East Lancashire Hospitals
NHS Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

Personal

Effective

Safe | Personal | Effective

East Lancashire Hospitals NHS Trust

TRUST BOARD MEETING (OPEN SESSION)

8 MAY 2019, 13.00

SEMINAR ROOM 5, ROYAL BLACKBURN HOSPITAL

AGENDA

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

OPENING MATTERS				
TB/2019/055	**Chairman's Welcome**	Chairman	v	
TB/2019/056	**Open Forum** To consider questions from the public	Chairman	v	
TB/2019/057	**Apologies** To note apologies.	Chairman	v	
TB/2019/058	**Declaration of Interest** To note the directors register of interests and note any new declarations from Directors.	Chairman	v	
TB/2019/059	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 13 March 2019.	Chairman	d✓	Approval
TB/2019/060	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2019/061	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2019/062	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2019/063	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information
QUALITY AND SAFETY				
TB/2019/064	**Patient Story** To receive and consider the learning from a patient story.	Director of Nursing	p	Information/ Assurance
TB/2019/065	**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.	Acting Medical Director	d✓	Information
TB/2019/066	**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.	Acting Medical Director	d✓	Approval

TB/2019/067	**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.	Acting Medical Director	d✓	Information/ Assurance
ACCOUNTABILITY AND PERFORMANCE				
TB/2019/068	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed, with items being raised by exception: • Introduction (Chief Executive) • Performance (Director of Operations) • Quality (Acting Medical Director) • Workforce (Director of HR and OD) • Safer Staffing (Director of Nursing) • Finance (Director of Finance)	Executive Directors	d✓	Information/ Assurance
STRATEGY				
TB/2019/069	**Evolving the Acute Offering**	Acting Chief Executive	p	Information/ Approval
GOVERNANCE				
TB/2019/070	**NHSI Self Certification Declaration**	Assoc. Director of Corporate Governance	d✓	Information/ Approval
TB/2019/071	**Finance and Performance Committee Update Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d ✓	Information/ Assurance
TB/2019/072	**Audit Committee Update Report** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information/ Assurance
TB/2019/073	**Quality Committee Update Report** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information/ Assurance
TB/2019/074	**Remuneration Committee Information Report**	Chairman	d✓	Information
TB/2019/075	**Trust Board Part Two Information Report** To note the matters considered by the Committee in discharging its duties	Chairman	d✓	Information
FOR INFORMATION				
TB/2019/076	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2019/077	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2019/078	**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?	Chairman	v	

	• 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?			
TB/2019/079	**Date and Time of Next Meeting** Wednesday 10 July 2019, 1.00pm, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.	Chairman	v	

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 59

8 May 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 13 March 2019 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

(59) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 1.00PM, 13 MARCH 2019

MINUTES

PRESENT

Professor E Fairhurst	Chairman	Chairman
Mr K McGee	Chief Executive	
Mrs P Anderson	Non-Executive Director	
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
Mrs C Pearson	Director of Nursing	
Dr D Riley	Medical Director	
Mr R Smyth	Non-Executive Director	
Professor M Thomas	Associate Non-Executive Director	Non-voting
Mr M Wedgeworth	Associate Non-Executive Director	Non-voting
Mr J Wood	Director of Finance	

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Associate Director of Corporate Governance/ Company Secretary	
Miss K Ingham	Corporate Governance Manager/Assistant Company Secretary	Minutes
Mrs A Brown	Associate Director of Quality and Safety	Observer
Mrs A Tumilty	Aspirant Chairs Programme	Observer
Mr R McLean	East Lancashire Patient Voices Group	Observer
Mrs EL Cooke	Senior Communications Manager	Observer
Mrs J Macnamara	Clinical Director for Cancer Services	For Item TB/2019/038
Mrs S Ridehalgh	Patient Experience Facilitator	For Item TB/2019/038
Mrs V Edmonson	Patient	For Item TB/2019/038

APOLOGIES

Mr K Moynes	Director of HR and OD	Non-voting
Miss N Malik	Non-Executive Director/ Vice Chair	
Mr D Wharfe	Non-Executive Director/Vice Chair	

TB/2019/028 CHAIRMAN'S WELCOME

Professor Fairhurst welcomed the Directors and members of the public to the meeting.

TB/2019/029 OPEN FORUM

Mr McLean asked when the anticipated improvements to the Trust's emergency care pathway would be seen. Mr Bannister confirmed that there had been a number of developments within the emergency care pathway in the recent months, including changes to the assessment and management of patients and the introduction of the respiratory assessment unit and ambulatory emergency care and surgical ambulatory services. In addition, the Trust is in the planning stages of an extension to the main emergency department. Directors noted that despite difficulties in meeting the four hour standard, the Trust had seen an improvement in patient experience.

Dr Riley commented that improvements were being seen, particularly when the complexity and acuity of patients was taken into consideration. He went on to confirm that in the last six months there had been a significant improvement in the reduction of ambulance handover times and there are fewer patients waiting for treatment on trolleys.

Mr McLean commented that whilst the Trust did not provide adult mental health services there was undoubtedly an impact on the Trust services, particularly the emergency care pathway when treating/managing patients with mental health issues. He asked how this had impacted the Trust and how had pathways improved for those patients. Mr Bannister confirmed that Lancashire Care NHS Foundation Trust (LCFT) was the provider of mental health services and reported that the Trust and LCFT worked closely together to improve the speed of access to services for patients requiring mental health services when they presented at the Trust's emergency department. LCFT had developed a mental health decision unit; however there are a number of patients who are unable to access the unit due to the severity of their conditions.

TB/2019/030 APOLOGIES

Apologies were received as recorded above.

TB/2019/031 DECLARATIONS OF INTEREST REPORT

Mrs Bosnjak-Szekeres presented the Directors' Register of Interests report for approval and confirmed that the register is available for the general public to view via the Trust website.

RESOLVED: Directors approved the Directors' Register of Interests and agreed to notify Mrs Bosnjak-Szekeres of any changes.

TB/2019/032 MINUTES OF THE PREVIOUS MEETING

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

RESOLVED: The minutes of the meeting held on 9 January 2019 were approved as a true and accurate record.

TB/2019/033 MATTERS ARISING

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

TB/2019/034 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/2018/114: Action Matrix – Mrs Pearson reported that the first meeting of the Patient Participation Panel took place on 26 February 2019. The panel is made up of 15 members who have a variety of experiences. The Panel elected Mr Woolley as the Chair and developed the terms of reference and ground rules for the Panel at the meeting. Mrs Pearson suggested that the Panel members be invited to a future Board meeting to share their work as a one off replacement for the patient story item.

TB/2019/013: Corporate Risk Register (CRR) – Dr Riley confirmed that the majority of the revisions that the Board had requested be made to the Corporate Risk Register had been completed. The remainder of the changes would be presented to the Risk Assurance Meeting (RAM) for inclusion in the future iterations of the document.

TB/2019/017: Equality, Diversity and Inclusion – Mrs Quinn confirmed that the Shadow Board will commence in May 2019. It would sit outside the Trust's governance structures and is an opportunity for the Trust to develop future Executive Board members.

TB/2019/019: Integrated Performance Report – Mr McGee reported that as part of the Trust's Vital Signs work the ways in which reports are presented will develop, including the

presentation of the Integrated Performance Report.

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

TB/2019/035 **CHAIRMAN'S REPORT**

Professor Fairhurst reported that she had spent some time with the staff working in the Speech and Language services to see the ways in which their roles have been developed and the innovative practices that are taking place in the service, such as the therapists undertaking swallowing endoscopies to assess swallowing of liquids. She commented that much of the workforce transformation taking place is being engendered and led by the staff on the front line and there was a need to consider the ways in which we can utilise these developments.

Directors noted that Professor Fairhurst had attended the NHS Providers 'round table' event relating to Trusts' experiences of the CQC Well-Led reviews and that she had been asked to be part of the NHS Providers Regulation Reference Group.

Professor Fairhurst confirmed that she had recently undertaken her induction to become a CQC Executive Reviewer alongside Mr McGee.

She went on to report that she, along with others who had received honorary awards from UCLan, had attended a celebratory event and been given a tour of the new Medical School.

Directors noted that Professor Fairhurst had recently attended a Mosque Open Day at the Darussalam Education Centre. The Mosque is the first in the area to offer family prayer where women, children and men can congregate together at prayer times.

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

TB/2019/036 **CHIEF EXECUTIVE'S REPORT**

Mr McGee presented his report to Directors and highlighted a number of items for information. He reported that there had been significant pressure on the Trust's emergency care pathway, particularly due to the high number of patients being seen and the acuity of some of those patients.

Mr Wood provided an update on the Trust's preparations for Brexit. He confirmed that weekly meetings have been implemented to determine and review the key risks associated with the UK's withdrawal from the EU and will remain in place until an outcome is confirmed by Parliament. A desktop exercise has been undertaken to determine plans to ensure continuity of services and identify and address issues in the supply chain in a 'no deal' Brexit scenario.

Mr McGee highlighted the work that was being undertaken in relation to a range of workforce matters, including the Workforce Race Equality Standard (WRES), national NHS Staff Survey and workforce implications from the NHS Long Term Plan. He confirmed that there had been an increase in the number of male nurses being employed by the Trust. Directors noted the developments in the mental health and wellbeing services for staff at the Trust.

Mr McGee gave an update in relation to the development of the Integrated Care Partnership (ICP) across the Pennine Lancashire system. He confirmed that the place based Community Services Neighbourhood Teams were being developed and were designed to ensure that primary and community services are better integrated.

Directors noted the information within the report relating to the use of the Trust seal.

Mr McGee highlighted the rating of the Trust's maternity services and confirmed that the Trust is one of only nine Trusts in the country that were rated as 'better than average'. He went on to highlight the ELHT&Me 'Big NHS Walk' which will take place on Sunday 23 June 2019. The walk will start at both main sites and walker would meet at the mid-point of the route between the sites. It is hoped that the walk will raise considerable funds for the Trust's charity. Mrs Hughes encouraged members of the Board and other staff to take part in the event.

Mr McGee highlighted the section of the report which provides an overview of the media coverage and social media activity since the last meeting.

In response to Mr Wedgeworth's question regarding the extent to which the Trust was involved in the prevention agenda, Mr McGee confirmed that prevention was a vital part of the work and the Trust would be looking to see a shift in resources over a sustained period of time to increase the spend on prevention. Directors noted that this needed to be done in a controlled and sensible way in order not to have a detrimental effect on patient care.

RESOLVED: Directors received the report and noted its content.

TB/2019/037 CQC INSPECTION REPORT

Mrs Pearson presented the report and advised members about the outcome of the CQC inspection. The Trust received and overall rating of "Good" with some services rated "Outstanding". The Trust devised an action plan in response to the inspection report and progress against the plan will be monitored via the Quality Committee. The Board congratulated the staff on the pleasing inspection result.

RESOLVED: Directors received the report and noted its content.

TB/2019/038 PATIENT STORY

Mrs Pearson introduced Mrs Edmonson, Mrs Ridehalgh and Mrs McNicholas to the Board and confirmed that Mrs Edmonson had agreed to share her experience of the Breast Care services at the Trust.

Mrs Edmonson reported that she had first attended the Trust following a referral from her GP under the 'two week wait' for a mammogram and other exploratory tests for breast cancer, following noticeable changes to the look and feel of her breasts. Following the mammogram and other tests, she met with Mrs McNicholas to go through the results and was formally diagnosed as having breast cancer. She had a series of other tests carried out to determine the severity of the cancer and her operation was arranged for 7 November 2017.

When Mrs Edmonson went back for her post-operative appointment she was informed that the cancer was a very aggressive type three cancer and it required immediate further treatment. After additional surgery Mrs Edmonson developed a large haematoma and has had severe scarring from the surgery. She needed to undergo both chemotherapy and radio therapy and confirmed that, prior to either form of treatment being undertaken, she met with the team who would undertake the treatment and the process and possible side effects were outlined to her. Mrs Edmonson went on to provide an overview of the side effects that she experienced and confirmed that she still had pain in her feet and skin hypersensitivity.

When Mrs Edmonson received the news that she was free of the cancer, she and her family arranged a party to celebrate and invited Mrs McNicholas, her consultant, as a way of thanking her for her care. Mrs McNicholas commented that it was amazing to see and hear the ways in which her work impacts on the lives of patients and their families. Mrs Edmonson commented that all of the staff involved in her care, from the domestic staff to the consultants had been polite, caring and not deterred by any of the issues and difficulties that she had experienced.

In response to Mrs Pearson's question, Mrs Edmonson suggested that the only time that she had felt slightly frustrated with the service was when she had been discharged early in the day and had needed to wait on the ward until she could be collected by her husband due to the need to wait for medication to be prepared and brought to the ward area. She stated that she felt as though someone else could have had her bed whilst she waited in either a waiting area or day room type environment.

Mr Barnes asked what the Trust is able to do to manage pain for patients who are undergoing the various therapies that Mrs Edmonson underwent. Mrs McNicholas stated that Mrs Edmonson's pain was neuropathic pain and was suffered by less than 1% of the

patients that receive either chemotherapy or radiotherapy. As such, it is very difficult to manage the pain as standard painkillers have little to no effect on this type of pain.

Mrs Edmonson suggested that a patient information card be developed to give patients an idea of the things that they may need whilst undergoing treatment. In response to Mrs Anderson's question, Mrs McNicholas suggested that expanding the role of Cancer Care Co-ordinators to include providing advice and support to patients undergoing follow up treatment may help to convey additional information that could be helpful to patients.

Ms Hughes suggested that Mrs Edmonson may be willing to share her experiences in a more formal and structured way. Mrs Edmonson confirmed that she would be happy to share her experiences and help the Trust in any way that she could. It was agreed that Mrs Hughes and Mrs Edmonson would meet to discuss this matter further outside the meeting.

Professor Thomas asked that the issues around waiting on the wards for medication to take home be addressed and an update provided at the next meeting.

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

Mrs Hughes agreed to contact Mrs Edmonson outside the meeting to further discussion regarding sharing her experiences.

Mr Bannister to provide an update on the issues around the waiting on the ward for medication to take home following a discharge at the next meeting.

TB/2019/039 CORPORATE RISK REGISTER (CRR)

Dr Riley referred Directors to the previously circulated report and confirmed that there were three risks on the register that related to information technology (IT); he suggested that these three items be collated under one IT risk. Directors agreed that this was a sensible suggestion.

Dr Riley went on to provide an overview of the risks on the register, particularly the newly proposed risks for inclusion on the register, namely Risk ID 7816: *Medical (psychiatric) waiting lists* and Risk ID 8016: *Management of Holding Lists*. He confirmed that there was a recommendation to de-escalate Risk ID 7513: *radiology capacity issues impacting on patient flow, Referral to Treatment (RTT) and patient experience.*

Directors noted that two further risks had been discussed at the Risk Assurance Meeting (RAM) in January, but had not been suggested for inclusion on the corporate risk register at that time, although one was now recommended for inclusion. The risk recommended for inclusion on the register related to the potential of losing EU workers in the event of a 'no

deal' Brexit.

Mr Smyth suggested that there was a lack of clarity around the detail in the 'assurances' and 'actions' sections on the register and therefore it was difficult to determine what actions had taken place to mitigate the risks.

In response to Mr Smyth's comments regarding the use of escalation areas and patient moves, Mr Bannister reported that the reason for Risk ID 1810: *Failure to adequately manage the Emergency Capacity and Flow System* being included on the register was because the overall risk is not sufficiently mitigated and there was a need to be clear about the assurance being sought as complete mitigation of the risk was not possible; however further actions to manage the risk are in place. It was agreed that discussion on this particular area would be undertaken outside the meeting.

RESOLVED: **Directors were assured by the data presented and approved the proposed revisions to the register.**

Mr Bannister and Mr Smyth will meet to discuss the mitigation of risks and the recording of actions to reduce and manage risks.

The three IT related risks will be brought together under one overarching risk.

TB/2019/040 BOARD ASSURANCE FRAMEWORK

Dr Riley presented the report and provided an overview of the proposed changes to the Board Assurance Framework (BAF). He confirmed that following the discussions that had taken place at the last Board meeting, the risk ratings of BAF risks 2 (workforce) and 5 (constitutional standards) had been reviewed and the scoring revised. BAF risk 2 had been rescored at 20 (likelihood score 4 and consequence score 5) with BAF risk 5 being rescored at 12 based on the positive performance across the majority of standards.

Directors briefly discussed the revised ratings and approved the document.

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

TB/2019/041 SERIOUS INCIDENTS REQUIRING INVESTIGATION REPORT

Dr Riley referred Directors to the previously circulated report and highlighted the Never Event that had been reported retrospectively in October 2018. He confirmed that the incident took place in July and was reported through the appropriate channels. It was originally not thought to constitute a Never Event, but following a thorough investigation it

was found to have met the criteria for reclassification and reporting as a Never Event. He provided a brief overview of the incident and confirmed that it was an insulin dosing incident. The members of staff who had administered the drugs immediately recognised the error and action was taken to ensure that the patient did not come to harm.

Directors noted the high levels of compliance in relation to the duty of candour declarations. Dr Riley commented that whilst the levels of compliance were good, there were instances of duty of candour letters not being entered into patients' files, as their notes had been moved from the department after their episode of care had ended.

Dr Riley highlighted the section of the report detailing all policy revisions and developments in training/learning as a result of incidents/investigations.

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

Dr Riley to provide an update on the actions taken to improve the practice of the duty of candour letters being entered into patients' files.

TB/2019/042 NATIONAL NHS STAFF SURVEY

Mrs Quinn referred Directors to the previously circulated report and confirmed that the overall response rate was 45%, which provided a representative response rate. She provided an overview of the report and confirmed that the Trust had achieved a staff engagement score of 3.93, which placed the Trust third in the North West and seventh nationally. Directors noted that there had been a significant reduction in the number of staff members completing the survey in the Integrated Care Group and the Estates and Facilities Divisions and work was taking place to understand why this was the case and encourage improved response rates in the coming year.

Mrs Quinn confirmed that the Picker Institute was in the process of providing feedback to the individual Divisions on their specific results and provided an overview of some of the actions that have been undertaken since the embargoed results of the survey had been given to the Trust, including the development of the Early Resolution Policy and the revised Health and Wellbeing Strategy.

Mr McGee stated that of all the information and pieces of evidence that the Trust receives about its performance, the results of the staff survey were amongst the most important and informative.

Directors noted that the detailed reports from the Picker Institute will be reviewed and it will inform the next round of 'Big Conversations'. It was agreed that an update report will be

provided to the Board in July 2019.

In response to Mrs Anderson, Mrs Quinn confirmed that the Trust has good working relationships with the various Unions operating within the organisation.

Mr Wedgeworth remarked that whist there was a significant amount of information in the survey results to be pleased about, there seemed to have been a reduction in the response rate from the clinical Divisions and asked whether this was an indication of morale levels within those areas. Mr McGee suggested that there was a need to provide a suitable opportunity for staff working in clinical areas to complete the surveys, either electronically or by hard copy.

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

An update on the actions stemming from the national Staff Survey report to be provided to the Board in July 2019.

