting to the Radiology vacancies. 7. Training of chest reporting radiographers. 8. Training of MSK reporting radiographers 9. Training of CT Reporting radiographers.		
What assurances are in place:	• None identified	What are the gaps in assurance:	None identified
Actions to be carried out			
• Ongoing discussions with supplier being led by Director of Finance – Ongoing			

Title:	Loss of facility for Level 3 Containment in pathology				
Trust-wide/ Divisional	Divisional				
Identified in BAF Risk ID	BAF/05	Title	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).		
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: 3 Consequence: 5 Total: 15	Target Rating:	Likelihood: 1 Consequence: 5 Total: 5
Risk Handler:	Pamela Henderson	Risk Owner:	Jonathan Wood	Linked to Risks:	N/A
What is the Hazard:	• Changes to air pressure to resolve the air pressure fault (risk 7342) have caused rips and bubbling of the vinyl wall covering from the wall. If the wall covering integrity is damaged beyond immediate repair the CL3 facility will be put out of use. The vinyl has split on many occasions and continues to be an ongoing hazard.		What are the risks associated with the Hazard:	• If the vinyl wall covering is damaged, the containment properties of the facility are compromised and therefore it cannot be used. • Crowthorn Ltd has reassessed the remedial action undertaken by Engie Raised concern about the ongoing viability of the repairs as vinyl has ripped repeatedly and been repaired on multiple occasions and is likely to continue being breached until fully refurbished.	
What controls are in place:	• The contractor, Atlas, has been appointed by Consort and plans will be finalised between all Consort, Atlas and the Trust next week commencing 15th Oct 2018. The plan then needs approval by HSE. All things being equal the contractor should be on site in November. The works programme will take up to 50 weeks.		Where are the gaps in control:	None identified	

	Monitoring remains in place. The back stop date for the completion of the works will be November 2019. Once completed the facility will be brought up to the correct prevailing standards. • The vinyl wall covering is checked every morning before processing is started and findings recorded on a worksheet. If tears are found, Engie is informed immediately and work does not start until they have filled the breach with silicon sealant. This will only be effective as long as the breaches are small. • Current safe procedures for working in CL3 to be adhered to as per policy • Visual inspection of vinyl wall covering recorded daily and repairs conducted before any processing can begin. • Consort to repair/refurbished wall covering to repair damage.		
What assurances are in place:	• Completed worksheets available demonstrating checks are conducted daily. • Risk assessment and actions reviewed at departmental quality meetings and CLM governance meetings. • Refurbishment plan available from Consort (timeline TBA).	What are the gaps in assurance:	None identified
Actions to be carried out			
• Discussion with PFI partners and specialists progressing to remedy issues – 30/11/2018 • Consort have taken on the proposed refurbishment and plans are going out to tender in the near future. Consort to repair/refurbish wall covering to repair damage – 30/04/2019 • Building work scheduled to commence on 4th Jan 2019 by Atlas.			

Title	Failure to comply with the 62 day cancer waiting time				
Trust-wide/ Divisional	Trust-wide				
Identified in BAF Risk IDs	BAF/05	Title	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).		
ID	7008	Current Status	Live Risk Register – All risks accepted	Opened	01/08/2018
Initial Rating	Likelihood: 3 Consequence: 3 Total: 9	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 2 Total: 6
Risk Handler:	David OBrien	Risk Owner:	John Bannister	Linked to Risks:	N/A
What is the Hazard:	Cancer treatment delayed. Potential to cause clinical harm to a patient if the treatment is delayed.		What are the risks associated with the Hazard:	Trust fails to achieve compliance with the 85% national standard for the cancer 62 day waiting time target. The Trust is performance managed for failure to comply with cancer waiting time targets - the cancer waiting times are key performance indicators for all NHS providers. Potential to cause clinical harm to a patient if the treatment is delayed. There is also a risk to the patient experience and risk of adverse publicity/reputation to the Trust	
What controls are in place:	Immediate ongoing actions to improve performance a) CNS engagement with virtual PTL b) Cancer escalation process modified and re-issued c) Cancer Hot List issued twice weekly d) Additional theatre capacity e) Daily prioritisation of elective and		Where are the gaps in control:		

	cancer activity by clinical and pathway urgency. f) Additional Alliance funding provided to Radiology for in-house Cancer Reporting in March g) Re-validate previous months (review all treatments capture, all breaches and re-allocations) h) Continued micro-management of all patients at risk on hot list i) Senior Directorate Managers to attend all PTLs in coming weeks to gain assurance of efficient and appropriate process. j) Weekly performance forecast issued to Cancer Management Team and DGMs. k) Ongoing Breach analysis		
What assurances are in place:		What are the gaps in assurance:	
Actions to be carried out			
The following actions are being implemented to improve performance:- a) Patient education - Ongoing b) Collaborative working with Primary Care - Ongoing c) Recruitment to vacancies within Clinical service - Ongoing d) Capacity review - Ongoing e) Pathway review – New alliance pathway for Prostate, Upper GI, Colorectal and Lung – 30/04/2020 f) Investment of Alliance Funding in pathways to improve processes - Ongoing g) Establishment of Template Biopsy Service at ELHT for Urology – 31/03/2018 h) Additional Capacity lists being undertaken - Ongoing i) Outsourced Radiology Scanning and Reporting - Ongoing j) 62 Day Cancer Recovery Action Plan - Ongoing k) Liaise with CCG colleagues including reporting and monitoring to the Pennine Tactical Group - Ongoing			

Title:	Risk that PACS downtime occurs and brings delay to patient pathways or delays in operating theatre activity.				
Trust-wide/ Divisional	Trust-wide				
Identified in BAF Risk IDs	BAF/05	Titles	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk of safety & poor patient experience).		
ID	7552	Current Status	Live Risk Register – all risks accepted	Opened	25/10/2017
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:	Victoria Hampson	Risk Owner:	John Bannister	Linked to Risks:	N/A
What is the Hazard:	• Lack of data available while treating patient could cause harm. • The system is regularly failing / turning over so that images are not available as required. • The system is regularly failing / turning over so that images are not available as required. The impact of this for the Orthopaedic team is that clinics are delayed/ overrunning and patients are waiting longer than required. • On occasion patients have left having not been able to get the necessary information to talk through their appropriate care. • The impact for theatres is also real and in the past cases have had to be cancelled		What are the risks associated with the Hazard:	The risks are: • Trust targets • Delays in patient pathway. • Downtime in clinics and theatres due to regular system failure. • Poor patient experience having to wait around while backup systems are used. • Some occasions backup systems have failed • Increased complaints. • Concerns re patient in theatre and system going down meaning may have to stop / delay operating. This may cause patient harm. • This is happening weekly and in some instances daily • Clinics are delayed and the impact on patients is they have to wait around. The impact on the	

	due to delays and unavailability of appropriate images.		consultants is then the clinic over runs into the afternoon session.
What controls are in place:	• Currently we have backup systems involving getting physical or disk copies of images but this still puts big delays in the system. • Although there is a plan to bring the new PACS online early next year the current situation is that the risk is still very much live and frequently effecting patient care. • Finance Director involved in discussions with Managed Equipment Service who holds the contract for the provision of PACS equipment. • Trust is hoping to get a PACS system that is fit for purpose. • We are reliant on the PACS and IT teams.	Where are the gaps in control:	• The above controls can`t stop the system from going down. • The impact of this for the Orthopaedic team is that clinics are delayed or overrunning and patients are waiting longer than required. • On occasion patients have left having not been able to get the necessary information to talk through their appropriate care. • The impact for theatres is also real as cases have had to be cancelled in the past due to delays and unavailability of appropriate images.
What assurances are in place:	• Current controls can only reduce the potential impact patients.	What are the gaps in assurance:	• Controls are being manually implemented and can`t stop the system from going down.
Actions to be carried out			
• New PACS online system to go operational early next year - 31.03.19			

Title:	Potential loss of images (OCT and FFA) if equipment should fail or be stolen				
Trust-wide/ Divisional	Divisional				
Identified in BAF Risk ID	BAF/05	Title	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk of safety & poor patient experience).		
ID	4353	Current Status	Live Risk Register – all risks accepted	Opened	
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:		Risk Owner:		Linked to Risks:	N/A
What is the Hazard:	The imaging equipment at Royal Blackburn Hospital and Burnley General Hospital are used on a daily basis for all out-patient clinics, as well as the FFA equipment at Royal Blackburn Hospital. Thousands of images per year. All patient information and images are stored on the machines hard drive as there is no server in ophthalmology to back these images up. The machine at BGH is currently taking seven minutes to store one image which is a concern to EBME. There is the potential loss of images / information if the machine breaks down as there is no backup for this equipment. There has been loss of images during the cyber-attack and images have previously been lost when using previous topcom machine. There has been ad hoc saving to disc (at BGH site) but this is not straightforward to do.		What are the risks associated with the Hazard:	The imaging equipment at Royal Blackburn Hospital and Burnley General Hospital are used on a daily basis for all out-patient clinics, as well as the FFA equipment at Royal Blackburn Hospital. Thousands of images per year. All patient information and images are stored on the machines hard drive as there is no server in ophthalmology to back these images up. The machine at BGH is currently taking seven minutes to store one image which is a concern to EBME. There is the potential loss of images / information if the machine breaks down as there is no backup for this equipment. There has been loss of images during the cyber-attack and images have	

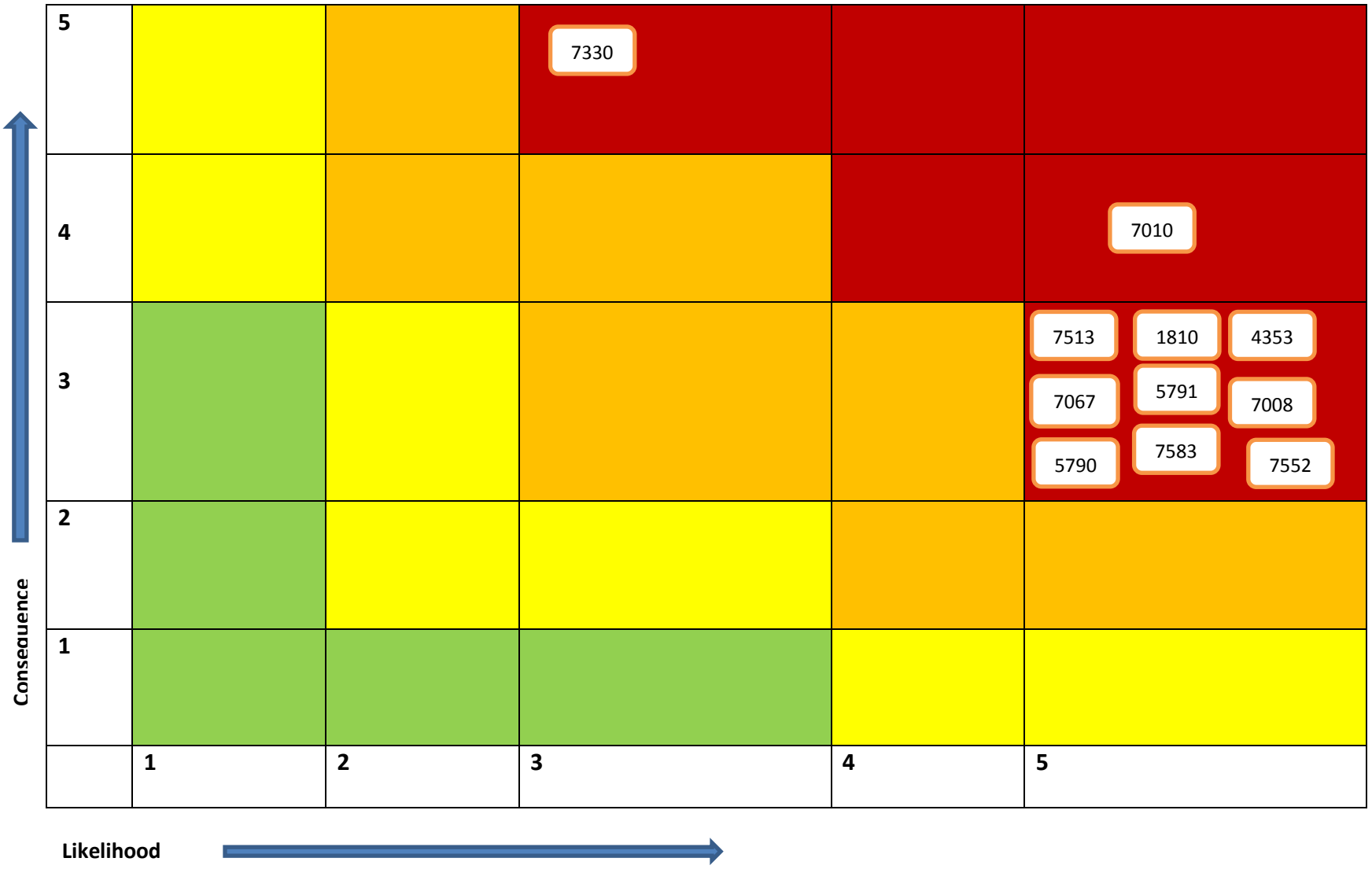
			previously been lost when using previous topcom machine. There has been ad hoc saving to disc (at BGH site) but this is not straightforward to do.
What controls are in place:	Machine has full service contract. In house support from EBME Locks in place on FFA and OCT rooms to prevent theft of equipment. Disc back up is only control that has been in place ad hoc and there is no protocol or established time period for this procedure or designated (experienced) responsible person to do.	Where are the gaps in control:	No server in place for Ophthalmology images No back up in place for Ophthalmology images
What assurances are in place:		What are the gaps in assurance:	
Actions to be carried out			
• Short term 'fix' (control) to image storage – 28.02.19 • Long term image storage solution – 05.12.2020			

Title:	Aggregated risk – Inability to identify, track & monitor the cohorts of women and newborns who require and have screening due to lack of an end-to-end IT System for Maternity.				
Trust-wide/ Divisional	Divisional				
Identified in BAF Risk ID	BAF/05	Title	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety & poor patient experience).		
ID	7330	Current Status	Live Risk Register – all risks accepted	Opened	29/01/2018
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 3 Consequence: 5 Total: 15	Target Rating:	Likelihood: 2 Consequence: 5 Total: 10
Risk Handler:	Angela O`Toole	Risk Owner:	Christine Pearson	Linked to Risks:	7123 - Inadequate Safeguarding Information Recorded in Maternity Notes (12).
What is the Hazard:	• Inability to identify the cohort of women, fetus' 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, collect data and track this cohorts of women • Potential for litigation. • Potential for adverse media coverage and negative reputation to the Trust. • An emerging hazard relating to the Newborn Physical Infant Examination		What are the risks associated with the Hazard:	•Inability to achieve the national mandated screening target for the Antenatal and Newborn Screening Programme and provide assurance to Public Heath England and Quality Assurance. •Abnormal screening results not identified and acted upon within the required timescales. •Significant avoidable harm to a mother and baby. •The current system is not robust, designed or organized to reduce the likelihood of errors occurring and the impact of errors when they occur. •The current paper based system does not support staff to deliver reliable safe systems of care. •Poor patient experience. •Potential fines for not meeting national targets / KPI's. •Potential to be identified as outliers nationally in national		

	whereby assurance is not being provided to PHE and QA that neonates are being referred and followed up within a timely manner.		reports for example the National Maternal Perinatal Audit / National Neonatal Audit. •Potential for staff to be stressed and fatigued when involved in clinical incidents due lacking of equipment for them to provide safe, personal, effective care. •Potential for the Trust to be identified as having a poor safety culture due to lack of resources. •Midwives and Maternity Support Workers manually input data in a variety of ways.
What controls are in place:	•Dedicated clinic for quadruple screening. •Limited locally designed databases to track and monitor the cohort	Where are the gaps in control:	•The local databases that have been developed have no staffing resources dedicated to checking this daily and is reliant on staff ad hoc checking the databases •The quad clinic is still reliant on staff booking women into this clinic and there is error still for women to be missed as this is not done electronically. •The CERNER EPR IT system procured by the trust is forecasted to implement in 2020. As yet there is no programme of works for when the maternity system will be implemented. •There is no interoperability between Athena, BadgerNet and NIPESMART thereby limited assurance is provided to PHE and QA that neonates are being screened appropriately and ongoing referrals being undertaken within the required timescales.
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:	•The current paper-based system for identifying and tracking cohorts of women for screening isn`t effective, reliable and robust.
Actions to be carried out			

- To work alongside IM&T in the procurement of an end to end maternity system – 29/03/2019
- To work alongside IM&T to develop and implement an end to end Maternity System – 29/03/2019
- To work with IM&T to develop and implement an end to end maternity system – 29/03/2019

One page representation of the Corporate Risk Register as at 30th November 2108 mapping all risks onto the 5X5 Matrix based on current score (9 Risks in total)



East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 14

9 January 2019

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. Since the last report to the Board, the BAF risks have been cross-referenced with the risks on the Corporate Risk Register (CRR) and this is indicated in the CRR report to the Board.

The Audit Committee carried out an in-depth review of risks 2 and 5 as part of its annual review of the BAF. The Finance and Performance Committee received the BAF and revised the risks within its remit at its meeting held on 26 November 2018. The Quality Committee reviewed the BAF risks on 21 November 2018.

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:

Quality Committee (November 2018)

Audit Committee, Executive Directors (October 2018)

Finance and Performance Committee (November 2018)

Operational Delivery Board (November 2018)

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. As requested at the Trust Board meeting in November 2018 the potential sources of assurance sections of each risk have been updated to indicate whether the source of assurance is an internal or external source.
5. 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.

6. There is a **proposed increase to the risk score**, from **16 to 20** based on the increased likelihood of the risk materialising (likelihood **5** x consequence **4**).
7. The following key controls have been included:
   a) The Trust has developed an executive overview group as recommended which started during November 2018. This meeting will take place every two weeks with oversight being visible through an Executive Leadership Wall.
8. The Potential Sources of Assurance section has been updated to include the introduction of the Financial Assurance Board (FAB) which will strengthen governance and oversight.
9. The actions planned and updates have been revised to include:

a) The transformation programme is working with the Pennine Lancashire Partnership Delivery Group to agree the strategic goals for the system to ensure that transformation plans are aligned to these in future and to ensure that ELHT business plans are also aligned. The business planning round for 2019/20 will be improved in respect of alignment and prioritisation. The first event was held on 4 December 2018. The outcomes of the planning day will inform the Value Stream Analysis (VSA) programme for 2019/20.

b) There will be an increased systematic view of benchmarking information to support change.

c) A Transformation and Improvement Practitioner is being appointed for Pennine Lancashire/ELHT. The associated training programme commenced.

10. The following action has now been completed and moved to the potential sources of assurance column:

a) Revised Performance Assurance Framework was presented to the Finance and Performance Committee on 29 October 2018 and to the Operational Delivery Board on 31 October. The final version was presented to the Finance and Performance Committee on 26 November 2018

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

11. The **risk score remains 12** (likelihood 3 x consequence 4).

12. The potential sources of assurance have been updated to include:

a) Further scrutiny has been added to the Medical and Non-Medical Agency Group in relation to nursing staff.

b) Implementation of Allocate rostering and publication dates for rosters

13. Actions and updates have been updated as follows:

a) *"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"* has been removed and replaced with: Culture and Leadership Programme is now entering phase 2 (Design) and an update will be presented to the Trust Board on 9 January 2019.

b) *"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" has been replaced with: The national WRES lead attended the Trust in October 2018 and following this, a refreshed WRES action plan will be produced. A broader Workforce Transformation Group will be established from February 2019 to consider the wider diversity agenda.

c) Funding has been secured from the NHS North West Leadership Academy (NWLA) to deliver a shadow Board programme aimed at improving opportunities to manage talent for greater diversity at sub-Board and Board level.

d) Vital signs improvement programme is underway to improve employee experience from recruitment to leaving the organisation.

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

14. The **risk score remains 12** (likelihood 3 x consequence 4).

15. The key controls section has been updated to include:

a) ICS level Planning Group has been formed and met for the first time on 3 December 2018. The Director of Service Development attends to represent the ICP. The role of the group is around the 5 year plan which is due to be developed by summer 2019.

16. The potential sources of assurance have been reviewed and the following points have been included:

a) The Trust is producing an ELHT demand and capacity plan to be signed off by the Executive Team. The wider system demand and capacity plan will be signed off by the Partnership Delivery Group.

b) The Pennine Lancashire Partnership Delivery Group is the engine/delivery room for the ICP. The group has been given delegated authority from the Pennine Lancashire Leaders Forum. The planning process is driven through this group. The Pennine Lancashire system planning reports into the Partnership Delivery Group.

17. The actions planned and updates section had been reviewed and now includes the following updates:

a) Meetings are ongoing regarding the acute programme and more focused work will take place on the four priority areas: Stroke; Vascular; Head and Neck; and Diagnostics.

b) Ongoing progress is being made with more focus on the future model of care (not the current model of care). An update will be provided at the Finance and Performance Committee in January 2019.

c) The model (stage 1) had been signed and providers are working on the detail (stage 2). A timetable has been produced, presented to local commissioners and approved by them (1 year plan). Milestones have been developed and a financial exercise has been undertaken to determine the resources required to implement the new model.

d) A Planning Group has been formed and a demand and capacity exercise will be completed by 14 January 2019,

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

18. The **risk score remains at 20** (likelihood 5 x consequence 4).

19. The potential sources of assurance section now includes:

a) The following item has been moved to the potential sources of assurance column:

i. Revised Performance Accountability Framework presented to the Finance and Performance Committee on 29 October 2018 and to the Operational Delivery Board on the 31 October 2018, with final approval by the Finance and Performance Committee at the end of November.

b) The introduction of the Financial Assurance Board (FAB) will strengthen governance and oversight.

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

20. The **risk score remains 16** (likelihood 4 x consequence 4.

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

a) Internal Audit (MIAA) have carried out an emergency care risk assessment audit which gained an assurance rating of 'Significant Assurance' in November 2018.

b) The Performance Assurance Framework - Revised document presented to the Finance and Performance Committee and Operational Delivery Board at the end of October, with final approval at the end of November.

22. Gaps in control have been updated to include:

a) Insufficient bed capacity to ensure there are no delays from decision to point of admission.

b) The heating system failure at Accrington Victoria Community Hospital necessitated a temporary cessation of patients to Ward 2 results in a loss of 19 beds.

23. The gaps in assurance section has been updated to include:

a) Temporary funding secured for an additional member of staff enabling the Nursing Assessment Performance Framework (NAPF) team to carry out further assessments.

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

a) The Patient Participation Panel held an open day on 13 December 2018. The launch of the panel will take place in January 2019 and will initially be made up of 15-20 people.

b) There have been updates to the section relating to the emergency care pathway, including:

i. Ambulatory Care Emergency Unit opened as planned on 14 September 2018. Fortnightly service reviews carried out to ensure service delivery as expected.

ii. Business case approved by the Trust Board and submitted to NHSI in July 2018 for the extended acute medical facility. Still no formal response from NHSI received.

iii. Frailty Assessment Unit due to open on 7 January 2019.

c) The system wide action plan for mental health services has been agreed by the ICS in November.

d) 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). Escalation ward in Victoria wing in Burnley due to open on 15 November 2018. The 24 bed unit opened in November 2018.

e) Received the draft CQC report for factual accuracy checks in late November with the final report awaited.

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance, 31 December 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 The Trust is working across the Pennine Lancashire footprint a single transformation plan. 'the Pennine LancsWay'. 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 and workforce strategy. TheTrust has been selected to be in the 1st 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. There are a number of delivery steering groups covering the transformation themes, which monitor delivery, consider risks/mitigation and set direction. This programme is now evolving as a result of the Trust and the system developing its Pennine Lancashire Way improvement methodology, resulting from being a part of the NHSI Vital Signs programme. The initial phase of this programme is covering the frailty pathway (whole system working), Theatres improvement and a HR/workforce development piece. The impact in each of these areas is reported through the Operational Delivery Board and the Finance and Performance committee. We are also developing an executive overview group as recommended which has started during November 2018. This meeting will take place every two weeks with oversight being visible through an Executive Leadership Wall.	Monthly performance and Sustaining Safe, Personal and Effective Care report which reports to the Operational Delivery Board, Finance and Performance Committee and the Trust Board with associated information papers and minutes. **(Internal)** Performance monitoring in all areas covering quality, delivery, finance and people (staff/patients) **(Internal)** a. Monthly performance report b. Incident reporting (eg SIRI Report) c. Complaints data d. ICO breaches e. WRES reporting f. Number of disciplinaries/grievances g. Patient stories h. Staff survey i. Friends and families tests System-wide reporting is currently being developed through the Pennine Lancs Business Intelligence group and the Pennine Lancs Way programme. **(External)** 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. **(Internal)** Agreed transition to one transformation plan and one improvement methodology - allowing all schemes to gain traction and improve delivery. **(Internal/External)** ICP system level aiming to prioritise health improvements that can deliver beneficial outcomes more quickly. **(External)** Care Professional Board workshop with a wider audience held in August 2018 resulted in the creation of Pennine Lancashire Professional Leadership Committee, bringing together relevant professionals to support the Pennine Lancashire transformation. Several senior ELHT clinicians attending and actively participating in the Professional Leadership Committee and associated workshops. **(External)** Medial Director of the Trust appointed as the Professional Lead for the Pennine Lancashire ICP influencing the collaborative work on transformation. **(Internal/External)** Good track record of successfully bidding for tenders in the last 12 months. Finance and Performance Committee agreed process for the review of tenders and service implementation 12 months after the tender bid. **(Internal/External)** Emergency care pathway good example of collaborative working used as a blueprint for other system working moving away from organisational boundaries. **(Internal)** Model Hospital and GIRFT (Speciality benchmarked performance and efficiency data) reviewed at Clinical Effectiveness Committee. **(Internal/External)** The introduction of the Financial Assurance Board (FAB) will strengthen governance and oversight. **(Internal)** Revised Performance Assurance Framework presented to the Finance and Performance Committee on 29 October 2018 and to the Operational Delivery Board on 31 October. The final version was presented to the Finance and Performance Committee on 26 November 2018. **(Internal)**	15	10	16	5x4	16	20	20		• Dependency on stakeholders to deliver key pieces of transformation • System wide working and no one 'true north' as a system • Financial constraints • Short term regulatory targets detracting from the delivery of short to medium term objectives of the transformation programme. Opportunities to link transformation objectives to appraisals.	Capacity and resilience building in relation to the service redesign is in early phase. Risk that through the transition from the original transformation plan to the Pennine Lancashire Way programme that delivery of the aims of the original programme may not be achieved or are delayed. Gaps in control in respect of the following and their impact on the transformation programme: • Workforce improvement capacity • Workforce capability • Competing priorities • Dependency on stakeholders to deliver key pieces of transformation • System wide working and no one 'true north' as a system • Financial constraints • Short term regulatory targets detracting from the delivery of short to medium term objectives of the transformation programme. 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 transformation programme is working with the Pennine Lancashire Partnership Delivery Group to agree the strategic goals for the system to ensure that transformation plans are aligned to these in future and to ensure that ELHT business plans are also aligned. The business planning round for 2019-20 will be improved in respect of alignment and prioritisation. The first event was held on 4 December 2018. The outcomes of the planning day will inform the Value Stream Analysis (VSA) programme for 2019/20. A system wide value stream analysis for the frailty pathway took place in August 2018. This identified an agreed 'future state' for frailty. The programme will now ensure the delivery of this programme over the coming 12 months. This will pick up some of the improvement work of the original transformation plan. In addition the Pennine Lancs Way is also planning events in respect of a HR/workforce development and assisting in the theatres improvement journey. Regular reporting on progress through the Finance and Performance Committee Executive Overview Group for monitoring the progress and deliverables of the Pennine Lancashire Way improvement methodology was set up in November 2018. Divisions attending Finance and Performance Committee from September 2018 onwards to provide assurance on the delivery of SRCP. Increased systematic view of benchmarking information to support change. Transformation and Improvement Practitioner is being appointed for Pennine Lancashire/ELHT. Training Programme commenced.

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
3. Inability to staff escalation areas
4. Inability to create an integrated workforce
5. Unable to recruit a representative workforce
6. Inability to release staff for training and appraisal

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 Workforce planning at STP level, e.g. Apprenticeships, recruitment and retention initiatives, collaborative medical banks and talent management. Pennine Lancashire Workforce Transformation Group Divisional finance and performance meetings	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. **(Internal)** 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. **(Internal)** Workforce Control Group regularly reports to the Executive on workforce control measures and indicators. Dashboard developed. Annual report to the Quality Committee. **(Internal)** Medical and Non-Medical Agency Group in place. Dashboard giving overview of bank/agency usage presented to the Executive team meeting monthly. Additional scrutiny from a nursing prespective. **(Internal)** The Performance Assurance Framework **(Internal)** Lean Programme (Vital Signs) overall linking into workforce transformation. **(Internal)** Workforce Dashboard reporting key performance indicators within division on a monthly basis **(Internal)** Agency staffing group monitoring the use of agency spend **(Internal)** Implementation of Allocate rostering/ publication dates for rosters. **(Internal)** Uptake of flu vaccine across the workforce **(Internal)** Completion rates of the annual staff survey and low rates of turnover **(Internal)** Integrated performance report **(Internal)** Friends and family test (further detail in BAF risk 5) **(External)**	16	10	12	3x4	12	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). Varying incentive schemes/packages across provider sector. Implications of Brexit on the workforce - uncertainty/ workforce are yet to be determined. Integrated workforce assurance group Broader equality and diversity group	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. E&D Action Plan Culture and Leadership Programme is now entering phase 2 (Design) and an update will be presented to the Trust Board on 9 January 2019. 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. The national WRES lead attended the Trust in October 2018 and following this, a refreshed WRES action plan will be produced. A broader Workforce Transformation Group will be established from February 2019 to consider the wider diversity agenda. Funding has been secured from the NHS NorthWest Leadership Academy (NWLA) to deliver a shadow Board programme aimed at improving opportunities to manage talent for greater diversity at sub-Board and Board level. Vital signs improvement programme is underway to improve employee experience from recruitment to leaving the organisation. 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. 10 WRAPT (workforce planning projects underway across the organisation) HEE funding secured to develop clinical leadership for workforce transformation through the WRAPT process Establishment of a Care Academy for Pennine Lancashire to secure a talent pipeline locally Development of a Recruitment and Retention strategy to reflect emerging labour market and to sell ELHT and Pennine Lancashire as employer of choice

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 of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities.