TB/2019/043 INTEGRATED PERFORMANCE REPORT

Mr McGee introduced the report to the Directors and confirmed that the report related to the period to the end of February 2019. He confirmed that presentation of the report would be on an exception basis.

a) Performance

Mr Bannister confirmed that there were no specific performance issues to raise, as they all had been discussed in depth at the previous Finance and Performance Committee meeting.

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

b) Quality

Dr Riley reported that the Trust was on trajectory to achieve the required year end position in relation to cases of Clostridium Difficile cases assigned to the Trust. He went on to confirm that the Trust was in the process of developing an action plan to reduce sepsis related mortality. The team were congratulated by the Board on their efforts to achieve this important metric.

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

c) Workforce

Mrs Quinn reported that staff sickness levels continued to be a challenge and work was taking place across the Divisions to shape a revised approach to sickness management which would be presented to the Operational Delivery Board in April for discussion.

She also highlighted the ongoing issues in relation to the use and cost of agency staffing and confirmed that despite a slight reduction in spend in the reporting month, a revised meeting structure had been developed to ensure enhanced scrutiny of agency use and spend.

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

d) Safer Staffing

Mrs Pearson confirmed that there were no specific issues relating to staffing that required reporting that had not been discussed in depth at the Trust Board sub-Committees prior to this meeting.

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

e) Finance

Mr Wood confirmed that despite the finances being under pressure, the Trust remained on trajectory to achieve the required year-end financial position.

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

TB/2019/044 FLU VACCINATION COMPLIANCE REPORT 2018/19

Mrs Quinn referred Directors to the previously circulated report and confirmed that the Trust had vaccinated 93.6% of the staff working for the Trust. She went on to report that the Staff Wellbeing Team had undertaken a piece of work to determine the reasons why the remaining staff had chosen not to take up the offer of vaccination in order to address any myths or misunderstandings concerning the vaccination next year. Directors noted that planning for the 2019/20 vaccination programme was underway.

Professor Fairhurst commented that the uptake of the vaccination was another indicator of the Trust's engaged and motivated workforce.

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

TB/2019/045 SEVEN DAY SERVICES REPORT

Dr Riley confirmed that the report had not been to the Trust Board before and provided an overview of the background to why the report was required. He reported that there were 10 national standards for care over seven days that had been developed by the National Institute for Health and Care Excellence (NICE) with four of them being classified as priority standards. The report submitted to the Board sets out the results for the Trust against the standards. He confirmed that the Trust had been required to undertake spot audits and it is required to repeat this process twice a year and report the findings to the Board. Directors noted that the results of the audits presented an increase in performance. He highlighted the lack of comparison between some of the indicators in the report and the 'same day' standards for non-elective care.

It was agreed that the majority of the reporting relating to the seven day services would be undertaken via the Trust's Quality Committee. In response to Mr Wedgeworth's question, Dr Riley confirmed that, due to financial and staffing constraints, it was not possible to provide the same level of staffing over the weekend period or out of the standard working hours in comparison to weekdays. He went on to report that the Trust must make a decisions regarding investment in staffing based on a plethora of information, one being the overall performance of services against the finances available. He went on to confirm that the Trust's performance benchmarks well at a national and regional level.

Mr Barnes suggested that the Quality Committee be asked to carry out a deep dive into the matter of performance against the seven day service priorities and present the findings and any necessary actions to a future Board meeting. It was noted that any such action plan would have resource implications which would require debate at Board level.

Mr Wood suggested that the issue was not necessarily a matter for the Quality Committee to review and it should also be addressed within the remit of the Finance and Performance Committee.

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

A deep dive regarding the performance against the seven day services priorities will be carried out and the findings and associates actions/resource implications will be presented to the Finance and Performance Committee and/or Quality Committee.

TB/2019/046 FINANCE AND PERFORMANCE COMMITTEE UPDATE REPORT

Mr Wedgeworth presented the report on behalf of Mr Wharfe. He highlighted the

discussions that had been held at the last Committee meeting regarding the Trust's ambulatory emergency care department and the implication of the NHS Long Term Plan.

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

TB/2019/047 **AUDIT COMMITTEE UPDATE REPORT**

Mr Smyth provided an overview of the report and highlighted the outcome of the report relating to the Cyber Essentials Gap Analysis and the closing report from the Information Commissioners Office inspection visit that took place in October 2017. Directors noted the improvements that had been made to the way that information is managed and stored/protected in the Trust since the findings of the initial report were published.

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

TB/2019/048 **TRUST CHARITABLE FUNDS COMMITTEE UPDATE REPORT**

Mr Barnes highlighted the planned use of £500,000 from the charitable funds to purchase defibrillators. Mr Wood confirmed that since the last meeting of the Committee and the preparation of the report to the Board, a group has indicated that they would like to raise funds on behalf of ELHT&Me for the purchase of the defibrillators.

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

TB/2019/049 **REMUNERATION COMMITTEE INFORMATION REPORT**

The report was presented to the Board for information.

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

TB/2019/050 **TRUST BOARD PART TWO INFORMATION REPORT**

The report was presented to the Board for information.

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

TB/2019/051 **ANY OTHER BUSINESS**

There were no matters of business raised under this item.

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

TB/2019/052 **OPEN FORUM**

Mr McLean congratulated the Board and staff at the Trust on the outcome of the recent CQC inspection. He reported that he had recently spent a day with the community teams and

seen the great work that they do.

TB/2019/053 BOARD PERFORMANCE AND REFLECTION

Professor Fairhurst invited comments and observations about the meeting from the Directors. Mr McGee suggested that the majority of the meeting had been focused on internal issues and had not covered a great deal of external/stakeholder engagement. Professor Thomas commented that part of the job as the Board was to deal with the statutory and regulatory requirements, and that could lead to a mind-set where negative issues are laboured over at the expense of recognising and celebrating the positive work of the Trust. He went on to ask how the Board could go above and beyond the ways in which it currently communicated with staff groups. Mrs Hughes agreed to give some thought to this matter and liaise with Professor Thomas outside the meeting.

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

Mrs Hughes will liaise with Professor Thomas outside the meeting in relation to developing additional channels of communication between staff groups and the Board.

TB/2019/054 DATE AND TIME OF NEXT MEETING

The next Trust Board meeting will take place on Wednesday 8 May 2019, 13:00, Seminar Room 6, Learning Centre, Royal Blackburn Teaching Hospital.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 61

8 May 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

East Lancashire Hospitals NHS Trust

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2019/038: Patient Story	Mrs Hughes agreed to contact Mrs Edmonson outside the meeting to further discussion regarding sharing her experiences. Mr Bannister to provide an update on the issues around the waiting on the ward for medication to take home following a discharge at the next meeting.	Director of Communications and Engagement Director of Operations	May 2019 May 2019	Verbal Report Verbal Report
TB/2019/039: Corporate Risk Register (CRR)	Mr Bannister and Mr Smyth will meet to discuss the mitigation of risks and the recording of actions to reduce and manage risks. The three IT related risks will be brought together under one overarching risk.	Director of Operations Medical Director	May 2019 May 2019	Verbal Report Verbal Report **Complete**
TB/2019/041: Serious Incidents Requiring Investigation Report	Dr Riley to provide an update on the actions taken to improve the practice of the duty of candour letters being entered into patients' files.	Medical Director	May 2019	Verbal Report
TB/2019/042: National NHS Staff Survey	An update on the actions stemming from the national Staff Survey report to be provided to the Board in July 2019.	Director of HR and OD	July 2019	Agenda Item July 2019

Item Number	Action	Assigned To	Deadline	Status
TB/2019/045: Seven Day Services Report	A deep dive regarding the performance against the seven day services priorities will be carried out and the findings and associates actions/resource implications will be presented to the Finance and Performance Committee and/or Quality Committee.	Medical Director	May 2019	Verbal Report
TB/2019/053: Board Performance and Reflection	Mrs Hughes will liaise with Professor Thomas outside the meeting in relation to developing additional channels of communication between staff groups and the Board.	Director of Communications and Engagement	May 2019	Verbal Report

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 63

8 May 2019

Purpose Information

Title	Chief Executive's Report
Author	Mr S Whittaker, Communications Specialist
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

May 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.

Annual NHS cancer checks top two million for the first time

For the first time last year, the NHS in England carried out more than two million checks on people who feared they might have cancer.

In 2018, patients underwent a record 2.2 million cancer checks following urgent referral by their GP, almost 6,000 a day or more than four every minute.

That was an increase of almost a quarter of a million on the 1.9 million people who were seen in 2017.

Record numbers of people also received treatment for cancer, with 308,058 receiving a first treatment in 2018, almost 13,000 more than in 2017 and the first time the number has topped 300,000.

Staff praised as NHS productivity grows more than twice as fast as wider economy

A new study by health experts has shown that the productivity of the NHS has improved almost two and a half times as fast than the wider economy over the last 12 years, meaning more care and treatments for patients and better value for taxpayers.

According to the University of York's Centre for Health Economics, hard-working NHS staff provided 16.5% more care pound for pound in 2016/17 than they did in 2004/05, compared to productivity growth of only 6.7% in the economy as a whole.

Digital tool to help reduce avoidable lengthy stays in hospital

A new digital portal is being introduced by the NHS and councils which allows health and social care staff to see how many vacancies there are in local care homes, saving hours of time phoning around to check availability and helping people to get the right care or return home as quickly as possible.

The NHS, working with councils, reduced the number of lost bed days by 20% between 2017 and last year, and making the new tool – the Capacity Tracker – more widely available, is one of a number of measures being taken to reduce unnecessary delays leaving hospital still further.

First Chief Midwife appointed

The NHS has appointed England's first Chief Midwife to improve care for new and expectant mothers and their children and promote safer births as part of the NHS Long Term Plan.

Chief executive Simon Stevens announced that Professor Jacqueline Dunkley-Bent will be the first to take on the new role, to oversee delivery of a package of measures building on increased safety and support in maternity care.

The truth behind the shocking assaults on Lancashire hospital staff

Hospital staff in Lancashire are suffering an average of three assaults per day - as numbers of physical attacks hit a record high.

That was up from 1,057 in 2016/17 and just 398 in 2010/11, when published figures began with members of staff getting injured at least 207 times as a result of assaults last year.

Some 448 assaults took place at Lancashire Teaching Hospitals in 2017/18, 249 at Blackpool Teaching Hospitals**, 242 at East Lancashire Hospitals**, and 240 at University Hospitals of Morecambe Bay.

Cosmetic procedures: Firms warned over 'duty of care'

England's top doctor says practitioners offering cosmetic procedures should have training to help them protect vulnerable clients from "quick fixes".

Prof Stephen Powis believes providers should be officially registered and trained to spot people with body-image or other mental-health issues.

NHS England says only 100 out of 1,000 practitioners are currently registered.

NHS to test new rapid care measures for patients with the most urgent mental and physical health needs

People who arrive at A&E experiencing a mental health crisis will receive emergency care within one hour under NHS pilot schemes aimed at improving care and saving more lives.

The new standard, a significant step towards parity of esteem for mental health, is among a raft of proposed clinical improvements that aim to deliver rapid assessment and treatment for patients with the most serious conditions, and expand short waits for millions more NHS patients.

The NHS in England will offer free tampons and other sanitary products to every hospital patient who needs them

From this summer, all women and girls being cared for by the NHS will be given, on request, appropriate sanitary products free of charge.

Many already provide them but this will be mandated in the new standard contract with hospitals for 2019-20.

The announcement by NHS England and supported by the BMA, was welcomed by charity Freedom4Girls, which campaigns against period poverty.

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 update

Held a 'Learning Opportunity Workshop: Improving outcomes for Care Home Residents' on 4 April - bringing together colleagues from across Pennine Lancashire to celebrate local best practice, explore latest learning from successful Integrated Care Systems and collaborate in creating and supporting local solutions for 2019/20.

Work underway to align Integration, neighbourhoods and health and well-being priorities in BwD via a joint plan with Public Health and Wellbeing services. The plan includes partnership opportunities with Community Pharmacies in BwD, health coaching prevention pathways and aligning the Personalised Care 'coaching based training'

Programme team have visited 48 care homes, using care home business intelligence reports. Work commenced to triangulate this intelligence with Telemedicine data and next steps to work with locality managers and other local services to focus support.

Active participation in Lancashire County Council's Intermediate Care Review, initial report from the review is expected during April.

Pennine Lancashire welcomes multi-million pound Sport England boost

Pennine Lancashire is to benefit from potentially up to £10m in funding to help more people be physically active.

Last year Pennine Lancashire was successful in being named as one of 12 pilot areas to work with Sport England to develop bold new approaches to build healthier, more active communities. The pilot is called Together an Active Future and its primary aim is to increase activity levels for people with or at risk of poor mental wellbeing.

Sport England has announced that pilot areas will receive a minimum of £3m in Pathfinder funding to develop 'test and learn' initiatives. There is the possibility to unlock further funds of up to £10m if needed to scale up those initiatives that are most successful.

Diabetic Eye Screening returns to NHS provision

From 1 April 2019, responsibility for providing **diabetic eye screening across the whole of Lancashire** transferred to East Lancashire Hospitals NHS Trust.

East Lancashire Hospitals brings 10 years' experience of running an efficient and well-managed eye screening service including a high quality screening process, excellent levels of patient satisfaction and an 87% uptake rate.

Previously, the Lancashire Diabetic Eye Screening Programme (LDESP) was provided by EMIS Care as part of a national contract with NHS England.

Care navigators help support patients get to the right service faster

GP practices across Lancashire and South Cumbria are rolling out a new scheme to help support and guide patients to access the most appropriate service for their need. GPs in Blackburn with Darwen and East Lancashire have been running this service now for nearly a year in Blackburn with Darwen, and nearly two years in East Lancashire.

This scheme in Pennine Lancashire is called care navigation. General practice receptionists and admin staff have been given training to help them direct patients to the right health professional first time.

Three - ELHT Headlines

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

Use of the Trust Seal

There have been no further uses of the Trust Seal since the previous CEO report to the Board in March 2019.

East Lancashire best training hospitals for paediatric doctors

ELHT's paediatric department is rated 'Best in the north west' for training specialist child doctors (paediatricians).

The award comes after trainee doctors from Health Education England (North West) evaluated the training experience they received at the Royal Blackburn and Burnley General hospitals, and nominated the East Lancashire department for a 'PAFTA' – the Paediatric Awards For Training Achievements.

Trust safety initiative wins national Patient Safety Award

A groundbreaking safety initiative adopted from the airline industry and now used to protect patients undergoing surgery at the Royal Blackburn and Burnley General teaching hospitals has won a national award for patient safety.

Known as **10,000 feet**, the safety initiative started in East Lancashire thanks to Junior Charge Nurse Rob Tomlinson, who discovered how nurses in Australia were using the phrase to reduce the risk of hospital theatre errors caused by noise, distraction and poor communication.

Community End of Life care rated 'Outstanding' by CQC

The Trust's community end of life care provision has been awarded the highest possible **'Outstanding'** rating by independent inspectors from the Care Quality Commission.

During a routine inspection last summer, CQC inspectors met community specialist palliative care staff, management and community nurses, as well as visiting patients in their own homes.

The outcome was a glowing report in which ELHT's Community End of Life Care provision was praised for being "*personalised to patient's individual needs and taking into consideration the whole patient's circumstances, including financial.*"

Accessibility Guides now live

ELHT have partnered with AccessAble to create Detailed Access Guides for **Royal Blackburn Teaching Hospital** and **Burnley General Teaching Hospital**. More guides are on their way covering Pendle Community Hospital, Accrington Victoria Community Hospital and Clitheroe Community Hospital.

The Guides are 100% facts, figures and photographs and give loads of useful information to work out if somewhere is going to be accessible to you. They cover everything from parking to hearing loops, walking distances and accessible toilets.

New Children's Play Area

Children and their families who spend time at the Royal Blackburn are absolutely delighted with their new play area that opened in March.

Joined onto the Children's Unit, the play area is the product of precision planning by the Trust and the kindness of locally based international company, EG Group. The generous donation of around £100,000, has fully funded the exterior play area and its equipment. The work was also supplemented by the generous donations of time, labour and materials from a number of local companies.

'Gold standard' for work experience

Important work to develop a sustainable, local NHS workforce for the future has earned ELHT the **Fair Train Gold Standard,** the nationally accredited Work Experience Quality Standard.

In the past six months alone ELHT, in partnership with local colleges, has welcomed more than 300 students who have benefitted from the Trust's work experience and work placement initiatives.

Faster, easier diagnosis thanks to charity's significant scanner donation

Darwen-based charity has donated thousands of pounds to purchase a mobile bladder scanner for the Royal Blackburn Teaching Hospital.

Representatives from the WM and BW Lloyd charity recently visited the hospital to hand over a cheque for £8,000 to purchase a portable, hand-held ultrasound device which can perform quick, easy and non-invasive scans of the bladder.

Mini Racers for Children's Ward to Theatres Journey

Young patients visiting Burnley General will be on the fast track to a speedy recovery thanks to a new donation of a sit-in electric car.

Bowker BMW in Blackburn presented the Trust with one fully-automated sit-in miniature vehicle and one baby racer for use in the paediatric day surgery (ward 27) at Burnley Hospital.

Four – Communications and Engagement

A summary of the external communications and engagement activity.

March 2019

Communications and Engagement

Monthly Media Update

Top Stories...

- Your Accessibility Guide for East Lancashire Hospitals is now live!
- Community End of Life care rated 'Outstanding' following CQC inspection
- Hospital Safety Initiative Wins National Patient Safety Award
- Trust supports National No Smoking Day

Best training hospital for paediatric doctors

Press and Media Relations...

55	21	10	91%	+52
Mentions in all media	Media enquiries handled	Media releases issued this month	of stories were positive or neutral	The monthly media net score (positive minus neutral)

Projects the Communications Department has supported...

- ELHT&Me work
- STAR awards
- Additional car parking
- PLACE
- Phase 8

Website...

Our website got **94,229** page views by **32,686** people .

The most viewed webpage was – **Waiting Times**

Social media and digital...

Followers on social media:

9,515

5,698

5,698

22,553

Avg Weekly Facebook Reach

180,000

Twitter Impressions

77%

Facebook page responsiveness

652

Twitter mentions

The most talked about issues on our social networks..

- Employee of the month
- CQC report results
- No smoking day
- Big Butt Clean Up

Posts of the month...

Top Tweet earned 4,251 impressions

Happy 10th Birthday to Tia Taggart! Thank you very much to @Padiham_Fire and @LancashireFRS for visiting one of our patients and making them feel very special yesterday. pic.twitter.com/LQt6Rmdkbc

Facebook review rating:

4.5 out of 5

Routine activity:

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

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

Safe | Personal | Effective

Five - Chief Executive's Meetings

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

April 2019 Meetings

Date	Meeting
1 April	Every minute matters summit
2 April	Exec Team
3 April	NHS Quest Experience Day
4 April	A&E Delivery Board
4 April	Employee of the Month
4 April	Visit to ELCAS
5 April	Lancashire and South Cumbria Provider Board
8 April	Meeting with David Fillingham, Vital Signs
9 April	Exec Team
9 April	Meeting with Chairman and Peter Mileham, Chairman of Rosemere Cancer Foundation
9 April	Chairman/CEO meeting
10 April	Pennine Lancashire Chief Officers discussion
10 April	Board Strategy
11 April	HSJ Provider Summit 2019
12 April	A&E Delivery Board planning
15 April	Dr Julie Higgins Joint Chief Officer, EL and BwD CCGs
15 April	Pennine Lancs Mental Health Improvement meeting
16 April	Exec Team
16 April	Finance Assurance Board
17 April	Pennine Lancashire Chief Officers discussion
17 April	AOs, CEOs and ICS Exec Meeting
17 April	Rory Deighton NHS Confed
18 April	Back to the floor – Emergency Department
18 April	Pennine Lancs briefing with Graham Burgess
18 April	Meeting with Dennis Gizzi, Chief OfficerNHS Chorley and South Ribble CCG / NHS Greater Preston CCG
23 April	Exec Team

Date	Meeting
23 April	Meeting with David Dalton
24 April	Pennine Lancashire Chief Officers discussion
24 April	Team Brief filming
24 April	Meeting with Bill McCarthy, Regional Director North West
25 April	Retirement presentation Chief Executive Wendy Swift, Blackpool Teaching Hospitals
29 April	Vital Signs – Transformation Guiding Board

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

8 May 2019

Item 65

Purpose Information
Assurance

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

Summary: This report presents an overview of the Corporate Risk Register (CRR) for March - April 2019 and some risks which were present at the Risk Assurance Meetings (RAM) by the Divisions and Corporate services for review, scrutiny and approval for inclusion onto the CRR. The Corporate Risk Register is presented for approval with any changes in month highlighted in the body of the report.

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation 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	Yes
Equality	No	Confidentiality	No

Previously considered by: Executive Team on 23 April 2019.

Table 1: The Corporate Risk Register as of April 2019 RAM meeting:

The following 10 'live' risks currently on the CRR were discussed, reviewed, scrutinised and recommended at the RAM meeting which held in April, 2019.

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
8061	Management of Holding List	16
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
5791	Aggregated Risk - Failure to adequately recruit to substantive nursing & midwifery posts may adversely impact on patient care and finance.	15
5790	Aggregated risk – Failure to adequately recruit to substantive medical posts may adversely impact on patient care and finance.	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
7330	Aggregated risk – Inability to identify, track & monitor the cohorts of women and new borns who require and have screening due to lack of an end-to-end IT System for Maternity.	15

Risks de-escalated from the CRR at April RAM meeting:

1. The following risk was recommended for de-escalation from the CRR at the April RAM meeting.

Table 2: Risk recommended for de-escalation from the CRR.

Risk	Title	Current Score
4353	Potential loss of images (OCT and FFA) if equipment should fail or be stolen	12

Details of risk presented for and approved for de-escalation can be found in appendix 2.

IT-related risks discussed at April RAM meeting:

2. **IT-related Risks on the CRR**: Following the discussions at the March Trust Board meeting all the IT related risks on the register are now under one risk handler. The delay in implementation of the Electronic Patients Record (EPR) system will hinder the improvements in Safe, Personal, Effective care, but action is taken to mitigate the risks presented. The Associate Director of Performance & Informatics now leads on all IT-related risks reviewed all of the three IT-related risk. Actions are now being effectively implemented in mitigating these risks as follows:
   a) **7552** - Risk that PACS downtime occurs and brings delay to patient pathways or delays in operating theatre activity and
   b) **7330** - Aggregated risk – Inability to identify, track & monitor the cohorts of women and new-borns who require and have screening due to lack of an end-to-end IT System for Maternity.
3. The risk handler advised that the current score has reduced for the following risk:
   a) (4353 - Potential loss of images (OCT and FFA) if equipment should fail or be stolen) risk score to be reduced from 15 to 12 as sufficient storage capacity has now been setup to address the potential loss of images due to diminished storage capacity.
4. It was noted that the risk around maintenance and the slow nature of the equipment should be raised as a distinct risk to be owned by the Division although IT will still be involved in providing support with driving this forward.
5. The Risk Assurance meeting discuss the suggestion that all IT-related risks on the CRR should to be merged into one overarching risk. It was agreed that currently the risks will continue to be managed in their current format, but there will be an overarching responsibility by the risk handler (Associate Director of Performance and Informatics) to monitor the risks and ensure that all mitigations are undertaken in a timely manner.

Trust-wide Risk Register

6. After some discussions members agreed that due to its increasing importance and some of the challenges faced in effectively managing cross-divisional risks, it were important for the Trust-wide risk register to be reviewed at the Operational Delivery Board (ODB) alongside the CRR.

Corporate Risk Register (Appendix 1):

7. Details of the current Corporate Risk Register can be found in appendix 1, as appendix 2 presents the risk recommended for de-escalation from the CRR while appendix 3 provides a one page representation of all risks on the CRR by current score.

Conclusion

8. Members of the Board are hereby requested to:
   a) Review, scrutinise and approve the Corporate Risk Register (appendix 1).
   b) Gain assurance that risks on the CRR are being robustly managed in line with best practice and the Trust Risk Management Strategy.

David Tita, Risk Manager, April 2019

	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**				
Risk ID	7010		Date opened	25/08/2016	
Risk Handler	Allen Graves		Exec Director/Risk Lead	Jonathan Wood	
Identified in BAF Risk ID	BAF/04: The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework.				
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)				
Initial Rating	**Likelihood: 3** **Consequence: 5** **Total: 15**	Current Rating:	**Likelihood: 5** **Consequence: 4** **Total: 20**	Target Rating:	**Likelihood: 4** **Consequence: 3** **Total: 12**
What is the Hazard	• Failure to meet the targets will result in the Trust having an unsustainable financial position going forward and the likely imposition of special measures		What are the risks associated with the hazard	• If Divisions deliver their SRCP and meet their Divisional financial plans the Trust will achieve its agreed control total. • Breach of control totals will likely result in special measures for the Trust, adverse impact on reputation and loss of autonomy for the Trust. • Sustainability and Transformational funding would not be available to the Trust. • Cash position would be severely compromised.	
What controls are in place	• Standing Orders. • Standing Financial Instructions. • Procurement standard operating practice and		What are the gaps in controls	• Individual acting outside control environment in place.	

	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	• None identified.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected Completion date	Progress on implementation of action	RAG Rating
1	Per individual linked risks	Allen Graves	27/09/2018	27/09/2018	completed	
2	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.	Allen Graves	Ongoing	Ongoing	On track	

Title	**Management of Holding List**				
Risk ID	8061		Date opened	05/02/2019	
Risk Handler	Natalie Hudson		Exec Director/Risk Lead	John Bannister	
Identified in BAF Risk ID	**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. (Poor patient experience and risk to patient safety).				
Linked to Risks:	N/A				
Initial Rating	**Likelihood: 4 Consequence: 4 Total: 16**	Current Rating:	**Likelihood: 4 Consequence: 4 Total: 16**	Target Rating:	**Likelihood: 2 Consequence: 4 Total: 8**
What is the Hazard	• Patients waiting past their intended date for review appointment and subsequently coming to harm due to a deteriorating condition or suffering complications due to delayed decision making or clinical intervention.		What are the risks associated with the hazard	• At ELHT Directorates utilise holding lists to manage patients who require a future follow appointment but due to capacity constraints, there are not the available slots to book into. Patients are also added to a holding list when clinics are cancelled due to annual or study leave and there is no available capacity to rebook. • Reports are readily available which identify patients waiting on a holding list and how long they have been waiting. They can be seen prospectively and retrospectively. Some of these patients may have comments in their PAS record which identify their urgency but many do not. • In some Directorates due to capacity constraints patients are waiting past their intended date for review. The risk to patients is that they may come to harm due to a deteriorating condition or complications due to	

			delayed decision making or clinical intervention.
What controls are in place	The following controls have been put into place: (1) Meeting held between the Divisional Triad and the Ophthalmology Triad to discuss the current risk and agree next steps (Friday 19th Jan). (2) Escalated concerns to the Executive Team through Exec Part 2 Meeting (Tuesday 23rd Jan). (3) Request sent to all Directorates requesting all patients on holding lists who expected their appointment before the end of January who do not have a booked appointment to be initially assessed for any potential harm that could have been caused due to the delay to being seen. Suitable RAG ratings need to be applied to all these patients (Wednesday 6th February). Information to be collected in a standardised format. (4) RAG status for each patient to be added to the comments field on the patient record in OWL to capture current RAG status. This will allow future automated reports to be produced (starting weekend 2nd and 3rd Feb). (5) Meeting held with the Directorate Managers from all Divisions to understand the position of all Directorate holding lists (Wednesday 30th January and weekly thereafter). (6) All patients where harm is indicated or flagged Red to be actioned immediately. Directorates to agree plans to manage these patients depending on numbers. (7) A process has been agreed to ensure all	What are the gaps in controls	• Patients currently booked into appointments that are not RAG rated will drop into the Holding List if appointments are cancelled and will not have a RAG rating identified. • Patients that are added to the holding list from other sources such as theatres Wards and Med Sec's will currently not have a RAG identified.

	follow up patients in the future are assigned a RAG rating at time of putting them on the holding list. Rolling out new process from 6th February across the Trust. (8) An automated reporting system is in development to ensure oversight of the risk stratified lists by speciality. (9) Underlying demand and capacity gaps must be quantified and plans put in place to support these specialities in improving the current position and reduce the reliance on holding lists in the future. (10) Report being provided weekly to the Executive Team.		
What assurances are in place	• All coding sheets being monitored in outpatient clinic to ensure RAG rating completed at time of appointment. • All patients to have RAG rating recorded on Outpatient Waiting List. • Automated report produced to show RAG status of patients on holding list and identify any who have not been given a RAG rating. • Failsafe officer appointed in Ophthalmology to track holding list and manage clinical urgency of patients waiting in conjunctions with responsible consultants.	What are the gaps in assurance	• Demand and Capacity gaps within specialities which may result in delayed appointments outside of RAG rating recommendation. • If clinicians do not comply with RAG rating process in clinic this will be captured on the automated report but will need administrative process to be followed to complete retrospective RAG rating following clinic appointment.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected Completion date	Progress on implementation of action	RAG Rating
1	Weekly review of the Holding List by identified fail safe officer	Natalie Hudson	07/03/2019	08/04/2019 (Completion date changed	On track	

					from 07/03/2019 due to recruitment to the failsafe officer post for Ophthalmology which has now been filled and start date agreed.		
	2	Standardised DCO1 referral form for Trust Wide use	Susan Elliston	07/03/2019	07/03/2019	Completed on 06/03/2019	
	3	Detailed capacity and demand comparison	Leigh Hudson	07/05/2019	07/05/2019	02/04/2019	
	4	Progress Report and Harm assessment to be provided to Trust Quality Committee	Natalie Hudson	30/04/2019		On track	
	5	Automated holding list report to be integrated in Trust's weekly ops meeting	Natalie Hudson	30/04/2019		On track	

Title	**Aggregated Risk - Failure to obtain timely Mental Health treatment impacts adversely on patient care, safety and quality.**				
Risk ID	7067	Date opened	06/10/2016		
Risk Handler	Jonathan Smith	Exec Director/Risk Lead	John Bannister		
Identified in BAF Risk ID	**BAF/03:** 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).				
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 - 8).				
Initial Rating	**Likelihood: 5** **Consequence: 3** **Total: 15**	Current Rating:	**Likelihood: 5** **Consequence: 3** **Total: 15**	Target Rating:	**Likelihood: 2** **Consequence: 3** **Total: 6**
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 cause deterioration of the patient. • Staff generally do not have training in physical interventions and restraint.		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. • 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.	What are the gaps in controls	• 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 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	What are the gaps in assurance	• The daily system teleconference between health and social partners was stood down from daily to twice weekly w/c 2-7-18.

	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 in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	Progress on implementation of action	RAG Rating
1	Emergency Care Improvement Programme mental health "Deep dive" – audit.	Jillian Wild	29/06/2018	29/06/2018	Completed	
2	Daily teleconference with LCFT commenced 9-7-18 due to LCFT being at OPEL level 4.	Jillian Wild	27/09/2018	27/09/2018	Completed	
3	New procedures to be introduced for creating a safe environment to cohort high risk mental health patients.	Jillian Wild	27/09/2018	27/09/2018	Completed	
4	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.	Jillian Wild	Ongoing	Ongoing	On track	
5	Outcomes of VSA to be incorporated into work streams for improvement of mental health provision in ED (including partnership working with LCFT).	Jonathan Smith / Jillian Wild	28/06/2019	28/06/2019	On track	

Title	**Aggregated Risk: Failure to adequately manage the Emergency Capacity *and* Flow system.**				
Risk ID	1810	Date opened	05/07/2013		
Risk Handler	Tony McDonald	Exec Director/Risk Lead	John Bannister		
Identified in BAF Risk ID	**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).				
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).				
Initial Rating	**Likelihood: 5** **Consequence: 3** **Total: 15**	Current Rating:	**Likelihood: 5** **Consequence: 3** **Total: 15**	Target Rating:	**Likelihood: 3** **Consequence: 3** **Total: 9**
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 controls are in place	• Daily staff capacity assessment. • 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.	What are the gaps in controls	• Trust has no control over the number of attendees accessing ED/UCC services.

What assurances are in place	• Regular reports to a variety of specialist and Trust wide committees. • Consultant recruitment action plan. • Escalation policy and process. • Monthly reporting as part of Integrated Performance Report. • Weekly reporting at Exec Team. • System Oversight by Pennine Lancashire A+E Delivery Board.	What are the gaps in assurance	• None identified

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected Completion date	Progress on implementation of action	RAG Rating
1	Numerous actions are incorporated within the Emergency Care Pathway Redesign Programme which forms part of the Trust's Transformation Programme.	Jonathan Smith	Ongoing	Ongoing	On track	
2	Review the impact of the newly introduced Full Capacity Protocol and refined patient flow meetings.	Jonathan Smith	01/09/2016	01/09/2016	Completed	
3	Development of Ambulatory and Emergency Care Unit and new pathways.	Jonathan Smith	01/09/2019	Ongoing	On track	
4	Mitigating actions are deployed on a daily basis at an operational level to reduce the risk to patient care.	Jonathan Smith	Ongoing	Ongoing	On track	

Title	**Aggregated risk –Failure to adequately recruit to substantive nursing posts may adversely impact on patient care and Finance.**				
Risk ID	5791	Date opened	11/09/15		
Risk Handler	Julie Molyneaux	Exec Director/Risk Lead	Christine Pearson		
Identified in BAF Risk ID	**BAF/02:** 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.				
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 - (15)				
Initial Rating	**Likelihood: 3** **Consequence: 5** **Total: 15**	Current Rating:	**Likelihood: 3** **Consequence: 5** **Total: 15**	Target Rating:	**Likelihood: 2** **Consequence: 2** **Total: 4**
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 actual staffing levels and Care Hours per Patient Day (CHPPD) • E-rostering KPI's • Ongoing recruitment campaigns • Overseas recruitment as appropriate		What are the gaps in controls	• Unplanned short notice leave and sickness. • Non elective activity impacting on associated staffing • Break downs in discharge planning • Individuals acting outside control environment	

	• 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	• None identified.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	Progress on implementation of action	RAG Rating
1	All current planned actions completed as shown in “what controls are in place”	Julie Molyneaux	03/09/2018	03/09/2018	Completed	
2	Non-Medical Bank and Agency Group	Julie Molyneaux	Ongoing	Ongoing	On track	
3	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	Julie Molyneaux	Ongoing	Ongoing	On track	

Title	**Aggregated risk – Failure to adequately recruit to substantive medical posts may adversely impact on patient care and Finance.**				
Risk ID	5790	Date opened	11/09/15		
Risk Handler	Simon Hill	Exec Director/Risk Lead	Damian Riley		
Identified in BAF Risk ID	**BAF/02:** 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.				
Linked to Risks:	7268 - Clinical, financial and organisational risks of (SOS) and T&O short and long term rota gaps – (9). 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 - (8). 7816 - Medical (psychiatric) waiting list (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**
What is the Hazard	• Gaps in medical rotas require the use of locums to meet service needs at a premium cost to the Trust.		What are the risks associated with the hazard	• Escalating costs for locums. • Breach of agency cap. • Unplanned expenditure. • Need to find savings from elsewhere in budgets. • Impact on staff stress and wellbeing.	
What controls are	• Divisional Director signs off for locum usage. • Ongoing advertisement of medical vacancies.		What are the gaps in controls	• Reduction in agency staffing costs form previous year has already been	

in place	• Consultant crosses cover at times of need. • Development of alternate roles. • Offer of OH support if felt needed.		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	• Unexpected operational pressures could further stress an already stressed system.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	Progress on implementation of action	RAG Rating
1	Per individual linked risks.	Simon Hill	10/07/2017	10/07/2017	Completed	
2	Ongoing recruitment and innovative packages offered.	Simon Hill	Ongoing	Ongoing	On track	
3	Workforce transformation and new models of skill mix.	Simon Hill	Ongoing	Ongoing	On track	
4	On-going pressure to reduce locum rates.	Simon Hill	Ongoing	Ongoing	On track	
5	All requests to exceed capped rates to be approved by medical directorate on a case by case basis.	Simon Hill	Ongoing	Ongoing	On track	

Title	**Loss of facility for Containment Level 3 in pathology**				
Risk ID	7583	Date opened	26/11/2017		
Risk handler	Pamela Henderson	Exec Director/Risk Lead	Jonathan Wood		
Identified in BAF Risk ID	**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).				
Linked to Risks:	N/A				
Initial Rating	**Likelihood: 3 Consequence: 5 Total: 15**	Current Rating:	**Likelihood: 3 Consequence: 5 Total: 15**	Target Rating:	**Likelihood: 1 Consequence: 5 Total: 5**
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. • Limitation in operational capacity leading to delays in diagnosis. • Loss of service and income. • Patient safety concerns.		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. • Potential delays in diagnosis which may trigger patient safety concerns. • Limitation in operational capacity may lead to loss of service and income.	
What controls are in place	• Emergency remedial work has been assessed for sealability by Crowthorne Ltd in order to continue to provide an emergency fumigation service (requirement for CL3 facility). • Visual inspection of vinyl wall covering recorded daily by Laboratory staff and repairs conducted before any processing can begin. If tears are found, Engie is informed immediately and work does not start in the facility until they have filled the breach with silicon sealant. • Current safety procedures for working in CL3 to be adhered to as per policy.		What are the gaps in controls	• Unexpected breach could occur between the daily (and weekly) checks.	

	• Contractor has been appointed and is working to an agreed program with Pathology, Estates and Consort.		
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 work due to be completed by September 2019. • Risk will be regularly monitored at the Capital Board.	What are the gaps in assurance	• Unexpected breach could occur between the daily (and weekly) checks. • Project meetings may be stood down in times of high activity within the Trust.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	Progress on implementation of action	RAG Rating
1	Discussion with PFI partners and specialists progressing to remedy issues.	Pamela Henderson	30/11/2018	30/11/2018	Completed.	
2	Consort to commission refurbishment work.	Pamela Henderson	30/04/2019	30/04/2019; Action was completed on 04/01/2019	Completed.	
3	Building work being undertaken as per program.	Pamela Henderson	06/09/2019	06/09/2019	Program of works on track.	
4	Internal laboratory commissioning tests.	Pamela Henderson	20/09/2019	20/09/2019	Arrangements in place to carry out the relevant checks.	