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 System Leaders' Forum meets to discuss strategy. Engagement by senior leaders in wider transformation programmes. Regular Board updates and decisions on key actions. At Pennine Lancashire level health improvement priorities agreed (HIMPs). HIMPs reporting to the Professional Leadership Commitee (PLC) Number of senior clinicians involved with ICS work groups. Professional Leadership Commitee (PLC) has ELHT representation. ICS Finance Group and ICP Finance and Investment Group with ELHT senior representation . The ELHT Chief Executive is the senior responsible officer (SRO) for the Pennine Lancashire Transformation Programme, sits on the System Leaders Forum and on the Integrated Care System for Lancashire and South Cumbria (ICS) Programme Board. 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 transformation programme. ICS level Planning Group has been formed and met for the first time on 3 December 2018. The Director of Service Development attends to represent the ICP. The role of the group is around the 5 year plan which is due to be developed by summer 2019.	Verbal and written updates, where appropriate Board approvals will be established and permissions will be provided by the Board to let Executives progress the generation of ideas and options with external stakeholders. **(Internal)** The Pennine Lancashire and ICS Cases for Change have been published. **(Internal/External)** Pennine Lancashire resource in post working on developing models of care against specific improvement priorities (paediatrics, respiratory and frailty). **(Internal/External)** 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 needed to link into the new structures. **(Internal/External)** ICS governance oversight forms part of the Audit Committee standing agenda for 2018/19. **(Internal/External)** Fostering good relationships with GP practices and Federations e.g. service pilots and as a result of tenders and general dialogue. **(Internal/External)** Pennine Lancashire ICP Memorandum of Understanding agreed by stakeholders. **(Internal/External)** ELHT Chief Executive chairing the ICS Providers' Forum. ELHT 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. **(Internal/External)** Component business cases at Pennine Lancashire level forming a draft overarching ICP plan. Plan on a page for the ICP, connecting to the Plan on a page for ELHT completed and shared with the Commissioners. **(Internal/External)** CEO of ELHT and Accountable Officer of East Lancashire CCG jointly chairing the Pennine Lancashire ICP Programme. Posts for Portfolio Holders at ICP level are in development. Cultural development programme for system level leadership established with involvement of all senior leaders across the ICP. **(Internal/External)** 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. **(Internal)** ICS architecture on clinical services is developing (eg pathology, stroke and frailty). Positive feedback from service reviews (stroke and endoscopy). Structures in place for the Out of Hospital stream with the Trust significantly contributing to the workstream. **(Internal/External)** Mitigation in place for creating single teams across the system, e.g, 'one workforce' with timelines for implementation. Progress covered under BAF risk 2. **(Internal)** Clinical leadership through the Professional Leadership Committee (PLC) at Pennine Lancashire ICP level giving consistent message about the importance of working as a system. Strengthening the relationship with primary care networks' leadership. Associate Medical Director for Service Improvement appointed, increasing our capacity for clinical leadership in relation to service improvements. **(Internal/External)** Pennine Lancashire Delivery Group has ELHT representation and is chaired by the Trust's Chief Executive. A&E Delivey Board meets monhtly, chaired by the ELHT Chief Executive. Progress on collaborative efforts in relation to the emargency pathway is covered under BAF risk 5. **(Internal/External)** Vital Signs is a system wide transforamtion programme across the Pennine Lancashire ICP. Patient experience strategy envisages good patient and public involvement to support the collaborative transformation. Progress with work covered under BAF risk 1. **(Internal/External)** Producing ELHT demand and capacity plan to be signed off by the Executive Team. The wider system demand and capacity plan will be signed off by the Partnership Delivery Group. **(Internal/External)** Pennine Lancashire Partnership Delivery Group is the engine/delivery room for the ICP. The group has been given delegated authority from the Pennine Lancashire Leaders Forum. The planning process is driven through this group. The Pennine Lancashire system planning reports into the Partnership Delivery Group. **(Internal/External)**	16	12	12	3x4	12	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 changes 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. 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. Prioritisation of diagnostics, pathology and cancer work streams agreed. Next steps in a process to be agreed. Update in Quarter 4. Meetings are ongoing regarding the acute Programme and more focused work will take place on the four priority areas: 1. Stroke 2. Vascular 3. Head and Neck 4. Diagnostics Pennine Lancashire ICP component business case prepared and consultation in progress. Focus on developing at LDP level wider deliverables. 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. Ongoing progress is being made with more focus on the future model of care (not the current model of care). An update will be provided at the Finance and Performance Committee in January 2019. Good co-production on developing clinical model across the ICS for CAMHS services was presented to the Commissioners on 6 August, outcome awaited. The model (stage 1) had been signed and providers are working on the detail (stage 2). A timetable has been produced, presented to local commissioners and approved by them (1 year plan). Milestones have been developed and a financial exercise has been undertaken to determine the resources required to implement the new model. A Planning Group has been formed and a demand and capacity exercise will be completed by 14 January 2019,

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. **(Internal)** Regular Performance Review meetings between Executives and Divisions. Using the Performance Accountability Framework (PAF) to provide assurance that action is taken to help ensure the delivery of objectives. **(Internal)** 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. **(Internal)** Use of data sources (e.g. Model hospital data.) to drive improvement and mitigate deterioration. Evidencing the routine use of benchmarking data to drive positive change. **(Internal)** External audit view on value for money. **(External)** Revised Performance Accountability Framework presented to the Finance and Performance Committee on 29 October 2018 and to the Operational Delivery Board on the 31 October 2018, with final approval by the Finance and Performance Committee at the end of November. **(Internal)** The introduction of the Financial Assurance Board (FAB) will strengthen governance and oversight. **(Internal)**	16	12	20	5x4	20	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. Lack of standardisation in applying 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. Review of divisional governance processes. Understanding the changes in income services (NHS and private). Weaknesses in appraisals and accountability framework.	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. 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			
Monthly divisional performance meetings feeding into the ODB and Finance and Performance Committee and weekly operational performance meeting covering RTT, cancer, 4 hour performance and holding list management monitoring delivery against the divisional business plans and the operational delivery standard. Engagement meetings with CQC and CQC Steering Group in place monitoring performance against the CQC standards. 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. **(Internal)** Regular deep dive into the IPR through Finance and Performance Committee. **(Internal)** Delivery of RTT and most cancer standards, action plan for 62 day cancer standard in place, emergency care pathway action plan in place, both monitored through the Finance and Performance Committee, and at operational level through the Operational Delivery Board and Executive. **(Internal)** System wide approach to Emergency Care Pathway, as part of monthly A&E Delivery Board supported operationally by the A&E Delivery Group. **(Internal/External)** ED performance and four hour improvement action plan aligned with the NHSI Rapid Improvement Collaborative and agreed by NHS England. **(Internal)** Performance monitoring provided through the Emergency Care Pathway Programme Board (progress reporting) as part of the transformation programme governance. **(Internal)** 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. **(Internal)** Trust rated 'Good' by CQC in 2016.**(Internal/External)** Silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments continues. There are currently eight Silver Accreditation of a ward approved by the Trust Board with further three awaiting approval. **(Internal)** 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. **(Internal)** Significant reduction in the number of complaints upheld by the Ombudsman. Comprehensive system for addressing complaints. Reduction on overall number of complaints, 50+ and 40+ days continues with regular reporting at operational and Board level. **(Internal)** Internal Audit (MIAA) have carried out an emergency care risk assessment audit which gained an assurance rating of 'Significant Assurance' in November 2018. **(External)** 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. **(Internal/External)** 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. **(Internal/External)** CQC Steering Group meets regularly and is chaired by the Director of Nursing and includes representation by all the Clinical Divisions. **(Internal)** Mini mock-CQC visits regularly carried out and focussing on all areas with regular reporting back to the Quality Committee. **(Internal)** Reduction in use of nursing bank and agency staff continues, revisiting the specialing policy with further reduction in spend. **(Internal)** 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. **(Internal)** Patient Safety Walkrounds **(Internal)** Delayed Transfers of Care have been reduced to below 3% and target achieved in the last quarter. **(Internal)** Positive response and results from the most recent National Staff Survey. **(Internal/External)** The Performance Assurance Framework - Revised document presented to the Finance and Performance Committee and Operational Delivery Board at the end of October, with final approval at the end of November. **(Internal)** System-wide approach to elective care pathway through the System Scheduled Care Board, supported operationally by the Access and Choice Committee. **(Internal)** 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. **(Internal)** Weekly monitoring of complaints and reporting to the Patient Experience Committee and End of Life Care Group **(Internal)** 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. **(External)** 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. **(Internal)**	15	9	12	4x4	12	16	16		Restrictions in the supply of medical, nursing, midwifery and other staff groups to meet demand. Refrence in BAF risk 2. 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. Insufficient bed capacity to ensure there are no delays from decision to point of admission. The heating system failure at Accrington Victoria Community Hospital necessitated a temporary cessation of patients to Ward 2 results in a loss of 19 beds.	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 and the delivery of the 62 day cancer standard Extended waiting times for mental health patients. Continued non-elective activity is placing pressure on the elective care and the RTT standard. Wards and departments overdue for refurbishment due to the lack of decant facilities. Temporary funding secured for an additional member of staff enabling the Nursing Assessment Performance Framework (NAPF) team to carry out further assessments.	Review of the complaints element of the Patient Experience Strategy has been launched and a user friendly version developed and presetned to the Patient Experience Committee in October 2018 and launched in November. The Patient Participation Panel held an open day on 13 December 2018. The launch of the panel will take place in January 2019 and will initially be made up of 15-20 people. 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. Plans for staffing and estates challenges have progressed as follows: 1. Emergency care pathway action plan in place and is monitored monthly through the ECP Programme Board. Redesign emergency care workforce plan carried out as planned and agreed with NHSI, awaiting response. 2. Ambulatory Care Emergency Unit opened as planned on 14 September 2018. Fortnightly service reviews carried out to ensure service delivery as expected. 3. Business case approved by the Trust Board and submitted to NHSI in July 2018 for the extended acute medical facility. Still no formal response from NHSI received. 4. Frailty Assessment Unit due to open on 7 January 2019. Board receives regular SRCP and transformation updates. Nursing Assessment and Performance Framework (NAPF) assessments are continuing. Nine Silver Accreditation of wards approved by the Trust Board. with a furher X to be presented to the Trust Board for approval. 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. Core 24 (Lancashire Care Foundation Trust mentnal health programme) 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. Unit has opened in August 2018. The Trust continues to work with external partners. The system wide action plan for mental health services has been agreed by the ICS in November 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). Escalation ward in Victoria wing in Burnley due to open on 15 November 2018. The 24 bed unit opened in November 2018. Received the draft CQC report for factual accuracy checks in late November with the final report awaited.

TRUST BOARD REPORT

9 January 2019

Item	**15**
Purpose	Information Action Monitoring

Title	Serious Incidents Requiring Investigation Report (October and November 2018)
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 October and November 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

Previously considered by:

Contents:

Executive Summary

Trust has reported 19 strategic executive information system incidents in October and November 2018:

- All duty of candours have been served in appropriate cases, 1incident breached the 10 day Duty of candour target which is outlined under the duty of candour section of the paper.
- Root Cause Analysis (RCA) Investigations are in progress with nominated leads

Trust has requested 12 internal root cause analysis investigations within the Divisions:

- All duty of candours have been served in appropriate cases, 2 incidents breached the 10 day duty of candour target which is outlined under the duty of candour section of the paper.
- Root cause analysis investigations are in progress

Part 1: Overview of Serious Incidents Requiring Investigations (SIRI) reported since last Board report

Strategic executive information system* (STEIS) – *SIRIs reported in October and November 2018

1. There have been 19 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 Associate 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:

	eIR	Division	Incident reported	Reported to STEIS	Category/Allegation	Relevant to Duty of candour	Rapid Review received	Any immediate changes initiated	Level of harm	Next steps
1	1152 939	FC	01/10/18	09/10/18	Screening incident	N	11/10/18	The process has been mapped using information provided by the screening team midwife. Records and databases have been reviewed. Trust guidelines have been reviewed.	Low / Minor	RCA to SIRI
2	1151 792	SAS	10/09/18	06/11/18	Possible delay in treatment	Y	RCA referred from DSIRG	Complaint into care received – investigation initiated	Severe / Major	RCA to SIRI
3	1154 662	ICG	01/11/18	14/11/18	Extravasation injury	Y	12/11/18	Initial judgement – no immediate changes indicated – full investigation initiated	Severe / Major	RCA to SIRI
4	1153 078	ICG	03/10/18	05/10/18	Fall with harm	Y	09/10/18	Initial judgement – no immediate changes	Severe / Major	RCA to SIRI

								indicated – full investigation initiated		
5	1155 337	FC	14/11/18	19/11/18	Screening incident	Y	20/11/18	Information shared with all junior doctors and senior medical staff at handover meetings and grand rounds.	Moderate	RCA to SIRI
6	1155 424	ICG	15/11/18	19/11/18	Category (Grade) 3 pressure ulcer	Y	19/11/18	Initial judgement – no immediate changes indicated – full investigation initiated	Moderate	RCA to SIRI
7	1154 588	ICG	31/10/18	07/11/18	Incident raised by NWAS – concerns in care	Y	07/11/18	Round table meeting / full investigation	Severe / Major	RCA to SIRI
8	1154 146	ICG	23/10/18	24/10/18	Fall with harm	Y	25/10/18	Initial judgement – no immediate changes indicated – full investigation initiated	Severe / Major	RCA to SIRI
9	1155 219	SAS	12/11/18	12/11/18	Possible delay/failure to carry out diagnostic test	Y	12/11/18	Complaint received and investigation initiated	Moderate	RCA to SIRI
10	1154 429	ICG	29/10/18	30/10/18	Possible treatment issue	Y	30/10/18	Initial judgement – no immediate changes indicated – full investigation initiated	Death / Catastrophic	RCA to SIRI
11	1153 003	ICG	02/10/18	11/10/18	Category (Grade) 3 pressure ulcer	Y	11/10/18	Initial judgement – no immediate changes indicated – full investigation initiated	Moderate	RCA to SIRI
12	1150 446	ICG	17/08/18	23/10/18	Attempted self harm	N	05/09/18	Initial judgement – no immediate changes indicated – full investigation initiated	No harm - Impact not prevented	RCA to SIRI
13	1152	SAS	02/10/18	09/10/18	Possible	Y	08/10/18	Process of	Moderate	RCA

	995				delay in treatment			hospital cancelled/rebooked appointments to be reviewed		to SIRI
14	1156046	ICG	28/11/18	29/11/18	Fall with harm	Y	29/11/18		Death / Catastrophic	RCA to SIRI
15	1154342	ICG	26/10/18	30/10/18	Possible Treatment issue	Y	01/11/18	Round table/debrief and full investigation initiated	Death / Catastrophic	RCA to SIRI
16	1154088	ICG	22/10/18	25/10/18	Possible delay in treatment	Y	25/10/18	Initial judgement – no immediate changes indicated – full investigation initiated	Death / Catastrophic	RCA to SIRI
17	1150881	FC	24/08/18	28/11/18	delay to interpret or act on test results	Y	RCA referred from DSIRG	Initial judgement – no immediate changes indicated – full investigation initiated	Moderate	RCA to SIRI
18	1154333	ICG	26/10/18	01/11/18	Category (Grade) 3 pressure ulcer	Y	01/11/18	Initial judgement – no immediate changes indicated – full investigation initiated	Moderate	RCA to SIRI
19	1153664	ICG	14/10/18	15/10/18	Fall with harm	Y	16/10/18	Initial judgement – no immediate changes indicated – full investigation initiated	Severe / Major	RCA to SIRI

Nb: The incidents where there has been a delay in reporting to STEIS is either due to:

1. *Awaiting rapid review to determine the level of harm*
2. *Incident not thought to be STEIS but then on presentation to DSIRG panel agreed for this to be escalated to STEIS.*

Part 2: **Overview of Divisional Serious Incident Reporting Groups (DSIRG) reported since last Board report**

Non-strategic executive information system – serious incidents requiring investigations reported in October and November 2018:

2. There were 12 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	Relevant to Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of Harm	Next steps
1	eIR1 150736	SAS	22/08/18	Radiation incident	N	N	Importance of ID checks reiterated	Low / Minor	RCA to DSIRG
2	eIR1 119782	SAS	09/01/17	Tip of cannula snapped which remained within patients hand	Y	Y	Complaint to RCA – no immediate changes initiated	Moderate	RCA to DSIRG
3	eIR1 153295	ICG	08/10/18	Oral and nutrition/hydration incident	N	Y	Initial judgement – no immediate changes indicated – full investigation initiated	Low / Minor	RCA to DSIRG
4	eIR1 152735	SAS	27/09/18	Complication post-surgery	N	Y	Rare risk/complication of surgery – no immediate changes initiated	Low/minor	RCA to DSIRG
5	eIR1 155968	ICG	26/11/18	Grade 2 pressure ulcer	N	N	Initial judgement – no immediate changes indicated – full investigation initiated	Low / Minor	RCA to DSIRG
6	eIR1 153877	ICG	18/10/18	Fall with harm	Y	N	Accidental fall – no immediate changes initiated	Moderate	RCA to DSIRG
7	eIR1 1558	SAS	23/11/18	Delay in treatment	Y	Y	Review of hospital cancellation	Moderate	RCA to DSIRG

	24						appointments process		
8	eIR1 152893	SAS	30/09/18	Information Governance Breach – case notes unavailable for surgery	N	N	Initial judgement – no immediate changes indicated – full investigation initiated	Low / Minor	RCA to DSIRG
9	eIR1 153528	ICG	11/10/18	Medication error	N	Y	Initial judgement – no immediate changes indicated – full investigation initiated	No harm - Impact not prevented	RCA to DSIRG
10	eIR1 154121	DCS	23/10/18	Delay in diagnosis / treatment	Y	Y	Initial judgement – no immediate changes indicated – full investigation initiated	Moderate	RCA to DSIRG
11	eIR1 153476	DCS	10/10/18	Delay in diagnosis / treatment	Y	Y	Initial judgement – no immediate changes indicated – full investigation initiated	Moderate	RCA to DSIRG
12	eIR1 155597	FC	19/11/18	Unexpected transfer to NICU	N	Y	Initial judgement – no immediate changes indicated – full investigation initiated	No harm - Impact not prevented	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. A daily duty of candour report is sent out to divisional Quality and Safety Teams for assurance and to monitor compliance.

4. Of the above reported incidents Duty of candour has been delivered within the timescale apart from the below:-

Ref	Division	Incident date reported	Duty of candour commenced	Duty of candour completed	Breach mitigation
1154121	DCS/ICG	23/10/2018	24/10/2018	12/12/2018	Incident was reported when a complaint letter came through and investigation initiated. DoC letter sent and uploaded to Datix 12/12/2018 – 26 days breach Daily updates with DCS as to who is serving DoC due to confusion caused with the incident being cross divisional. Meeting held with DCS, Deputy Medical Director and Patient Safety Manager to discuss and agree a process when an incident is identified as cross divisional and who is to serve the duty of candour.
1153476	DCS/SAS	10/10/2018	16/10/2018	03/12/2018	Verbal apology given in clinic on 09/10/2018 this is not evident within the case notes, , letter sent 28/11/2018 and uploaded to Datix 03/12/2018, 24 days breach. Daily updates with DCS as to who is serving DoC due confusion caused with the incident being cross divisional. Meeting held with DCS, Deputy Medical Director and Patient Safety Manager to discuss and agree a process when an incident is cross divisional and who is to serve the duty of candour
1154088	ICG	22/10/2018	29/10/2018	13/11/2018	Consultant tried to contact next of kin to discuss to no avail, letter sent on 13/11/2018 - 1 day breach.

5. Patient Safety and Risk, central team, are undertaking a duty of candour audit on 30 sets of case notes for assurance on compliance in line with the regulation and an update will be provided in the next report.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

9 January 2019

Item 16

Purpose Information
Monitoring

Title	Themes from the Planning Day 2019/20
Author	Mrs K Atkinson, Associate Director of Service Development
Executive sponsor	Mr M Hodgson, Director of Service Development

Summary: This paper provides an update on the Trust Planning Process for 2019/20 and the key themes arising from the planning day held on 4th December 2018. The agreed approach for planning across the Integrated Care Partnership is also described.

Recommendation: The Trust Board is asked to note the paper.

Report linkages

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

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	Yes

Executive Summary

1. This paper provides an update on the planning process for 2019-20, in particular the key themes which arose from the Trust Planning Day held on 4th December 2018.

National Planning Context

2. The NHS Long Term Plan, due for publication in December 2018, will set out the key priorities for the NHS over the next 10 years.
3. Initial high-level planning guidance received in October 2018 has indicated that this year's planning process will require the development of:
   a) Organisational one-year operating plans (due 4th April 2019)
   b) Aggregate system one-year plans (due 11th April 2019)
   c) One-year contracts (due 21st March 2019)
   d) System five-year strategic plans, reflective of the NHS Long Term Plan (due Summer 2019)
4. Final detailed planning guidance is expected during December.

Planning Pay

5. In preparation for the 2019-20 planning round a Planning Day was held on 4th December 2018. The planning day was an opportunity for Trust Executives, Divisional Senior Teams, Corporate team representatives and system partners to collectively discuss and identify the key transformation and strategic priorities for 2019-20 which will:
   a) Support the ongoing delivery of Safe, Personal and Effective care;
   b) Support the re-fresh of the Clinical Strategy and refinement of our clinical offering;
   c) Enable the Trust to participate fully in taking forward the transformation opportunities and priorities of the Pennine Lancashire Integrated Care Partnership (ICP);
   d) Ensure that the Trust responds to key opportunities for service development and redesign across the Lancashire and South Cumbria Integrated Care System (ICS).
6. The key themes and priority areas which came out from discussions on the day are outlined below.

Theme	Priority Areas	Divisional Priority	Trust-Wide Priority	ICP Priority	ICS Priority
Outpatient pathways and models of delivery	Outpatients Transformation - virtual clinics, patient-led follow-up, self-care, community models	■	■	■	
	Use of technology to enable transformation	■	■	■	
	Different use of estates	■	■	■	
Emergency Pathway	Ambulatory care	■	■	■	
	Acute medical clinical model (WRaPT) and Estates (Phase 6)	■	■	■	
	Acute surgical model	■	■	■	
	Acute Care Team	■	■		
New Models of Care	Neighbourhood teams	■	■	■	
	Intermediate Care redesign	■	■	■	
	Maternity transformation	■	■	■	■
	Paediatric/Maternity Hub development	■	■	■	
	Community paediatric service review	■	■	■	
Specialist Medical and Surgical Services	ICS reconfiguration work - Vascular, Urology, Head and Neck	■	■	■	■
	Stroke service developments (Hyper Acute Stroke Units)	■	■	■	■
	Robotic Surgery	■	■	■	■
Elective services	BGH Elective Centre Strategy	■	■	■	
	Theatres - productivity and efficiency, theatre inventory system	■	■		
	Private Patients Strategy	■	■		
Diagnostics	28 day diagnostic standard	■	■	■	■
	Reduction in report waiting times	■	■	■	■
	Diagnostic pathway review - aid earlier diagnosis	■	■	■	■
Demand Management	Diagnostic demand management (GIRFT) - System-wide review to agree pathways. Limit growth/demand	■	■		

7. Key enablers to transformation were identified as:
   a) Digital/IM&T
   b) Workforce
   c) New contracting models
   d) Culture, relationships and joint working with external partners
8. The key priorities and enablers identified clearly indicate the desire and need to work collaboratively across the ICP and ICS.

Next Steps

9. The planning day was designed to enable an initial discussion of the key priorities for the organisation.
10. This is very much the beginning of a process of wider engagement with the Trust Board, the wider organisation and key partners across the ICP and ICS to review and refine these priorities over the coming months.

11. Over the course of January to March 2019 these themes will be further developed within the context of:
    a) The NHS Long Term Plan priorities
    b) Refreshing the Trust's clinical strategy
    c) The development of our Improvement Programme and implementation of The Pennine Lancashire Way (Vital Signs Programme/Lean). This will result in agreement of the key Value Stream Analysis improvement events to be held during 2019-20.
    d) The development and agreement of ICP and ICS priorities for the next 12 months
12. In order to develop and agree ICP priorities for the next 12 months it has been agreed, via the Pennine Lancashire Partnership Delivery Group and Partnership Leaders' Forum, to hold a series of similar planning events for the two Local Integrated Care Partnerships of East Lancashire and Blackburn with Darwen in January. These events will identify wider local system priorities which will then be brought together with ELHT priorities at an ICP-wide system event to be held in February.

Conclusion

13. The Trust Board is asked to note the contents of this paper.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT **Item** **17**

9 January 2019 **Purpose** Information Assurance

Title	Equality, Diversity and Inclusion
Author	Mr N Makda, Equality & Diversity Manager
Executive sponsor	Kevin Moynes, Director of Human Resources and Organisational Development

Summary: The purpose of this annual report is to provide assurance of compliance against a number of national standards and compliance frameworks for equality, diversity and inclusion (ED&I).

The Board is asked to:

- Note the areas of progress and challenges for the coming year
- Sign off the report for publication as per legal requirement

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	Recruitment and workforce planning fail to deliver the Trust objectives 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	Yes	Confidentiality	No

Previously considered by: N/A

Executive summary

1. The purpose of this annual report is to provide assurance of compliance against a number of national standards and compliance frameworks for equality, diversity and inclusion (ED&I).
2. The report highlights areas of progress over the past year as well as acknowledging challenges for the future.

Background - Our legal duties

3. The Trust is required to provide assurance of delivery against a number of national standards and compliance frameworks for equality, diversity and inclusion (ED&I). These include:
    - The Equality Act (2010)
    - The NHS Constitution
    - The Public Sector Equality Duty (PSED)
    - The NHS Equality Delivery System (EDS2)
    - The Workforce Race Equality Standard (WRES)
    - The Workforce Disability Equality Standard (WDES)
    - Sexual Orientation Monitoring Standard (SOMS)
    - The Accessible Information Standards (AIS)
4. The Equality Act 2010 has brought with it a new – legal – public sector equality duty (PSED) requiring public bodies to declare their compliance with the duty on an annual basis. This means that ELHT must show compliance with both the *general and specific duties* of the Public Sector Equality Duty. For the general duty showing how we have due regard to the need to:
    - Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
    - Advance equality of opportunity between people who share a protected characteristic and people who do not share it
    - Foster good relations between people who share a protected characteristic and people who do not share it.
5. Protected characteristics – in the context of the Public Sector Equality Duty – are defined as:
    - Age
    - Disability

- Gender Re-assignment / Transgender
- Marriage and civil partnership
- Pregnancy and maternity
- Race – this includes ethnic or national origins, colour or nationality
- Religion or belief
- Sex (gender)
- Sexual orientation

6. For the specific duty ELHT must:
    - Publish information to demonstrate compliance with the general duty
    - Publish data on the make-up of the workforce
    - Publish data on those affected by ELHT policies and procedures
    - Publish one or more equality objectives

Introduction

7. Since 2015 all NHS organisations have been required to demonstrate how they are addressing race equality issues in a range of staffing areas through the *Workforce Race Equality Standard (WRES)*.
8. Recent research has demonstrated that the treatment and experience of Black Minority Ethnic staff (BME) within the NHS is significantly worse, on average, than that of NHS white staff. The publication of the *Snowy White Peaks of the NHS (2014)* indicated that Black Minority Ethnic staff (BME) staff were absent from leadership or senior positions of many organisations even where the workforce had substantial numbers of Black Minority Ethnic staff (BME) staff and where the organisation provided services to communities with large number of Black Minority Ethnic (BME) patients. The report also summarised research over recent years showing BAME staff were treated less favourably by every measure, including promotion, grading, discipline, bullying, and access to non-mandatory training.
9. We know from research West et al (2001) that: "*The experience of black and minority ethnic NHS staff is a good barometer of the climate of respect and care for all within the NHS. Put simply, if black and minority ethnic staff feel engaged, motivated, valued and part of a team with a sense of belonging, patients were more likely to be satisfied with the service they received".*

10. The Equality Delivery System (EDS2) is a toolkit which aims to help organisations improve the services they provide for their local communities and provide better working environments for all groups. There are four goals within the EDS2
    - Goal 1 – Better Health Outcomes
    - Goal 2 – Improved Patient Access and Experience
    - Goal 3 – A Representative & Supported Workforce
    - Goal 4 – Inclusive Leadership
11. The EDS goals are divided into eighteen outcomes. For most of these outcomes, the key question is "How well do people from protected groups fare, compared with people overall?"
12. The EDS2 has four grading options:
    - Red – Under-developed (i.e. no evidence of activity for protected groups)
    - Amber – Developing (i.e. evidence of activity (often good) but not for all protected groups)
    - Green – Developed (i.e. good evidence of activity for most protected groups)
    - Purple – Excelling (i.e. good evidence of activity for all protected groups).
13. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand.

Overview/narrative to eliminate unlawful discrimination

14. The Trust has continued to embed its values in the organisation. All staff receive an annual values based appraisal to ensure staffs reflect on their behaviours, identifying areas for improvement in themselves and others. The past year has seen 92% of values based appraisals completed. The Trust has focused on more promotion of the values, through promotional engagement campaigns. One of these was around the *Compassionate & Collective Culture and Leadership Programme* and staffs from across our geographical areas were part of the Trust wide initiative which included staff who are members of Workforce Race Equality Standard (WRES) group.
15. The Trust launched an Anti-Bullying and Harassment Pledge in October 2016. On reflection of staff survey results, including NHS and internal surveys around bullying and harassment, the pledge has had some impact but evidence suggests this is not breaking down systemic barriers within the organisation as had been hoped. To support this, the Trust has now introduced a Resolution Policy which integrates both

the bullying and grievance policies. The policy provides a framework of informal resolution including mediation.

16. The Trust actively encourages raising concerns and whistleblowing via the freedom to speak up guardian and open sessions have been offered encouraging staff to talk about their experiences.
17. All the Trust's formal policies and procedures go through an Impact assessment.
18. The Trust has implemented a Workforce Race Equality Standard action plan focusing on identifying and addressing the inequalities within the Trust. The WRES data can be found on the public website at http://www.elht.nhs.uk and at Appendix 2.
19. The 2018 WRES data showed a significant improvement on 4 indicators between BME and non-BME staff in relation to recruitment and targeted work, narrowing the gap in relation to staff appointed following shortlisting. The Trust is now performing above the national average. Work will be needed to recognise the barriers around the 3 staff survey WRES indicators, as this is an area identified for the Trust for further improvement.
20. There remains some challenge for the Trust with the Workforce Race Equality Standard which has resulted in refreshing its annual action-plan to ensure that this is focused on making measurable improvements. The Trust's Workforce Race Equality Standard data and action plan can be found at Appendix 1.
21. The Trust has communicated the requirements of the Accessible Information Standard (AIS) widely within its services, and has provided reminders about how staff should act to consistently work with the requirements of the standard. Feedback from clients and relatives is used to improve services. Good practice is in place across Trust services thanks to input from specialists including physios, speech and language therapists and outpatients. An AIS review was carried out during April 2017 to test the effectiveness of services response to AIS to date, and to seek further best practice examples to share. Through the AIS work the Trust is working with Health Communications to send out information in alternative formats including text reminder for appointments, emails, large print, etc.
22. Reviewing the Equality Impact Assessment process to be more inclusive of staff, carers and service users. Identifying the positive and negative implications to changing service provision and developing a stronger quality.

23. We recognise that unconscious bias plays a part in recruitment, so through training we ensure managers and employees understand their responsibilities under the Equality Act 2010 and that fair and non-discriminatory practices are followed.

Overview/narrative to advancing equality of opportunity

24. The Trust's beliefs and approach to equality and diversity are described in its Equality & Diversity Strategy 2015 – 2019. The strategy can be found at www.elht.nhs.uk
25. The Workforce Race Equality Standard Group has been developed to support with improving the WRES metrics.
26. Implementation of Sexual Orientation and Gender Identity guides. This piece of work focused on disseminating new guidance for clinicians in relation to sexual orientation and gender identity.
27. The Trust published its gender pay gap calculations showing how large the pay gap is between their male and female employees. ELHT is committed to being an inclusive employer and to addressing inequalities in all aspects of employment. We therefore have taken positive steps via an action plan to tackle the gender pay gap.
28. The Trust has implemented the Accessible Information Standards.
29. The Trust has recently completed a data validation exercise for disabled staff with the aim of improving the completeness and robustness of monitoring data.
30. The Trust utilises the inclusive recruitment toolkit and matrix developed by Diversity by Design Consultancy. Its designed to support local managers reduce the inequalities experienced by staff from protected characteristics in regards to recruitment and career progression. The matrix has been identified as having a significant impact on the inequalities that minority groups can experience around career progression and recruitment.

Overview/narrative to foster good relations

31. Bias and prejudice are covered in unconscious bias training events for recruitment and equality and diversity.
32. The Trust frequently uses its communications channels to make staff aware of festivals, news or events related to protected characteristics.
33. In October 2018, the Trust hosted its local WRES annual workforce conference with special guest speaker Dr Habib Naqvi from NHS England. The focus was on

'Diversity & Leadership - and emphasised the ways the Trust can improve its approach to race equality and the retention and promotion of BME staff. The event was well attended with a number of Senior and Executive Directors who pledged to undertake more work around the WRES in their areas.

34. As part of Trust's commitment to equality and diversity, a reverse mentoring scheme has been established.

Equality Delivery System (EDS2) – grading of activity

35. The Trust chose to re-grade 3 outcomes graded as either 'developing' or 'excelling' in the previous grading exercise. In determining our EDS2 objectives, we reviewed local and national data, patient feedback, complaints analysis, staff survey results and aspects for service delivery that present a local challenge. It was noted that our initial proposed EDS2 objectives were very broad; they were not outcome focused from the analysis of the experience of particular protected groups and were not specifically measurable. The following EDS2 objectives are proposed for 2018/19:

- Goal 1.3: Transitions from one service to another are made smoothly with everyone well informed
- Goal 2.4: People's complaints about services are handled respectfully and efficiently
- Goal 3.5: Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
- Goal 4.3; Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination.

36. Appendix 7 shows the results of those EDS2 objectives that were regraded.

Challenges & Opportunities for the coming year

37. The WRES has presented some challenges in the past year. Whilst an improvement in 4 indicators is noted, the same cannot be said for the remaining 5 indicators i.e. Board representation, staff bullying, disciplinary, discrimination and being treated fairly. For 2018, there will be further analytical work to build robust evidence around this to ensure the Trust can make the changes needed to make the process fairer and promote equality of opportunity.

38. April 2018 will see the reporting of the Sexual Orientation Information Standard and Workforce Disability Equality Standard. In addition, the publication of reporting on any Gender Pay Gap. In relation to these we need to look at effective work plans to implement and delivery targets on the above with being aware of the limitations to resources.

39. In relation to service provision our ongoing challenge is around monitoring of demographic data. The Trust sees significant gaps in data regarding sexual orientation, religion/belief and disability. Therefore this is an area of focus over the coming year. We also see this for employment data and actions will be set to address this.

40. The Trust will strengthen our governance structures by forming an *Inclusion Group.* This will build shared responsibility and accountability for achieving improvements by explicitly embedding equality, diversity and inclusion into the performance management of divisions.

41. Goal Alignment - The Trust will optimise our efforts by linking our equality, diversity and inclusion strategy to our corporate objectives. Equality, diversity and inclusion will be clearly defined as an integral part of our Trusts vision, firmly embedded and fundamental to its success. A standalone or silo approach to equality, diversity and inclusion will not be enough to create change or visible progress. We will align all of our interventions directly with the objectives of the organisation and to help us prioritise effort and show impact.

42. Inclusive Leadership - To make sustained diversity and inclusion progress it is imperative that we have the right level of leadership commitment and accountability at all levels within the organisation. Diversity and inclusion is '*everybody's business'* and everyone in the Trust is therefore expected to take an active part. Our Board of Directors will lead by example in relation to inclusive practice and our senior leadership team will focus on operational embedding of equality, diversity and inclusion to stimulate action and commitment to behaviour change.

43. Awareness and Education - To foster a diverse and inclusive workplace we need to create the right levels of equality, diversity and inclusion awareness and education, focusing on *unconscious bias*. This will be a central component to engage the hearts and minds of all our staff, inspire team actions and accountability for change.

44. Data Driven Decision Making - We need to monitor what good looks like to ensure our interventions have an impact and report regularly to the Board of Directors.

A data-driven approach will enable us to dispel any myths regarding our baseline (*where are we now?*) and track progress. We will identify a small number of metrics we feel are the most critical to ensure success and use quality improvement (QI) methodology to experiment with new ideas and interventions.

45. The Trust will use the learning from the national *"Breaking Though Programme"* to develop an in-house leadership development programme for minority staff in agenda for change bands 4 -7. This will support the development of a diverse talent pipeline to senior leader roles via sponsorship, mentoring and coaching.

Development of a Shadow Board

46. An opportunity has arisen for the Trust to take part in a strategic leadership development programme designed and funded by the Northwest Leadership Academy
47. The aim of the programme is to create a diverse pool of potential strategic leaders across the Trust who are able to work with the Board to shape and deliver the Trust's strategic objectives.
48. The programme involves the identification of potential future talent, the delivery of three one day modules and the formation of a 'Shadow Board'. Participants are also offered the opportunity to be mentored
49. The Shadow Board, which runs outside of the Trust's governance structures, will be chaired by the Trust chair or Non-Executive Director and discuss papers to be presented to the Trust Board.
50. In order to get maximum value from this development commitment is required from the Board as outlined in the paper. It is also envisaged that participants would be asked to lead/co-lead future strategic projects across the Trust.
51. Refer to Appendix 1 for the full Shadow Board briefing paper

Conclusion

52. This report has provided progress against a number of national standards and compliance frameworks whilst recognising areas for development and challenges for the organisation.
53. Whilst there have been a number of areas of good practice to celebrate, there remains an improvement needed around some of the more simple structures of the organisation in relation to equality monitoring, initial recruitment and also retention as

well as increasing understanding of lived experiences and voices of staff, service users and carers in relation to different protected groups.

54. The EDS2 re-grading has shown that there is still action to be taken in order to get more traction in areas of service accessibility, transition from services and complaints.

55. In relation to staffing it is expected that programmes of work such as the NHS Equality Standards will begin to see a positive change in the experiences of staff from protected groups.

56. In producing this report, and the activities detailed within, it is felt there are no substantial areas where the Trust is failing in its duty to comply within the Equality Act 2010, whilst acknowledging that there are areas for improvement in raising the standard of equity for some protected groups. In July 2018 the Trust will publish a new Equality, Diversity & Inclusion Strategy for the next four years.

Recommendations

57. The Committee is asked to;

- Note the areas of progress and challenges for the coming year
- Sign off the report for publication as per legal requirement

Appendices

58. Appendix 1 - shadow Board briefing for trust board

59. Appendix 2 - Workforce Race Equality Standard (WRES) indicators and action plan.

60. Appendix 3 - Progress against 2017/18 WRES Action Plan

61. Appendix 4 - Workforce Race Equality Indicators Metric 1 - Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.

62. Appendix 5 – WRES comparison by protected characteristics

63. Appendix 6 - Staff in Post by ethnicity, disability, sexuality, religion & belief and gender

64. Appendix 7 – Employee Relations data by protected characteristics

65. Appendix 8 - Equality Delivery System 2 re-grading

Appendix 1 - SHADOW BOARD BRIEFING FOR TRUST BOARD

An exciting opportunity has arisen for staff in senior positions within the Trust to participate in a leadership development programme – **Shadow Board**, which is being funded by NHS North West Leadership Academy. The purpose of this programme is to help the Trust identify and develop its future leaders, to create a more diverse leadership pool and to provide additional input and insight into existing Trust Board issues.

Your role as Executive Director is crucial to ensuring that this development activity adds maximum value to the Trust.

Shadow Board consists of a number of elements.

1) Participation in three one-day modules
    - Is intended to ensure participants understand the roles of the trust board directors, in terms of strategy, finance and statutory financial responsibilities, corporate governance in order to provide assurance and culture of the organisation..

2) Attendance at and time to prepare for monthly shadow board meetings throughout the year.
3) Mentoring.
4) Contribution to projects of strategic interest/importance at a strategic level.

Maximising the investment
In order to achieve maximum return on expectation Executive Directors are asked to:

- **Identify** a number of candidates within their Directorate, typically working at Band 8b or above who would provide diversity of thought and experience (both clinical and non-clinical) and who would benefit from the programme. Who aspire to a Board level position or equivalent in the future (it is expected that participants wouldn't just be identified through the current organisation structure).
- **Fully support** the development of participants from their area. This may involve discussions around what needs to be done to enable participants to fully attend (i.e. having discussions to identify alternative arrangements to cover workload), setting expectations in terms of full commitment to attend etc.
- **Support participants** by having on-going and follow up discussions about their learning
- **Identify** a number of strategic projects for participants to work on/lead
- **Support participants** by enabling them to get involved in strategic projects identified by the Board
- **Participating** in the programme evaluation process

Identifying participants:
We are encouraging more applications than places as we need to encourage a diverse range of staff to participate in the programme. By diverse we don't just mean protected

characteristics but also diversity of thought and experience. So when you are thinking about the potential talent within your area please think beyond your structure and look for those who you have identified as having potential, and are (or have experience of) working at Band 8b or equivalent. We also encourage you to think about the balance in representation between clinical and non-clinical areas within your remit.

Depending on how the programme evaluates further programmes may or may not be run in the future.

Application process
Applications are by signed expression of interest and individuals are expected to evidence that they have been identified as having potential.

Benefits

- The objectives of the Shadow Board programme are:
- To identify the top end of the talent pool within the Trust and more broadly within the NHS.
- To support the integration of more diversity of thought and perspective into Trust boards.
- Delivering future value to the NHS.
- To create a pool of potential strategic leaders across the Trust who are able to work with the board to shape and deliver the Trust's strategic objectives.
- To provide an insight into executive responsibilities and develop strategic leadership thinking for future potential leaders.

To date a number of Trusts within the NHS have participated in this programme including; Lancashire Care NHS FT, South West Yorkshire Partnership Foundation Trust, Mid-York's NHS Foundation Trust, Harrogate and District NHS Trust and North Lincolnshire and Goole NHS Trusts. Other Trusts who are currently working on implementing this programme include Leeds and Rotherham.

Design

- The programme involves:
- An introductory 1.5 hour event (11th April)
- Three one day modules spread out over a number of months delivered by an external consultant. (19th May, 22nd June and 13th July)
- The formation of a 'shadow board' which runs in parallel with the Trust Board over a year. Members of the board are programme participants. It is chaired by either the Chair or Vice-Chair of the Trust. Terms of reference are created by participants on the programme. It considers past and/or future agenda items from Trust Board meetings.
- Mentoring opportunities for participants by non-executive directors.

It is proposed that for the first cohort potential participants are identified directly by Trust Executive Directors. 15 places are available, it is expected that more than 15 potential

participants are identified. These individuals are then invited to an introductory session AND asked to complete an application form. The cohort is then created from those who've applied in order to maximise its diversity.

Costs of the programme:
The funding for the delivery of the three modules has come through the NHS NW Leadership Academy. There are other costs associated with the programme that the Trust will need to be aware of. These include: The cost of the time involved for each of the participants. This includes attendance at the three day modules, preparation for and participation in each of the shadow board meetings. The admin cost of setting up and running the shadow board meetings. This includes a member of admin staff attending to write the minutes.

Ensuring return on expectation:
In order to gain maximum return on expectation this programme needs the full support of the Trust Board. This support includes:

- **Time and commitment of the Chair** in; preparing for and running the Shadow Boards (it is anticipated that this Board would run for at least a year). The role of the Chair of the Shadow Board is to identify each Board agenda, provide feedback to the members of the Shadow Board on the quality of the conversations as well as feeding discussions back into the Trust Board. This includes attending at least 3 Shadow Board meetings over a 12 month period.

- **Time and commitment of all Non-Executive Directors** to provide mentoring to participants where required. The amount of time required would be negotiated on an individual by individual basis, but could be in the region of 3 meetings of approx. 1.5 hours over a 12 month period.

- **Commitment from the Executive Directors** to fully support the development of participants from their area. This may involve discussions around what needs to be done to enable participants to fully attend (i.e. having discussions to identify alternative arrangements to cover workload), setting expectations in terms of full commitment to attend etc.

- **Commitment from the Executive Directors** to identify a number of candidates (at least 15) who would provide diversity of thought and experience and who would benefit from the programme (it is expected that participants wouldn't just be identified through the current organisation structure).

- **Commitment from the Executive Directors** to identify a number of strategic projects for participants to work on/lead – by March 2019 in the first instance.

- **Commitment and involvement of the Board/Company Secretary** to ensure smooth exchange of board papers to the shadow board members and briefing of 'trust board etiquette' of the trust board. Identify 'admin support' to work with provider to ensure rooms set up with PowerPoint etc. and catering organized.

Providing lasting value – learning transfer:

As with all development programme formats it is the process of transferring learning into the workplace that lasting value can be harnessed.

It is suggested that in order to provide lasting value to the Trust a number of strategic projects are identified which members of the shadow board would be expected to take a strategic lead on either in partnership with a member of the Trust Executive or independently.

It is also suggested that participants are strongly encouraged to create action learning sets/learning exchanges outside of the formal learning programme

WHAT YOU NEED TO DO NEXT:

Identify potential staff in your directorate – Band 8b or higher – using the 9 box grid (see e/mail attachment)	**Notes**
Hold a discussion individually with each identified staff member BEFORE to: a) Let them know they've been identified as having potential; b) Clarify whether it's a development opportunity they are interested in; c) Inform them of the commitments required (including the dates – see below); d) Ask them to sign and return the expression of interest form (see below) by the deadline of 8th March 2019 to nazir.makda@elht.nhs.uk e) Ask them to attend the introductory event & assessment (see below)	
Plan future dates for 1:1 discussions with the individuals over the duration of the programme	

Timetable

Title	Date	Time	Venue	Notes
Assessment / Interviews	15th March 2019	9.30-16.00	Seminar room 3, Learning Centre RBTH	
Introduction	2nd April 2019	9.30-11.30	Seminar room 4, Learning Centre RBTH	
Module 1	2nd May 2019	9.00 - 17.00	Seminar room 3, Learning Centre RBTH	
Trust Board	8th May 2019	Information only Papers from Board made available to nominees prior to shadow board		
Shadow Board	6th May 2019	9.30-12.00	Board Room, Trust HQ	
Module 2	11th June 2019	9.00 - 17.00	Seminar room 4, Learning Centre RBTH	

Trust Board	11th Sep 2019	Information only Papers from Board made available to nominees prior to shadow board		
Shadow Board	9th Sep 2019	9.30-12.00	Board Room, Trust HQ	
Module 3	23rd Oct 2019	9.00 - 17.00	Seminar room 3, Learning Centre RBTH	
Trust Board	13th Nov 2019	Information only Papers from Board made available to nominees prior to shadow board		
Shadow Board	11th Nov 2019	9.30-12.00	Board Room, Trust HQ	

Expressions of Interest	
Name	
Role	
Band	
Network	

What are your aspirations for the future? (E.g. what type of role, in what timeframe)

Max 250 words

What do you hope to gain from this development opportunity and why is now the right time?

Signature …….. Date
(Executive Sponsor)

Signature …… Date
(Nominee/Candidate)

Appendix 2: WRES Indicators & Action Plan 2018/19

	Criteria	Tracking Progress against previous year	Target/ What success would look like	Where are we now?	Action Plan	By whom?	By when?
1	**Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.**		Increase the numbers of staff from BME groups across all AfC Bands 1-9 and VSM to 22%	The % of BME staff in the workforce has increased by 0.33% (60) in the current year, although most of the increase is in lower level roles. The total BME is at 15.69% still not reflective of the local population of 22%, 6% short. For non-clinical staff, BME staff were clearly over-represented at Band 6 and not represented at all among very senior management. For clinical staff, BME staff were clearly over-represented at Band 5 and not represented at all above Band 8C. Among medical staff, there was a clear over-representation of BME staff at the non-consultant	• Internal promotion and positive action to support BME staff in achieving and sustaining promotion. • Advertising all our vacancies on an external website dedicated to attract BME staff. • Look at development process – facilitate individuals to apply for permanent post or acting up • Developing external relationships with BME organisations, local community groups, schools and networks to promote employment opportunities at all levels including apprenticeships • Talent management is absolutely critical here. ELHT cannot establish diversity if there are very few staff from diverse backgrounds already at senior management levels. There is a need to fill current vacancies and future leadership pipelines with the correct numbers of people from diverse backgrounds • 'acting-up' (secondment) opportunities is a key enabler for career progression.	All Line managers Resourcing Manager All Line managers Workbased Learning Team All Line Managers All Line Managers	Mar 20

				grades	Access to such opportunities should be especially encouraged amongst BME staff, and should focus on positions and grades that are under-represented within the Trust		
2	**Relative likelihood of staff being appointed from shortlisting across all posts.**		The likelihood of BME and white staff being appointed from shortlisting is, on average, over time, the same.	The data suggests that the gap between white and BAME staff groups is closing and although white applicants are still relatively more likely to be appointed (2.63 times) this is an improvement when compared with last year when white staff were 3.08 times more likely to start work with the Trust.	• Interrogate recruitment data to evaluate external success in recruitment vs internal applicants • Hold the relevant individuals department or profession to account for their decisions in recruitment/career progression outcomes whilst considering what continuous improvement methods might assist in improving changing patterns of appointment and promotion. • Independent member to the interview panel (from another service, or a BME member of staff) to encourage accountability. Their role is not dissimilar to the role of a patient representative on some interviews. Research suggests that the positive impact of diversity on group performance (including on an interview panel) has less to do with what these additional panel members say, but rather that their presence affects expectations of others • Promote the use of Positive Action in recruitment/promotion i.e. encouraging particular groups to apply, apply the Rooney Rule guaranteed interview	Resourcing Manager Director of HR/OD All Recruiting managers	Mar 20

					scheme for BME groups, tie-breaker rule. • Unconscious Bias training mandatory for all recruiting managers • Asking shortlisting panels to be cautious when using "previous experience" as a criteria – in other words to recognise that BME staff will tend to have gained more qualifications to compensate for the likelihood of having had less opportunity to gain experience at a higher level e.g. through acting up • Explore TRAC to see if our BME staff are actually applying for our band 7+ posts and check outcomes (not being shortlisted or appointed or they are just not applying); monitor all applicants, internal and external to see how things look statistically (with a focus on encouraging our own staff)	Equality & Diversity Manager Recruiting Managers Equality & Diversity Manager / Resourcing Manager	
3	**Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.**		Decrease the WRES score for indicator Three to 0.30 or below	Very slight improvement as BME staff is 1.76 times more likely to enter a formal disciplinary process than White staff compared to 1.78 times last year .	• Set up a panel to address the 'employment relation' issue (e.g. grievances, allegations of B/H, misuse of social media, competency issues etc.) – whether that be, an informal discussion with the staff concerned, formal reprimand, mediation, retraining, reflection, through to suspension and more formal action, if deemed necessary • Development of "resolution champions"	Director of HR/OD Associate Director of HR Staff Guardian	Mar 20

					to support staff who are having issues or problems at work. • Adopt good practice from the Mersey Care initiative "learning and just culture" • To review the checks and balances contained within the disciplinary policy and the feasibility of an added management filter before the formal disciplinary process is triggered • Undertake a detailed audit / root cause analysis of formal disciplinary cases in the last 12 months, to establish whether any trends or patterns are identifiable & address these issues appropriately • HR Best practice training for all managers • Publicise across the Trust HR Portal	Head of Engagement & wellbeing Head of HR HR Project Manager / Asst HR Business Partner	
4	**Relative likelihood of staff accessing non-mandatory training and CPD.**		Decrease the WRES score for indicator Four to 0.50 or below	Relative likelihood of white staff being funded for training 1.16 times greater compared to the previous year 1.19 times greater.	• Clear definition of non-mandatory training and CPD • All line managers to identify BME development opportunities at Appraisal • BME staff access to mentoring (including reverse mentoring), shadowing, coaching and encouragement to join NHS Leadership Academy and other courses (Note ELHT should avoid a reliance on sending staff away on courses as the	Equality & Diversity Manager All Line managers	Mar 20

					sole or primary means of encouraging more BME staff development. Such courses can be invaluable but there is growing evidence that the key to staff development is whether such courses are complemented by opportunities for "stretch assignments" such as acting up, secondment, involvement in project teams or developing pilots). • Conduct appraisal audits and holding individuals accountable for their decisions • Engage with staff to ascertain whether there are examples and evidence of training requests not being supported	Equality & Diversity Manager / Integrated Diabetes Service Manager	
5	**KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.**	↔	The aspirational target for all staff would be 0% however a realistic target would be: BME percentage is equal to or less than White percentage	Fairly static between the two years but is still higher than the Trust would expect. Although BME staff still report high levels of harassment, bullying or abuse from patients the percentage was higher for White Staff in figures in the last 12 months.	• Publicise Zero Tolerance posters in hot spot areas • Support for staff that have experiencing harassment, bullying or abuse from patients, relatives	Communications manager All Line Managers	Mar 20
6	**KF 26. Percentage of staff experiencing harassment,**		BME percentage is equal to or less than White percentage	Small variance between White & BME Staff. BME staff remains more likely than white staff to	• Leaders at every level in the Trust must take responsibility for creating a culture in which difficult topics can be talked about openly, honestly, and without fear of repercussion	All managers	Mar 20

	bullying or abuse from staff in last 12 months			experience harassment, bullying or abuse from other staff this increased by 4% on last year.	• Publicise widely the informal resolution mechanism available including Mediation, Resolution Champions, Staff Guardian, etc. • Train all managers in the application of the Resolution policy. • Raise awareness of Freedom to Speak up staff guardian • Facilitated conversations training for managers to enable early informal resolution of issues and champion roles for raising of concerns including bullying, harassment and discrimination. • HR Best practice training (which includes Bullying & Harassment)for all managers • Publicise across the Trust HR Portal	Head of Occupational Health / Staff Guardian HR Project Manager Assistant HR Business Partner	
7	**KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.**		BME percentage is equal to or more than White percentage	BME staff remain less likely than white staff to believe that their trust provides equal opportunities for career progression. The gap between white and BME staff on this indicator increased from 13 percentage points in 2016 to 19 percentage point in 2017	• Making improvements to the appraisal process following an audit of Trust wide practice; focusing managers on leading conversations and identifying meaningful career progression or promotion for all staff • Capture BME staff stories of working in ELHT (positive or negative) and highlight best practice or barriers to career progression or promotion	Education Business Manager Equality & Diversity Manager Integrated Diabetes Service Manager	Mar 20

					• Publicise BME Role Models so that people can take inspiration from them. • Implement the WRES communication Plan including articles in Team Brief, Staff Newsletter, CEO Blog, E-bulletin, Message of the Day, Staff App, intranet OLI	Communications Manager	
8	**Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? B) Manager/team leader or other colleagues**		BME percentage is equal to or less than White percentage	BME staff remain significantly more likely to experience discrimination at work from colleagues and their managers, the percentage of BME staff reporting that in the last 12 months they have personally experienced discrimination at work from staff increased by 2%	• Reinforce the trust's values and behaviours expected of all staff • Facilitated conversations training for managers to enable early informal resolution of issues and champion roles for raising of concerns including discrimination. • Raise awareness of Freedom to Speak up staff guardian • Cultural awareness training for managers • HR Best practice training (which includes Bullying & Harassment)for all managers • Publicise across the Trust HR Portal	Communications Manager Head of Occupational Health Staff Guardian Equality & Diversity Manager HR Project Manager Assistant HR Business Partner	Mar 20
9	**Percentage difference between the organisations' Board voting membership**		Increase Board BME voting members to 20%	At 31 March 2018, the Board voting membership included 1 Non-Executive Director from a BME Background 6.0%, compared to 94% White Board members.	• The Trust Board to communicate a clear business case explaining why more diverse appointments (including in senior positions) are important • Accountability and holding decision-makers to account for their actions.	Chairman, Chief Executive All Exec Directors	Mar 20

	and its overall workforce.				Knowing that as a recruiting manager, shortlisting or interview panel member, you will have to justify your decision-making is likely to lead to more thorough thought processes • Trust board members to be trained as mentors for BME senior managers in bands 7 and above	Organisational Development Consultant	

Appendix 3 – Progress against 2017/18 WRES Action Plan

	Indicator	Action planned	Responsible for action	Completion Date	Evidence of Achievement/ exception
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	• Deep dive by collecting and analysing staff data to identify where the specific blocks to talent are in the Trust. • • Pilot an area where there is an under-representation, by review of HR/OD policies, processes, utilise positive action to recruit diversity. • Make Managing Difference/ Unconscious Bias training mandatory for all recruiting managers via inclusion in recruitment training accompanied with change in the process. • Work towards increasing representation of BME staff in overall workforce so its reflective of the local population • Develop partnership working with CCG's, Local council, Job Centre, NHS Trusts on shared initiatives i.e. WRES	WRES Working Group Diversity by Design Head of Engagement Equality & Diversity Manager	March 2018	• Deep dive data captured and analysed by department, service, and occupation. Data has remained broadly the same for the last 6 years. Identified specific areas where there is clearly a failure to recruit BME staff especially in more senior grades. • This action has slipped this will be carried forward to 2018 action plan. • Over 300 recruiting managers attended the Unconscious Bias training last year • Big conversation event held for BME staff to identify issues and concerns, stakeholders invited to be involved in various initiatives e.g. WRES working group, fair treatment champion, etc. • WRES work is communicated via internal communication channels • Partnership working with Job Centre • Jobs advertised in BME publications Inc. Asian Image
2	Relative likelihood of staff being appointed from shortlisting across all posts.	• Critically examine recruitment processes by piloting an area of under-representation including; Rejecting non-diverse shortlists; ○ Change in process, challenging and sifting out selection bias; (needs to be	WRES Group Diversity by Design	March 2018	• Recruitment process reviewed and recruitment policy updated • Unconscious bias training for recruiting managers is now mandatory • Diversity by Design have developed a matrix, working with recruitment team to adapt the matrix with the TRAC system

	Indicator	Action planned	Responsible for action	Completion Date	Evidence of Achievement/ exception
		designed out) ○ Drafting job specification & PS in a more inclusive way; (focus on a combination of excellence – e.g. level of skill etc. – and then crucially on the personal attributes (identity, background, experiences) the person brings – e.g. the difference they bring. ○ Skills mix creating opportunities for different skills, backgrounds and attributes, not just the chosen few ○ Re-design recruitment materials to specify Trusts desired values and behaviours • Recruitment panel members must have completed Unconscious Bias training accompanied with a change in process of shortlisting and interviewing • Spot checks / audits of vacancies, analysis by banding	Employment Services/ Equality and Diversity Manager	Ongoing	• Encouraged recruiting managers to use Positive action "Tie Breaker" rule • Vacancies are being audited and checked for any discrepancies • Positive action initiatives have taken place including, localised advertising of career opportunities in BME publication i.e. Asian image and Engagement activities within the local BME communities, schools and colleges to promote career opportunities within ELHT • Expressions of interest have been advertised across the Trust for some senior posts via global email. .
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	• Dealing with difference training to build confidence in managers in resolving disputes/incidents/problems so that they feel able to deal with BME colleagues in the same way as white colleagues • Unconscious bias training for disciplinary/appeal panels	Equality & Diversity Manager	February 2018	• Bullying & harassment training • A new resolution policy developed • A new panel is in the process of being set up. The aim is to agree the best way to address the 'employment relation' issue (e.g. grievances, allegations of B/H, competency issues etc.

	Indicator	Action planned	Responsible for action	Completion Date	Evidence of Achievement/ exception
		• The development of Diversity Ambassadors who review Disaplinaries			
4	Relative likelihood of staff accessing non-mandatory training and CPD.	• Monitor uptake of non-mandatory training and CPD, identify reasons/rationale why BME staff are refused funding for non-mandatory training and CPD	Equality & Diversity Manager	January 2018	• All courses are advertised to all staff via MOTD, Ebulletin, global emails, PDR, learning hub, etc. • 10 BME colleagues have completed Leadership Development Stepping Up Programme from the NW leadership academy • Majority of BME staff have received an appraisal/PDR
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	• High profile bullying and harassment campaign with executive leadership on tackling bullying and harassment.	All divisions HRBP's	March 2018	• A refreshed communications campaign regarding the Trust's zero tolerance approach to bullying, harassment, abuse and violence
6	**KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**	• Review of Bullying & Harassment policy • Encourage all staff to first pursue informal mechanisms to resolve issues i.e. Mediation, fair treatment champions, staff side, staff guardian, etc.	Bullying & Harassment working group	November 2017	• Bullying & Harassment task & finish group in place • Bullying and harassment policy reviewed and A new resolution policy developed • Fair Treatment Champions, Staff Guardian and Mediation service in place and have had positive impact on helping staff to address conflict and reduce the number of cases reaching a formal level. • Corporate Induction includes a section on what we expect of staff at work in relation to dignity and respect for one another. All staff are expected to carry out their work in ways which are consistent with the trust values and behaviours.