Title	**Failure to comply with the 62 day cancer waiting time.**				
Risk ID	7008	Date opened	01/08/2018		
Risk Handler	William Wood	Exec Director/Risk Lead	John Bannister		
Identified in BAF Risk ID	**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).				
Linked to Risks:	N/A				
Initial Rating	**Likelihood: 3 Consequence: 3 Total: 9**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 3 Consequence: 2 Total: 6**
What is the Hazard	• Cancer treatment delayed. • Potential to cause clinical harm to a patient if the treatment is delayed. • Damage to Organisational reputation.		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 cancer activity by clinical and pathway urgency.		What are the gaps in controls	• Multiple Actions require recruitment of 'difficult to recruit' personnel. • Patient choice and compliance is a factor which cannot easily by influence.	

	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	• None identified	What are the gaps in assurance	• None identified

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	Progress on implementation of action	RAG Rating
1	Patient education.	William Wood	Ongoing	Ongoing	On track	
2	Collaborative working with Primary Care.	William Wood	Ongoing	Ongoing	On track	
3	Recruitment to vacancies within Clinical service.	William Wood	Ongoing	Ongoing	On track	
4	Capacity review.	William Wood	Ongoing	Ongoing	On track	
5	Pathway review – New alliance pathway for Prostate, Upper GI, Colorectal and Lung.	William Wood	30/04/2019	Ongoing	On track	

	6	Investment of Alliance Funding in pathways to improve processes.	William Wood	Ongoing	Ongoing	On track	
	7	Establishment of Template Biopsy Service at ELHT for Urology.	William Wood	31/03/2019	31/03/2019	On track	

Title	Risk that PACS downtime occurs and brings delay to patient pathways or delays in operating theatre activity.				
Risk ID	7552		Date opened	25/10/2017	
Risk Handler	Mark Johnson		Exec Director/Risk Lead	Jonathan Wood	
Identified in BAF Risk ID	**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 of safety & poor patient experience).				
Linked to Risks:	N/A				
Initial Rating	**Likelihood: 5** **Consequence: 3** **Total: 15**	Current Rating:	**Likelihood: 5** **Consequence: 3** **Total: 15**	Target Rating:	**Likelihood: 3** **Consequence: 3** **Total: 9**
What is the Hazard	• Lack of data available while treating patient could cause harm. • The system is periodically failing / turning over so that images are not available as required. This may be due to PACs or networking issues. • 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 due to delays and unavailability of appropriate images.		What are the risks associated with the hazard	The risks are: • Trust targets • Delays in patient pathway. • Downtime in clinics and theatres due to periodic 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. • The impact on the consultants is then the clinic over runs into the afternoon session.	
What controls are in place	• Backup systems involving getting physical or disk copies of images. • MDT computers have been upgraded to		What are the gaps in controls	• Physical copies of images via backup are not instantaneous. • Time gap whilst waiting for new equipment and	

	reduce PACs access speed. All wards in process of having at least 1 PACS enhanced machine. • Images available at both the modality and via the Radiology department. • VNA viewer via Web Browser enabled to allow access to images without requirement to view via PACS. – May 2019 • Sectra PACs go live on track for Sept 2019 • Rebuild of new high speed IT network, completed, with links to BGH. • 24/7 IT support in place with senior manager backup to escalate PACS issues. • New PACS infrastructure in place and being commissioned. • New configuration of PACS allows for significantly more resilience and stability. • New PACS operational board being set up to monitor wider PACs delivery.		system to come on line – relaying on physical intervention.
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 in mitigating this risk							
	No	**Action**	**Action Lead**	**Due date**	**Expected completion date**	**Progress on implementation of action**	**RAG Rating**
	1	Commission new Sectra PACS system	Tom Newton	31/03/2019	19/09/2019 (Original completion date was 29.03.2019 but was moved to 31.08.2019 and then to 19/09/2019 as project has commenced).	Delays due to contractual processes from supplier. All new PACS hardware in place, testing of new software ongoing. VNA commissioned and image / data migration underway.	
	2	VNA Viewer	Tom Newton	31/05/2019	31/05/2019	Date scheduled for viewer release to coincide with VNA software upgrade.	
	3	View station upgrades	Mark Johnson	01/06/2019	28/06/2019	All MDT stations upgraded. List provided of all wards requiring hardware update. IT team working through list. PC base units and SSD's ordered.	
	4	PACs operational board	Tom Newton	02/05/2019	02/05/2019	ToR developed. Aligning diaries for first meeting. Informal operational and formal project groups are already in place. PACs is a standing agenda item on eHealth Board	

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.**				
Risk ID	7330		Date opened	29/01/2018	
Risk Handler	Mark Johnson		Exec Director/Risk Lead	Jonathan Wood	
Identified in BAF Risk ID	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 & poor patient experience).				
Linked to Risks:	7123 - Inadequate Safeguarding Information Recorded in Maternity Notes (12).				
Initial Rating	**Likelihood: 3 Consequence: 5 Total: 15**	Current Rating:	**Likelihood: 3 Consequence: 5 Total: 15**	Target Rating:	**Likelihood: 2 Consequence: 5 Total: 10**
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 whereby assurance is not being provided to PHE and QA that neonates are being referred and followed up within a timely		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 /

	manner.		KPI's. • Potential to be identified as outliers nationally in national 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.	What are the gaps in controls	• 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. • 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.	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.

	• Risk assessment to be monitored via the Risk Assurance Meeting once accepted on to the Trust Risk Register.		

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Completion/ due date	Expected completion date	Progress on implementation of action	RAG Rating
1	To review and identify gaps in data submission.	Angela O`Toole	12/08/2018	12/08/2018	Completed	
2	To continue to monitor processes in division in relation to record keeping.	Angela O`Toole	12/08/2018	12/08/2018	Completed	
3	To work alongside Informatics to explore solutions to the data capture and reporting issues.	Angela O`Toole/ Mark Johnson	29/03/2019	01/08/2019 (Original completion date moved from 29/03/2019 as to meeting to explore options & opportunities being planned for 17/04/2019.	On Track	
4	To work alongside IM&T to develop and implement an end to end Maternity System.	Angela O`Toole/ Mark Johnson	29/03/2019	31/12/2020 (Original completion date moved from 29/03/2019 due inability to specify solution prior to the April 2019 meeting. Cerner solutions for Family Care to be implemented timely.	On Track	

	Appendix 2: Risk recommended for de-escalation from the CRR				
Title	**Potential loss of images (OCT and FFA) if equipment should fail or be stolen**				
Risk ID	4353		Date opened	10/09/2014	
Risk Handler	Mark Johnson		Exec Director/Risk Lead	Jonathan Wood	
Identified in BAF Risk ID	**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 of safety & poor patient experience).				
Linked to Risks:	N/A				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 4 Consequence: 3 Total: 12**	Target Rating:	**Likelihood: 2 Consequence: 3 Total: 6**
What is the Hazard	• All patient information and images from OCT/FFA are stored on the machines hard drive as there is no server in ophthalmology to back these images up (thousands of images per year). Hence, there is no back up in place and no additional storage which could result in running out of space and/or losing images.		What are the risks associated with the hazard	• Loss of images stored on the equipment - thousands of images collected per year (There has been loss of images during the cyber-attack and images have previously been lost when using previous topcom machine). • System slows down completely as more and more images are saved (The machine at BGH is currently taking seven minutes to store one image which is a concern to EBME).	
What controls are in place	• Machine has full service contract. • In house support from EBME • EBME will continue to work with IT Services and liaise with the manufacturer where necessary • Locks in place on FFA and OCT rooms to prevent theft of equipment. • Disc back up is only control that has		What are the gaps in controls	• Awaiting final specification for Topcon server (space requirement). • Optos server built but not yet capturing images.	

	been in place ad hoc and there is no protocol or established time period for this procedure or designated (experienced) responsible person to do. • New server built for Optos equipment to allow image back up. • New server built for Heidleberg machines with data being transferred to new storage on ELHT data centre. • Additional storage added to modalities to expand local system storage. • Initial specification received for TopCon and server build underway.		
What assurances are in place	• None identified	What are the gaps in assurance	• None identified

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	Progress on implementation of action	RAG Rating
1	Urgent meeting between Ophthalmology & IT	Joanne Preston	04/12/2018	04/12/2018	Completed	
2	Visit / scoping exercise by IT to Ophthalmology department	Debbie Wilson	05/12/2018	05/12/2018	Completed	
3	Short term (control) to image storage	Debbie Wilson	28/02/2019	01/05/2019 (Original completion date planned for	02/0402019 On track Heidelberg solution now in place and	

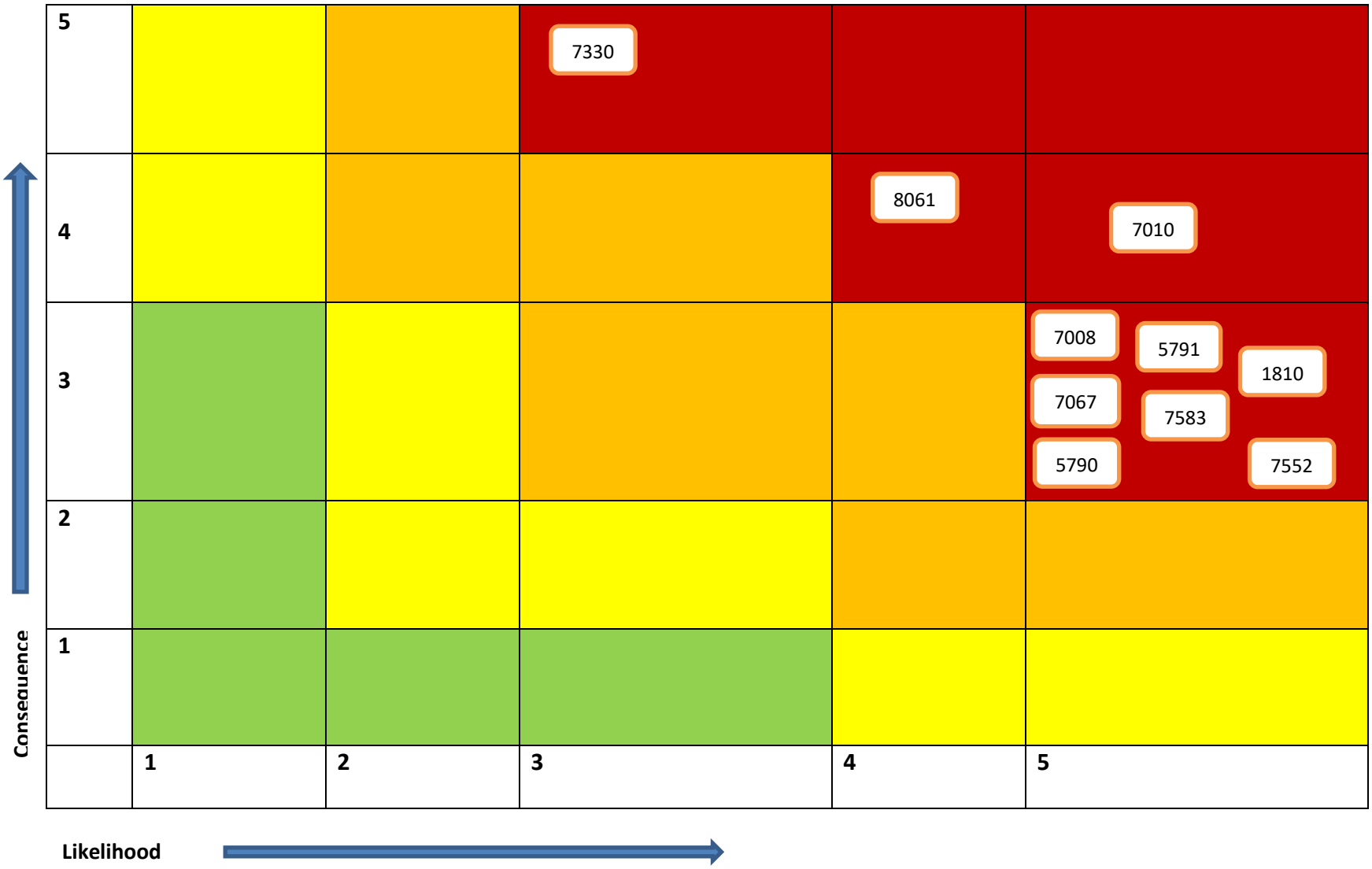
					28/02/2019 and moved to 29/03/2019 has now been set for 01/05/2019). Rationale in next column.	archiving images (5000 of 18000 images transferred). New server built for Optos machine, awaiting final specification for Topcon server. However, once received a server will be built immediately.	
	4	Long term image storage solution	Joanne Preston	05/12/2020	05/12/2020	On track	
	5	Enhance ELHT IT infrastructure to be able to ensure new image store from Ophthalmology is now part of wider Trust complete system backup arrangements.	Debbie Wilson	01/07/2019	01/07/2019	02/04/2019 On Track, ELHT has expanded its system backup licences and capacity to encompass Ophthalmology requirements.	
	6.	Meeting to be arranged with Heidelberg, key clinicians, IT Services, EBME to discuss options around operational solutions short and long-term	Arif Patel	04/04/2019	04/05/2019	Discussion via email with CMIO, Consultant and Head of EBME around operational robustness, which has led to this request.	

RAG Key:

	Outstanding/Overdue		In progress & on track		Completed

Appendix 3: One page representation of the Corporate Risk Register as at 16th April, 2109 mapping all risks onto the 5X5 Matrix based on current score (10 Risks in total)

East Lancashire Hospitals NHS Trust



Safe | Personal | Effective

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

8 MAY 2019

Item 66

Purpose Discussion
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 March Board meeting.
A new risk score of 16 (4x4) is recommended for BAF risk 5 increasing it from the previous score of 12, with the likelihood score increasing by one score. The risk scores for the rest of the BAF risks have not changed.

Recommendation: The Board is asked to discuss and approve the recommended changes to the risk score to BAF risk 5 together with the scores for the rest of the BAF risks and changes to the controls/assurances and updates presented in this 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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

Executive Team on 23 April 2019

Operational Delivery Board on 24 April 2019

Quality Committee on 2 May 2019

(66) Board Assurance Framework Review

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

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.

4. The Executive Team are in discussions about the renaming of this particular risk to correctly reflect the risk and in order to include the risk not just in relation to transformation programme, but also the service redesign and quality improvement work programmes. It is felt that the risk is more about the delivery of the Trust annual plan that would in turn adversely affect the delivery of sustainable, safe, person and effective care, than any component programmes listed above. The change to the strategic risk description will be reflected in the July report following further work by the Executive Directors.
5. The risk score remains 20 (likelihood 5 x consequence 4).
6. The key controls section has been thoroughly revised to reflect the developments under the Vital Signs Programme and now contains the following:
   a) The 2019 operational plan for the Trust has been developed in conjunction with the ICP partners to achieve a single plan for the local system. Each scheme in the plan will focus on improving all elements of the quadruple aim of Quality,

Delivery, Finances and the Impact on People, whether that be patients, staff or the public.

b) The programme is monitored through the Improvement Practice Office who report to the Operational Delivery Board and the Finance and Performance Committee, as well as Executives through the Leadership Wall.

c) Current work streams underway include Frailty, Theatres, Hire to Retire, Neighbourhoods and Diagnostics.

7. The potential sources of assurance section now include:

a) Monthly performance and finance reports include the financial impact of transformation schemes which are reported to the Operational Delivery Board, Finance and Performance Committee and the Trust Board with associated information papers and minutes (internal source of assurance).

b) Emergency care pathway Board and A&E Delivery Board are good examples of collaborative working used as a blueprint for other system working moving away from organisational boundaries (internal/external assurance).

c) The Executive Overview Group for monitoring the progress and deliverables of the Pennine Lancashire Way improvement methodology was set up in November 2018 (internal/external assurance.

d) For the year 2019/20, the systematic approach to planning has been aligned with the national and ICS strategy.

8. The actions planned and updates section has been revised in detail and now contains the following:

a) The business planning round for 2019-20 has improved in respect of alignment and prioritisation. Following the planning event that was held on 4 December 2018, the outcomes of the planning day informed the Value Stream Analysis (VSA) programme for 2019/20. The list of objectives and priorities from the planning process, aligned at an ICP level, has been agreed.

b) Various Vital Signs programme activities have been, or are due to be, held as set out below:

i. Diagnostics programme - a 5 day radiology event was held in March

ii. Frailty programme - speciality inpatient and transition discharge events were held during March and April.

iii. Frailty programme - a 3 day neighbourhood's event for Pendle East is planned for the 29th of April

iv. Frailty programme - an Older Peoples Rapid Assessment (OPRA) unit 2 day event is planned

v. Emergency care pathway - a full week mental health event will be held on the week commencing on the 20th of May.

vi. Emergency care pathway – a patient flow facilitators 3 day event will be held in June.

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

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

10. Executive Team have had discussions about increasing the risk score in the future based on the uncertainty around the Treasury position in relation to the pensions and its impact on the workforce, together with the current uncertainty about the impact on constitutional standards and timeliness of care, including the potential backlog that might result that will in turn lead to a future cost.

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

a) The Workforce Dashboard is reporting key performance indicators within division on a monthly basis. Details of these are reported on a quarterly basis to the Finance & performance committee (internal assurance).

b) The collaboration is continuing across the ICS on agency usage (external assurance).

c) Joint work is taking place across the ICS to consider implications and options to mitigate the impact on pensions (external assurance).

d) Broader quality and diversity group and a better understanding of workforce demographics in relation to the over 55 workforce (external assurance).

e) Workforce Solutions Board now aligned to deliver Trust Business Plan & Clinical Strategy (internal assurance).

12. The gaps in assurance section has been updated to include the following:

a) Uncertainty about the national approach to pension issue.

b) The regulators stance on safe staffing and substitution of roles in place of the registered workforce.

c) Lack of data/intelligence regarding the number of nurses and clinical staff in the 55+ age category and the related risk of 'brain drain' in the coming years. Work has been done by ICS across the system, but it does not contain the level of

detail needed for each Trust. Efforts need to be made to understand and refine the workforce data in order to address the Trust issues.

13. Actions and updates have been updated as to include the following:
    a) Currently there are a further 113 external nurses in the recruitment pipeline due to start with the Trust between now and May 2019. 16 nurses have been sourced and started via the Global Learners Programme with a further 33 in the registration process for the programme.
    b) E&D Action Plan to be updated by July 2019.
    c) Culture and Leadership Programme is now entering phase 2 (Design) and an update is to be presented to the Quality Committee in June.
    d) The Vital Signs programme is underway to improve the employee experience from recruitment through to them leaving the organisation. The Hire to Retire Value Stream Analysis (VSA) has now delivered improvements over 90 days and is now working on improvements for the next 90 days that will be reported in June.
    e) HEE funding secured to develop clinical leadership for workforce transformation through the WRAPT process. The training commences in May 2019.
    f) Launch of the volunteer learning passport in January 2019 enabled the mobility of volunteers between organisations. There was an evaluation period at the end of February 2019 and a wider rollout is now being considered nationally and across the ICS.
    g) An apprenticeship strategy is now in place, as well as additional further proposals, to support a passport levy between partner organisations. A paper will come to the ODB to explore expansion in May 2019.
14. The following action has now been completed and moved to the potential sources of assurance column:
    a) Alignment of Workforce Transformation Board to oversee the delivery of priorities.