	Indicator	Action planned	Responsible for action	Completion Date	Evidence of Achievement/ exception
					• Managers evaluate staff performance against the Trust values and behaviours through the performance appraisal process. • Bullying & Harassment training • 12 staff has completed Accredited Mediation Training to support with resolving disputes and conflicts at work • Promotion of zero tolerance via the National Bullying & Harassment week • Ongoing promotion of fair treatment champions, Staff Guardian and Mediation service. • In areas where bullying is identified as an issue, interventions have been put in place including anti-bullying training, which sets out the Trust's expectations regarding acceptable and unacceptable behaviours
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	• 2 way mentoring- build into the objectives of all managers above band 5 including VSM to mentor BME colleagues to share experience, in how to manage mixed groups of staff and improve opportunities so that BME colleagues have access to internal/informal networks (this way we are not recruiting/promoting from the same pond)	All Senior managers	March 2018	• Increase in appraisal rates for all staff, managers evaluates staff performance against the Trust values and behaviours through the performance appraisal process. • 2 Senior BME Managers have agreed to become Role Models; more will be identified in the coming weeks, months
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? B) Manager/team leader or	• Tougher sanctions for those who are found to be discriminating, this will act as a deterrent. • Integrate diversity within the performance management processes, including measuring employees on their ability to work well with	Equality & Diversity Manager	March 2018	• Equality & Diversity master class including unconscious bias for all staff. • Recruitment and selection training for new managers or managers new to recruitment includes impact of equality and diversity for recruitment and selection. • Mediation service, staff guardian and fair treatment champions has had positive impact on helping staff to

	Indicator	Action planned	Responsible for action	Completion Date	Evidence of Achievement/ exception
	other colleagues	others and measuring managers on their ability to drive and implement diversity initiatives. Measurements for managers in their appraisals. 360 from staff contributing to measurement of achievement of the 'soft' targets e.g. behaviour etc. • Continue with employee engagement activities so that views are sought out; staff are listened to and see that their opinions count and make a difference to Safe Personal Effective care.	Staff Engagement Team	Ongoing	address conflict and reduce the number of cases reaching a formal level. • Corporate Induction includes a section on what we expect of staff at work in relation to dignity and respect for one another. All staff are expected to carry out their work in ways which are consistent with the trust values and behaviours. • Managers evaluate staff performance against the Trust values and behaviours through the performance appraisal process.
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	• Senior executives must take accountability by ensuring executive sponsorship for this target; consider using positive action for next Board member recruitment. • Explore the introduction of a 'reciprocal mentoring scheme' for BME staff to be paired up with members of the Exec/managers that report directly to the Exec team. • Explore succession planning that considers positive action for all board and senior positions and development of the talent pool generally.	Trust Board Executive Team/Senior Managers	March 2018	• 2 non-exec recruited in the last year by the NHS Improvements. • Reciprocal mentoring received by BME via the Diverse leader Programme and other leadership programs • NHS workforce race equality: a case for diverse boards publication disseminated to Board Members • Board receive regular updates on the WRES • Executive Directors attend the WRES group and feed back to Board

Appendix 4 – Workforce Race Equality standards metric 1 analysis by Agenda for Change bands Oct 2018

Key:			Increase	Decrease
Ethnicity Summary				
Ethnicity	**Headcount**	**Headcount %**	**Difference**	**Difference %**
White	6846	82.89%	185	0.13%
BME	1296	15.69%	60	0.33%
Not Stated	117	1.42%	-34	-0.46%
Grand Total	**8259**	**100.00%**	**211**	
Ethnicity by Band				
Ethnicity & Band	**Headcount**	**Headcount %**	**Difference**	**Difference %**
White	**6846**	**82.89%**	**185**	**0.13%**
Band 1	116	1.40%	7	0.05%
Band 2	1408	17.05%	35	-0.01%
Band 3	1021	12.36%	29	0.04%
Band 4	542	6.56%	5	-0.11%
Band 5	1416	17.14%	54	0.22%
Band 6	1190	14.41%	21	-0.12%
Band 7	546	6.61%	9	-0.06%
Band 8A	211	2.55%	4	-0.02%
Band 8B	59	0.71%	3	0.02%
Band 8C	22	0.27%	0	-0.01%
Band 8D	17	0.21%	2	0.02%
Band 9	10	0.12%	0	0.00%
Non AfC	288	3.49%	16	0.11%

Black Minority Ethnic	**1296**	**15.69%**	**60**	**0.33%**
Band 1	31	0.38%	4	0.04%
Band 2	238	2.88%	11	0.06%
Band 3	112	1.36%	1	-0.02%
Band 4	43	0.52%	3	0.02%
Band 5	318	3.85%	4	-0.05%
Band 6	162	1.96%	6	0.02%
Band 7	44	0.53%	3	0.02%
Band 8A	15	0.18%	0	0.00%
Band 8B	5	0.06%	0	0.00%
Band 8C	2	0.02%	0	0.00%
Non AfC	326	3.95%	28	0.24%
Not Stated/Undefined	**117**	**1.42%**	**-34**	**-0.46%**
Grand Total	**8259**	**100.00%**	**211**	

Key:

	High Under-representation of BME staff

Appendix 5 – WRES comparison by protected characteristics

	Indicator	Data 1st April 2017 to 31st March 2018				Narrative – the implications of the data and any additional background explanatory narrative
		RACE	GENDER	DISABILITY	SEXUALITY	
1	Percentage of BME/ Disabled/LGBT/Women staff, VSM (including executive Board members and senior medical staff) compared with the percentage of white staff in the overall workforce	Refer to appendix 1	Refer to appendix 2	Refer to appendix 3	Refer to appendix 4	
2.	Relative likelihood of BME/Disabled/LGBT/Women staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts	White staff 2.15 more likely to be appointed from shortlisting	Men are 0.38 times more likely to be appointed from shortlisting	Non-disabled people are staff 2.99 times more likely to be appointed from shortlisting	Heterosexual staff are 0.44 times more likely to be appointed from shortlisting	Gender and Sexuality are both very positive as it's below 1. Disability & Race are negative.
3.	Relative likelihood of BME/Disabled/LGBT/Women staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	BME staff 1.75 times more likely	Men staff 2.31 times more likely	Disabled staff are 1.02 times likely	LGB are 0.00 times likely	Men & BME staff fair worst LGB & Disability positive
4	Relative likelihood of BME/ Disabled/LGBT/Women staff accessing non-mandatory training and CPD as compared to White staff	White staff 1.19 times more likely to access CPD	Women 2.93 times more likely to access CPD	Non-disabled staff 0.99 times more likely to access CPD	No Data available, this will be reported from 2019.	Men & BME staff fair worst Disability positive

	Staff Survey Indicators 2017	RACE		GENDER		DISABILITY		SEXUALITY		
5.	KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**White**	**BME**	**Male**	**female**	**Yes**	**No**	**Heterosexual**	**LGB**	Disabled staff fair worst in this indicator
		26%	**22%**	**22%**	**26%**	**33%**	**24%**	**25%**	**29%**	
6.	KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	**20%**	**24%**	**19%**	**20%**	**31%**	**18%**	**23%**	**20%**	Disabled staff fair worst in this indicator
7	KF21. Percentage believing that the Trust provides equal opportunities for career progression or promotion	**87%**	**68%**	**76%**	**87%**	**78%**	**86%**	**85%**	**91%**	BME staff fair worst in this indicator
8	Q17B. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	**5%**	**16%**	**17%**	**9%**	**16%**	**9%**	**6%**	**8%**	BME, Disability & Men fair worst
9	Boards are expected to be broadly representative of the population they serve	**94%**	**6%**	**62%**	**38%**	**0%**	**22%**	**78%**	**0%**	12% Undisclosed LGB 72% Undisclosed disability

Appendix 6 Staff in Post by Ethnic Origin

	Non-Clinical Staff					Clinical Staff					All Staff				
Payband	**White**	**BME**	**Total**	**White**	**BME**	**White**	**BME**	**Total**	**White**	**BME**	**White**	**BME**	**Total**	**White**	**BME**
				%	%				%	%				%	%
Non-contracted hours	18	7	25	72.0%	28.0%	1	0	1	100.0%	0.0%	19	7	26	73.1%	26.9%
Band 1	91	52	143	63.6%	36.4%	0	0	0	0.0%	0.0%	91	52	143	63.6%	36.4%
Band 2	557	441	998	55.8%	44.2%	418	209	627	66.7%	33.3%	975	650	1625	60.0%	40.0%
Band 3	454	48	502	90.4%	9.6%	529	100	629	84.1%	15.9%	983	148	1131	86.9%	13.1%
Band 4	388	48	436	89.0%	11.0%	136	14	150	90.7%	9.3%	524	62	586	89.4%	10.6%
Band 5	214	61	275	77.8%	22.2%	994	439	1433	69.4%	30.6%	1208	500	1708	70.7%	29.3%
Band 6	131	79	210	62.4%	37.6%	951	182	1133	83.9%	16.1%	1082	261	1343	80.6%	19.4%
Band 7	108	34	142	76.1%	23.9%	412	34	446	92.4%	7.6%	520	68	588	88.4%	11.6%
Band 8A	58	16	74	78.4%	21.6%	141	8	149	94.6%	5.4%	199	24	223	89.2%	10.8%
Band 8B	34	5	39	87.2%	12.8%	22	1	23	95.7%	4.3%	56	6	62	90.3%	**9.7%**
Band 8C	16	1	17	94.1%	**5.9%**	6	0	6	100.0%	**0.0%**	22	1	23	95.7%	**4.3%**
Band 8D	12	0	12	100.0%	**0.0%**	4	0	4	100.0%	**0.0%**	16	0	16	100.0%	**0.0%**
Band 9	11	0	11	100.0%	**0.0%**	0	0	0	0.0%	**0.0%**	11	0	11	100.0%	**0.0%**
VSM	19	0	19	100.0%	**0.0%**	3	0	3	100.0%	**0.0%**	22	0	22	100.0%	**0.0%**
Medical: Consultants	0	0	0	0.0%	**0.0%**	147	114	261	56.3%	43.7%	147	114	261	56.3%	43.7%
Medical: Non-consultant career grades	0	0	0	0.0%	**0.0%**	57	92	149	38.3%	61.7%	57	92	149	38.3%	61.7%
Medical: Trainee grades	0	0	0	0.0%	**0.0%**	14	120	134	10.4%	89.6%	14	120	134	10.4%	89.6%
TOTAL	**2111**	**792**	**2903**	**72.7%**	**27.3%**	**3835**	**1313**	5148	74.5%	25.5%	**5946**	**2105**	**8051**	**73.9%**	**26.1%**

Appendix 6 Staff in post by Gender

	Non-Clinical Staff					Clinical Staff					All Staff				
Payband	**Male**	**Female**	**Total**	**Male**	**Female**	**Male**	**Female**	**Total**	**Male**	**Female**	**Male**	**Female**	**Total**	**Male**	**Female**
				%	%				%	%				%	%
Non-cont. hours	6	19	**25**	24.0%	76.0%	1	0	**1**	100.0%	0.0%	7	19	**26**	26.9%	73.1%
Band 1	45	105	**150**	30.0%	70.0%	0	0	**0**	0.0%	0.0%	45	105	**150**	30.0%	70.0%
Band 2	277	751	**1028**	26.9%	73.1%	68	563	**631**	10.8%	89.2%	345	1314	**1659**	20.8%	79.2%
Band 3	74	430	**504**	14.7%	85.3%	78	563	**641**	12.2%	87.8%	152	993	**1145**	13.3%	86.7%
Band 4	51	385	**436**	11.7%	88.3%	19	131	**150**	12.7%	87.3%	70	516	**586**	11.9%	88.1%
Band 5	87	193	**280**	31.1%	68.9%	121	1329	**1450**	8.3%	91.7%	208	1522	**1730**	12.0%	88.0%
Band 6	60	151	**211**	28.4%	71.6%	83	1051	**1134**	7.3%	92.7%	143	1202	**1345**	10.6%	89.4%
Band 7	48	94	**142**	33.8%	66.2%	48	400	**448**	10.7%	89.3%	96	494	**590**	16.3%	83.7%
Band 8A	22	53	**75**	29.3%	70.7%	20	134	**154**	13.0%	87.0%	42	187	**229**	18.3%	81.7%
Band 8B	13	26	**39**	33.3%	66.7%	3	20	**23**	13.0%	87.0%	16	46	**62**	25.8%	74.2%
Band 8C	10	8	**18**	55.6%	44.4%	0	6	**6**	0.0%	100.0%	10	14	**24**	41.7%	58.3%
Band 8D	2	10	**12**	16.7%	83.3%	1	3	**4**	25.0%	75.0%	3	13	**16**	18.8%	81.3%
Band 9	5	6	**11**	45.5%	54.5%	0	0	**0**	0.0%	0.0%	5	6	**11**	45.5%	54.5%

VSM	14	5	**19**	73.7%	26.3%	1	2	**3**	33.3%	66.7%	15	7	**22**	68.2%	31.8%
Medical: Consultants	0	0	**0**	0.0%	0.0%	197	96	**293**	67.2%	32.8%	197	96	**293**	67.2%	32.8%
Medical: Non-consultant career grades	0	0	**0**	0.0%	0.0%	102	49	**151**	67.5%	32.5%	102	49	**151**	67.5%	32.5%
Medical: Trainee grades	0	0	**0**	0.0%	0.0%	72	70	**142**	50.7%	49.3%	72	70	**142**	50.7%	49.3%
TOTAL	**714**	**2236**	**2950**	**24.2%**	**75.8%**	**814**	**4417**	**5231**	**15.6%**	**84.4%**	**1528**	**6653**	**8181**	**18.7%**	**81.3%**

Appendix 6 Staff in Post by Disability Status

	Non-Clinical Staff							Clinical Staff											
Payband	**Yes**	**No**	**Unspecified**	**Total**	**Yes**	**No**	**Unspecified**	**Yes**	**No**	**Unspecified**	**Total**	**Yes**	**No**	**Unspecified**	**Yes**	**No**	**Unspecified**	**Total**	**Yes**	**No**
Non-contract hours	2	9	14	**25**	8.0%	36.0%	56.0%	0	1	0	**1**	0.0%	100.0%	0.0%	2	10	14	**26**	7.7%	38.5%
Band 1	9	79	62	**150**	6.0%	52.7%	41.3%	0	0	0	**0**	0.0%	0.0%	0.0%	9	79	62	**150**	6.0%	52.7%
Band 2	29	599	400	**1028**	2.8%	58.3%	38.9%	14	328	289	**631**	2.2%	52.0%	45.8%	43	927	689	**1659**	2.6%	55.9%
Band 3	28	359	117	**504**	5.6%	71.2%	23.2%	19	441	181	**641**	3.0%	68.8%	28.2%	47	800	298	**1145**	4.1%	69.9%
Band 4	12	342	82	**436**	2.8%	78.4%	18.8%	3	103	44	**150**	2.0%	68.7%	29.3%	15	445	126	**586**	2.6%	75.9%
Band 5	4	217	59	**280**	1.4%	77.5%	21.1%	41	777	632	**1450**	2.8%	53.6%	43.6%	45	994	691	**1730**	2.6%	57.5%
Band 6	2	136	73	**211**	0.9%	64.5%	34.6%	28	787	319	**1134**	2.5%	69.4%	28.1%	30	923	392	**1345**	2.2%	68.6%
Band 7	5	98	39	**142**	3.5%	69.0%	27.5%	9	322	117	**448**	2.0%	71.9%	26.1%	14	420	156	**590**	2.4%	71.2%
Band 8A	4	55	16	**75**	5.3%	73.3%	21.3%	6	108	40	**154**	3.9%	70.1%	26.0%	10	163	56	**229**	4.4%	71.2%
Band 8B	2	24	13	**39**	5.1%	61.5%	33.3%	0	17	6	**23**	0.0%	73.9%	26.1%	2	41	19	**62**	3.2%	66.1%
Band 8C	0	10	8	**18**	0.0%	55.6%	44.4%	0	2	4	**6**	0.0%	33.3%	66.7%	0	12	12	**24**	0.0%	50.0%

Band 8D	0	6	6	**12**	0.0%	50.0%	50.0%	0	4	0	**4**	0.0%	100.0%	0.0%	0	10	6	**16**	0.0%	62.5%
Band 9	0	6	5	**11**	0.0%	54.5%	45.5%	0	0	0	**0**	0.0%	0.0%	0.0%	0	6	5	**11**	0.0%	54.5%
VSM	0	5	14	**19**	0.0%	26.3%	73.7%	0	1	2	**3**	0.0%	33.3%	66.7%	0	6	16	**22**	0.0%	27.3%
Medical: Consultants	0	0	0	**0**	0.0%	0.0%	0.0%	0	247	46	**293**	0.0%	84.3%	15.7%	0	247	46	**293**	0.0%	84.3%
Non-consultant	0	0	0	**0**	0.0%	0.0%	0.0%	3	134	14	**151**	2.0%	88.7%	9.3%	3	134	14	**151**	2.0%	88.7%
Medical: Trainee	0	0	0	**0**	0.0%	0.0%	0.0%	3	134	5	**142**	2.1%	94.4%	3.5%	3	134	5	**142**	2.1%	94.4%
TOTAL	**97**	**1945**	**908**	**2950**	**3.3%**	**65.9%**	**30.8%**	**126**	**3406**	**1699**	**5231**	**2.4%**	**65.1%**	**32.5%**	**223**	**5351**	**2607**	**8181**	**2.7%**	**65.4%**

Appendix 6 Staff in Post by Sexuality

	All Staff										
Payband	**Heterosexual**	**Bisexual**	**Gay**	**Lesbian**	**Not Disclosed**	**Total**	**Heterosexual**	**Bisexual**	**Gay**	**Lesbian**	**Not Disclosed**
							%	%	%	%	%
Non-contracted hours	21	0	0	1	4	**26**	80.8%	0.0%	0.0%	3.8%	15.4%
Band 1	99	0	0	2	49	**150**	66.0%	0.0%	0.0%	1.3%	32.7%
Band 2	1332	5	5	6	311	**1659**	80.3%	0.3%	0.3%	0.4%	18.7%
Band 3	883	2	6	5	249	**1145**	77.1%	0.2%	0.5%	0.4%	21.7%
Band 4	483	0	1	4	98	**586**	82.4%	0.0%	0.2%	0.7%	16.7%
Band 5	1433	4	9	12	272	**1730**	82.8%	0.2%	0.5%	0.7%	15.7%
Band 6	1103	3	5	10	224	**1345**	82.0%	0.2%	0.4%	0.7%	16.7%
Band 7	510	0	2	1	77	**590**	86.4%	0.0%	0.3%	0.2%	13.1%
Band 8A	191	0	1	2	35	**229**	83.4%	0.0%	0.4%	0.9%	15.3%
Band 8B	54	0	2	0	6	**62**	87.1%	0.0%	3.2%	0.0%	9.7%
Band 8C	18	0	1	0	5	**24**	75.0%	0.0%	4.2%	0.0%	20.8%
Band 8D	10	0	2	0	4	**16**	62.5%	0.0%	12.5%	0.0%	25.0%
Band 9	9	0	0	0	2	**11**	81.8%	0.0%	0.0%	0.0%	18.2%
VSM	16	0	0	0	6	**22**	72.7%	0.0%	0.0%	0.0%	27.3%

Medical: Consultants	210	0	1	1	81	**293**	71.7%	0.0%	0.3%	0.3%	27.6%
Medical: Non-consultant career grades	116	2	0	0	33	**151**	76.8%	1.3%	0.0%	0.0%	21.9%
Medical: Trainee grades	115	2	6	1	18	**142**	81.0%	1.4%	4.2%	0.7%	12.7%
TOTAL	**6603**	**18**	**41**	**45**	**1474**	**8181**	**80.7%**	**0.2%**	**0.5%**	**0.6%**	**18.0%**

Appendix 6 Staff in Post by Religious Belief

Payband	Christianity	Islam	Hinduism	Buddhism	Judaism	Sikhism	Other	Atheism	Undisclosed
	%	%	%	%	%	%	%	%	%
Non-contracted hours	26.9%	19.2%	0.0%	0.0%	3.8%	0.0%	11.5%	15.4%	23.1%
Band 1	39.3%	15.3%	0.0%	2.0%	0.0%	0.0%	5.3%	4.0%	34.0%
Band 2	55.1%	10.3%	0.1%	0.1%	0.1%	0.0%	6.4%	8.4%	19.5%
Band 3	57.4%	7.2%	0.1%	0.3%	0.0%	0.0%	6.0%	6.2%	22.9%
Band 4	63.1%	5.1%	0.0%	0.2%	0.0%	0.0%	6.0%	7.0%	18.6%
Band 5	60.6%	9.5%	0.3%	0.2%	0.1%	0.1%	4.9%	8.7%	15.7%
Band 6	60.4%	6.5%	0.5%	0.1%	0.1%	0.0%	4.9%	8.6%	18.8%
Band 7	66.8%	3.7%	1.0%	0.3%	0.2%	0.0%	4.6%	6.4%	16.9%
Band 8A	59.4%	3.1%	1.3%	0.0%	0.0%	0.0%	7.0%	11.4%	17.9%
Band 8B	74.2%	4.8%	0.0%	0.0%	0.0%	0.0%	1.6%	11.3%	8.1%
Band 8C	58.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	16.7%	25.0%
Band 8D	62.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	12.5%	25.0%
Band 9	72.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	9.1%	18.2%
VSM	59.1%	0.0%	0.0%	4.5%	0.0%	0.0%	0.0%	4.5%	31.8%
Medical: Consultants	26.3%	13.3%	11.9%	1.0%	0.3%	1.0%	4.1%	10.2%	31.7%
Non-con grades	19.9%	33.8%	13.2%	2.0%	0.0%	0.0%	2.6%	6.0%	22.5%
Medical: Trainee grades	21.1%	32.4%	2.1%	1.4%	0.7%	0.7%	9.2%	14.1%	18.3%
TOTAL	**56.5%**	**8.9%**	**1.0%**	**0.3%**	**0.1%**	**0.1%**	**5.5%**	**8.1%**	**19.5%**

Appendix 7 – Employee Relations Data by protected characteristics

Bullying & Harrassment cases: Equality and Diversity data

01/04/2017 - 31/03/2018

Gender

	Number	%
Male	11	30.6%
Female	25	69.4%
Total	36	100%

Disability

	Number	%
Yes	2	5.6%
No	25	69.4%
Undisclosed	9	25.0%
Total	36	100%

Age Band

	Number	%
18-25	3	8.3%
26-35	8	22.2%
36-50	19	52.8%
51+	6	16.7%
Total	36	100%

Sexuality

	Number	%
Heterosexual	29	80.6%
Bisexual	0	0.0%
Gay	2	5.6%
Lesbian	1	2.8%
Undisclosed	4	11.1%
Total	36	100%

Religious Belief

	Number	%
Christianity	20	55.6%
Islam	3	8.3%
Hinduism	0	0.0%
Buddhism	1	2.8%
Other	5	13.9%
Atheism	2	5.6%
Undisclosed	5	13.9%
Total	36	100%

Grievance cases: Equality and Diversity data

01/04/2017 - 31/03/2018

Gender

	Number	%
Male	13	28.9%
Female	32	71.1%
Total	45	100%

Disability

	Number	%
Yes	2	4.4%
No	26	57.8%
Undisclosed	17	37.8%
Total	45	100%

Age Band

	Number	%
18-25	2	4.4%
26-35	8	17.8%
36-50	14	31.1%
51+	21	46.7%
Total	45	100%

Sexuality

	Number	%
Heterosexual	36	80.0%
Bisexual	0	0.0%
Gay	1	2.2%
Lesbian	0	0.0%
Undisclosed	8	17.8%
Total	45	100%

Religious Belief

	Number	%
Christianity	29	64.4%
Islam	4	8.9%
Hinduism	0	0.0%
Buddhism	0	0.0%
Other	3	6.7%
Atheism	1	2.2%
Undisclosed	8	17.8%
Total	45	100%

Appendix 8 - Equality Delivery System Scores

Goal	Outcome		Grade
1	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Developing
1	1.2	Individual people's health needs are assessed and met in appropriate and effective ways	Achieving
1	1.3	Transitions from one service to another are made smoothly with everyone well informed	Developing
1	1.4	When people use services their safety is prioritised and they are free from mistakes, mistreatment and abuse	Achieving
1	1.5	Screening, vaccination and other health promotion services reach and benefit all local communities	Achieving
2	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Excelling
2	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	Achieving
2	2.3	People report positive experiences of the NHS	Achieving
2	2.4	People's complaints about services are handled respectfully and efficiently	Developing
3	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Achieving
3	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Undeveloped
3	3.3	Training and development opportunities are taken up and positively evaluated by all staff	Achieving
3	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	Achieving
3	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Undeveloped
3	3.6	Staff report positive experiences of their membership of the workforce	Achieving
4	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.	Achieving
4	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed.	Undeveloped
4	4.3	Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination.	Developing

Culture and Leadership Programme

East Lancashire Hospitals NHS
NHS Trust

Item 18

Our Culture and Leadership Programme

Phase 2- Update and Design Principle Approval

Emma Schofield, Deputy Director of HR&OD

Trust Board

9 January 2019

Safe | Personal | Effective

Year 1 Focus


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

Our People Vision

- We deliver a safe, personal and effective care because we own, understand and embody our values and behaviours
- We all work together to deliver a service we are proud of each and every day to be the best we can be
- We understand what ELHT wants to achieve. We know what is expected of us because we have clear objectives and get authentic, regular feedback on our performance
- We invest in and train our managers and leaders to ensure they have the skills to lead, engage and create high performing teams.
- We are empowered individually and as teams to deliver our services and we build on our strengths and address our areas for development
- We engage with our colleagues, patients, carers and the public because we care about their experience, so that we can listen, respond and improve
- We take personal responsibility for our learning, innovation, behaviours and our decisions
- We work together to provide safe, personal and effective care

Safe | Personal | Effective

Development of our Approaches - Approval & Implementation

Enabler

HR&OD:

- Research, Design and lead Testing
- Training
- Delivery & Implementation Arrangements & Advice

Enabler

Change Team:

- Input into Design;
- Feedback;
- Supports Implementation;
- Champion Approach;

Enabler

Enabling Group:

- Input into Design;
- Endorse Approach for Approval.
- Develop communication and engagement plan

Trust Board Approval of Approach

Delivery
Executive Team & Divisional Triads Buy in and Role Model Approach & Lead Implementation

There are 8 priority areas that have emerged from the design phase for action over the next 12 months

Timeline for implementation over the next 12 months

Safe | Personal | Effective

Any Questions…

Safe | Personal | Effective

Programme Design Principles

- These principles will guide the design of our ELHT approaches (i.e. our approach to talent management):
- The C&L programme is a priority transformation programme and is part of the Executive visibility wall (A3). The CEO is sponsor to the programme. We use our continuous improvement methodology.
- Our bespoke ELHT approaches are designed to meet our needs and underpinned by research evidence and staff feedback.
- The HR &OD Team are responsible for the design of the approach, delivery of training and provision of advice to support implementation
- The Executive Team and Divisional triads are accountable for delivery, implementation and gaining buy in to the approach
- The 'Enabling Group' (chaired by the Director of Operations) is responsible for shaping and endorsing the approach. Approval will be sought via the Quality Committee and Trust Board
- The 'Change Team' and 'Engaging Managers Programme Alumni' play an important role in shaping the design, providing feedback and supporting implementation of our approaches
- The communications and engagement team support the Enabling Group to design and implement the communications plan.
- Design principles are developed for each approach (by the HR&OD Team) and endorsed by the enabling group, to describe our ELHT requirements and expected outcomes. Our approach to change will be based on an incremental progression
- Approaches are underpinned by the principles of compassionate, collective and inclusive leadership and our diagnostic findings. Our Standards of Behaviour will be integrated into our employment life cycle.
- Approaches will be designed based on customer feedback and Trust requirements and are fully documented to support consistent and lasting implementation.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

9 January 2019

Item 19

Purpose Information Assurance

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

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

Recommendation: Members of Finance are Performance Committee are requested to note the attached report for assurance.

Report linkages

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

(19) Integrated Performance Report for the period to November 2018

Impact

Legal	Legal	Legal	Legal
Equality	Equality	Equality	Equality

Previously considered by: Not applicable

Board of Directors, Update

Corporate Report

Executive Overview Summary

No never events were reported during November 2018. A total of nine incidents were reported to StEIS during the period.

Two clostridium difficile infections were detected during November, which is on trajectory for the month. Cumulative position is 21 against trust target of 27 for the year. No MRSA during November.

Nursing and midwifery staffing in November 2018 continued to be a challenge, although of note is a slight improvement in month, with 9 areas falling below an 80% average fill rate for registered nurses on day shifts as opposed to 14 areas in October.

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

The Emergency Care 4 hour standard remains below the 95% threshold at 80.7% (Pennine A&E Delivery Board).

The proportion of delayed discharges has improved to 3.4% which is below the 3.5% threshold. This equates to 28 beds lost per day.

The number of ambulance handovers over 30 minutes decreased during November. The HAS compliance remained above the threshold and the average handover time has decreased in November to 17:41 minutes from 19:16 minutes in October.

There were 22 mental health breaches of the 12 hour trolley wait standard in November, all as a result of waits for mental health beds within Lancashire Care Foundation Trust.

The 6wk diagnostic target was met in November at 0.3%

The number of operations cancelled on the day decreased in November and there were no breaches of the 28 day standard.

The Referral to Treatment (RTT) target was again achieved at 92.6% above the 92% standard.

There were no breaches of the 52wk standard at the end of November.

The cancer 62 day target was not met during October at 81.0%, however the GP 2 week and 31 day standards were achieved.

Sickness rates are above threshold (5.1%) and remain higher than last year (4.7%)

The vacancy rate increased to 7.8% in November and remains above threshold and

above last year (6.8%).

Compliance against the Information Governance Toolkit remains below threshold as well as Trust appraisal rates (AFC staff). All other areas of core skills training are above threshold.

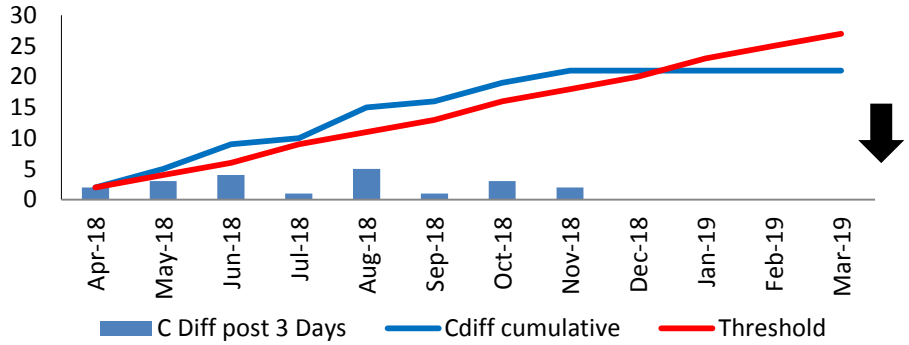
While the revised 2018-19 underlying control total for the Trust of a £15.798 million deficit has been met for the first eight months of 2018-19, with a deficit of £10.879 million reported, the current 'likely' forecast indicates a financial pressure of £3.629 million against the Trust's plan for the year as a whole. This pressure is a combination of pay pressures (agency and locum costs) and likely slippage in the release of efficiency schemes in the final two quarters. The Trust will need to mitigate this pressure in order to deliver its financial plan.

Introduction

This report presents an update on the performance for April - November 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

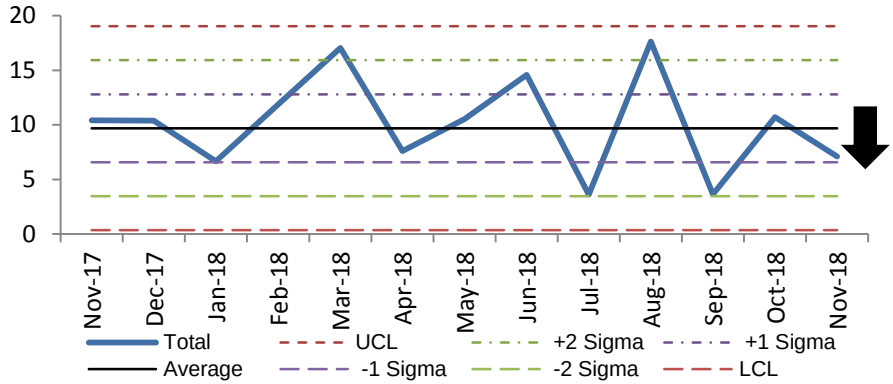


There were no post 2 day MRSA infections reported in November. Year to date there has been 1 case attributed to ELHT.

There were two Clostridium difficile toxin positive isolates identified in the laboratory in October which were post 3 days of admission.

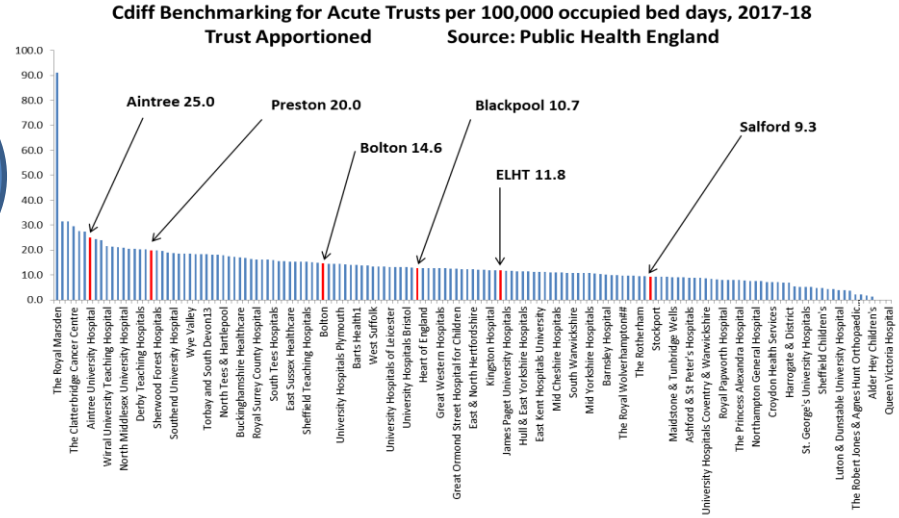
The year to date cumulative figure is 21 against the trust target of 27. The detailed infection control report will be reviewed through the Quality Committee.

C Difficile per 100,000 occupied bed days



The rate of infection per 100,000 bed days decreased in November to 7.1, below average.

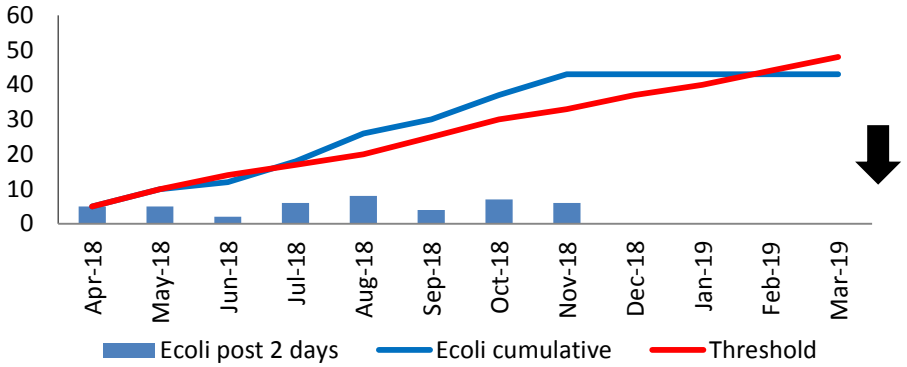
C Difficile benchmarking



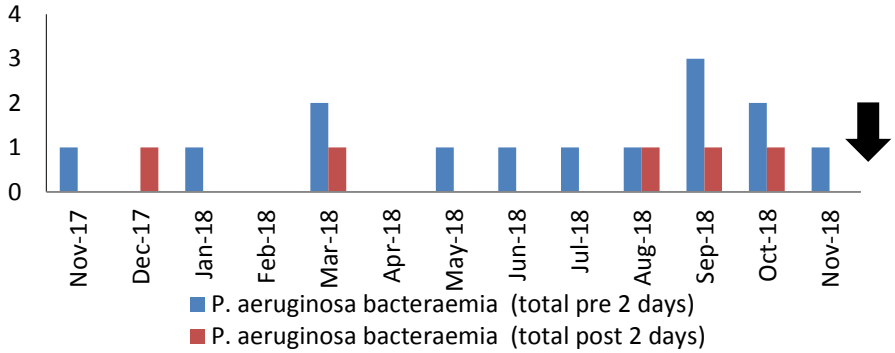
ELHT ranked 71st out of 151 trusts in 2017-18 with 11.8 clostridium infections per 100,000 bed days. The best performing trust had 0 and the worst performer had 91 infections per 100,000 bed days.

SAFE

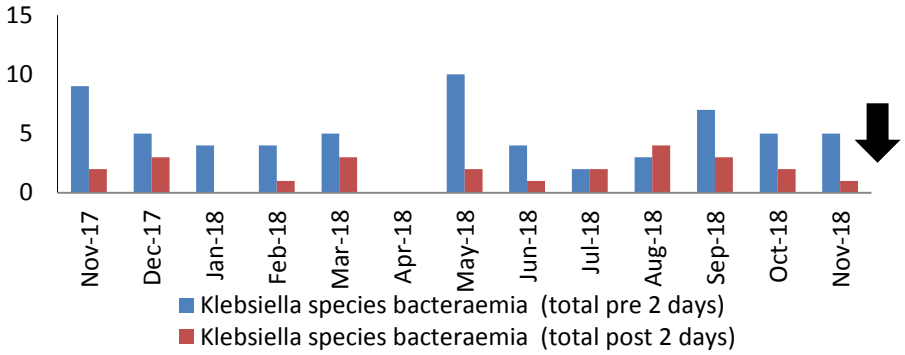
E. Coli



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 November, which is above the monthly threshold.

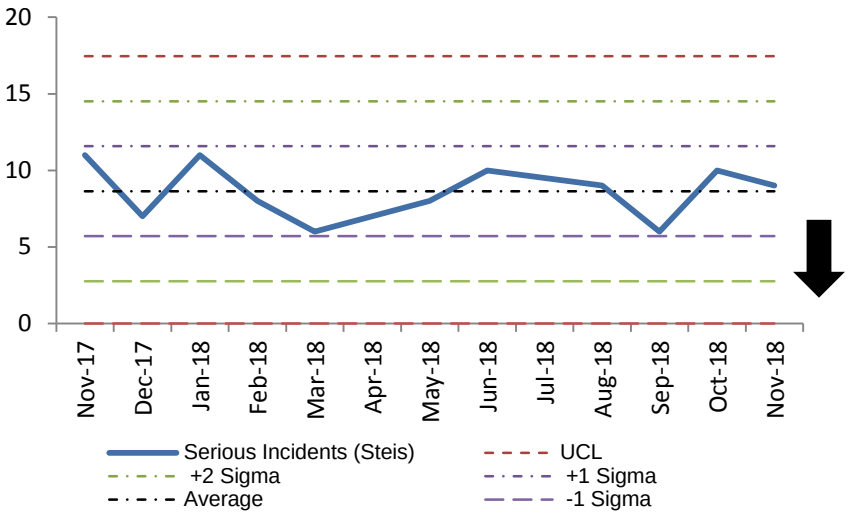
From April 2017, NHS Trusts must report cases of bloodstream infections due to *Klebsiella species* and *Pseudomonas aeruginosa* to Public Health England.

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.

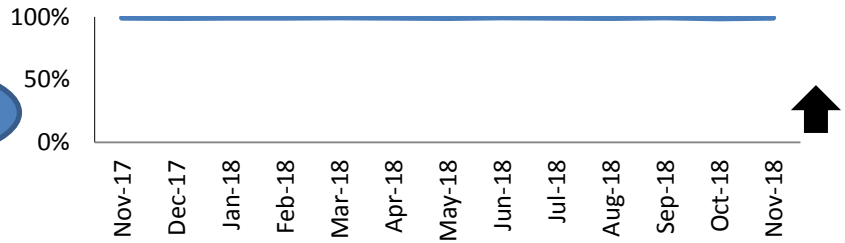
The work on catheter care, prevention of line infections, sepsis and improving hydration will help prevent healthcare associated bloodstream infections

SAFE

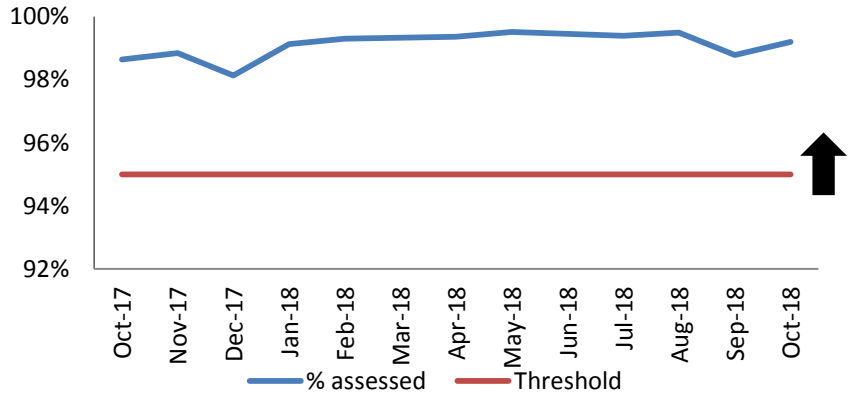
Serious Incidents



% Harm Free



VTE assessment



There were no never events reported in November.

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

StEIS Category	No. Incidents
Treatment Delay	3
Pressure Ulcer Grade 3	2
Sub optimal care of deteriorating patient	1
Slips Trips Falls	1
Diagnostic Incident	1
Treatment problem/ issue	1

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

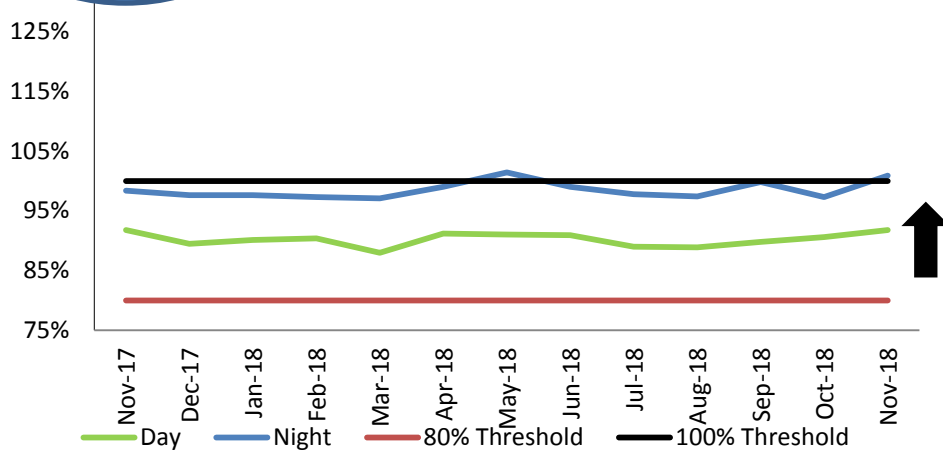
The Trust remains consistent with the percentage of patients with harm free care at 99.3% for November using the National safety thermometer tool.

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

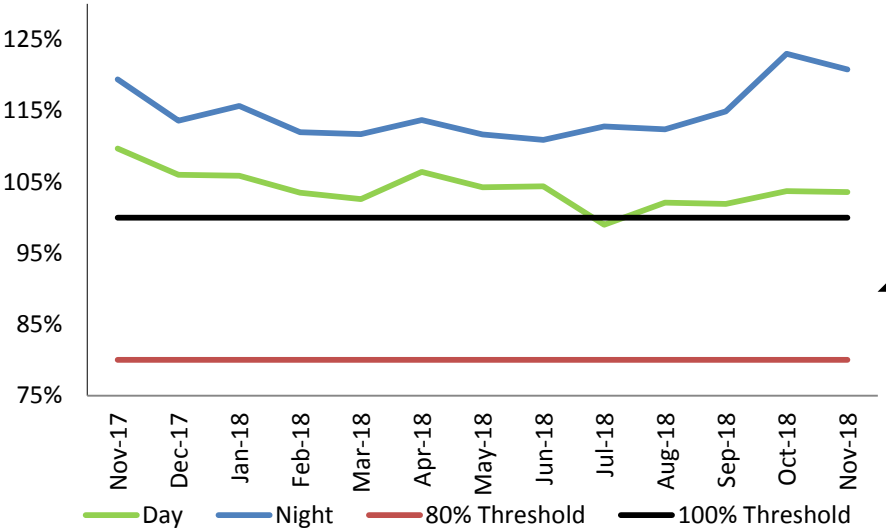
Pressure Ulcers	Hospital Aquired	Community Aquired
Grade 2	2	2
Grade 3	0	1
Grade 4	0	0

SAFE

Registered Nurses/ Midwives



Care Staff



Nursing and midwifery staffing in November 2018 continued to be a challenge, although of note is a slight improvement in month with 9 areas falling below an 80% average fill rate for registered nurses on day shifts as opposed to 14 areas in October.

The causative factors remain as in previous months, compounded by escalation areas being opened, pressures within the emergency department, vacancies, sickness and the ability to fill all requests through ELHT internal bank or via agency. Safe care (acuity data) is utilised when considering safe staffing and the redeployment of staff and safe staffing is monitored throughout the day.

Of the 9 areas below the 80% for registered nurses on day shifts, the majority were due to lack of co-ordinator presence which is in addition to safe staffing levels, leaving 1 area of concern for registered nurses:

Ward 16 - The majority of the low fill rate was due to co-ordinator unavailability. There were a total of 9 shifts which were below previously agreed safe staffing levels. However on 8 of these occasions there were a reduced number of beds in operation and registered nurse staffing remained at a ratio of 1:8 in daylight hours.

2 areas on the day shift and 1 area for the night shift for health care support workers fell below the 80% average fill rate

Ward 2 (ACV) - was only opened for 15 days within the month of November with some beds closed within that time frame, hence the figures looking skewed.

Ward C4 – Whilst the ward only had 26% of day shifts with the agreed 4 health care support workers present, the ward has trainee nursing associates working on the ward, who are currently not counted within planned and actual staffing

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.

SAFE

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
Nov-18	91.8%	103.6%	100.9%	120.8%	26,380	8.68	9	2	0	1

Red Flag Incidents

There were 5 red flag incidents reported in November, 1 relates to the emergency department and the inability to reliably carry out intentional rounding. The division has given assurance that no harm occurred as a consequence. Three of the red flags relate to SAS (C18a, C18a, C22), 2 of them were as a result of agency staff not arriving, leaving one registered nurse for a period of time until help could be sent from other areas of the trust. One relates to a ward which was staffed to its current establishment but the staff felt the acuity was such that they should have had a second health care support worker on the night shift. This resulted in a delay answering call bells and providing basic care needs in a timely manner. The division has provided assurance that there were no harms as result of the red flag incidents.

The 5th red flag relates to the gynaecology ward and will be discussed with the Family Care section of this report

Actions taken:

- 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, utilising acuity and dependency (Safe Care)
- 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 were given initially. Between 3/10/18 and 21/11/18, **7** nurses have arrived, with the first nurse recently passing her OSCE and achieving her NMC registration. Of the original offers of employment, another 9 nurses are in regular contact with us and are expected to arrive, hopefully in the New Year. Despite everyone's best efforts, 9 nurses have disengaged with us and are not answering emails and attempts to keep in touch and the Trust will make a decision in the next couple of weeks to withdraw the offer of employment. Skype interviews are due to take place the week commencing the 17th December for a further cohort of Indian nurses and the Trust hopes to be able to offer another 20 posts (supported by finance)
- The Trust has agreed to recruit a further 20 trainee nursing associates.

Family Care

On reviewing Datix 10 incidents were reported overall as Red Flag events in Family Care Division in November.
Of these, 10 incidents reported 2 have been excluded as they related to medical staffing.
Of the remaining 8 incidents reported 5 of them occurred within Maternity Services and 1related to the Gynaecology Ward and 2 the Paediatric Unit, all related to staffing issues.
The incidents were reported under the following category and sub-categories:

Maternity Services - 5
2 staffing issue – staff shortage – other. *No harm, impact prevented*.
1 staffing issue – staff shortage midwives. *No harm, impact prevented.*
2 staffing issue – staff indicated concerns. *No harm, impact prevented.*

3 of the above 5 incidents related to the number of Transitional Care babies being on the Postnatal Ward

Gynaecology Ward – 1
1 staffing issue- less than 2 registered nurses on a shift. *No harm, impact not prevented.*

Due to vacancies and sickness Gynaecology had to use agency this month to fill the shifts. There was a red flag incident this month when from 2am till 7am there was only 1 registered nurse on duty as an agency nurse did not turn up for the shift. The duty sister on the BGH site was informed and was aware to support the ward and the acuity was safe and no patients came to any harm.

Paediatric Unit – 2
1 staffing issue – staff shortage nursing. *No harm, impact prevented*.
1 staffing issue – staff shortage other. *No harm, impact prevented*.

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, Matron on Call, and Night Manager were informed of plans and communication was excellent throughout.

Maternity
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.

Maternity

Month	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Staffed to full Establishment	01:30.0	01:29	01:28.7	01:28.6	01:29	01:28.2	01:28.7	01:29.2	01:29	01:27	01:26	01:28
Excluding mat leave and vacancies	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	01:30	01:28.4	01:27.5	01:29
With gaps filled through ELHT Midwife staff bank	01:30.1	01:28.3	01:28.7	01:28.5	01:28.4	01:28.5	01:28.8	01:29.4	01:29	01:27	01:26	01:28
	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	Bank Usage 9.28 WTE	Bank Usage 9.5 WTE	Bank Usage 6.5WTE	Bank Usage 5.74WTE

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 for the period 01/10/18 - 31/03/18

NICU

Staffing pressures in November on NICU were due to sickness approximately 7 WTE, mainly short term, over the month, combined with also high activity resulting in closure of the unit to external activity at times.
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.

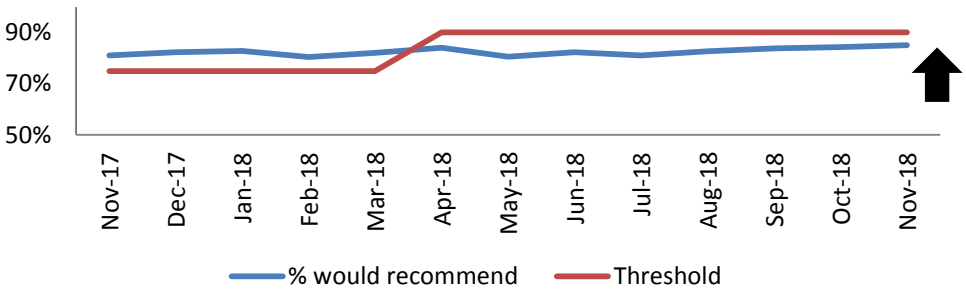
Paediatrics

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

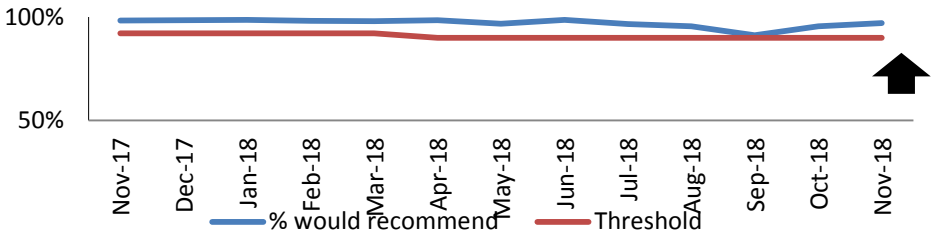
Friends & Family A&E



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.

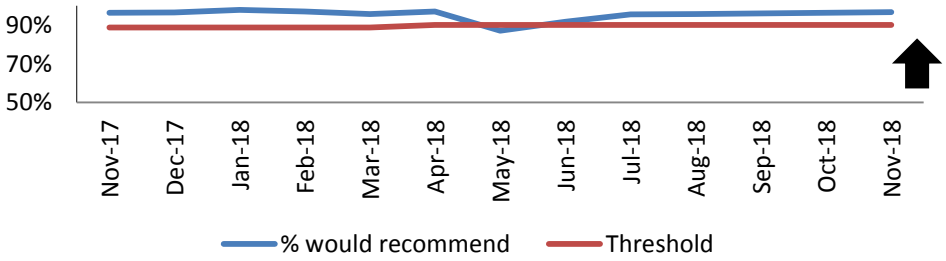
The proportion that would recommend A&E to friends and family has increased in November to 85.1% with a response rate of 20.2%

Friends & Family Inpatient



The proportion that would recommend inpatient services has improved to 97.1% in November. The response rate was 47.3%

Friends & Family Community

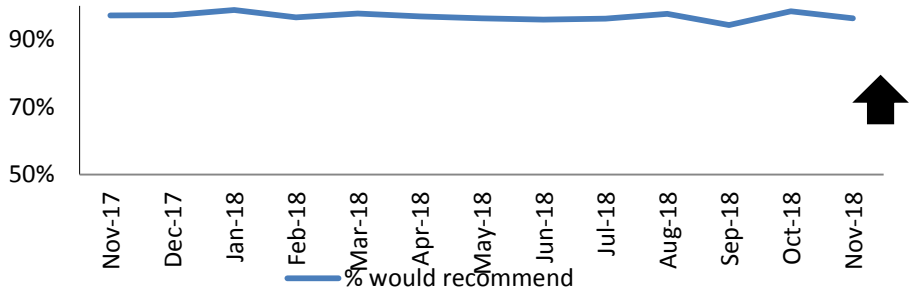


Community services would be recommended by 96.7% in November.

Maternity services would be recommended by 96.3% in November.

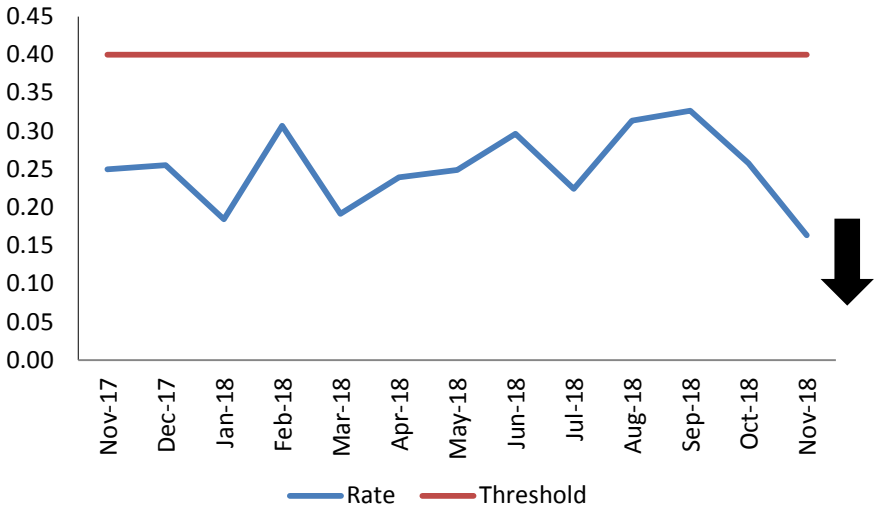
Volunteer support is now available for inputting responses and matrons are alerted to areas with low response rates.

Friends & Family Maternity



CARING

Complaints per 1000 contacts



The Trust opened 20 new formal complaints in November.
The number of complaints closed was 27.

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 November the number of complaints received was 0.16 Per 1,000 patient contacts.

Patient Experience

November 2018 Totals	Dignity	Information	Involvement	Quality	Overall
	Average Score %	Average Score %	Average Score %	Average Score %	Average Score %
Trust	97%	91%	93%	93%	93%
Integrated Care Group - Acute	97%	90%	93%	92%	92%
Integrated Care Group - Community	96%	94%	94%	97%	95%
Surgery	95%	86%	91%	93%	91%
Family care	99%	96%	97%	97%	97%
Diagnostic and Clinical	92%	90%	90%	73%	86%

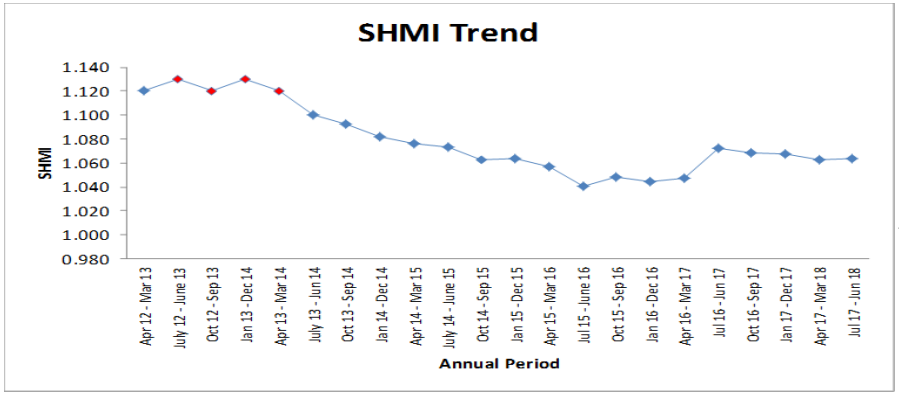
The table demonstrates divisional performance from the range of patient experience surveys in November 2018. The threshold is a positive score of 90% or above for each of the 4 competencies.

The overall Trust performance from the range of patient experience surveys is above the threshold of 90% for all of the 4 competencies in November 2018.

Two divisional areas fell below threshold in November - the Information competency in Surgical Division and the Quality competency in Diagnostic & Clinical Support.

EFFECTIVE

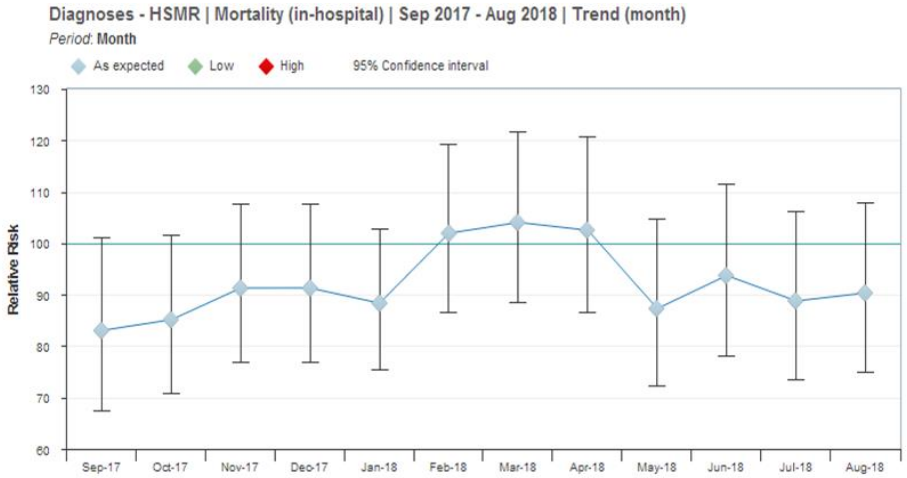
SHMI Published Trend



Dr Foster HSMR rolling 12

	HSMR Rebased on latest month Sep 17 – Aug 18 (Risk model May 18)
TOTAL	92.5 (CI 88.0 – 97.1)
Weekday	91.1 (CI 86.0 – 96.4)
Weekend	96.6 (CI 87.6 – 106.2)
Deaths in Low Risk Diagnosis Groups	52.6 (CI 26.2 – 94.2)

Dr. Foster HSMR monthly Trend



The latest Trust SHMI value as reported by the Health and Social Care Information Centre and Care Quality Commission for the period July 17 to June 18 has remained at 1.063 and is still within expected levels, as published in November 2018.

The latest indicative 12 month rolling HSMR (September 17 – August 18) remains 'significantly better than expected' at 92.5 against the monthly rebased risk model.

The weekday HSMR is also 'significantly better than expected'

Septicaemia continues to alert on the HSMR and the SHMI.

There are currently two 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.

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.

EFFECTIVE

Structured Judgement Review Summary

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

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

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

	Month of Death															
Stage 1	pre Oct 17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	TOTAL
Deaths requiring SJR (Stage 1)	46	50	37	28	34	29	29	28	24	24	27	19	30	30	17	452
Allocated for review	46	50	37	28	34	27	26	23	21	16	19	12	17	16	4	376
SJR Complete	43	49	33	26	26	26	21	17	11	4	12	6	4	2	0	280
1 - Very Poor Care	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	3
2 - Poor Care	8	4	4	3	4	2	1	1	1	2	1	0	0	1	0	32
3 - Adequate Care	13	16	8	10	7	8	8	2	1	0	4	1	0	0	0	78
4 - Good Care	17	25	19	9	14	13	10	12	6	2	6	3	3	1	0	140
5 - Excellent Care	3	4	2	3	1	3	2	2	3	0	1	2	1	0	0	27
Stage 2																
Deaths requiring SJR (Stage 2)	10	4	4	4	4	2	1	1	1	2	1	0	0	1	0	35
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	0	1	1	0	0	0	0	0	0	0	0	0	0	0	5
Allocated for review	6	4	3	3	4	2	1	1	1	2	1	0	0	1	0	29
SJR-2 Complete	6	4	3	3	4	2	1	1	1	2	0	0	0	0	0	27
1 - Very Poor Care	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2
2 - Poor Care	3	1	2	1	1	1	0	1	0	0	0	0	0	0	0	10
3 - Adequate Care	2	3	1	2	2	1	0	0	1	2	0	0	0	0	0	14
4 - Good Care	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
5 - Excellent Care	0	0	0	0	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	Aug-18	Sep-18	Oct-18	Nov-18	Total
stage 1 requiring allocation	0	0	0	0	0	2	3	5	3	8	8	7	13	14	13	76
stage 1 requiring completion	3	1	4	2	8	1	5	6	10	12	7	6	13	14	4	96
Backlog	3	1	4	2	8	3	8	11	13	20	15	13	26	28	17	172
stage 2 requiring allocation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
stage 2 requiring completion	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	2
Backlog	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	2

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:

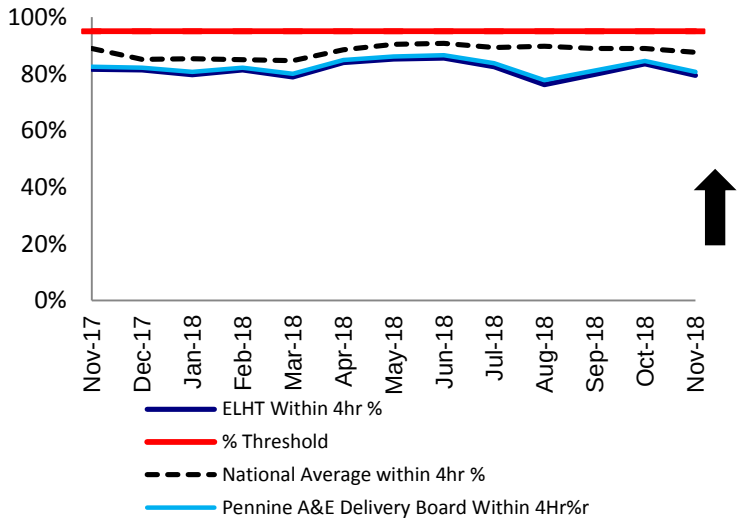
1. NHS Staff Health and Wellbeing
2. Reducing the impact of serious infections
3. Improving services for people with mental health needs who present to A & E
4. Preventing ill health by risky behaviours (2018/2019 only).
5. Personalised care/support planning

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%	100.0%	100.0%	100.0%							100%	100%		
national	**SEPSIS PART B - ANTIBIOTIC ADMINISTRATION - TOTAL %**	90.0%	90.4%	93.4%	90.6%	92.2%	100.0%	96.9%							91.5%	96.4%		
national	**SEPSIS PART C - ANTIBIOTIC REVIEW -** % Prescriptions Reviewed within 72 Hrs	Q1 25% Q2 50% Q3 75% Q4 90%	100%				90%								100%	90%		
national	**REDUCTION IN ANTIBIOTIC CONSUMPTION- PART D**- Total antiobiotic consumption per 1000 admissions	4845.1	5107.3												5,107			
national	-Antibiotic % Reduction on 2016 baseline	-2.0%	5.4%												5.4%			
national	- Total consumption of carbapenem per 1000 admissions	31.9	42.1												42.1			
national	-Carbapenam % Reduction on 2016 baseline	-3.0%	32.2%												32.20%			
national	- Increase proportion of antiobiotic usage within the Access group of the AWaRe category	>=55%	58.4												58.4			

RESPONSIVE

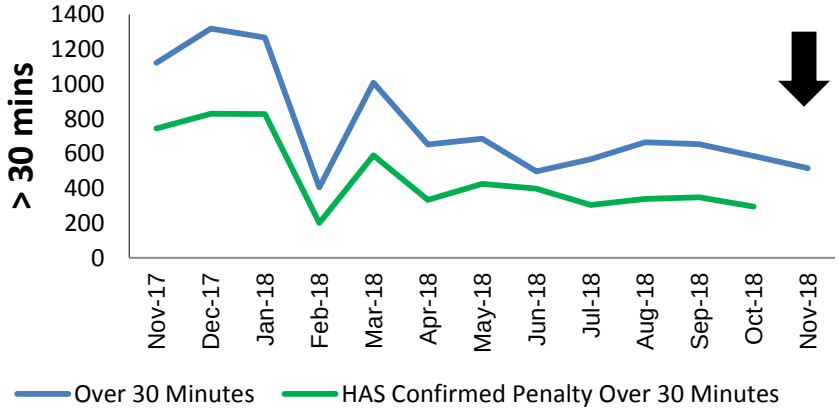
A&E 4 hour standard % performance



Overall performance against the ELHT Accident and Emergency four hour standard deteriorated in November to 79.5%, which remains below the 95% threshold. The performance against the Pennine A&E Delivery Board four hour standard has also deteriorated to 80.7% in November.