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.

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

16. The potential sources of assurance section had been reviewed and now includes the following:
    a) A Joint Accountable Officer for the CCGs is now in post.
    b) A system Financial and Investment Group for the ICP is looking into the priorities and aligning them with the financial envelope for the local system.
    c) Creation of a single team to deliver the transformation agenda at an ICP system level.
    d) Priorities of the individual organisations and those of the system not are now aligned and agreed. (*moved from gaps in control to assurance*)

17. The gaps in control section has been updated as follows:
    a) Priorities of the individual organisations and those of the system not being aligned or agreed. (*moved to assurance*)
    b) There is a need for consistent leadership across the system in order to ensure that we continue prioritising in line with the system affordability.

18. The gaps in assurance section has been updated as follows:
    a) Creation of single team to deliver the transformation agenda at system level. (*moved to assurance*)
    b) Understanding what is happening to providers with regard to financial milestones in the ICS.

19. Actions and updates have now been updated to include the following:
    a) The work programme developed as part of the planning process was discussed by the Provider Board at ICS level and work on developing future configuration continues, but no timelines for completion are set at this stage.
    b) 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 was provided at the Trust Board in March 2019. A neighbourhood system event was held at end of January 2019. Subsequent 'big ticket' events were held and Value Stream Analysis (VSA) planned under the Vital Signs programme.
    c) Good co-production on developing clinical model across the ICS for CAMHS services was presented to the Commissioners on 6 August and the clinical model was accepted. 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 neighbourhood system event was held at end of January 2019 to support ongoing discussions about affordability with help from the Northumberland, Tyne and Wear Trust.

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

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

21. The potential sources of assurance section has been updated and now includes the following sources of internal assurance:
    a) Rates relating to agency medical and nursing rates.
    b) Off framework agency usage.
    c) Extra contractual payments to staff (in relation to capacity lists, etc.)
    d) Agreed control total for 2019/20.

22. The gaps in assurance section has been updated with the following:
    a) Need to improve oversight of agency spend, capacity list spend and variations to national contracts.
    b) Understanding of financial milestones and financial delivery of partner organisations in the ICS (also covered in BAF risk 3).

23. The actions planned/update section now includes:
    a) Shared Cost Improvement Programme (CIP) and Quality, Innovation, Productivity and Prevention (QIPP) Group established with the CCGs.
    b) Quality Improvement (QI) established a Resources Committee to improve the business case process with CCGs planned for Q1.

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

24. The **risk score increases to 16** based on an increased likelihood score (likelihood **4** x consequences **4**). The increase is recommended as a result of difficulties encountered in fulfilling the standards relating to 4 hours, 18 weeks Referral to Treatment (RTT) and holding lists. The 18 weeks standard has deteriorated for three

consecutive months. The Quality Committee is due to receive a report on the 2 May and the Board will be presented with information in relation to the holding list position.

25. Potential sources of assurance have been updated to include the following:
    a) Under internal assurances, regular deep dives are now taking place into the Integrated Performance Report (IPR) through Finance and Performance Committee including RTT, all cancer standards and the emergency care standards.
    b) Under external assurances, the Inpatient survey 2018/19 results are being presented to the Executive team in May by Quality Health.
26. The gaps in assurance section has been updated with the following:
    a) Increase in Delayed Transfers of Care and increasing number of longer stay patients.
    b) Demand and capacity issues relating to senior medical vacancies are affecting the 18 weeks RTT and holding list position.
27. The actions have been updated to include the following:
    a) The Trust is developing a full clinical model regarding the emergency care pathway and it is anticipated for this to be ready for presentation and sign off in 2019. External support has been sourced for the patient flow modelling.
    b) The Trust's lifecycle upgrade programme (estates and facilities) is currently being developed and is expected to be signed off by the end of April 2019.
    c) The CQC inspection report was published on 12 February 2019, identifying improvements in a number of areas and some outstanding services. An action plan has been drafted and it will be monitored by the Quality Committee. The Trust has returned the action plan in relation to the notices regarding fridges, storage of documents and fluid thickening.
    d) Efforts across clinical teams and system partners have been re-focused to reduce long Length of Stay (LoS) patients and Delayed Transfers of Care (DTOC).
    e) The Patient Participation Panel held an open day on 17 January 2018. The panel was launched on 27 February 2019. Two meetings were held to date and panel members are receiving training
    f) Report to the Quality Committee on the holding list and 18 week RTT action plans to be refreshed and finalised to ensure that coherent action plans are in

place to improve performance. Reporting to the Finance & Performance Committee by the end of May/June

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance, 30 April 2019.

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. Inability to provide financial assurance to the Board
3. Reduced ability to integrate primary and secondary care
4. Reduced ability to have the right workforce planning
5. Reduced ability to achieve access and operational standards
6. Reduced ability to improve quality standards

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**			
						Q2	**Q3**	**Q4**	**Q1 2019/20**
We have developed the 2019 plan for the Trust in conjunction with the ICP partners to achieve a single plan for the ICP. Each scheme will focus on improving all elements of the quadruple aim of Quality, Delivery, Finances and the impact on people, whether that be patients, staff or the public. The programme is monitored through the Improvement Practice Office who report to the Operational Delivery Board and the Finance and Performance Committee, as well as the Executives through the leadership wall. All schemes are aligned to our clinical, financial, operational and workforce strategy. Current workstreams underway include Frailty, Theatres, Hire to Retire, Neighbourhoods and Diagnostics.	**Internal Assurances** Monthly performance and Finance reports include the financial impact of transformation schemes which reports to the Operational Delivery Board, Finance and Performance Committee and the Trust Board with associated information papers and minutes. Performance monitoring in all areas covering quality, delivery, finance and people (staff/patients): 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 j. Finance Assurance Board 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. Emergency care pathway board and A&E delivery board are good examples of collaborative working used as a blueprint for other system working moving away from organisational boundaries. The introduction of the Financial Assurance Board (FAB) has strengthened governance and oversight. 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. Executives sponsorship of each transformation/improvement scheme - weekly reviews. Post advertised/interviews for transformation/improvement. **External Assurances** System-wide reporting is currently being developed through the Pennine Lancs Business Intelligence group and the Pennine Lancs Way programme. ICP system level aiming to prioritise health improvements that can deliver beneficial outcomes more quickly. 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. **Internal / External Assurances** Agreed transition to one transformation plan and one improvement methodology - allowing all schemes to gain traction and improve delivery. Medial Director of the Trust appointed as the Professional Lead for the Pennine Lancashire ICP influencing the collaborative work on transformation. Good track record of successfully bidding for tenders in the last 12 months. Finance and Performance Committee agreed process for the review of tenders and service implementation 12 months after the tender bid. Model Hospital and GIRFT (Speciality benchmarked performance and efficiency data) reviewed at Clinical Effectiveness Committee. Agreed the alignment of the neighbourhood improvement programme with the wider system improvement programme**.** Executive Overview Group for monitoring the progress and deliverables of the Pennine Lancashire Way improvement methodology set up in November 2018. For 19/20 the systematic approach has been aligned with national and ICS strategy.	16	10	20	5x4	20	20	20	20

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.*
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. No single clinical strategy group for Pennine Lancashire bringing together primary and secondary care clinicians.	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 business planning round for 2019-20 has improved in respect of alignment and prioritisation. The first planning event was held on 4 December 2018. The outcomes of the planning day informed the Value Stream Analysis (VSA) programme for 2019/20. The list of objectives and priorities from the planning process, aligned at an ICP level and system plan, has been agreed. Various Vital Signs activities have been, or are due to be, held as set out below; Under the diagnostics programme a 5 day radiology event was held in March Under the frailty programme speciality inpatient and transition discharge events were held during March and April. Under the frailty programme a 3 day neighbourhoods event for Pendle East is planned for the 29th of April Under the frailty programme an Older People's Rapid Assessment (OPRA) unit 2 day event is planned Under the emergency care pathway a full week mental health event will be held on the week commencing on the 20th of May. Under the emergency care pathway a patient flow facilitators 3 day event will be held in June.

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**			
						Q2	**Q3**	**Q4**	**Q1 2019/20**
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	**Internal Assurances** On-going monitoring of vacancies and bank/agency usage at Trust Operational Delivery Board via Trust performance report. Performance measures, time limited focus groups with action plans, board and committee reports, regulatory and inspection agencies, stakeholders, internal audit. WRES action plan with timelines in place. Regular reporting to the Board on progress. Work with the Fanshawe Report. Ongoing monitoring of workforce diversity through the re-establishment of the Diversity and Inclusion Steering Group and Trust Operational Delivery Board. Workforce Control Group regularly reports to the Executive on workforce control measures and indicators. Dashboard developed. Annual report to the Quality Committee. Medical and Non-Medical Agency Group in place. Dashboard giving overview of bank/agency usage presented to the Executive team meeting monthly. Additional scrutiny from a nursing perspective. The Performance Assurance Framework Lean Programme (Vital Signs) overall linking into workforce transformation. Agency staffing group monitoring the use of agency spend. Implementation of Allocate rostering/ publication dates for rosters. Uptake of flu vaccine across the workforce. Completion rates of the annual staff survey and low rates of turnover. Integrated performance report. Implementation of new absence management process to support staff attendance and to mitigate need for use of bank and agency. Workforce Dashboard reporting key performance indicators within division on a monthly basis, Details of these reported on a quarterly basis to the Finance & performance committee. A Senior Medical Staffing Performance Review Group established - responsibility for reviewing all consultant job plans, consultant vacancies etc. adding further rigor on our appropriate use of resource. Workforce Solutions Board now aligned to deliver Trust Business Plan & Clinical Strategy. **External Assurances** Friends and family test (further detail in BAF risk 5) Benchmarking of agency spend is available through the Model Hospital data. Collaboration across the ICS on agency usage. Joint work taking place across the ICS to consider implications and options to mitigate the impact on pensions. Broader quality and diversity group and a better understanding of workforce demographics in relation to the over 55 workforce. - MOVED FROM GAPS IN ASSURANCE	16	10	25	4x5	12	12	20	20

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.*
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	Inability to control external factors (Brexit, visas etc). National approach to pension issue. Regulators stance on safe staffing and substitution of roles in place of registered workforce. Lack of data/intelligence regarding the number of nurses and clinical staff in the 55+ age category and the related risk of 'brain drain' in the coming years. Work has been done by ICS across the system but it does not contain the level of detail needed for each Trust. Efforts need to be made to understand and refine the workforce data in order to address the Trust issues.	Currently there are a further 113 external nurses in the recruitment pipeline due to start with the Trust between now and May 2019. 16 nurses have been sourced and started via the Global Learners Programme with a further 33 in the registration process for the programme. HCA recruitment continues, contributing to the reduction in HCA bank shift requests adding further stability and flexibility to our support workforce. E&D Action Plan to be updated by July 2019. Festival of Diversity held for the last week in April. Culture and Leadership Programme is now entering phase 2 (Design) and an update is to be presented to the Quality Committee in June. 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 Inclusion Group will be established from February 2019 to consider the wider diversity agenda. Shadow Board commenced in April 2019, with its first meeting in May 2019. Vital Signs improvement programme is underway to improve employee experience from recruitment through to them leaving the organisation. The Hire to Retire VSA has now delivered improvements over 90 days and is now working on improvements for the next 90 days reporting in June. 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 has included 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 Retention Strategy is being developed to underpin a system wide approach to recruitment. 10 Workforce Repository and Planning Tool (WRAPT) planning projects are underway across the organisation. HEE funding secured to develop clinical leadership for workforce transformation through the WRAPT process. Training commences in May 2019. 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. Launch of volunteer learning passport in January 2019 enabling mobility of volunteers between organisations. There was an evaluation period at the end of February 2019 and now considering a wider rollout across the ICS and nationally. An apprenticeship strategy is now in place, as well as additional further proposals, to support a passport levy between partner organisations. A paper will come to the ODB to explore expansion in May 2019. (AMENDED AND-MOVED TO ASSURANCES SECTION) Exploration of opportunities to manage medical agency staffing differently has commenced in January 2019. Proposed restructure of Trust Medical Staffing team to amalgamate the existing locum booking team with the Temporary Staffing team, to ensure greater consistency of service provided to the whole workforce

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**			
						Q2	**Q3**	**Q4**	**Q1 2019/20**
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 Committee (PLC) Number of senior clinicians involved with ICS work groups. Professional Leadership Committee (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.	**Internal Assurances** 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. 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. 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 / External Assurances** The Pennine Lancashire and ICS Cases for Change have been published. Pennine Lancashire resource in post working on developing models of care against specific improvement priorities (paediatrics, respiratory and frailty). Health and Wellbeing Improvement Partnerships (HIMPs) at Pennine Lancashire level reviewed around the health improvement priorities and the majority are relatively well established with minor changes needed to link into the new structures. ICS governance oversight forms part of the Audit Committee standing agenda for 2018/19. Fostering good relationships with GP practices and Federations e.g. service pilots and as a result of tenders and general dialogue. Pennine Lancashire ICP Memorandum of Understanding agreed by stakeholders. 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. Component business cases at Pennine Lancashire level forming a draft overarching ICP plan. Plan on a page for the ICP, connecting to the Plan on a page for ELHT completed and shared with the Commissioners. CEO of ELHT and Accountable Officer of East Lancashire CCG jointly chairing the Pennine Lancashire ICP Programme. 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. 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. 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. Pennine Lancashire Delivery Group has ELHT representation and is chaired by the Trust's Chief Executive. A&E Delivery Board meets monthly, chaired by the ELHT Chief Executive. Progress on collaborative efforts in relation to the emergency pathway is covered under BAF risk 5. Vital Signs is a system wide transformation programme across the Pennine Lancashire ICP. Patient experience strategy envisages good patient and public involvement to support the collaborative transformation. Progress with work covered under BAF risk 1. 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. 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. Joint accountable officer for CCG's is now in post. A system financial and investment group for the ICP looking into the priorities and aligning them with the financial envelope for the local system. Creation of single teams to deliver the transformation agenda at ICP system level. (MOVED FROM GAPS IN ASSURANCE) Priorities of the individual organisations and those of the system aligned/agreed. (MOVED FROM GAPS IN ASSURANCE)	16	12	12	3x4	12	12	12	12

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.*
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. There is a need for consistent leadership across the system. in order to ensure that we continue prioritising in line with system affordability. Building trust and confidence and agreeing collaborative approaches to service provision	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. Ensuring consistent capacity to work externally as well as internally by building system collaboration into the leadership roles and having good joined leadership programmes. Adequate assurance mechanism that the service integration plans are on track together with the rigour of governance arrangements/lack of delegation from the sovereign bodies to the system. it is unclear what the impact of the changes in senior leadership in partner organisations will be. Understanding what is happening to providers with regard to financial milestones in the ICS.	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. Developed work programme discussed by the Provider Board at ICS level. and work on developing future configuration continues, no timelines for completion set at this stage. Meetings are ongoing regarding the acute Programme and more focused work is taking place in Stroke, Vascular, Urological Cancer and Diagnostics. A range of services are being developed for Head & Neck. Pennine Lancashire ICP component business case. Focus on 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 was provided at the Trust Board in March 2019. Neighbourhood system event held at end of January 2019. Subsequent 'big ticket' events were held and Value Stream Analysis (VSA) planned under the Vital Signs Programme. Good co-production on developing clinical model across the ICS for CAMHS services was presented to the Commissioners. Clinical model accepted,. A neighbourhood system event held at end of January 2019. supporting, ongoing discussions about affordability with help from the Northumberland, Tyne and Wear Trust.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. The Director of Service Development has led discussions with other providers of CAMHS services about potential future configurations and alliance, the model was universally supported.

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**			
						Q2	**Q3**	**Q4**	**Q1 2019/20**
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.	**Internal Assurances** Monthly reporting to Finance and Performance reports and the Board to reflect financial position. Separate reporting available to support assurances on the transformation programme. Regular Performance Review meetings between Executives and Divisions. Using the Performance Accountability Framework (PAF) to provide assurance that action is taken to help ensure the delivery of objectives. 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. 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. 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. The introduction of the Financial Assurance Board (FAB) will strengthen governance and oversight. Rates relating to agency medical and nursing rates. Off framework agency usage. Extra contractual payments to staff (capacity lists etc.) Agreed control total for 2019/20. **External Assurances** External audit view on value for money. Model Hospital benchmarking (including cost per Weighted Activity Unit). ICS Led Theatre Productivity analysis.	16	12	20	5x4	20	20	20	20

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.*
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. Lack of consistency in divisional governance processes. Understanding the changes in income services (NHS and private). Weaknesses in appraisals and accountability framework. Improve oversight of agency spend, capacity list spend and variations to national contracts. Understanding financial milestones and financial delivery of partner organisations - ICS.	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. Cash borrowings have increased above plan as a consequence of not delivering A&E PSF and non cash backed SRCP. Detailed plan for 2019-20 to be developed in light of additional financial focus. Merge medical + non-medical temporary staffing groups for improved oversight chaired by DOF. Shared Cost Improvement Programme (CIP) and Quality, Innovation, Productivity and Prevention (QIPP) group established with the CCGs. Quality Improvement (QI) established Resources Committee to improve the business case process with CCG's planned for Q1.