The number of attendances during November was 16,354 and of these 13,198 were treated and left the department within 4 hours. (Pennine A&E Delivery Board)

Ambulance Handovers



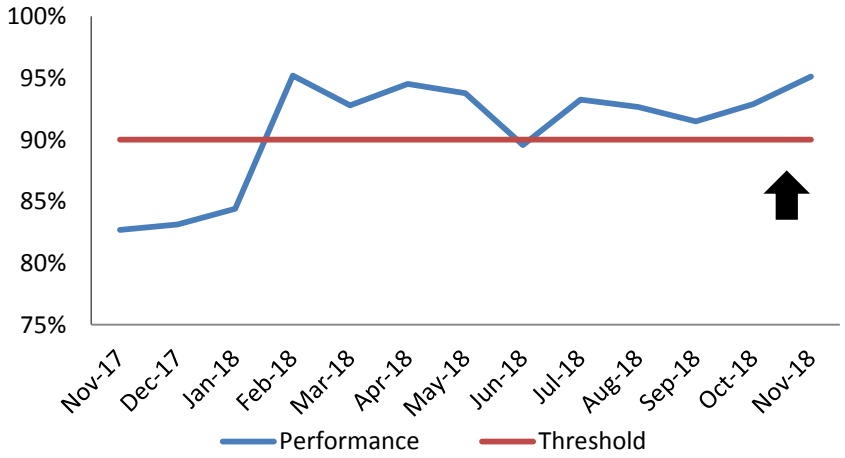
The national performance also deteriorated to 87.6% in November (All types) with 13 out of 134 reporting trusts with type 1 departments achieving the 95% standard.

There were 22 reported breaches of the 12 hour trolley wait standard from decision to admit during November. 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 decreased to 517 in November compared with 586 for October. The average handover time has decreased in November to 17:41 minutes from 19:16 minutes in October.

The validated NWAS penalty figures are reported as at October as;- 171 missing timestamps, 247 handover breaches (30-60 mins) and 49 handover breaches (>60 mins).

HAS Compliance

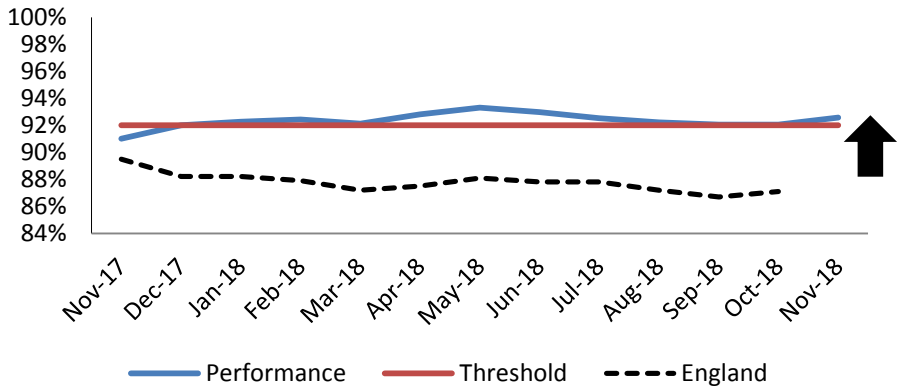


The ambulance handover compliance indicator measures the compliance with PIN entry on completion of patient handover. This was achieved at 95.1% in November, which is above the 90% threshold.

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

RESPONSIVE

RTT Ongoing



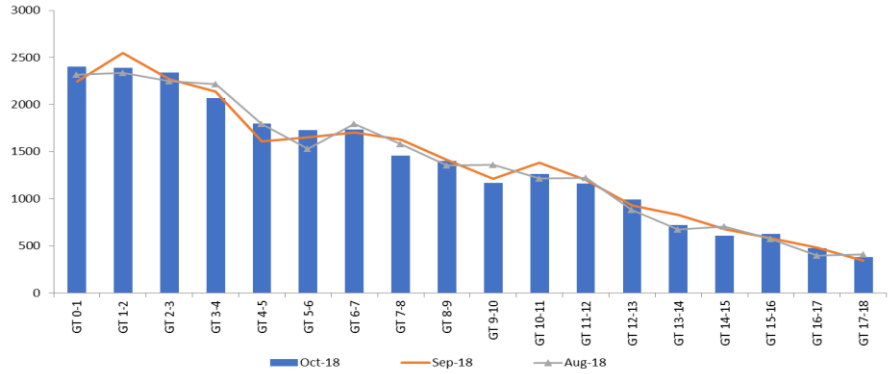
The 18 week referral to treatment (RTT) % ongoing position was achieved in November with 92.6% patients, waiting less than 18 weeks to start treatment at month end.

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

The total number of on-going pathways has reduced in November to 26,728 from 26,858 in October.

There has been a reduction in patients waiting over 18 weeks at the end of November to 1989 from 2135 in October.

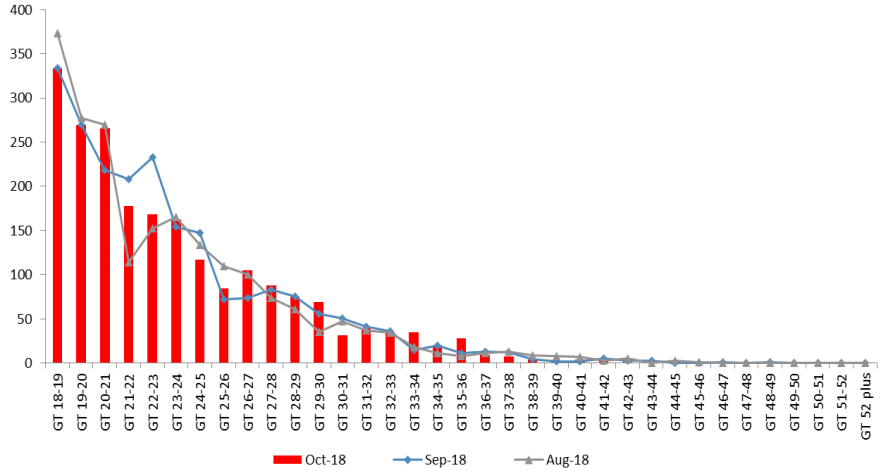
RTT Ongoing 0-18 Weeks



The median wait has reduced to 6.4 weeks in November from 6.6 weeks in October.

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

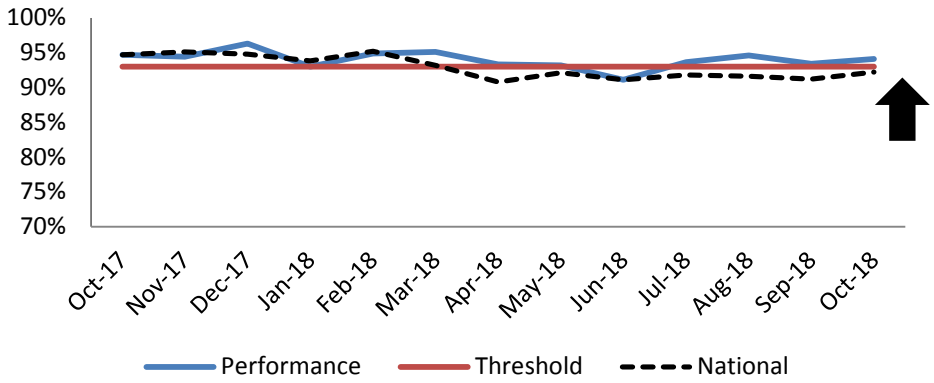
RTT Over 18 weeks



The latest published figures from NHS England show continued failure of the ongoing standard nationally (reported 1 month behind), with 87.1% of patients waiting less than 18 weeks to start treatment in October, compared with 86.7% in September.

RESPONSIVE

Cancer 2 Week

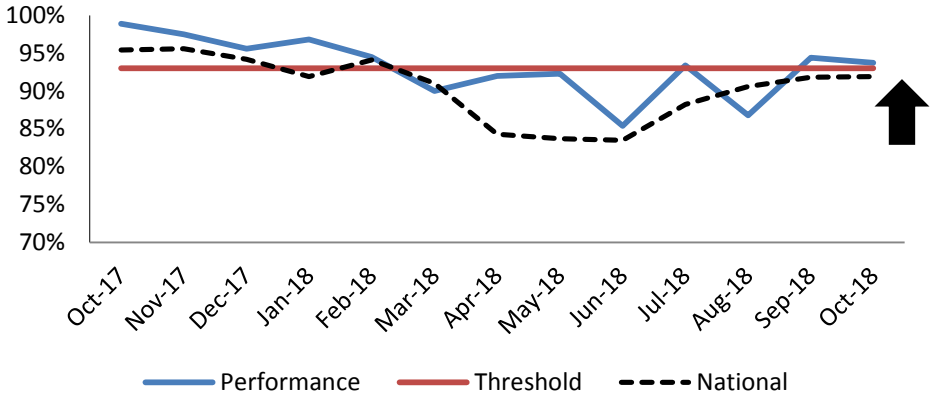


The cancer 2 week wait for GP referrals standard was achieved in October at 94.1%, above the 93% standard.

Quarter 2 performance was also above threshold at 93.9%

National performance remains below the standard in October.

Cancer 2 Week - breast

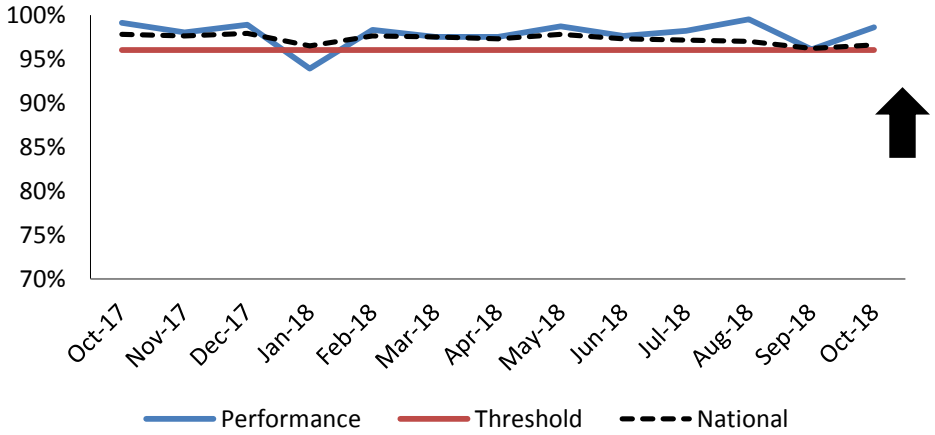


The 2 week breast symptomatic standard was achieved in October at 93.7%, above the 93% standard.

However the quarter 2 performance was below threshold at 91.8%

National performance remains below the standard in October.

Cancer 31 day

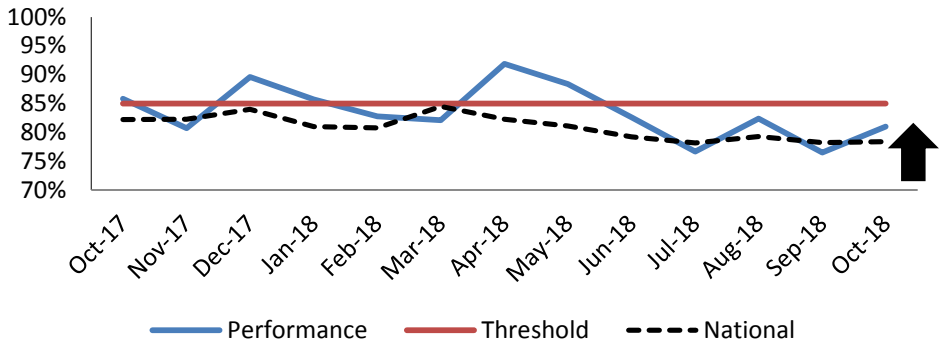


The 31 day target was achieved in October at 98.6%, above the 96% standard.

The standard was also met for quarter 2 at 98.1%

RESPONSIVE

62 Day Cancer

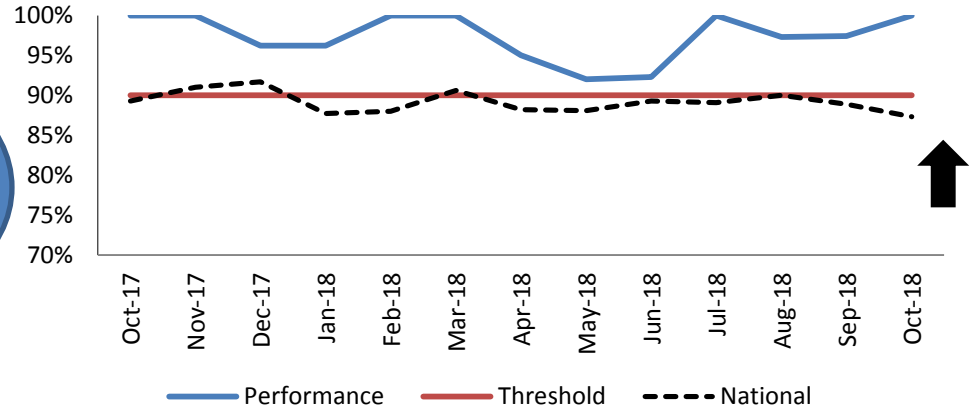


62 day performance was not achieved in October at 81%, below the 85% threshold.

Quarter 2 performace was also below threshold at 79.3%

National performance has been consistently below the standard.

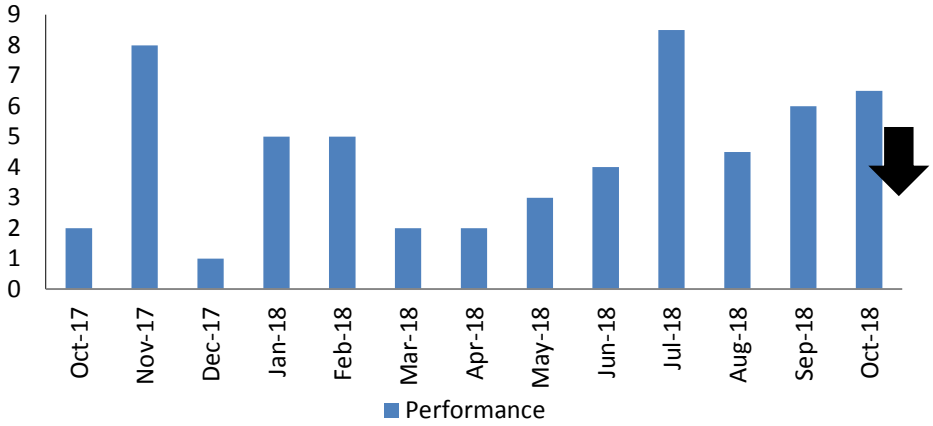
62 Day Screening



The 62 day screening standard continued to be achieved in October at 100%

Quarter 2 was also acheived at 96.5%

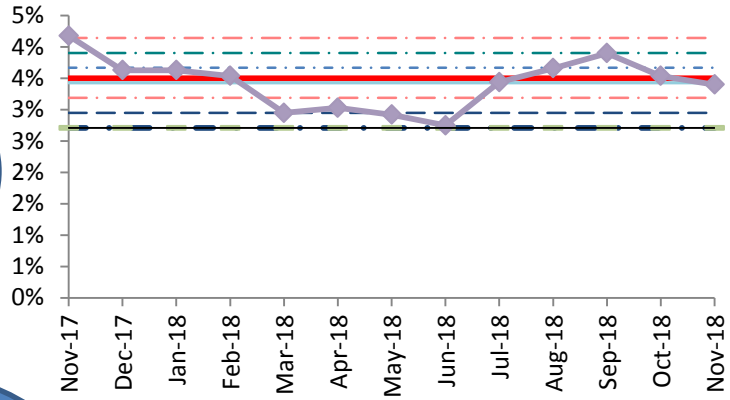
Cancer Patients Treated > Day 104



There were 6.5 breaches allocated to the Trust, treated after day 104 in October 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

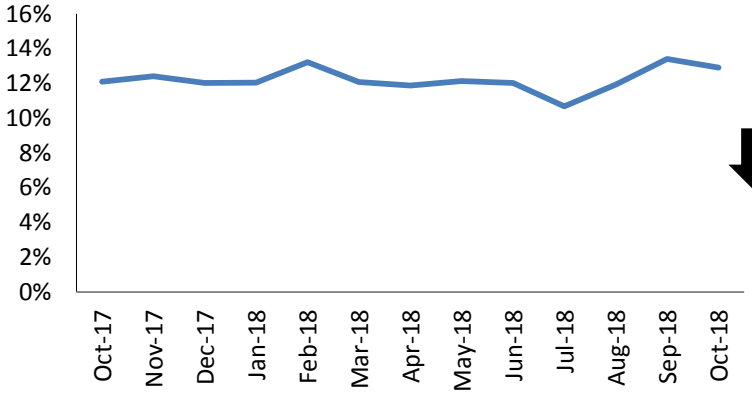


The proportion of delays reported against the delayed transfers of care standard has reduced during November to 3.4% which is below the threshold of 3.5%.

This equates to an average of 28 beds lost per day in November. The top three reasons for the bed days lost due to delayed discharge are; 'Awaiting completion of assessment' (27%), 'Awaiting further non acute NHS care' (19%), 'Patient or family choice' (14%). 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.

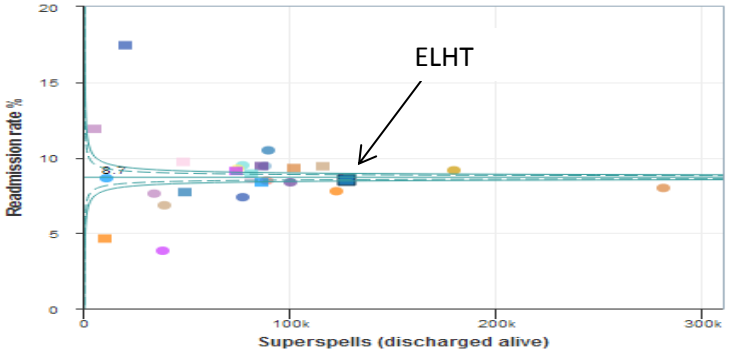
Emergency Readmissions



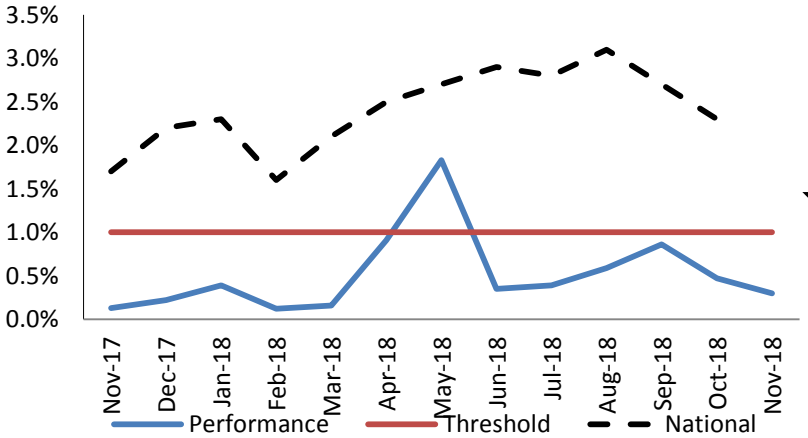
The emergency readmission rate has increased to 12.5% in October 2018 (reported 1 month behind) compared to 12.1% in October 2017.

Dr Foster benchmarking shows the ELHT readmission rate is

Readmissions within 30 days vs North West - Dr Foster
March 2017 - February 2018



Diagnostic Waits



In November 0.3% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is within the 1% threshold. Nationally, the performance is still failing the 1% target at 2.3% in October (reported 1 month behind), compared with 2.7% in September.

RESPONSIVE

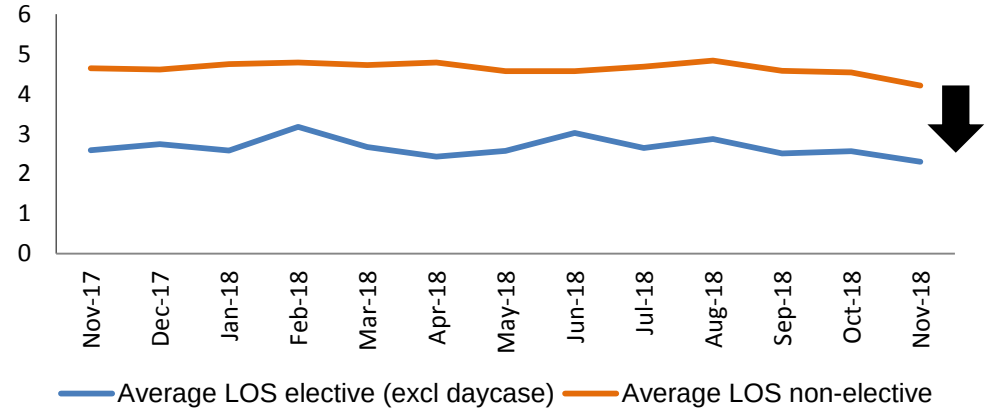
Average Length of Stay Benchmarking

Dr Foster Benchmarking September 17 - August 18

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	61,463	9,833	51,630	3.2	2.6	-0.6
Emergency	54,625	54,625	0	4.5	4.8	0.3
Maternity/ Birth	13,356	13,356	0	2.1	2.4	0.3
Transfer	206	206	0	9.7	26.0	16.3

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

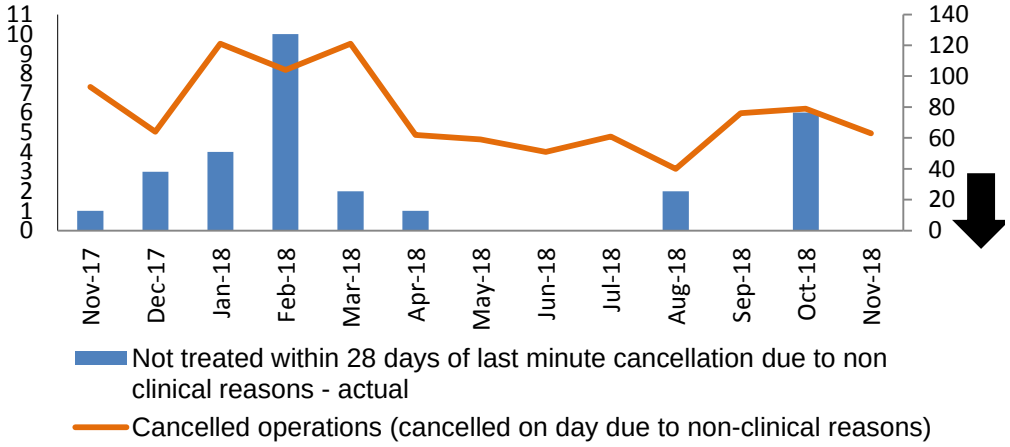
Average Length of Stay



The Trust non elective average length of stay decreased to 4.2 days in November, compared to 4.5 in October.

The elective length of stay (excluding day case) has decreased to 2.3 days in November from 2.6 days in October.

Operations cancelled on day - 28 day standard

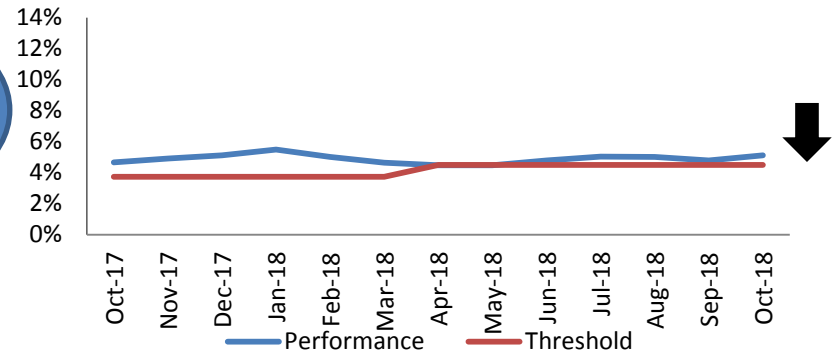


There were 63 operations cancelled on the day of operation - non clinical reasons, in November. There were no 'on the day' cancelled operations not rebooked within 28 days in November.

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

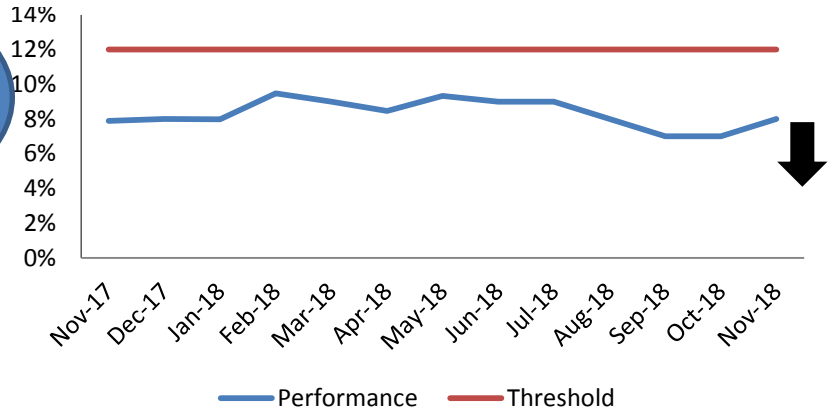


The sickness absence rate has increased from 4.80% in September to 5.12% in October 2018. The current rate is higher than the previous year (4.67%).

High sickness rates are a financial risk as bank and agency expenditure increases to cover shifts. Rates are highest in Estates and Facilities and the Integrated Care Group.

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

Turnover Rate

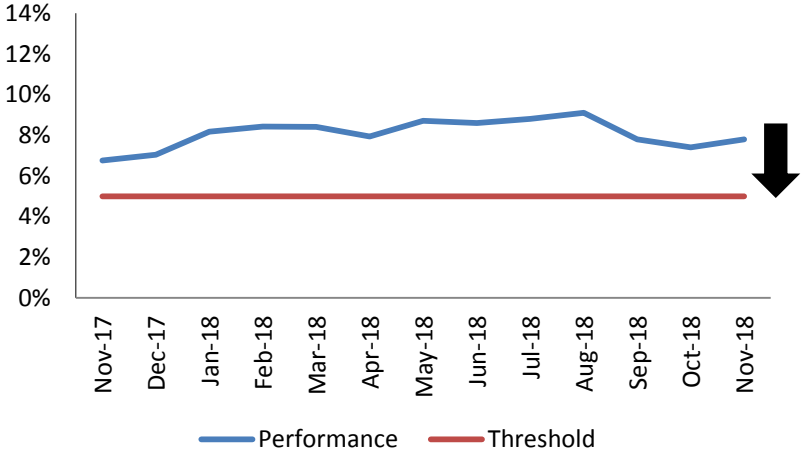


The trust turnover rate has increased to 8% in November and the vacancy rate has also increased to 7.8% in November from 7.4% in October.

Overall the Trust is now employing 7415 FTE staff in total. This is a net increase of 17 FTE from the previous month. The number of nurses in post at November 2018 stood at 2303 FTE which is 15 less than last month and a net increase of 254 FTE since 1st April 2013.

As at 5th December 2018 there are 52 external/R&R nurses in the recruitment pipeline, scheduled to start between now and September 2019 and 40 changing posts internally. These figures include 4 overseas nurses through the HEE Global Learners Programme (GLP) who are predicted to start with the trust in January and February. This, together with the 7 already in post, will bring the total to 11 arrived in trust

Vacancy Rate



The vacancy rate for nurses now stands at 10.2% (262 FTE)

As of November 2018 there are 89 FTE Medical Posts vacant of which 24 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 5.56% (54 FTE).

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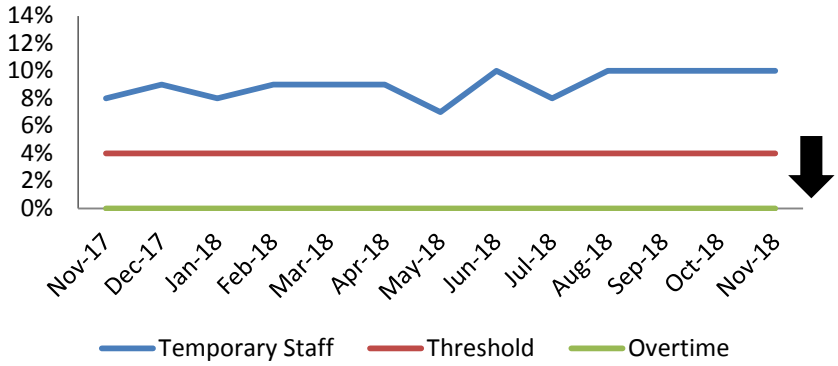
Temporary costs and overtime as % total pay



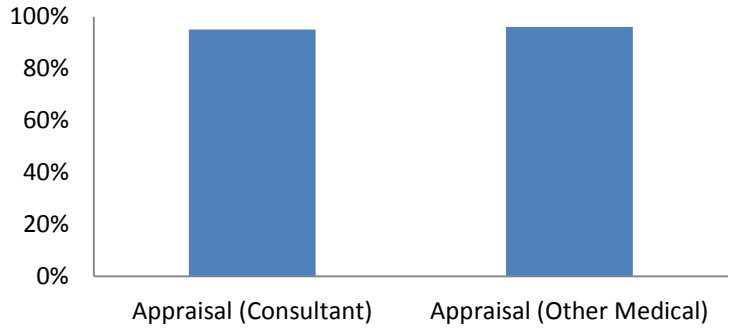
In 2017/18 East Lancashire Hospitals NHS Trust spent £27.4m on temporary staffing for the year. (£12,832,971 agency; £14,626,488 bank).

This represented 8% of the overall pay bill. (9% 2016/17;8% 2015/16; 9% 2014/15; 8% 2013/4; 5.5% 2012/13).

In November 2018 the Trust spent £2,780,322 on bank and agency. This was more than in November 2017 (£2,296,720) and less than in October 2018 (£3,016,567).

Total expenditure to date for 2018/19 is £21,850,021. £9.3million expenditure on agency staff and £12.4million expenditure on bank staff.

Appraisals, Consultant & Other Medical



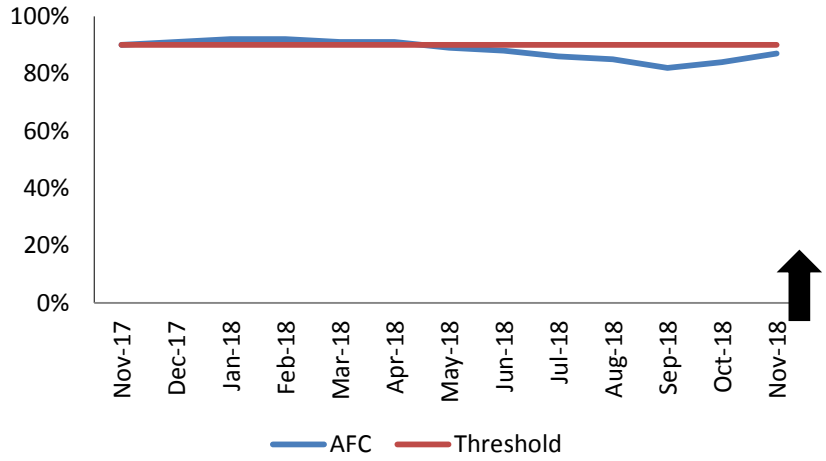
At the end of November 2018 there were 628 vacancies

Wte staff worked (8,152wte) was 164.6wte more than is funded substantively (8,317wte).

Pay costs are £754k less than budgeted establishment.

The appraisal rates for consultants and career grade doctors are reported cumulative year to date, April – November 2018 and reflect the number of reviews completed that were due in this period.
The consultant and medical staff appraisal rates are above threshold at 95% and 96% respectively.

Appraisals AFC



The AFC appraisal rate continues to be reported as a rolling 12 month figure and remains below threshold at 87% in November.

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.

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Job Plans

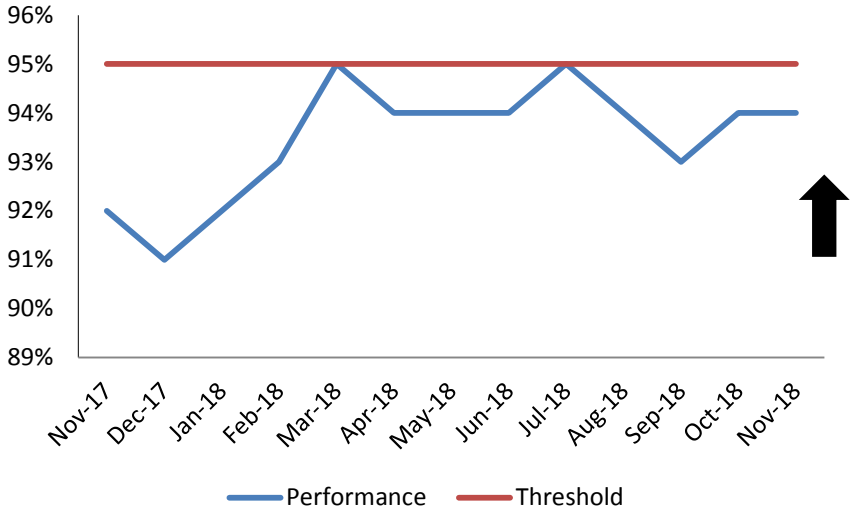
1st Stage Sign off	25	7.9%
2nd Stage Sign Off	216	68.4%
Complete	75	23.7%
TOTAL	316	100.0%

All job plans with the exception of Trauma & Orthopaedics, have been reviewed, at 1st or 2nd sign off stage.

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



Information governance toolkit compliance has remained at 94% in November below 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%

Core Skills Training % Compliance

	Target	Compliance at end November
Basic Life Support	90%	91%
Conflict Resolution Training Level 1	90%	98%
Equality, Diversity and Human Rights	90%	97%
Fire Safety	90%	98%
Health, Safety and Welfare Level 1	90%	99%
Infection Prevention	90%	98%
Information Governance	95%	94%
Prevent Healthwrap	90%	96%
Safeguarding Adults	90%	97%
Safeguarding Children	90%	96%
Safer Handling Theory	90%	96%

Ten of the eleven areas are currently at or above threshold for training compliance rates. Information governance remains below threshold in November.

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.

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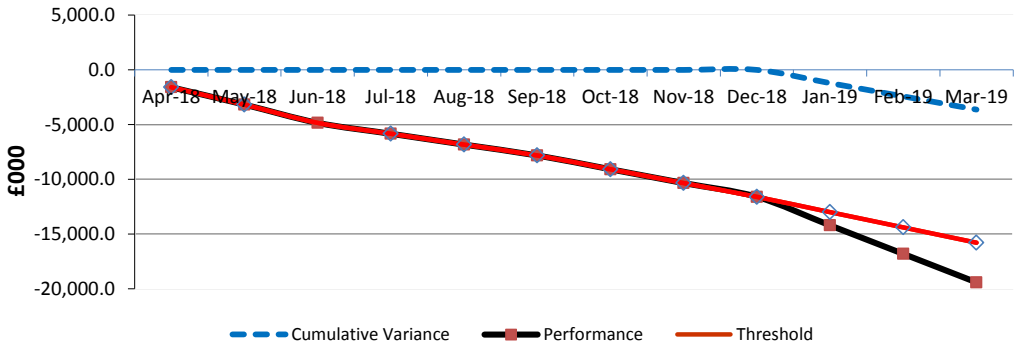
Finance & Use of Resource metrics

Area	Metric	Actual YTD Performance	Actual YTD Score	Forecast outturn Performance	Forecast outturn Score
Financial sustainability	Capital service capacity	0.6	4	0.5	4
	Liquidity (days)	(11.4)	3	(15.5)	4
Financial efficiency	I&E margin	(2.2%)	4	(3.1%)	4
Financial control	Distance from financial plan	(0.4%)	2	(1.5%)	3
	Agency spend	37.7%	3	42.0%	3
Total			3		4

Adjusted financial performance (deficit) *



* - excludes PSF allocation

The Trust's underlying control total for 2018-19 is a £15.798 million deficit.

Access to a Provider Sustainability Fund (PSF) of up to £8.050 million is reliant on 30% achievement of the 4 hour target and 70% achievement of the underlying control total.

The underlying position reported to 30th November 2018 of a £10.347 million deficit is consistent with the planned financial position. The PSF allocation of £3.098 million for the year to date reduces this deficit position to £7.249 million.

The current 'likely' forecast however indicates a financial pressure of £3.629 million against the Trust's plan for 2018-19. This pressure is a combination of pay pressures (agency and locum costs) and likely slippage in the release of efficiency schemes in the final two quarters. The Trust will need to mitigate this pressure in order to deliver its financial plan.

The Safely Releasing Cost Programme (SRCP) is £18.000 million for 2018-19. £9.980 million has been identified to date, of which £5.155 million is recurrent.

The Better Payment Practice Code (BPPC) targets continue to be achieved across all four areas for the year to date.

The 'Finance and use of resources metrics score' remains at 3 for the financial year to date, with 1 being the best level of performance and 4 being in financial special measures.

The cash balance at 30th November 2018 was £10.879 million, a reduction of £7.889 million in month. As a result, an application has been submitted to draw down in January 2019 £3.750 million of the

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	2,546	650	0	3,196	(42)	81%	700	1,846	2,546
SAS	3,720	2,121	1,216	18	3,355	365	57%	1,772	373	2,145
Family Care	2,423	709	76	0	784	1,639	29%	567	142	709
DCS	1,103	1,209	302	0	1,510	(407)	110%	41	1,167	1,209
Estates & Facilities	1,440	920	26	0	946	495	64%	60	860	920
Corporate Services	536	389	169	0	558	(22)	73%	16	350	366
Cross divisional	0	0	0	4,488	4,488	(4,488)		0	0	0
Targetted Transformation	5,624	2,086	460	616	3,163	2,461	37%	1,668	417	2,086
Total	**18,000**	**9,980**	**2,899**	**5,122**	**18,000**	**0**		4,826	5,155	9,981

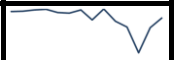
APPENDIX 1

Safe

		Threshold 18/19	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Monthly Sparkline
M64	CDIFF	27	3	3	3	2	3	5	2	3	4	1	5	1	3	2	
M64.1	Cdiff Cumulative from April	27	21	24	27	29	32	37	2	5	9	10	15	16	19	21	
M65	MRSA	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	
M124	E-Coli (post 2 days)	48	6	2	3	3	4	3	5	5	2	6	8	4	7	6	
M154	P. aeruginosa bacteraemia (total pre 2 days)		0	1	0	1	0	2	1	1	1	1	1	3	2	1	
M155	P. aeruginosa bacteraemia (total post 2 days)	4	0	0	1	0	0	1	2	0	0	0	1	1	1	0	
M156	Klebsiella species bacteraemia (total pre 2 days)		10	9	5	4	4	5	8	10	4	2	3	7	5	5	
M157	Klebsiella species bacteraemia (total post 2 days)	16	2	2	3	0	1	3	1	2	1	2	4	3	2	1	
M66	Never Event Incidence	0	2	0	0	1	0	1	1	0	0	0	0	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%	99.5%	99.4%	99.0%	99.3%	99.3%	99.6%	99.3%	99.2%	99.6%	98.9%	98.9%	99.6%	98.8%	99.3%	
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%	98.6%	98.9%	98.1%	99.1%	99.3%	99.2%	99.4%	99.5%	99.3%	99.4%	99.5%	98.8%	99.2%		
M69	Serious Incidents (Steis)		5	11	7	11	8	6	9	8	10	6	9	6	10	9	
M70	CAS Alerts - non compliance	0	0	3	2	2	0	0	2	0	0	0	0	0	0	0	
M146	Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80%	91%	92%	90%	90%	90%	88%	91%	91%	91%	89%	89%	90%	91%	92%	
M147	Safer Staffing -Day-Average fill rate - care staff (%)	80%	107%	110%	106%	106%	104%	103%	106%	104%	104%	99%	102%	102%	104%	104%	
M148	Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80%	99%	98%	98%	98%	97%	97%	99%	101%	99%	98%	97%	100%	97%	101%	

M149	Safer Staffing -Night-Average fill rate - care staff (%)	80%	118%	119%	114%	116%	112%	112%	114%	112%	111%	113%	112%	115%	123%	121%	
M150	Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80%	0	4	5	12	10	7	12	5	5	8	9	14	11	14	9	
M151	Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80%	0	1	0	1	0	0	1	0	0	0	1	3	3	2	2	
M152	Safer Staffing - Day -Average fill rate - care staff- number of wards <80%	0	1	1	1	1	1	1	0	1	1	1	1	0	0	0	
M153	Safer Staffing - Night -Average fill rate - care staff- number of wards <80%	0	1	1	1	1	1	1	1	1	1	0	0	0	0	0	

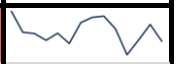
Caring

		Threshold 18/19	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Monthly Sparkline
C38	Inpatient Friends and Family - % who would recommend	90%	98.2%	98.3%	98.5%	98.6%	98.1%	97.9%	98.5%	96.8%	98.7%	96.6%	95.6%	91.2%	95.5%	97.1%	
C31	NHS England Inpatients response rate from Friends and Family Test		49.8%	47.7%	51.6%	48.6%	45.7%	47.8%	49.3%	36.2%	41.5%	48.6%	50.5%	47.9%	54.2%	47.3%	
C40	Maternity Friends and Family - % who would recommend	90%	96.0%	97.2%	97.2%	98.8%	96.6%	97.7%	96.8%	96.3%	95.9%	96.2%	97.6%	94.3%	98.4%	96.3%	
C42	A&E Friends and Family - % who would recommend	90%	82.5%	81.1%	82.3%	82.8%	80.4%	82.1%	84.1%	80.5%	82.3%	81.1%	82.7%	83.9%	84.3%	85.1%	
C32	NHS England A&E response rate from Friends and Family Test		20.3%	19.5%	20.3%	20.1%	20.9%	22.4%	23.1%	17.1%	20.8%	19.7%	20.0%	22.9%	20.6%	20.2%	
C44	Community Friends and Family - % who would recommend	90%	98.1%	96.3%	96.4%	97.7%	96.9%	95.6%	97.0%	87.1%	91.7%	95.5%	95.6%	96.0%	96.3%	96.7%	
C15	Complaints – rate per 1000 contacts	0.4	0.2	0.2	0.3	0.2	0.3	0.2	0.2	0.2	0.3	0.2	0.3	0.3	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	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Monthly Sparkline
M73	Deaths in Low Risk Categories - relative risk	Outlier	67.1	59.1	46.3	47.3	52.4	43.5	51.6	52.0	57.6	61.9	52.6				
M74	Hospital Standardised Mortality Ratio - Weekday (DFI Indicative)	Outlier	89.0	89.8	88.8	90.4	88.5	89.8	92.2	91.7	91.1	90.6	91.1				
M75	Hospital Standardised Mortality Ratio - Weekend (DFI Indicative)	Outlier	96.2	94.2	93.9	93.2	91.1	91.1	90.3	90.5	91.2	95.8	96.6				
M54	Hospital Standardised Mortality Ratio (DFI Indicative)	Outlier	90.8	90.9	90.1	91.1	89.1	90.2	91.7	91.4	91.1	91.9	92.5				
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Outlier															
M159	Stillbirths	<5	2	5	4	3	2	4	3	1	4	2	2	3	3	3	
M160	Stillbirths - Improvements in care that impacted on the outcome		0	0	0	0	0	1									
M89	CQUIN schemes at risk	0															

Responsive

		Threshold 18/19	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Monthly Sparkline
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95%	86.9%	81.6%	81.3%	79.6%	81.4%	78.9%	84.0%	85.3%	85.6%	82.5%	76.1%	79.8%	83.5%	79.5%	
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95%	87.5%	82.5%	82.1%	80.7%	82.2%	80.1%	84.9%	86.1%	86.6%	83.8%	77.8%	81.2%	84.6%	80.7%	
M62	12 hour trolley waits in A&E	0	2	4	4	5	12	23	9	3	34	37	34	19	29	22	
M81	HAS Compliance	90%	89.24%	82.68%	83.12%	84.40%	95.21%	92.79%	94.53%	93.79%	89.57%	93.26%	92.66%	91.49%	92.88%	95.13%	
M82	Handovers > 30 mins ALL	0	775	1122	1319	1267	405	1008	652	685	497	568	665	654	586	517	
M82.6	Handovers > 30 mins ALL (NWAS Confirmed Penalty)	0	461	745	829	827	201	589	334	426	399	305	340	349	296		
C1	RTT admitted: percentage within 18 weeks	N/A	64.8%	65.3%	79.0%	72.2%	72.2%	73.1%	69.7%	71.9%	71.6%	73.0%	72.9%	71.9%	72.9%	67.6%	
C3	RTT non- admitted pathways: percentage within 18 weeks	N/A	89.4%	89.0%	90.0%	90.7%	92.4%	92.1%	90.6%	93.5%	93.2%	92.4%	90.9%	89.5%	89.3%	89.6%	
C4	RTT waiting times Incomplete pathways %	92%	90.8%	91.0%	92.0%	92.3%	92.4%	92.1%	92.8%	93.3%	93.0%	92.5%	92.2%	92.1%	92.1%	92.6%	

C4.1	RTT waiting times Incomplete pathways Total	<25,920	25,680	25,340	24,031	22,968	23,006	24,124	23,754	24,320	24,418	25,086	26,690	26,986	26,858	26,728
C4.2	RTT waiting times Incomplete pathways - over 40 wks		14	43	33	34	40	34	25	25	25	9	19	15	12	10
C37.1	RTT 52 Weeks (Ongoing)	0	1	3	3	0	0	0	0	0	0	0	0	0	0	0
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1%	0.2%	0.1%	0.2%	0.4%	0.1%	0.2%	0.9%	1.8%	0.4%	0.4%	0.6%	0.9%	0.5%	0.3%
C18	Cancer - Treatment within 62 days of referral from GP	85%	85.8%	80.7%	89.6%	85.7%	82.8%	82.1%	91.9%	88.4%	82.6%	76.7%	82.4%	76.5%	81.0%	
C19	Cancer - Treatment within 62 days of referral from screening	90%	100.0%	100.0%	96.2%	96.2%	100.0%	100.0%	95.0%	92.0%	92.3%	100.0%	97.3%	97.4%	100.0%	
C20	Cancer - Treatment within 31 days of decision to treat	96%	99.1%	98.0%	98.9%	93.9%	98.3%	97.5%	97.5%	98.7%	97.6%	98.2%	99.5%	96.1%	98.6%	
C21	Cancer - Subsequent treatment within 31 days (Drug)	98%	100.0%	100.0%	98.0%	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94%	97.6%	100.0%	95.0%	94.8%	91.2%	96.0%	89.2%	97.5%	92.7%	91.4%	96.0%	92.2%	87.0%	
C24	Cancer - seen within 14 days of urgent GP referral	93%	94.7%	94.4%	96.3%	93.0%	94.9%	95.1%	93.3%	93.2%	91.1%	93.7%	94.6%	93.4%	94.1%	
C25	Cancer - breast symptoms seen within 14 days of GP referral	93%	98.9%	97.5%	95.6%	96.8%	94.5%	90.0%	92.0%	92.3%	85.4%	93.4%	86.8%	94.4%	93.7%	
C36	Cancer 62 Day Consultant Upgrade	85%	93.2%	88.9%	88.5%	89.4%	95.8%	92.3%	90.0%	90.4%	96.3%	90.0%	90.0%	89.3%	97.4%	
C25.1	Cancer - Patients treated > day 104		2	8	1	5	5	2	2	3	4	9	5	6	7	
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	1	3	4	10	2	1	0	0	0	2	0	6	0
M138	Cancelled operations (cancelled on day due to non-clinical reasons)		68	93	64	121	104	121	62	59	51	61	40	76	79	63
M55	Proportion of delayed discharges attributable to the NHS	3.5%	4.0%	4.2%	3.6%	3.6%	3.5%	3.0%	3.0%	2.9%	2.8%	3.4%	3.7%	3.9%	3.5%	3.4%
C16	Emergency re-admissions within 30 days		12.1%	12.4%	12.0%	12.1%	13.2%	12.1%	11.9%	12.1%	12.0%	10.7%	11.9%	13.4%	12.9%	
M90	Average LOS elective (excl daycase)		2.3	2.6	2.7	2.6	3.2	2.7	2.4	2.6	3.0	2.6	2.9	2.5	2.6	2.3
M91	Average LOS non-elective		4.6	4.6	4.6	4.8	4.8	4.7	4.8	4.6	4.6	4.7	4.8	4.6	4.5	4.2

Well led

		Threshold 18/19	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Monthly Sparkline
M77	Trust turnover rate	12%	8.1%	7.9%	8.0%	8.0%	9.5%	9.0%	8.5%	9.3%	9.0%	9.0%	8.0%	7.0%	7.0%	8.0%	
M78	Trust level total sickness rate	4.5%	4.7%	4.9%	5.1%	5.5%	5.0%	4.6%	4.5%	4.5%	4.8%	5.1%	5.0%	4.8%	5.1%		
M79	Total Trust vacancy rate	5%	6.9%	6.8%	7.0%	8.2%	8.4%	8.4%	7.9%	8.7%	8.6%	8.8%	9.1%	7.8%	7.4%	7.8%	
M80.3	Appraisal (AFC)	90%	89.0%	90.0%	91.0%	92.0%	92.0%	91.0%	91.0%	89.0%	88.0%	86.0%	85.0%	82.0%	84.0%	87.0%	
M80.3	Appraisal (Consultant)	90%	93.0%	94.0%	95.0%	93.0%	95.0%	97.0%	97.0%	97.0%	97.0%	97.0%	90.0%	95.0%	96.0%	95.0%	
M80.4	Appraisal (Other Medical)	90%	95.0%	95.0%	95.0%	96.0%	95.0%	98.0%	98.0%	98.0%	98.0%	98.0%	85.0%	94.0%	92.0%	96.0%	
M80.2	Safeguarding Children	90%	95.0%	95.0%	95.0%	95.0%	96.0%	96.0%	96.0%	96.0%	96.0%	97.0%	96.0%	96.0%	96.0%	96.0%	
M80.2	Information Governance Toolkit Compliance	95%	93.0%	92.0%	91.0%	92.0%	93.0%	95.0%	94.0%	94.0%	94.0%	95.0%	94.0%	93.0%	94.0%	94.0%	
F8	Temporary costs as % of total paybill	4%	8%	8%	9%	8%	9%	9%	9%	7%	10%	8%	10%	10%	10%	10%	
F9	Overtime as % of total paybill	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
F1	Adjusted financial performance (deficit) including PSF (£M)	(7.7)	(1.7)	(2.1)	(2.5)	(3.0)	(3.4)	(2.7)	(1.6)	(3.2)	(3.6)	(4.6)	(5.2)	(5.9)	(6.6)	(7.2)	
F1.1	Adjusted financial performance (deficit) excluding PSF (£M)	(15.8)									(4.8)	(5.8)	(6.8)	(7.8)	(9.1)	(10.3)	
F2	SRCP Achieved % (green schemes only)	100.0%	53%	54%	77%	79%	80%	107%	8%	17%	18%	29%	32%	50%	52%	55%	
F3	Liquidity days	>(14.0)	(7.8)	(8.8)	(9.2)	(9.6)	(10.0)	(10.5)	(5.4)	(9.4)	(5.7)	(8.4)	(10.0)	(9.3)	(10.2)	(11.4)	
F4	Capital spend v plan	85%	57%	68%	77%	88%	73%	95%	38%	81%	67%	61%	80%	82%	81%	77%	
F16	Finance & Use of Resources (UoR) metric - overall	3	3	3	3	3	3	3	3	3	2	3	3	3	3	3	
F17	Finance and UoR metric - liquidity	4	3	3	3	3	3	3	4	4	2	3	3	3	3	3	
F18	Finance and UoR metric - capital service capacity	4	3	3	3	3	3	3	2	3	4	4	4	4	4	4	
F19	Finance and UoR metric - I&E margin	4	3	3	3	3	3	3	4	4	4	4	4	4	4	4	
F20	Finance and UoR metric - distance from financial plan	4	2	2	2	2	2	2	4	1	1	2	2	2	2	2	

F21 Finance and UoR metric - agency spend	1	2	2	2	2	2	2	2	1	1	2	2	2	3	3	
F12 BPPC Non NHS No of Invoices	95%	96.0%	95.5%	95.7%	95.3%	95.4%	95.0%	95.2%	96.3%	96.5%	96.2%	95.9%	95.7%	95.8%	96.0%	
F13 BPPC Non NHS Value of Invoices	95%	95.4%	95.3%	95.4%	94.9%	95.1%	95.1%	96.9%	95.6%	96.1%	96.5%	96.7%	97.0%	97.2%	96.8%	
F14 BPPC NHS No of Invoices	95%	95.0%	95.1%	95.3%	94.0%	92.4%	95.6%	96.6%	97.3%	97.8%	98.1%	97.7%	96.7%	96.9%	96.8%	
F15 BPPC NHS Value of Invoices	95%	97.9%	98.0%	98.0%	97.7%	97.5%	98.2%	99.3%	99.5%	99.4%	99.3%	98.9%	98.6%	98.9%	98.2%	

Safe Staffing (Rota Fill Rates and CHPPD) Collection

Organisation : RXR East Lancashire Hospitals Trust
Month : Nov-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		540	402	360	282	360	360	360	204	74.4%	78.3%	100.0%	56.7%	67	11.37	7.25	18.63
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Acute Stroke Unit (ASU)	300 - GENERAL MEDICINE		1,800	1,560	1,440	1,428	1,080	1,080	1,080	1,116	86.7%	99.2%	100.0%	103.3%	627	4.21	4.06	8.27
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B18	320 - CARDIOLOGY		1,800	1,530	1,080	1,506	720	1,068	720	1,080	85.0%	139.4%	148.3%	150.0%	732	3.55	3.53	7.08
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B20	100 - GENERAL SURGERY		1,440	1,230	720	1,320	720	720	360	1,116	85.4%	183.3%	100.0%	310.0%	507	3.85	4.80	8.65
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B22	110 - TRAUMA & ORTHOPAEDICS		1,440	1,308	2,160	2,088	720	720	1,800	1,740	90.8%	96.7%	100.0%	96.7%	616	3.29	6.21	9.51
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B24	110 - TRAUMA & ORTHOPAEDICS		1,440	1,212	1,080	1,110	720	720	720	768	84.2%	102.8%	100.0%	106.7%	607	3.18	3.09	6.28
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B4	430 - GERIATRIC MEDICINE		1,440	1,200	2,160	2,004	720	732	1,440	1,704	83.3%	92.8%	101.7%	118.3%	708	2.73	5.24	7.97
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Blackburn Birth Centre	501 - OBSTETRICS		900	905	474	410	645	656	323	301	100.5%	86.4%	101.7%	93.3%	21	74.30	33.85	108.14
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C1	300 - GENERAL MEDICINE		1,440	1,104	1,440	1,194	720	720	1,080	1,116	76.7%	82.9%	100.0%	103.3%	496	3.68	4.66	8.33
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C10	300 - GENERAL MEDICINE		1,440	1,194	1,440	1,494	720	720	1,080	1,128	82.9%	103.8%	100.0%	104.4%	650	2.94	4.03	6.98
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C11	300 - GENERAL MEDICINE		1,440	1,188	1,440	1,356	720	744	720	1,056	82.5%	94.2%	103.3%	146.7%	655	2.95	3.68	6.63
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14A	100 - GENERAL SURGERY		1,260	1,230	720	714	720	732	360	492	97.6%	99.2%	101.7%	136.7%	488	4.02	2.47	6.49
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14B	100 - GENERAL SURGERY		1,260	1,158	720	954	720	720	360	768	91.9%	132.5%	100.0%	213.3%	467	4.02	3.69	7.71
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18A	100 - GENERAL SURGERY		1,260	1,242	720	846	720	720	360	600	98.6%	117.5%	100.0%	166.7%	500	3.92	2.89	6.82
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18B	100 - GENERAL SURGERY		1,260	1,248	720	840	720	720	360	516	99.0%	116.7%	100.0%	143.3%	511	3.85	2.65	6.50
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C2	301 - GASTROENTEROLOGY	MEDICINE	1,440	1,104	1,440	1,242	1,080	1,104	1,080	1,056	76.7%	86.3%	102.2%	97.8%	728	3.03	3.16	6.19
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C22	101 - UROLOGY	120 - ENT	2,160	2,046	1,440	1,764	1,080	1,092	1,440	1,488	94.7%	122.5%	101.1%	103.3%	965	3.25	3.37	6.62
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C3	300 - GENERAL MEDICINE		1,620	1,560	1,440	1,482	1,080	1,128	1,080	1,512	96.3%	102.9%	104.4%	140.0%	780	3.45	3.84	7.28
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C4	301 - GASTROENTEROLOGY	MEDICINE	1,440	1,182	1,440	1,104	1,080	1,056	1,080	1,032	82.1%	76.7%	97.8%	95.6%	715	3.13	2.99	6.12
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C5	430 - GERIATRIC MEDICINE		1,080	828	1,440	1,302	720	720	1,080	1,020	76.7%	90.4%	100.0%	94.4%	416	3.72	5.58	9.30
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C6	340 - RESPIRATORY MEDICINE	MEDICINE	1,440	1,176	1,080	1,056	1,080	1,104	720	720	81.7%	97.8%	102.2%	100.0%	722	3.16	2.46	5.62
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C7	340 - RESPIRATORY MEDICINE	MEDICINE	1,440	1,140	1,080	1,212	720	720	720	864	79.2%	112.2%	100.0%	120.0%	644	2.89	3.22	6.11
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C8	340 - RESPIRATORY MEDICINE	MEDICINE	1,800	1,512	1,440	1,464	1,080	1,080	720	948	84.0%	101.7%	100.0%	131.7%	545	4.76	4.43	9.18
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C9	300 - GENERAL MEDICINE		1,440	1,182	1,440	1,422	720	720	720	1,236	82.1%	98.8%	100.0%	171.7%	653	2.91	4.07	6.98
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Children's Unit	420 - PAEDIATRICS		4,680	4,426	1,080	1,056	3,465	3,445	315	315	94.6%	97.8%	99.4%	100.0%	1049	7.50	1.31	8.81
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Coronary Care Unit (CCU)	320 - CARDIOLOGY		1,440	1,212	720	696	1,080	1,080	-	12	84.2%	96.7%	100.0%	1200.0%	235	9.75	3.01	12.77
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Critical Care Unit	192 - CRITICAL CARE MEDICINE		5,898	6,528	948	762	5,796	6,144	360	288	110.7%	80.4%	106.0%	80.0%	567	22.35	1.85	24.20
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D1	300 - GENERAL MEDICINE		1,440	1,176	1,080	1,320	720	744	720	1,128	81.7%	122.2%	103.3%	156.7%	587	3.27	4.17	7.44
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D3	300 - GENERAL MEDICINE		1,440	1,182	1,080	1,140	720	732	720	1,008	82.1%	105.6%	101.7%	140.0%	580	3.30	3.70	7.00
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUA)	300 - GENERAL MEDICINE		3,600	3,432	2,160	2,484	3,240	3,156	1,440	1,704	95.3%	115.0%	97.4%	118.3%	1166	5.65	3.59	9.24
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUB)	300 - GENERAL MEDICINE		3,240	3,048	2,520	2,436	2,880	2,832	1,440	1,404	94.1%	96.7%	98.3%	97.5%	1172	5.02	3.28	8.29
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Neonatal Intensive Care Unit	420 - PAEDIATRICS		4,680	4,326	360	395	4,320	3,696	-	204	92.4%	109.7%	85.6%	20400.0%	727	11.03	0.82	11.86
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Surgical Triage Unit	100 - GENERAL SURGERY		1,440	1,428	720	954	1,080	1,236	360	696	99.2%	132.5%	114.4%	193.3%	526	5.06	3.14	8.20
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Antenatal Ward	501 - OBSTETRICS		1,440	1,669	696	708	1,080	1,140	720	708	115.9%	101.7%	105.6%	98.3%	149	18.85	9.50	28.36
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Burnley Birth Centre	501 - OBSTETRICS		1,350	1,318	360	348	1,080	1,044	360	360	97.6%	96.7%	96.7%	100.0%	62	38.09	11.42	49.51
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Central Birth Suite	501 - OBSTETRICS		3,636	3,820	720	720	3,624	3,708	720	720	105.1%	100.0%	102.3%	100.0%	248	30.35	5.81	36.16
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Gynaecology and Breast Care Ward	502 - GYNAECOLOGY		1,032	1,032	534	534	760	754	315	315	100.0%	100.0%	99.1%	100.0%	224	7.97	3.79	11.76
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Postnatal Ward	501 - OBSTETRICS		2,340	2,970	1,212	1,296	2,160	2,328	1,440	1,416	126.9%	106.9%	107.8%	98.3%	816	6.49	3.32	9.82
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Rakehead	314 - REHABILITATION		1,080	798	1,800	1,782	720	720	720	900	73.9%	99.0%	100.0%	125.0%	383	3.96	7.00	10.97
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 15	110 - TRAUMA & ORTHOPAEDICS		1,392	1,176	828	798	720	720	624	660	84.5%	96.4%	100.0%	105.8%	396	4.79	3.68	8.47
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 16	300 - GENERAL MEDICINE		1,800	1,410	1,440	1,644	720	720	1,080	1,692	78.3%	114.2%	100.0%	156.7%	733	2.91	4.55	7.46
RXR70	CLITHEROE COMMUNITY HOSPITAL - RXR70	Ribblesdale	314 - REHABILITATION		1,800	1,560	1,440	1,440	1,080	1,080	1,440	1,704	86.7%	100.0%	100.0%	118.3%	914	2.89	3.44	6.33
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Hartley	314 - REHABILITATION		1,440	1,110	1,080	1,374	720	720	720	1,056	77.1%	127.2%	100.0%	146.7%	690	2.65	3.52	6.17
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Marsden	314 - REHABILITATION		1,440	1,194	1,800	1,776	720	720	720	1,068	82.9%	98.7%	100.0%	148.3%	663	2.89	4.29	7.18
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Reedyford	314 - REHABILITATION		1,440	1,110	1,080	1,200	720	720	720	960	77.1%	111.1%	100.0%	133.3%	673	2.72	3.21	5.93
		Total			82,068	75,365	52,572	54,457	56,770	57,294	34,697	41,899	91.83%	103.59%	100.92%	120.76%	26380	5.03	3.65	8.68