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**			
						Q2	**Q3**	**Q4**	**Q1 2019/20**
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 Weekly operational performance meetings.	**Internal Assurances** IPR reporting to the ODB and at Board/Committee level. Regular deep dive into the IPR through Finance and Performance Committee including RTT, all cancer standards and the emergency care standards. ED performance and four hour improvement action plan aligned with the NHSI Rapid Improvement Collaborative and agreed by NHS England. Performance monitoring provided through the Emergency Care Pathway Programme Board (progress reporting) as part of the transformation programme governance. Regular reporting from the divisions into the operational sub-committees and the Quality Committee. Alignment with national priorities through the quality and safety governance mechanisms. Silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments continues. There are currently 11 Silver Accreditation of a ward approved by the Trust Board with further two awaiting approval. Increased number of assessments under the framework planned all inpatient wards completed in ICG and SAS. Work started on Family Care and Community Services and a plan is in place for 2019/20. 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. Quality Committee will oversee the CQC action plan. Mini mock-CQC visits regularly carried out and focussing on all areas with regular reporting back to the Quality Committee. Reduction in use of nursing -agency staff continues. 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. Quality Walkrounds in all clinical areas. **MOVED AND REVISED UNDER GAPS IN ASSURANCE** The Performance Assurance Framework - System-wide approach to elective care pathway through the System Scheduled Care Board, supported operationally by the Access and Choice Committee. Recovery plans in relation to the risks around some of the national trajectories addressed through the Emergency Care Pathway Transformation programme, Scheduled Care Programme, Cancer Improvement Action Plan. Regular monitoring by Executive Team and ODB. Weekly monitoring of complaints and reporting to the Patient Experience Committee and End of Life Care Group, focusing on reducing any 50+ day complaints (non currently in the system) Staffing (nursing/midwifery) report to Quality Committee. NAPF - operational monitoring through the Nursing and Midwifery Leaders' Forum monthly, receiving assurance from the Assistant Director of Nursing and NAPF team and monitoring by matrons at ward level where they carry out mini-NAPFs on a weekly basis to keep up the improvement work and report to Quality Committee (every other meeting). Escalation area in the Victoria Wing at BGTH is now in place **External Assurances** Trust rated 'Good' by CQC in 2018 with improvements in various areas and some outstanding services. Nurse staffing review as part of the IPR. Staff Care Allocate and daily monitoring of allocation for staff and three times daily matrons meetings to monitor. Audit carried out by MIAA for nurse staffing received significant assurance. Internal Audit (MIAA) have carried out an emergency care risk assessment audit which gained an assurance rating of 'Significant Assurance' in November 2018. **Internal / External Assurances** System wide approach to Emergency Care Pathway, as part of monthly A&E Delivery Board supported operationally by the A&E Delivery Group. PLACE assessments - percentage improved in all areas and monitoring continues. Annual PLACE report presented to the Quality Committee for assurance. Nursing and Midwifery Leaders' Forum also monitor. Patient Experience Committee receive minutes of the PLACE Steering Group. NAPF Team also monitors environmental issues linking to PLACE Assessments. Positive responses to Friends and Family Test and patient surveys with improvement areas identified. Monitoring at ward level, local divisions prepare monthly patient experience action plans that feed into the Patient Experience Committee that reports to the Quality Committee. Monitoring monthly by the Nursing and Midwifery Leaders' Forum. Positive response and results from the 2018 National Staff Survey. Inpatient survey 2018/19 results are being presented to the executive team in May by Quality Health.	15	9	12	4x4	16	16	12	16

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.*
Restrictions in the supply of medical, nursing, midwifery and other staff groups to meet demand. Reference in BAF risk 2. Risk of mental health providers not being able to ensure sufficient assessment and treatment capacity. 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. Increase in Delayed Transfers of Care and increasing number of longer stay patients. Demand and capacity issues relating to senior medical vacancies are affecting the 18 weeks RTT and holding list position.	Review of the complaints element of the Patient Experience Strategy has been launched and a user friendly version developed and presented to the Patient Experience Committee in October 2018 and launched in November. The Patient Participation Panel held an open day on 17 January 2018. The panel was launched on 27th February 2019 and it is made up of 15-20 people. Two meetings held and panel members receiving training. The Trust is developing a full clinical model regarding the emergency care pathway and ithis s anticipated to be ready for presentation and sign off in 2019. External support sourced for patient flow modelling. 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 opened on 7th January 2019. Surgical & Ambulatory Emergency Care unit moved to the old ambulatory care on 7th of Jan 2019 and additional beds opened on B14. Board receives regular SRCP and transformation updates. Nursing Assessment and Performance Framework (NAPF) assessments are continuing. Eleven Silver Accreditation of wards approved by the Trust Board. with a further two 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 was achieved by the end of March 2019. Objectives for 19/20 being set as part of the objective setting process. Core 24 (Lancashire Care Foundation Trust mental 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. Trust's lifecycle upgrade programme (estates and facilities) is currently being developed and is expected to be signed off by the end of April 2019. CQC report published on 12 February 2019, improvements in some areas and outstanding services. Action plan drafted and monitored by the CQC. Returned action plan in relation to notices regarding fridges, document storage and fluid thickening. Refocused efforts across clinical teams and system partners to reduce longLength of Stay (LoS) patients and Delayed Transfers of Care (DTOC). Report to the Quality Committee on the holding list and 18 week RTT action plans to be refreshed and finalised to ensure that coherent action plans are in place to improve performance. Reporting to the Finance & Performance Committee by the end of May/June

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 67

April 2019

Purpose Information
Monitoring

Title	Serious Incidents Requiring Investigation Report for February 2018 and March 2019
Author	Mrs R Jones , Patient Safety Manager
Executive sponsor	Dr D Riley, Medical Director

Summary: This report provides a summary of the Serious incidents that have occurred within the last 12 months, a breakdown of Serious Incidents reported in February and March 2019 and an overview of the CCGs Quality Dashboard.

Recommendation: Members are asked to receive the report, note the contents and are asked to approve the recommendations.

Report linkages

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

Impact

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

Contents **Page No**

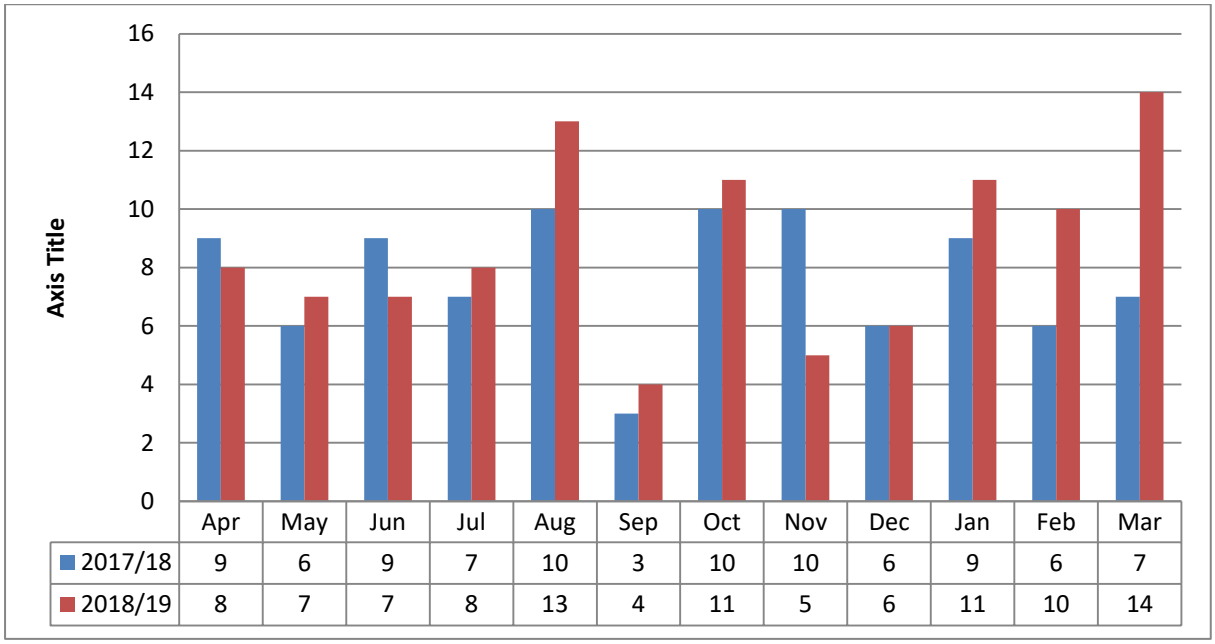
Executive Summary

1. In February and March 2019 the Trust reported 30 serious incidents, 24 to the Strategic Executive Information System (StEIS) and 6 to Divisional Serious Incident Review Group (DSIRG). Over the last 12 months the Trust has reported 163 serious incidents for investigation either to SIRI or DSIRG. There is a decrease of less than 1% from 2017/18 when 166 incidents reported.
2. Duty of candour has been served within the 10 working days on each of the StEIS reportable incidents, there were 2 duty of candour breaches reported to DSIRG which have now been completed.
3. Two of the top three reported incident categories identified have been escalated to the Falls and Pressure Ulcer Steering Group Leads to monitor over the next 2/4 months as part of the Harms Reduction Programme. The 3rd top reported incident identified, diagnosis failure/problem, the committing are asked to approve a recommendation to undertake a thematic review of the RCA Reports link to this category to see if a quality improvement programme needs to be considered, this will be taken to the Patient Safety and Risk Committee to take forward.
4. The Clinical Commissioner Group (CCG) dashboard provides assurance on improvements of investigations. There are no backlogs of incidents reported to StEIS on previous financial years; these have all been approved for closure. The current financial year 2018/2019 shows:
   a) 38 open investigation,
   b) 3 awaiting closure by the CCG
   c) 35 investigations are being completed
5. Once these have been approved at the Trusts SIRI panel they will be submitted to the CCG for final closure.

Part 1a: Overview of serious incidents reported through Strategic Executive Information System (StEIS) from April 2018 to March 2019

6. *Definition of StEIS reportable incident* - Serious incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisations ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

Graph 1: StEIS reportable incidents year on year



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	9	6	9	7	10	3	10	10	6	9	6	7
2018/19	8	7	7	8	13	4	11	5	6	11	10	14

7. When comparing the figures year on year there has been an increase in the number of Serious Incident reported from 92 in 2017/18 to 104 in 2018/19.

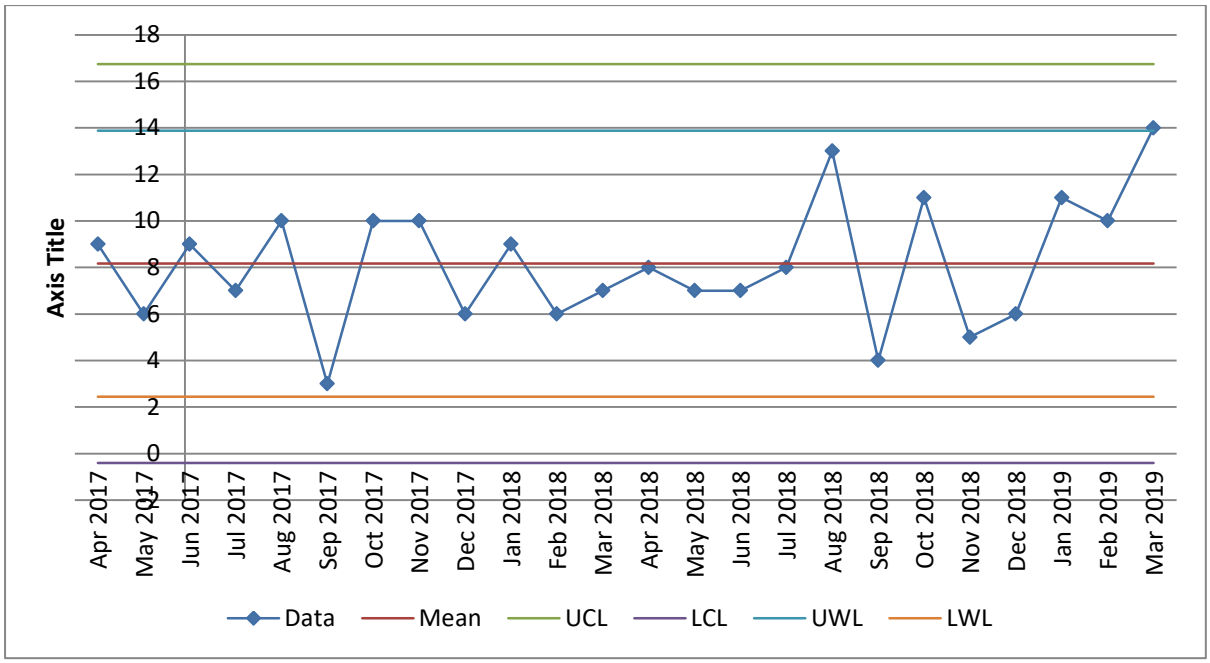
   a) A yearly increase of 13% on reported serious incidents.

   b) In 2017/18 the Trust reported 6 incidents that meet the criteria of the NHS Never Event Framework and in 2018/19 the Trust reported 2 which are categorised below:

      i. Overdose of insulin due to abbreviations or incorrect device x 1

      ii. Unintentional connection of a patient requiring oxygen to an air flowmeter x 1

Graph 2: Run Chart – StEIS Reportable Incidents (Control limits set by DATIX system)



8. The graph above shows that the Trust has reached the upper control limit for serious incident reporting in March prior to de-escalation, this shows an increase for 1 fixed point in time which will be monitored over the next 2-4 months. From April 2018 the Trust started monitoring de-escalation of incidents on Datix. Of the 104 incidents reported between April 2018 – March 2019 28 (27%) of these have been de-escalated to date which shows that Trust has a good reporting culture.

Nb: De-escalation is where the outcome of the investigation has identified no service or care delivery issues

The table below shows StEIS incidents by categories and lead division from April 2018 to March 2019

	Medical (ICG)	Community (ICG)	SAS	FC	DCS	Corp	Total
Antenatal and Newborn Screening	0	0	0	2	0	0	2
Communication problems	0	0	0	0	1	1	2
Diabetes related	0	0	1	0	0	0	1
Diagnosis failure / problem	6	0	7	0	2	0	15
Discharge or transfer problem	1	0	1	0	0	0	2
Maternity/Obstetrics	1	0	0	5	0	0	6
Medical devices & equipment	0	0	1	0	0	0	1
Medication	0	0	2	1	0	0	3
Neonatal / NICU	0	0	0	2	0	0	2
Personal Injury/Accident	1	2	0	0	0	0	3
Pressure ulcer	3	16	2	1	0	0	22
Problems with appointments/admissions	0	0	1	0	0	0	1
Return to theatre	0	0	1	0	0	0	1
Safeguarding - Adult	1	0	0	0	0	0	1
Safeguarding - Child	0	0	0	1	0	0	1
Self-harm	1	0	0	0	0	0	1
Slips, trips and falls	19	0	6	0	0	0	25
Treatment problem/issue	9	0	3	1	0	0	13
Violence/abuse/harassment	1	0	1	0	0	0	2
Total	43	18	26	13	3	1	104

Nb: Lead division is determined by the location of the incident, but the incident may involve cross divisional learning.

9. The top three categories for incidents reported over the last 12 months account for 59% of all incidents reported:
   a) Falls x 25 (24%) – of these 8 have been de-escalated, 2 requested for de-escalation awaiting confirmation, 8 still awaiting investigation completion and 7 upheld as lessons learnt
   b) Pressure Ulcers x 22 (21%) – of these 8 have been de-escalated, 2 upheld as lessons learnt and 12 are still undergoing investigation completion.
   c) Diagnosis failure / problem x 15 (14%) – of these 2 have been de-escalated, 6 upheld as lessons learnt and 7 are still undergoing investigation completion.
10. Out of the 62 (59%) serious incidents within the top 3 categories:
   a) 18 (29%) have been de-escalated
   b) 2 (3%) awaiting confirmation of de-escalation
   c) 15 (24%) lessons learnt identified

d) 27 (43%) still awaiting outcome of investigation

11. Of the 3 top categories of incidents, 2 of these categories Falls and Pressure ulcers have harms reduction programmes on going and the increase of incidents have been escalated to the harms reduction leads. These improvement programmes are monitored and assurance provided at Patient Safety and Risk Committee. The third category of diagnosis failure / problem requires a thematic review to understand what elements of care or service delivery issues were highlighted and key learning within the investigation reports.

Part 1b: Breakdown of serious incidents reported through Strategic Executive Information System (StEIS) reported in February and March 2019

12. There have been 24 serious incidents requiring investigation which have been reported through Strategic Executive Information System (StEIS). This is an increase of 84% on the same time period last year when 13 incidents were reported. The main reasons for the increase in the number of incidents reported are:

a) increase in reporting of pressure ulcers (10) – only 2 reported in the same time period last year

i. of the 10 pressure ulcers reported 7 of these were in the community settings and non-reported for the same period in 2018

b) patients falls (5) whilst under the care of ELHT – only 1 fall reported in the same time period last year

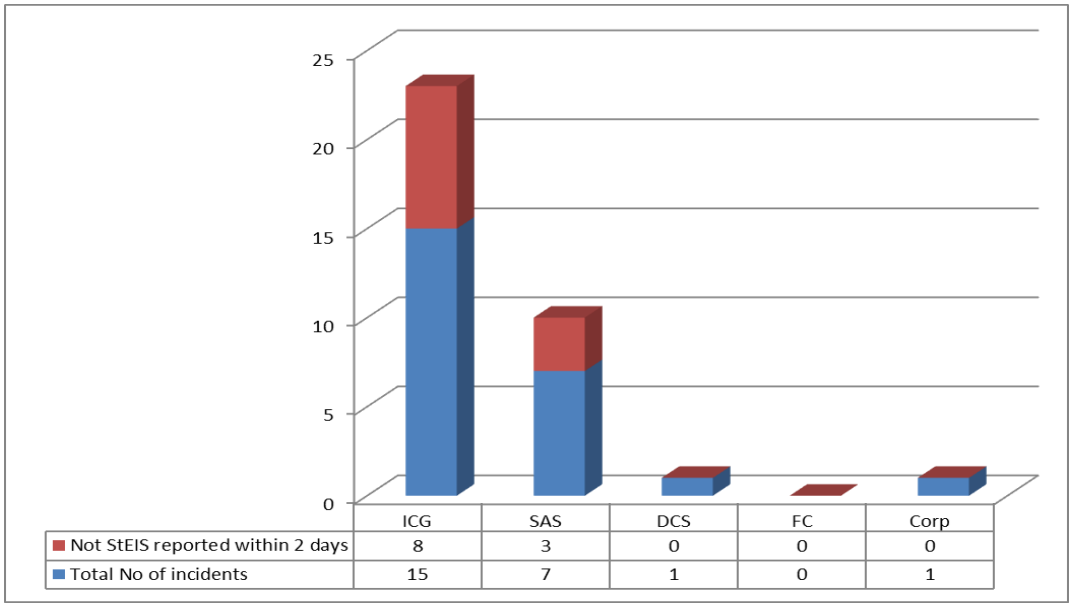
c) There have been 4 incidents reported though the Serious Judgement Review (SJR) process. No SJRs were reported for the same time period last year as it is a new process introduced in early 2018.

13. The Trust performance against key performance indicators required against the National Serious Incident Framework.

a) All serious incidents requiring duty of candour (DOC) were completed within 10 days

b) 11 serious incidents were not reported within the required 2 days

Graph 3: Overview by division



	ICG	SAS	DCS	FC	Corp
Not StEIS reported within 2 days	8	3	0	0	0
Total No of incidents	15	7	1	0	1

14. Incidents where there has been a delay in reporting to StEIS are due to the rapid reviews not being completed in time to determine the level of harm. A daily rapid review report is sent out to divisional Quality and Safety Teams for assurance and to monitor compliance. Assurance is sort from divisions at Patient Safety and Risk Committee and SIRI panel regarding their ongoing management of rapid reviews.
15. For further information for each of the 24 incidents requiring a SIRI level investigation see Appendix B for breakdown.