Ward Staff Summary - Nov 2018

Executed on: 28/12/2018 at: 11:17:41 AM

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:≥ 4.75% | G:< 4.50%

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	1,260	1,230	79.03%	720	714	119.89%	720	732	100.00%	360	492	145.16%	0	0	0	0	0	0	6.67	27.85%	3.68	0.68%
	5143	Ward C18A	1,260	1,242	79.03%	720	846	119.89%	720	720	100.00%	360	600	145.16%	0	0	0	0	0	0	2.73	11.35%	17.60	2.59%
	5144	Surgical Triage Unit	1,440	1,428	79.03%	720	954	119.89%	1,080	1,236	100.00%	360	696	145.16%	0	0	0	0	0	0	9.70	26.15%	30.80	3.64%
	5145	Ward C14B	1,260	1,158	79.03%	720	954	119.89%	720	720	100.00%	360	768	145.16%	0	0	0	0	0	0	4.88	20.38%	57.44	10.09%
	5146	Ward C18B	1,260	1,248	79.03%	720	840	119.89%	720	720	100.00%	360	516	145.16%	0	0	0	0	0	0	5.40	22.23%	8.31	1.47%
EC03: Urology																								
RBH	5128	Ward C22	2,160	2,046	79.03%	1,440	1,764	119.89%	1,080	1,092	100.00%	1,440	1,488	145.16%	0	0	0	0	0	0	-3.44	-15.72%	13.71	1.82%
EC04: Orthopaedic Services																								
BGH	4393	Ward 15	1,392	1,176	79.03%	828	798	119.89%	720	720	100.00%	624	660	145.16%	0	0	0	0	0	0	4.39	12.56%	110.40	11.70%
RBH	5366	Ward B24	1,440	1,212	79.03%	1,080	1,110	119.89%	720	720	100.00%	720	768	145.16%	0	0	0	0	0	0	5.18	17.12%	13.60	1.77%
	5367	Ward B22	1,440	1,308	79.03%	2,160	2,088	119.89%	720	720	100.00%	1,800	1,740	145.16%	0	0	0	0	0	0	1.47	3.15%	73.44	5.47%
EC05: Head & Neck																								
RBH	5119	Ward B20 Max Fac	1,440	1,230	79.03%	720	1,320	119.89%	720	720	100.00%	360	1,116	145.16%	0	0	0	0	0	0	1.37	4.98%	103.00	12.94%
EC09: Anaesth & Critical Care																								
RBH	5362	Elht Critical Care	5,898	6,528	79.03%	948	762	119.89%	5,796	6,144	100.00%	360	288	145.16%	0	0	0	0	0	0	16.05	12.71%	92.26	2.80%
ED: Family Care																								
ED07: General Paediatrics																								
RBH	5210	Inpatient	4,680	4,426	79.03%	1,080	1,056	119.89%	3,465	3,444.50	100.00%	315	315	145.16%	0	0	0	0	0	0	4.20	5.13%	99.07	4.18%
ED08: Gynae Nursing																								
BGH	4169	Gynae And Breast Care Ward	1,032	1,032	79.03%	534	534	119.89%	760	753.50	100.00%	315	315	145.16%	0	0	0	0	0	0	0.52	2.04%	34.20	4.54%
ED09: Obstetrics																								
BGH	4165	Birth Suite	3,636	3,820	79.03%	720	720	119.89%	3,624	3,708	100.00%	720	720	145.16%	0	0	0	0	0	0	-8.00	-11.92%	140.04	6.15%
	4192	Burnley Birth Centre	1,350	1,317.50	79.03%	360	348	119.89%	1,080	1,044	100.00%	360	360	145.16%	0	0	0	0	0	0	4.90	10.97%	36.92	3.10%
	4200	Antenatal Ward 12	1,440	1,669	79.03%	696	708	119.89%	1,080	1,140	100.00%	720	708	145.16%	0	0	0	0	0	0	-6.20	-20.07%	75.64	6.82%
	4203	Postnatal Ward 10	2,340	2,970	79.03%	1,212	1,296	119.89%	2,160	2,328	100.00%	1,440	1,416	145.16%	0	0	0	0	0	0	-6.58	-11.85%	39.00	2.11%
RBH	5256	Blackburn Birth Centre	900	904.50	79.03%	474	409.75	119.89%	645	655.75	100.00%	322.50	301	145.16%	0	0	0	0	0	0	2.75	5.80%	174.17	12.94%
ED11: Neonates																								
RBH	4215	Nicu	4,680	4,326	79.03%	360	395	119.89%	4,320	3,696	100.00%	0	204	-	0	0	0	0	0	0	1.02	1.23%	200.19	8.22%
EH: Integrated Care Group																								
EH05: Business Support Unit																								
RBH	6078	Ward C3	1,620	1,560	79.03%	1,440	1,482	119.89%	1,080	1,128	100.00%	1,080	1,512	145.16%	0	0	0	0	0	0	20.98	48.90%	8.52	1.27%

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 - Nov 2018

Executed on: 28/12/2018 at: 11:17:41 AM

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:≥ 4.75% | G:< 4.50%

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	3,600	3,432	79.03%	2,160	2,484	119.89%	3,240	3,156	100.00%	1,440	1,704	145.16%	0	0	0	0	0	0	13.09	15.98%	107.98	5.22%
	6092	AMU B	3,240	3,048	79.03%	2,520	2,436	119.89%	2,880	2,832	100.00%	1,440	1,404	145.16%	0	0	0	0	0	0	10.28	12.56%	184.04	8.38%
EH20: Respiratory																								
RBH	5063	Ward C6	1,440	1,176	79.03%	1,080	1,056	119.89%	1,080	1,104	100.00%	720	720	145.16%	0	0	0	0	0	0	4.54	13.76%	31.36	3.67%
	5064	Ward C8	1,800	1,512	79.03%	1,440	1,464	119.89%	1,080	1,080	100.00%	720	948	145.16%	0	0	0	0	1	0	4.64	12.11%	30.92	3.06%
	6027	Ward C7	1,440	1,140	79.03%	1,080	1,212	119.89%	720	720	100.00%	720	864	145.16%	0	0	0	0	0	0	5.62	18.57%	75.44	10.49%
EH25: Cardiology																								
RBH	5095	Coronary Care	1,440	1,212	79.03%	720	696	119.89%	1,080	1,080	100.00%	0	12	-	1	0	0	0	0	0	4.10	16.67%	24.84	4.21%
	5097	Ward B18	1,800	1,530	79.03%	1,080	1,506	119.89%	720	1,068	100.00%	720	1,080	145.16%	0	0	0	1	0	0	-3.48	-10.24%	107.88	9.82%
EH30: Gastroenterlogy																								
RBH	5050	Ward C2	1,440	1,104	79.03%	1,440	1,242	119.89%	1,080	1,104	100.00%	1,080	1,056	145.16%	0	0	0	0	0	0	8.77	24.55%	123.72	15.30%
	5062	Ward C4	1,440	1,182	79.03%	1,440	1,104	119.89%	1,080	1,056	100.00%	1,080	1,032	145.16%	0	0	0	0	0	0	12.02	34.84%	97.40	13.93%
	6103	Ward C11	1,440	1,188	79.03%	1,440	1,356	119.89%	720	744	100.00%	720	1,056	145.16%	0	0	0	0	1	0	7.49	20.96%	38.76	4.52%
	6106	C1 (Gastro)	1,440	1,104	79.03%	1,440	1,194	119.89%	720	720	100.00%	1,080	1,116	145.16%	0	0	0	0	0	0	10.75	32.58%	103.32	14.98%
EH35: Mfop & Complex Needs																								
BGH	4613	Rakehead Nursing Staff	1,080	798	79.03%	1,800	1,782	119.89%	720	720	100.00%	720	900	145.16%	0	0	0	0	0	0	3.06	9.28%	78.92	8.79%
	6094	Ward 16 Sept 13	1,800	1,410	79.03%	1,440	1,644	119.89%	720	720	100.00%	1,080	1,692	145.16%	0	0	0	1	0	0	3.51	8.52%	43.60	3.88%
PCH	4581	Marsden Ward	1,440	1,194	79.03%	1,800	1,776	119.89%	720	720	100.00%	720	1,068	145.16%	0	0	0	0	0	0	3.01	8.42%	20.00	2.04%
	4582	Reedyford Ward	1,440	1,110	79.03%	1,080	1,200	119.89%	720	720	100.00%	720	960	145.16%	1	0	0	0	0	0	3.71	12.69%	100.76	12.99%
	4583	Hartley Ward	1,440	1,110	79.03%	1,080	1,374	119.89%	720	720	100.00%	720	1,056	145.16%	0	0	0	0	0	0	6.29	20.33%	51.88	7.02%
RBH	5023	Ward D1	1,440	1,176	79.03%	1,080	1,320	119.89%	720	744	100.00%	720	1,128	145.16%	0	0	0	0	0	0	4.26	13.89%	62.84	8.19%
	5036	Acute Stroke Unit (B2)	1,800	1,560	79.03%	1,440	1,428	119.89%	1,080	1,080	100.00%	1,080	1,116	145.16%	0	0	0	0	0	0	9.77	20.93%	24.20	2.18%
	5037	Ward B4	1,440	1,200	79.03%	2,160	2,004	119.89%	720	732	100.00%	1,440	1,704	145.16%	0	0	0	0	0	0	8.21	18.69%	127.76	11.92%
	5048	Ward C10	1,440	1,194	79.03%	1,440	1,494	119.89%	720	720	100.00%	1,080	1,128	145.16%	0	0	0	0	0	0	10.02	27.13%	89.72	10.83%
	6096	Ward C5	1,080	828	79.03%	1,440	1,302	119.89%	720	720	100.00%	1,080	1,020	145.16%	0	0	0	0	0	0	9.02	27.34%	41.92	5.83%
	6105	Ward C9	1,440	1,182	79.03%	1,440	1,422	119.89%	720	720	100.00%	720	1,236	145.16%	0	0	0	0	0	0	4.09	11.45%	21.00	2.27%
EH44: Speciality Medicine																								
RBH	5040	Ward D3	1,440	1,182	79.03%	1,080	1,140	119.89%	720	732	100.00%	720	1,008	145.16%	0	0	0	0	0	0	2.57	8.66%	43.15	5.62%
EH70: Comm In Patient Care																								
AVH	R133	Avch Ward 2	540	402	79.03%	360	282	119.89%	360	360	100.00%	360	204	145.16%	0	0	0	0	0	0	2.85	11.99%	68.16	10.92%
CLI	R141	Ribblesdale Ward	1,800	1,560	79.03%	1,440	1,440	119.89%	1,080	1,080	100.00%	1,440	1,704	145.16%	0	0	0	0	0	0	2.64	6.01%	99.92	8.07%
Total for 45 wards shown					**91.83%**			**103.59%**			**100.92%**			**120.76%**	**2**	**0**	**0**	**2**	**2**	**0**	**218.82**	**11.79%**	**3,131.48**	**6.36%**

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

Item 20

9 January 2019

Purpose Information Assurance

Title	Finance and Performance Committee Update Report
Author	Miss K Ingham, Corporate Governance Manager/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 26 November 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 their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Finance and Performance Committee Update Report

At the meeting of the Finance and Performance Committee held on 26 November 2018 members considered the following matters:

1. The Committee received the Integrated Performance Report, including an overview of the current financial position to the end of October 2018. The members noted that there had been a decrease in the number of patients waiting in excess of 30 minutes to be handed over from the ambulance crew to the Trust and the average handover time for patients was 19 minutes and 16 seconds. Both these achievements are as a result of the work being undertaken between the Trust and North West Ambulance Services (NWAS). There were noted to have been 29 breaches of the 12 hour trolley wait standard in the reporting month, all were noted to be patients awaiting mental health assessments or beds. Members noted the increase in the number of patients having their operations cancelled on the day, with six patients falling outside the 28 day rebooking standard; there were no breaches of the 52 week standard in the reporting month of October 2018. Despite the vacancy rate falling slightly in the month, it remained above the threshold at 7.4% as did the sickness absence rate which stood at 4.8% for the same month.
2. Non-Executive Committee members sought further assurance from the HR team in relation to sickness absence management. The Non-Executive Committee members expressed their concerns in relation to workforce reporting and performance and it was agreed that the Chair of the Finance and Performance Committee would discuss the possible development of a Workforce Performance Committee with the Trust Chairman. It was suggested that the Workforce Performance Committee could report into the Finance and Performance Committee to gain the required levels of assurance.
3. The members received the financial performance report for the month of October and noted that the financial position had deteriorated by a further £1,087,000 in the month, bringing the underlying deficit positon to £9,085,000 before Provider Sustainability Funding of £2,535,000. Members noted the pay pressures and potential slippage in the release of efficiency savings in the second half of the year were risks to the year-end financial position. Mitigation plans are in place to manage and reduce these risks as much as possible. Members also received an update on the Model Hospital and Use of Resources.

4. In addition to the standard Sustaining Safe, Personal and Effective Care 2018/19 Report the Committee received an update on the two recent improvement events (Theatres and HR). In relation to progress against the Safely Releasing Costs Programme (SRCP), members noted that the Trust had a fully identified change programme. However, there had been some slippage in terms of delivery with £5,325,000 worth of schemes being RAG rated as red and at risk (30%) with £1,077,000 of these schemes awaiting commencement.
5. Committee members received the revised Performance Assurance Framework which incorporated comments received following the presentation of the document to the last meeting. following discussion the document was approved for dissemination across the Trust
6. The Committee received an update report on tenders; an update on bank and agency staffing; the timeframe for business planning; the Committee Specific Board Assurance Framework for review; and the minutes of the Contract and Data Quality Board for information.

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 27 December 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 21

9 January 2019

Purpose Information Assurance

Title	Quality Committee Update Report
Author	Miss K Ingham, Corporate Governance Manager/Assistant Company Secretary
Executive sponsor	Mrs T Anderson, Committee Chair

Summary: The report sets out the summary of the papers considered and discussions held at its meeting on 21 November 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	Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Quality Committee Update

At the meeting of the Quality Committee held on 21 November 2018 members considered the following matters:

1. The Committee received an update on the falls collaborative, which has helped to achieve a 28% reduction in the number of inpatient falls (572) between its implementation in 2014 and the most recent year-end figures in 2017. Committee members noted that the plan for the next two years is to continue reviewing falls on a monthly basis; undertake quarterly compliance audits against the falls change package and reduce falls by a further 20% by the end of 2020.
2. The Committee received the 2018/19 winter resilience plan which is aligned to the Pennine Lancashire Winter Plan and is based on the following 'big six' schemes for winter: primary care resilience; conveyance avoidance; ambulatory emergency care unit; respiratory and frailty pathway; flow improvement programme; and discharge to assess. Members noted that the Trust has opened two sub-acute wards, giving an additional 51 beds, the most recent being ward 19 at the Burnley General Teaching Hospital site. There is a plan to increase this bed base further with the potential to open a further 24 beds in ward 20 at the Burnley site in early January 2019 if required.
3. The Committee received the Serious Investigations Requiring Investigation (SIRI) report that had been presented to the Trust Board earlier in November and discussed the information relating to fractured neck of femur incidents. The report also included the findings of a recently concluded external level three investigation report into the death of a patient in 2015. The report identified a number of issues, including lapses in care, leadership, record keeping, communication and protocols at the time of the incident. The Committee members received assurance that these matters had been identified by the Trust at the time and actions carried out to ensure that such issues did not happen again.
4. Members received an update in relation to the recent CQC inspection; the draft report had been received for accuracy checking with a completion and return date of 30 November 2018.
5. The Committee received the annual security report covering the year to the end of 31 March 2018. Members noted that the Trust had declared full compliance against two of the four domains (Inform and Involve; and Strategic Governance), whilst the remaining two domains were partially compliant (Prevent and Deter; and Hold to

Account), with three amber and one amber categories respectively. The Committee members briefly discussed physical and non-physical assaults against staff by patients and it was noted that the most significant risk of physical assault was when staff were dealing with patients whose medical condition/treatment is a contributing factors, such as certain types of dementia.

6. The Committee received the Customer Relations Annual Report and noted that the Trust had received 343 new complaints within the 2017/18 year, 49 fewer than the previous year and the number of days that complaints are open has halved.

7. Members of the Committee received the Mental Health 12 Hour Breach Summary Report covering the period 1 June 2018 to 31 August 2018. Members noted that in the three month period a total of 105 patients have been subject to a 12 hour breach, all of which were patients with mental health needs. The average length of time spent in the department was 12 hours and 44 minutes, with three patients being in the department for in excess of 85 hours. The overall contributing factor to the reason for these breaches was determined to be a lack of bed availability; with all 105 patients breaching the wait time whilst waiting for a suitable bed to become available in the appropriate care setting. Members received an overview of the work that was taking place within the area by the Trust, social care and Lancashire Care NHS Foundation Trust (provider of mental health services) to improve access to mental health services.

8. The Committee also received an assurance report relating to Uro-Gynae Vaginal Mesh Implants following a letter received by Medical Directors from NHS Improvement and NHS England. The assurance report outlined the ways in which the Trust will monitor the use of vaginal mesh and review the internal guidance developed.

9. The Committee received the Quality Dashboard; an update report on the Nursing Assessment Performance Framework; an update on the Cancer Performance Improvement work; the Committee specific elements of the Board Assurance Framework; Corporate Risk Register; and Summary Reports from the following Sub-Committee Meetings:

   a) Patient Safety and Risk Assurance Committee (September 2018)
   b) Infection Prevention and Control Committee (September and October 2018)
   c) Health and Safety Committee (October 2018)
   d) Internal Safeguarding Board (November 2018)

e) Patient Experience Committee (October 2018)
f) Clinical Effectiveness Committee (October 2018)
g) Trust Education Directorate Strategic Board (August 2018) and Annual Self-Assessment Report for Health Education England (1 August 2017 to 31 July 2018)

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 27 December 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 22a

9 January 2019

Purpose Information
Assurance

Title	Trust Charitable Funds Committee Update Report
Author	Miss K Ingham, Corporate Governance Manager/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 28 October 2018.

The Annual Report and Accounts for the Charity are appended to this report for approval by the Corporate Trustee (Board members).

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

(22a) Trust Charitable Funds Committee Update Report

Trust Charitable Funds Committee Update

At the meeting of the Trust Charitable Funds Committee held on 28 October 2018 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.

1. The Committee received an overview of the medical equipment considerations for 2018/19 and noted that a strategic approach had been undertaken when determining the list and was based on the following criteria: technology, research and service development; continuous education and quality improvement; and clinical and financial efficiencies and sustainability. The Committee members noted the planned expenditure on equipment of £1,360,000 and requested an analysis of the spending and a note on the approval process Members noted that the demand for medical equipment totalled £2,640,000. It was agreed that the Committee would target areas where equipment was not already funded via the capital plan; equipment that did not meet the value threshold to be classified as a capital asset; and new, innovative equipment that would develop the services provided.
2. The Committee members sought further clarification on the infection prevention and control constraints relating to incorporating donors names on equipment purchased through their donations. It was agreed that the Estates and Facilities Team will be asked to attend the next meeting to report on this matter.
3. The Committee members received the report of the investment manager for the period ending 30 September 2018. It was noted that the portfolio was valued at £2,067,238 and had performed relatively well in the current market conditions. Income for the period was estimated to be in the region of £69,000.
4. The Committee noted that there had been no requests for funds in excess of £20,000 since the last meeting.
5. The Committee were updated on the work of the Fundraising Manager. Within the report there was a summary of the various fundraising activities that had taken place and further events planned for the period leading up to Christmas 2018. The Committee members noted that Ms Heinicke had commenced in post as the Community Fundraiser. Members noted the work that was being undertaken to encourage local businesses to select ELHT&Me as their chosen charity. The Committee members sought a clearer reconciliation between the funds reported to have been raised by the fund raising manager and the income reported in the Fund Performance and Utilisation report.

6. Committee members received the draft charitable funds accounts and annual report for 2017/18 and agreed to maintain the reserves limit set in the previous year at £500,000.
7. The Committee received a progress report and noted that steady progress was being made against meeting the objectives set out in the strategy. Income to the charity has increased in the year and was anticipated to increase further with the expansion of the fundraising team. The Committee members were encouraged, along with the Board members to become ambassadors for the charity and its associated appeals. Members sought further information in relation to the claiming of gift aid, particularly for donations under £20.00 which will be provided at the next meeting in January 2019.
8. The Committee also received the Investment Performance Report; Fund Performance and Utilisation Report; and the minutes of the Staff Lottery Committee.

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 21 December 2018

Trust Charitable Funds (ELHT&Me) Annual Report 2017/18

ELHT&me
your local hospital charity

CONTENTS

As Chairman of the East Lancashire Hospitals NHS Trust, the sole corporate trustee of the Charity, and Chairman of the Committee we are pleased to present the Charity's Annual Report for the period to 31 March 2018.

The Charitable Funds Committee acts on behalf of the corporate trustee and the Annual Report is designed to give an insight into the extent of the work that has been undertaken. We would like to take this opportunity to thank those individuals who have served on the Charitable Funds Committee, which acts on behalf of the Trust, during the course of the year and on their behalf to express our appreciation to the staff of the Trust for their dedication in caring for our local population.

Every single donor and fundraiser enables the Trust to enhance and improve the level of service it provides in so many ways. We would like to extend our sincere thanks and appreciation to everyone who has given their time and contributed throughout the year to improve the level of service the Trust is able to provide to all users.

Professor Eileen Fairhurst

Chairman
East Lancashire
Hospitals NHS Trust

Mr Stephen Barnes

Non-Executive Director
and Chairman of the
Charitable Funds
Committee
East Lancashire
Hospitals NHS Trust

Objectives and Activities

ELHT&Me was launched in 2016 and a strategy was produced to outline the Charity aims and objectives. The strategy was updated in 2017. The aims of the strategy were to increase engagement, participation and involvement. So that ELHT&Me is well recognised by the people and business of East Lancashire as their local hospital charity. This will head to an increase of donations to allow **ELHT&Me** to better support the trust.

The object of the Charity is 'for any charitable purpose or purposes relating to the general or any specific purposes of the East Lancashire Hospitals NHS Trust or the purposes of the National Health Service'.

The Trust, the sole corporate trustee of the Charity, provides a range of health care services, predominantly for the local population of East Lancashire of over half a million people. The main charitable activities of the Charity are to fund:

- improvements to the services provided to patients, primarily through the purchase of equipment that would be outside the NHS funding, as well as improvements to the patient environment and experience; and
- training for Trust staff and to help to develop and improve staff amenities.

During its second year the charity has been able to focus its efforts more squarely on what the role of the charity is all about. It is not to replace NHS funding but to provide those extras that will make a difference to the patients' experience. This may be through state-of-the-art medical equipment or by simple improvements to the patient environment.

In recognition to the NHS celebrating its 70th birthday, **ELHT&Me** launched its ambitious £1Million Appeal. Local businesses, institutions and individuals have been encouraged throughout the year to show their support.

Achievements and Performance

Enhanced chemotherapy chairs have improved patient experience.

Grant donations for ELCAS have improved connections to young people between appointments.

Donations to our Childrens ward have provided play items and sensory equipment outside the normal NHS funding.

£1 million Pound Appeal

The **£1 Million Appeal** is raising money for new equipment, improving facilities and enhancing the patient environment at ELHT's two acute (Royal Blackburn and Burnley General) and three community hospitals (Accrington Victoria, Clitheroe and Pendle).

All the people of Blackburn with Darwen and the rest of East Lancashire will benefit.

ELHT&Me created seven charitable funds to support the million pound appeal. This means patients, their loved ones, members of the public and staff can raise funds or make donations into an area which is important to them.

The seven areas are:

- *Children and babies health*
- *Supporting cancer patients*
- *Improving equipment*
- *Women's health*
- *Men's health*
- *Making patient areas more friendly*
- *Improving the patient experience*








FINANCIAL REVIEW

Total expenditure for 2017/18 of £760,000 compares to £770,000 in the previous financial year. At £177,000, expenditure on furniture and equipment represents the largest use of charitable funds.

Other significant areas of expenditure for the Charity were the £144,000 spent on staff welfare, training and amenities and the £110,000 spent on medical and surgical equipment, which included £19,000 for ten infusion pumps and £11,300 for recliner trolleys for the new Chemotherapy Unit at Burnley General Teaching Hospital.

Total income has increased to £669,000. Significant items include a legacy of £79,700 from the estate of Margery Sherrington to support neonatal services, as well as a £51,300 donation from the Issa Foundation, which has been used to purchase medical equipment for use in the treatment of diabetes, as well as for neonatal services.

When net losses on investments of £70,000 are taken into account, fund balances have fallen by £161,000 in 2017/18 to £2,305,000, £2,180,000 of which are unrestricted.

Investment Strategy and Policy

The aim of the investment strategy is to 'invest funds so as to provide as high a current income as possible, consistent with the objective of at least preserving the income generating value of capital over the long term'. The balance of investments after taking into account the reserved funds are managed in an investment portfolio designed to provide a return in the medium to longer term. The Charitable Funds Committee is assisted in this aspect by the professional advice of an independent Investment Funds Manager.

The Charitable Funds Committee aims to turn over the majority of charitable funds, excluding specific long term legacies, once every three years.

Analysis of expenditure	2017-18 £'000	2016-17 £'000
Expenditure on raising funds		
Investment Management and Admin Fees	14	20
	14	20
Expenditure on charitable activities		
Fund Raising Expenses	9	0
Staff welfare / training / amenities	144	205
Patient welfare / training / amenities	17	46
Retirement Gifts and Long Service Awards	44	28
Building and Engineering	7	29
Furniture and Equipment	177	93
Printing and Stationery	3	1
Computer/Office Equipment	14	36
Training	61	22
Medical and surgical equipment (maintenance)	2	0
Medical and surgical equipment	110	191
Other expenditure	158	99
	746	750
TOTAL	**760**	**770**

Reserves Policy

The Charity derives its income mainly from donations and legacies, the level of which cannot be accurately predicted year on year.

Since the charity aims to spend the income it receives for its charitable purpose, there are a number of reasons why it needs to retain a proportion of the income it receives as reserves, which include:

- ensuring income from donations and legacies are spent in line with the donors' wishes, particularly where restrictions have been placed on its use.
- ensuring sufficient funds are available to fund planned future projects;
- for gifts of endowment where the charity has no power to treat the monies as income to fund charity related expenditure; and
- meeting current or anticipated expenses such as management, administration and governance costs, including audit costs.

For these reasons, the Charity holds reserves at a minimum level of £500,000.

Analysis of income	2017-18 £'000	2016-17 £'000
Income from donations and legacies		
Donations	229	145
Legacies	82	54
Grants	0	158
	311	357
Income from other trading activities		
Income from training activities	104	48
Other income	165	156
	269	204
Income from investments		
Investments listed on the London Stock Exchange	88	92
Interest on cash/bank	1	1
	89	93
TOTAL	**669**	**654**

Reference and Administrative Details

Registered charity name ELHT&Me

Charities Charity Registration Number 1050478

Principal Office Address
East Lancashire Hospitals NHS Trust
Trust Headquarters
Royal Blackburn Hospital
Haslingden Road
Blackburn, BB2 3HH

Trustee East Lancashire Hospitals NHS Trust

The following key professional services are provided to the Charity by external organisations:

Charity bankers
Governing Banking Service c/o NatWest
Bolton Customer Service Centre,
PO Box 2027 Parklands, De Havilland Way,
Horwich,
Bolton. BL6 4YU

Charity external auditors
Grant Thornton LLP UK
4 Hardman Square
Spinningfields
Manchester, M3 3EB

Charity investment managers
Brewin Dolphin
1 The Avenue,
Spinningfields Square
Manchester, M3 3AP

Charity solicitors
Hempsons
City Tower
Piccadilly Plaza
Manchester, M1 4BT

Charity internal auditors
Mersey Internal Audit Agency (MIAA)
Regatta Place,
Brunswick Business Park
Summers Road
Liverpool, L3 4BL

STRUCTURE, GOVERNANCE & MANAGEMENT

The Charity which was formerly known as the East Lancashire Hospitals NHS Trust Charitable Fund and other related charities, is now known as ELHT&Me.

The Charity was created under a Trust deed executed on 28 January 2004 and constituted with East Lancashire Hospitals NHS Trust as sole corporate trustee. This deed consolidated a number of charitable funds held by the former Burnley Healthcare and Blackburn, Hyndburn and Ribble Valley Health Care NHS Trusts prior to their merger to form the East Lancashire Hospitals NHS Trust. A deed of amendment was executed on 11 July 2018 to provide clarity as to the purposes for which the charitable funds are held and to simplify the administration of the Charity.

Charitable funds received by the charity are accepted, held and administered as funds and property held on Trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990.

In practice, responsibility for the monitoring and approval of activities relating to charitable fundraising and the uses to which charitable funds are applied has been delegated by the Trust Board to the Charitable Funds Committee. The terms of reference for the Committee are reviewed annually by the Trust Board and compliance with these terms of reference is also assessed on an annual basis by the Committee and reported back to the Trust Board as part of the reporting from the Charitable Funds Committee.

Membership of the Charitable Funds Committee is drawn from the Trust Board and comprises a Non-Executive Director Chair of the Committee, one further Non-Executive Director/Associate Non-Executive Director member, the Director of Finance (as lead director for the Committee), the Director of Nursing and the Director of Communications and Engagement.

The Associate Director of Corporate Governance/ Company Secretary, together with the Deputy Director of Finance or Financial Controller and the Fundraising Manager are normally in attendance at meetings of the Committee to provide advice and assistance.

All Trust Board members are entitled to attend the meeting and have sight of the supporting documents. The Committee provides regular reports of its decisions to the formal Trust Board meetings.

There are a number of individual funds within the umbrella of the Charity, each of which has a designated funds manager with day-to-day responsibility for the administration of the fund, being involved in fundraising activities and decisions on how donations should be expended within the financial framework of the charity.

Director recruitment and appointment

There are different recruitment and appointment processes for the executive and Non-Executive members of the Trust Board. From 1 April 2016, NHS Improvement has had responsibility for the appointment of Non- Executive members to NHS Trust Boards on behalf of the Secretary of State for Health and Social Care. Executive members of the Board are subject to the recruitment and appointment processes of the Trust.

Committee Membership

Stephen Barnes

Non-Executive Director and Committee Chairman

Christine Hughes

Director of Communications and Engagement

David Wharfe

Non-Executive Director (to Feb 2018)

Christine Pearson

Director of Nursing

Jonathan Wood

Director of Finance

Richard Smyth

Non-Executive Director

Board Members of the Corporate Trustee

Name	Position	Committee Member
Professor Eileen Fairhurst	Chairman	
Mr Kevin McGee	Chief Executive Officer	
Mr John Bannister	Director of Operations (non-voting)	
Mr Stephen Barnes	Non-Executive Director	Committee Member Committee Chair
Mr Martin Hodgson	Director of Service Development	
Mrs Christine Hughes	Director of Communications and Engagement (non-voting)	Committee Member
Miss Naseem Malik	Non-Executive Director	
Mr Kevin Moynes	Director of HR and OD (non-voting)	
Mrs Christine Pearson	Director of Nursing	Committee Member
Mr Richard Slater	Non-Executive Director	
Mr Richard Smyth	Non-Executive Director	
Dr Damian Riley	Medical Director	
Professor Mike Thomas	Non-Executive Director	
Mr Mike Wedgeworth	Non-Executive Director	
Mr David Wharfe	Non-Executive Director	Committee Member (to February 2018)
Mr Jonathan Wood	Director of Finance and Deputy Chief Executive	Committee Member
Mr Keith Griffiths	Director of Sustainability (non-voting) (to April 2018)	

Declaration

The Corporate Trustee declares that it has approved the annual report of ELHT&Me for 2017/18.

Signed on behalf of the charity's Corporate Trustee:

Stephen Barnes

Non-Executive Director
Charitable Funds Committee Chair
East Lancashire Hospitals NHS Trust

Jonathan Wood

Director of Finance
East Lancashire Hospitals NHS Trust

ELHT&Me

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@ELHT_Charity

Charity number: 1050478

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 23

9 January 2019

Purpose Information

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

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 14 November 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 their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Trust Board Part Two Information Report

1. At the meeting of the Trust Board on 14 November 2018, the following matters were discussed in private:
   a) Round Table Discussion: Lancashire and South Cumbria Integrated Care System (ICS) Memorandum of Understanding (MoU)
   b) Round Table Discussion: Pathology Collaboration Revised Strategic Outline Case
   c) Round Table Discussion: CQC Feedback
   d) Sustaining Safe, Personal and Effective Care 2018/19 Update Report
   e) Tender Update
   f) Serious Untoward Incident Report
   g) 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, 21 December 2018