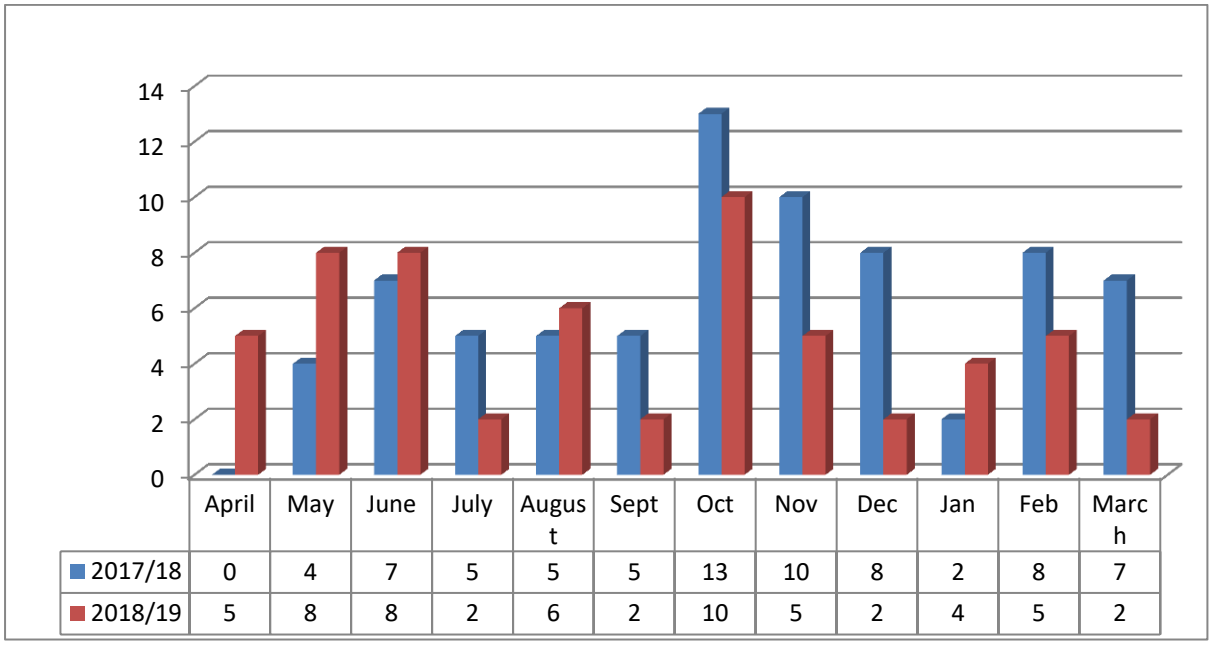
Recommendation(s):

16. Thematic review of the investigation reports completed on the incidents reported under diagnosis failure / problem category to identify if there are any cross Trust quality improvement programmes that need to be considered.

Part 2a: Overview of Divisional Serious Incident review group (DSIRG) from April 2018 to March 2019

17. *Definition of DSIRG reportable incident*: These incidents do not meet the criteria of harm under the NHS Serious Incident Framework which would be reportable on StEIS, but have been identified as incidents that raise a level of internal concern and warrant an investigation to ensure lessons are learned and actions taken to prevent future harm.

Graph 4: Reportable incidents to DSIRG year on year

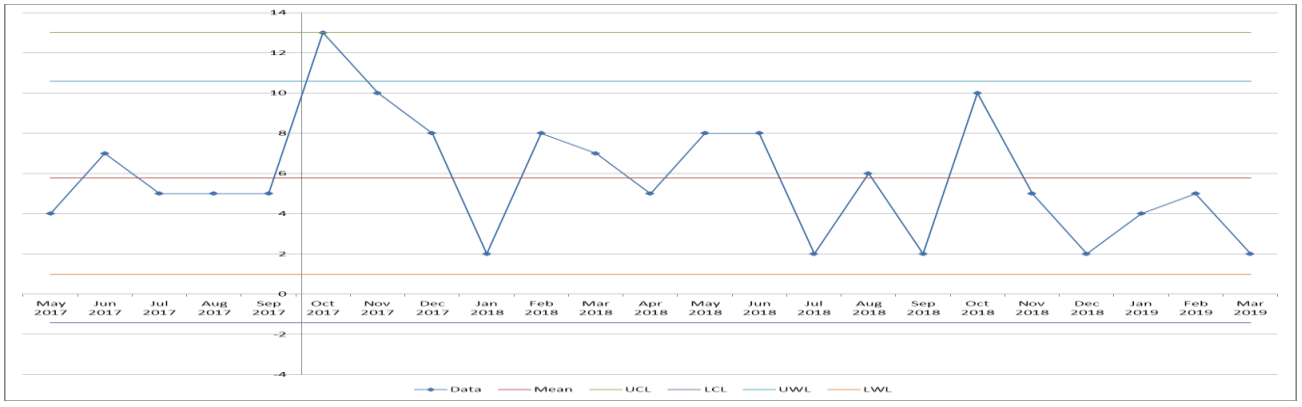


	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
2017/18	0	4	7	5	5	5	13	10	8	2	8	7
2018/19	5	8	8	2	6	2	10	5	2	4	5	2

18. When comparing the figures year on year there has been a decrease in the number of Divisional Serious Incidents reported from 74 in 2017/18 to 59 in 2018/19.

a) A yearly decrease of 20% on reported serious incidents.

Graph 5: Run Chart – DSIRG Reportable Incidents (Control limits set by DATIX system)



19. The above graph shows that there is a downward trend in serious incidents being presented through the Trust's internal divisional serious incident review group.

The table below shows DSIRG incidents by categories and lead division from April 2018 to March 2019

	ICG	SAS	FC	DCS	Total
Anaesthetics	0	1	0	0	1
Communication problems	0	1	1	0	2
Consent	0	1	0	0	1
Diabetes related	0	1	0	0	1
Diagnosis failure / problem	5	3	0	2	10
Discharge or transfer problem	1	1	0	0	2
Enteral Nutrition	1	0	0	0	1
High Risk Sepsis	1	0	0	0	1
Ill health	0	1	1	0	2
Infection Control Incident	7	0	1	0	8
Maternity/Obstetrics	0	0	5	0	5
Medical devices & equipment	0	1	0	0	1
Medication	2	2	0	0	4
Neonatal / NICU	0	0	3	0	3
Oral Nutrition & Hydration	1	0	0	0	1
Personal Injury/Accident	0	1	0	0	1
Pressure ulcer	3	0	0	0	3
Problem with patient records/information	0	1	1	0	2
Problems with appointments/admissions	1	1	0	0	2
Return to theatre	0	1	0	0	1
Self harm	1	0	0	0	1
Slips, trips and falls	4	0	0	0	4
Theatres	0	1	1	0	2
Treatment problem/issue	5	2	0	0	7
Total	32	19	13	2	66

20. The top three categories for incidents reported over the last 12 months account for 37% of all incidents reported:
    a) Diagnosis failure/problem (10) 15%
    b) Infection control incidents (8)12%
    c) Treatment problem/issue (7)10%

21. Investigations have been completed and presented to DSIRG with lessons learned and action taken which is shared within the areas the incidents have occurred. Action plan monitoring of these incidents are being undertaken to ensure these are embedded with evidence provided and uploaded to our internal incident management system, Datix.

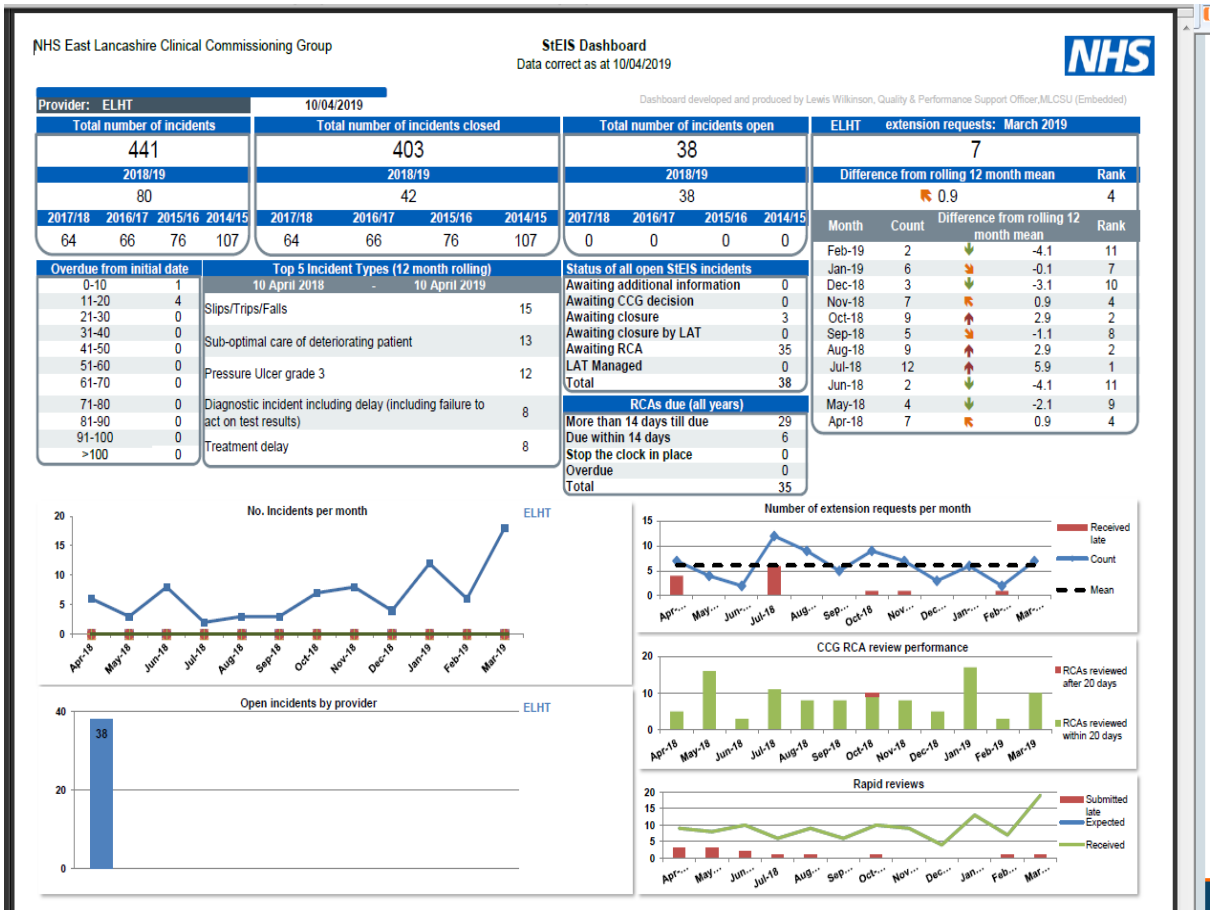
Part 2b: Breakdown of Incidents reported to Divisional serious incident reporting groups (DSIRG) in February and March 2019

22. There were 6 non-strategic executive information system incidents deemed to be serious incidents requiring investigation.
    a) There has been a 40% decrease on the same time period last year when 15 incidents were reported.
23. The Trust performance against the Duty of Candour key performance indicator:
    a) 1 incident which was reported on 5th February breached duty of candour by 8 days due to family not contactable until the 27th February, a letter then followed. (eir1159773)
24. *For the time period of February and March 2019 there has been 1 other DOC breach for an incident reported in the December/January 2019 SIRI Paper.*
    a) 1 of the incidents which were reported on 24th January but had breached in February by 2 days. A discussion was had with the patients' next of kin on the 8th February around the death of the patient but not around concerns in care given, a letter was sent on 11th February 2019. (eir1159017)
25. For further information for each of the 6 incidents requiring a DSIR level investigation see Appendix B for breakdown.

Recommendation(s):

26. It is recommended that these completed investigations undergo the thematic review considered on page 10 of the report as these incidents are also reported under the same category.

Part 3: Overview of the CCG StEIS Dashboard



27. There are 38 incidents open for 2018/2019, 3 of which are awaiting closure by the CCG and 35 are currently undergoing investigation which will be presented to SIRI panel in the coming months. Overdue incidents from initial date have all had extension requests and are currently undergoing investigation. There were 2 rapid reviews which were sent to the CCG out of the 72 hours timeframe in February and March, this was due to:

a) February: 2018/2811 the rapid review was requested on Tuesday 5th February 2019, a round table meeting was held and the rapid review was updated was uploaded to the incident management system, signed off and submitted to the CCG on 14th February 2019.

b) March: 2019/6142.The rapid review was requested on Friday, 15 March 2019. There was a delay in the rapid review being written as the member of staff took a period of leave. This was picked up on Tuesday, 19 March 2019 and Division confirmed the rapid review was being completed by another member of staff. The rapid review was uploaded to the incident management system on 20

March 2019 following which it was signed off and submitted to the CCG on 21 March 2019.

28. RCAs that have been approved by SIRI panel for closure were submitted to the CCG for closure within the timeframe.
29. All incidents relating to previous financial years have all been closed on StEIS.

Appendix A:

Number	eIR	Division	Incident reported	Reported to STEIS within 2 working days	Category/Allegation	Relevant to Duty of candour	Rapid Review	Any immediate changes initiated	Level of harm	Next steps
1	1161568	SAS	08/03/19	Y	Alleged Abuse	Y	Y	Police investigation / safeguarding involved - RCA on hold until police investigation has been completed.	No further police investigation and charges dropped. Requested de-escalation from StEIS 09/04/2019	Awaiting CCG feedback
2	1161840	SAS	14/03/19	Y	Slips Trips Falls – fracture neck of femur	Y	Y	Unwitnessed fall, patient sent for xray and referred to physio and occupational therapist	Severe / Major	RCA to SIRI
3	1161058	ICG	28/02/19	N	Pressure Ulcer – grade 3	Y	Y	Advised 2 hourly turns	Moderate	RCA to SIRI
4	1160912	ICG	26/02/19	Y	Pressure Ulcer – grade 3	Y	Y	Repositioning advice given and wound plan put in place	Moderate	RCA to SIRI
5	1162461	ICG	25/03/19	N	Pressure Ulcer – grade 3	Y	Y	Repositioning advice given to family	Moderate	RCA to SIRI
6	1161141	SAS	01/03/19	N	Pressure Ulcer – grade 3	Y	Y	Padding to be used to damaged skin (pt nursed in ICU)	Moderate	RCA to SIRI

7	1158820	SAS	21/01/19	N	Possible treatment delay	Y	Y	No immediate changes on initial judgement	Moderate	RCA to SIRI
8	1160833	ICG	24/02/19	N	Possible sub optimal care of deteriorating patient (SJR2)	N	Y	No immediate changes on initial judgement	Death / Catastrophic	RCA to SIRI
9	1159664	ICG	04/02/19	Y	Diagnostic incident	Y	Y	No immediate changes on initial judgement	Death / Catastrophic	RCA to SIRI
10	1161746	ICG	12/03/19	Y	Pressure Ulcer – grade 3	Y	Y	No immediate changes on initial judgement	Moderate	RCA to SIRI
11	1160977	ICG	27/02/19	N	Pressure Ulcer – grade 3	Y	Y	Upgraded pressure relieving equipment	Moderate	RCA to SIRI
12	1162490	SAS	26/03/19	Y	Slips, Trips, Falls – fracture neck of femur	Y	Y	x-ray and surgery planned	Severe / Major	RCA to SIRI
13	1149709	SAS	03/08/18	N	Possible medication incident (SJR2)	N	Y	No immediate changes on initial judgement	Death / Catastrophic	RCA to SIRI
14	1161945	ICG	15/03/19	N	Pressure Ulcer – grade 3	Y	Y	High risk mattress ordered and further advice given	Moderate	RCA to SIRI
15	1162347	DCS	22/03/19	Y	Treatment delay (SJR2)	N	Y	No immediate changes on initial judgement	Moderate	RCA to SIRI
16	1162381	ICG	23/03/19	N	Possible treatment Delay	Y	Y	No immediate changes on initial judgement	Moderate	RCA to SIRI

17	1160418	ICG	17/02/19	Y	Slips Trips Falls – Fracture neck of femur	Y	Y	Unwitnessed fall, x-ray obtained and surgery planned.	Moderate	RCA to SIRI
18	1161865	SAS	14/03/19	Y	Possible sub optimal care of deteriorating patient (SJR2)	N	Y	No immediate changes on initial judgement	Death / Catastrophic	RCA to SIRI
19	1160792	ICG	23/02/19	N	Slips, trips and falls – fracture neck of femur	Y	Y	Patient sent for x-ray and surgery planned	Severe / Major	RCA to SIRI
20	1160936	ICG	26/02/19	Y	Slips Trips Falls – Fracture neck of femur	Y	Y	x-ray taken and surgery planned	Severe / Major	RCA to SIRI
21	1160079	ICG	11/02/19	Y	pressure ulcer – Grade 3	Y	Y	Splint removed due to pressure damage	Moderate	RCA to SIRI
22	1161546	ICG	08/03/19	N	Pressure Ulcer – Grade 3	Y	Y	Non-compliance – reiterated the importance of pressure relieving. Further advice given.	Moderate	RCA to SIRI
23	1162232	ICG	21/03/19	Y	Pressure Ulcer – Grade 4	Y	Y	Importance of concordance and pressure relief to patient and family	Severe / Major	RCA to SIRI
24	1161881	Corp	14/03/19	Y	Adverse Media effect	Y	N	No immediate changes on initial judgement	Severe / Major	RCA to SIRI

Appendix B

	eIR1	Division	Incident reported	Category/Allegation	Relevant to Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of Harm	Next steps
1	1161408	ICG	06/03/19	Delay in diagnosis - fracture	N/A	Y	No immediate changes made at initial judgement	No harm - Impact not prevented	RCA to DSIRG
2	1160091	SAS	11/02/19	Delay in diagnosis and treatment	N/A	Y	No immediate changes made at initial judgement	Low / Minor	RCA to DSIRG
3	1159773	ICG	05/02/19	Treatment problem/issue	Y	Y	No immediate changes made at initial judgement	Moderate	RCA to DSIRG
4	1159747	SAS	05/02/19	Return to theatre	N/A	N	No immediate changes made at initial judgement	Low / Minor	RCA to DSIRG
5	1161420	ICG	06/03/19	Treatment problem – delay in referral to SALT	Y	Y	No immediate changes made at initial judgement	Moderate	RCA to DSIRG
6	1160631	SAS	21/02/19	Transfer problem	N/A	Y	To ensure staff aware of transferring policy. To ensure all staff up to date with epidural training	No harm - Impact not prevented	RCA to DSIRG

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

8 May 2019

Item 68

Purpose ~~Information~~ ~~Action~~ Monitoring

Title	Integrated Performance Report (April 2018 - March 2019)
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 March 2019

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 the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objective Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil

regulatory requirements

Impact

Legal	Legal	Legal	Legal
Equality	Equality	Equality	Equality

Previously considered by: Not applicable

Board of Directors, Update

Corporate Report

Executive Overview Summary

Positive News

- There were no never events.
- There was one clostridium difficile infections detected during March, which is below trajectory for the month. The cumulative position is 26 against trust target of 27 for the year.
- No hospital acquired MRSA infections were detected during March 2019.
- HSMR remains 'better than expected' and the SHMI is 'as expected'.
- All cancer standards were met in February. The 62 day standard has shown improvement to 87.8% above the 85% standard.
- Delayed discharges decreased in March to 3.3% which is below the 3.5% threshold.
- The number of ambulance handovers over 30 minutes decreased during March
- The Trust is reporting that it has met the 2018-19 financial plan and is reporting an underlying £15.8 million deficit; and a £10.2 million deficit after receipt of the Provider Sustainability Funding (PSF) monies.

Areas of Challenge

- A total of nineteen incidents were reported to StEIS during March 2019. This includes one medication error causing serious harm.
- Nursing and midwifery staffing in March 2019 continued to be a challenge, with 8 areas falling below an 80% average fill rate for registered nurses on day shifts.
- There was an improvement of the 'Emergency Care 4 hour standard' to 81.0%, which remains below the 95% threshold.
- There were 23 breaches of the 12 hour trolley wait standard in March. Of these, 22 were as a result of waits for mental health beds within LCFT, 1 was a physical breach.
- The Referral to Treatment (RTT) target was not achieved at 91.4%. (Activity data for the Integrated Musculoskeletal service has been included this month following discussion with NHSI/E)
- There was one breach of the 28 day standard for operations cancelled on the day.
- Sickness rates remain above threshold at 5.2%
- The vacancy rate has increased in March to 10% which is above threshold.
- Compliance against the Information Governance Toolkit and Appraisal (AFC staff) remains below threshold.
- Temporary costs as % of total pay bill remains above threshold at 8%

No Change

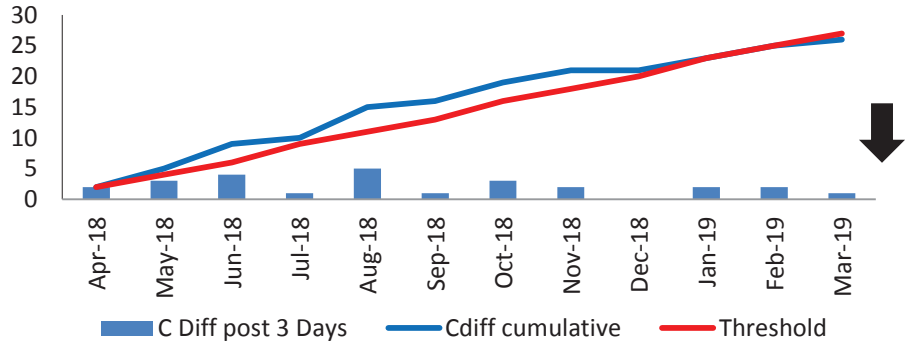
- The HAS compliance remained above the threshold.
- The 6wk diagnostic target was met in March at 0.6%
- There were no breaches of the 52wk standard at the end of March.
- All areas of core skills training except IG and Appraisal compliance are above threshold

Introduction

This report presents an update on the performance for April - March 2019 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

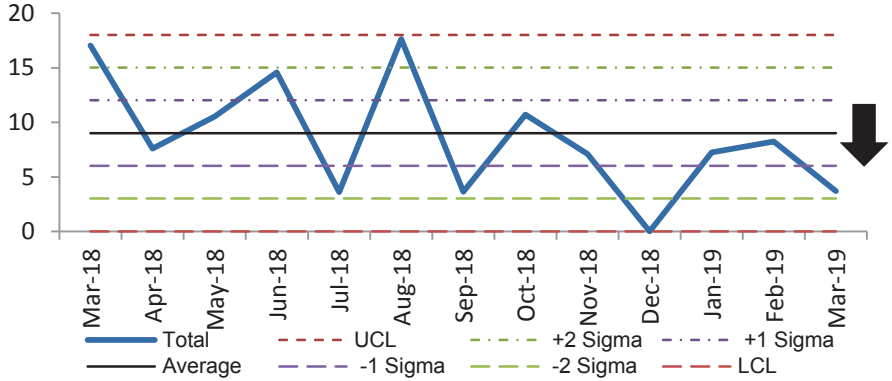


There were no post 2 day MRSA infections reported in March. Year to date there has been 1 case attributed to ELHT.

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

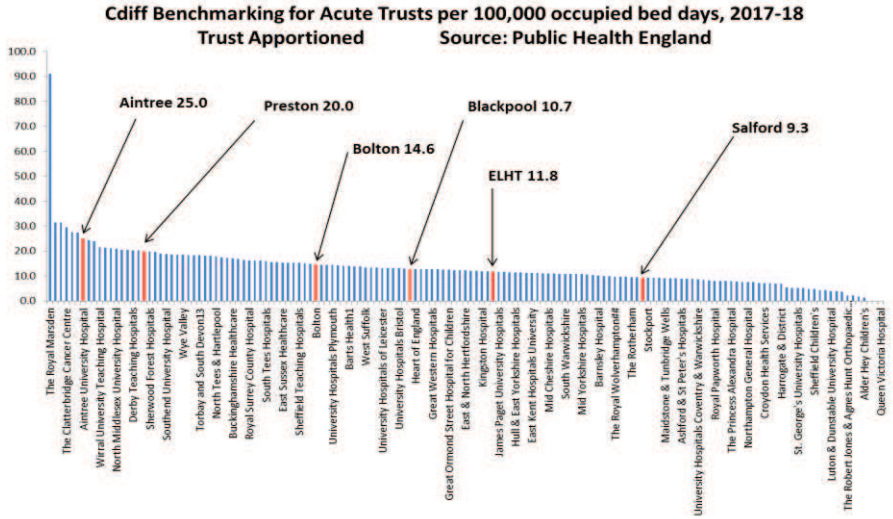
The year to date cumulative figure is 26 against the trust target of 27. The detailed infection control report will be reviewed through the Quality Committee.

C Difficile per 100,000 occupied bed days



The rate of infection per 100,000 bed days decreased in March to 3.7, below average.

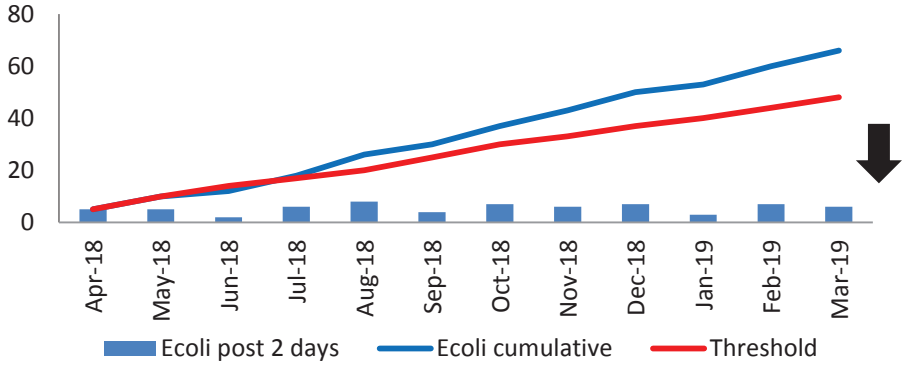
C Difficile benchmarking



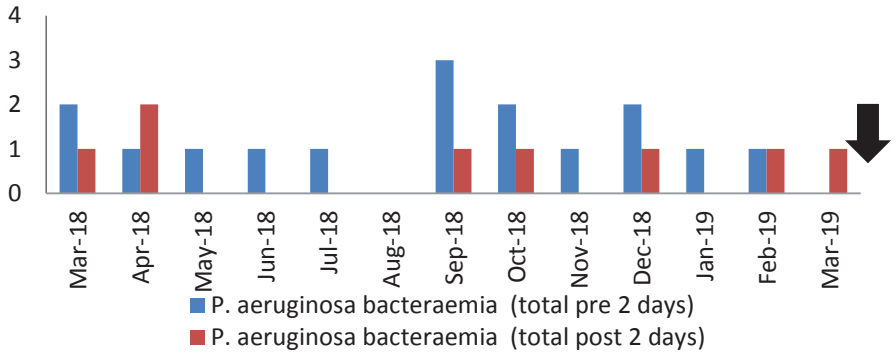
ELHT ranked 71st out of 151 trusts in 2017-18 with 11.8 clostridium infections per 100,000 bed days. The best performing trust had 0 and the worst performer had 91 infections per 100,000 bed days.

SAFE

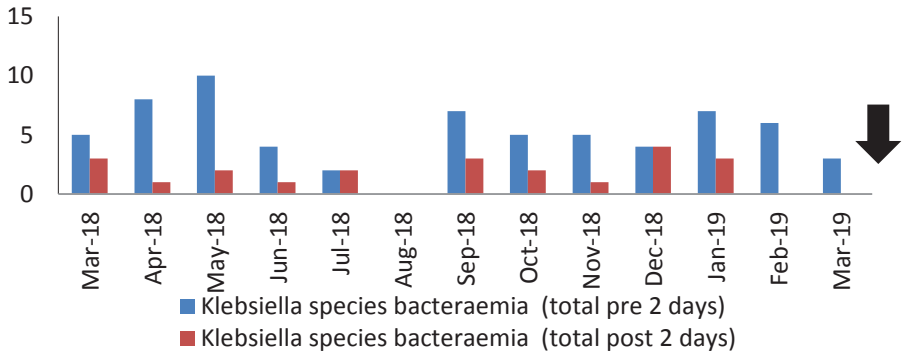
E. Coli



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. The year end figure was 66 cases.

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

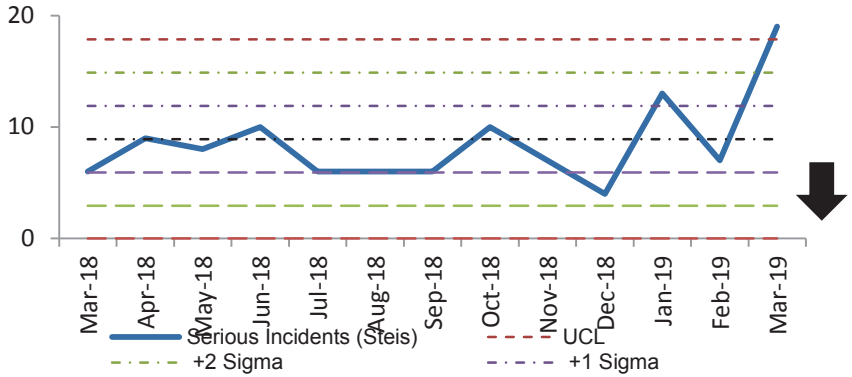
From April 2017, NHS Trusts must report cases of bloodstream infections due to *Klebsiella species* and *Pseudomonas aeruginosa* to Public Health England.

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

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

SAFE

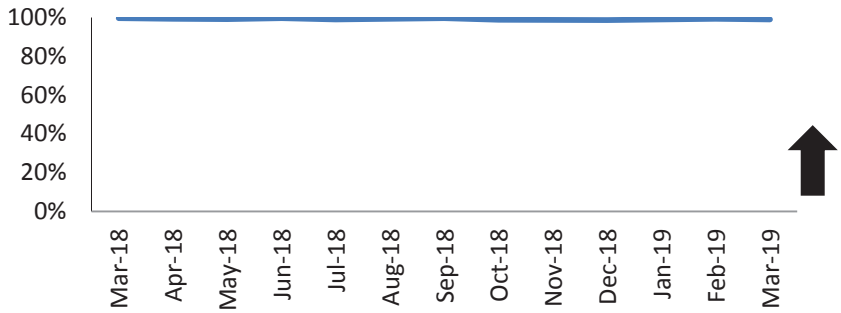
Serious Incidents



There were no never events reported in March.
The Trust unverified position for incidents reported to the Strategic Executive Information System (StEIS) in March was nineteen incidents. These incidents were categorised as follows:

StEIS Category	No. Incidents
Pressure ulcer	9
Slips, trips & falls	2
Sub optimal care of deteriorating patient	2
Treatment delay	3
Medication	1
Adverse media incident	1
Alleged Abuse of adult patient by staff	1

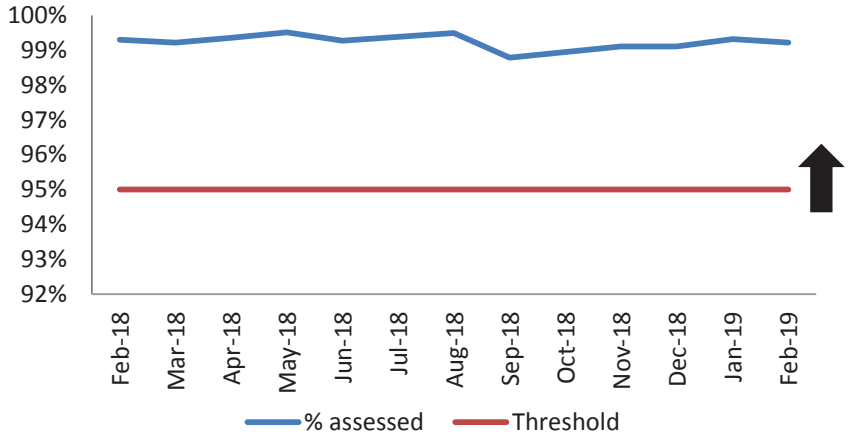
% Harm Free Care from safety thermometer



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 99.1% for March using the National safety thermometer tool.

VTE assessment

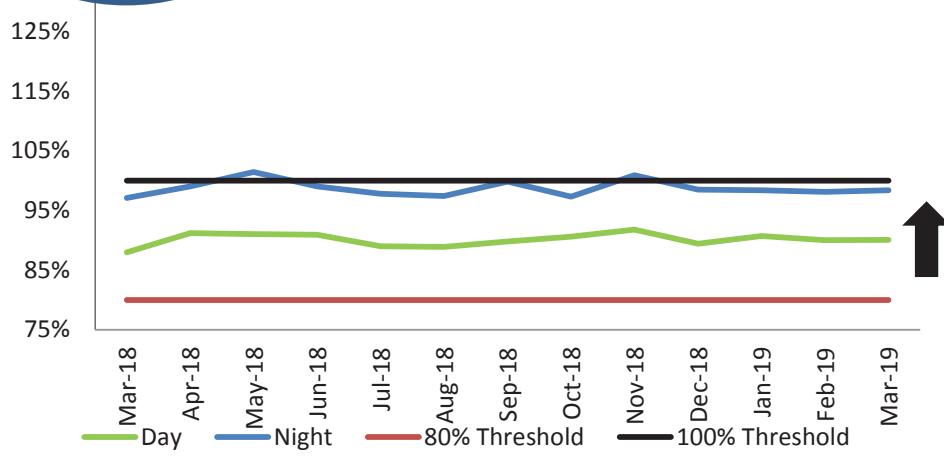


For March we are reporting the current pressure ulcer position, pending investigation, as follows:

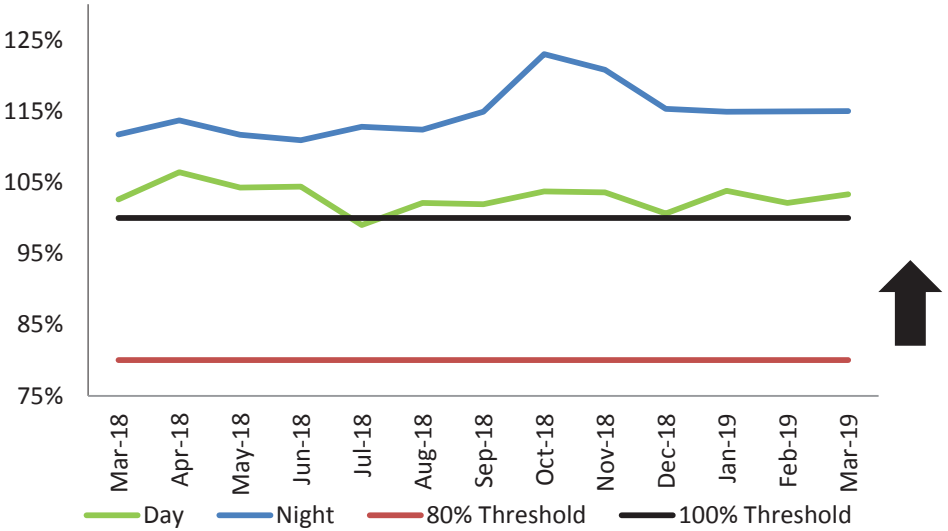
Pressure Ulcers	Hospital Aquired	Community Aquired
Grade 2	4	0
Grade 3	2	2
Grade 4	0	1
Acquired potential deep tissue injury	7	
Unstageable acquired - to be determined later	2	

SAFE

Registered Nurses/ Midwives



Care Staff



Nursing and midwifery staffing in March 2019 continued to be a challenge. The causative factors remain as in previous months, compounded by escalation areas being open, pressures within the emergency department, vacancies, sickness and the ability to fill all requests through ELHT internal bank or via framework 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 8 areas below the 80% for registered nurses on day shifts, 7 were due to lack of co-ordinator presence which is in addition to safe staffing levels., leaving one area of concern:

Reedyford Ward – The majority relate to lack of coordinators, however the ward fell below agree staffing numbers on 4 late shifts. No harm has been identified.

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.

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
Mar-19	90.1%	103.3%	98.3%	115.0%	27,129	8.8	8	1	0	0

Red Flag Incidents

There were 3 red flag incidents reported in the red flag category of DATIX in March 2019

ASU (B2) – Unable to reliably carry out intentional rounding. At the initial start of the night shift there was a health care support worker last minute sickness and I registered nurse short. 2 patients had been identified as high risk of falls and another had been aggressive to staff the previous night. Additional support was sent to the ward at 20:15. No harms were identified.
C14B – Less than 2 Registered nurses present on a ward during any shift - . An agency nurse did not arrive for the shift therefore; C14A had to help with care needs. This was resolved at midnight when a second RN arrived. The division can provide assurance that no harm occurred as a result of this incident.
Gynaecology Ward - Less than 2 Registered nurses present on a ward during any shift – 2 Registered nurses allocated but 1 RN felt unwell and had to leave on the night shift. Risk assessment undertaken by late shift coordinator and duty sister. Only 5 patients all stable with an experienced band 5 and HCA. Ward managed with this staffing with the support of duty sister. No incidents or concerns reported.

In addition C1 submitted a number of IR1's relating to staff shortages. Safe staffing numbers were maintained and the ADNS, Matron and Staff Guardian met with the staff members and the union to resolve the issues. There were no harms identified.

Actions taken to mitigate risk:
- 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 recruitment.
- The Trust has engaged with Health Education England (HEE) to work collaboratively with the Global Learners Programme. 13 nurses arrived between October 18 and March 19, of these 9 have their NMC registration and 1 is awaiting the outcome of their OSCE. 3 further nurses are due to take their OSCE in June. Between the end of April and the end of September a further 12 nurses are expected. This leaves 27 nurses in various stages of the process to still arrive

SAFE

Family Care March 2019

Maternity

No Exceptions to report. 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 Midwife to Birth Ratio

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Staffed to full Establishment	01:29	01:28.2	01:28.7	01:29.2	01:29	01:27	01:26	01:28	01:27	01:27	01:27	01:27
Excluding mat leave and vacancies	01:30	01:29.3	01:29.9	01:30.8	01:30	01:28.4	01:27.5	01:29	01:28	01:28	01:28	01:28
With gaps filled through ELHT Midwife staff bank	01:28.4	01:28.5	01:28.8	01:29.4	01:29	01:27	01:26	01:28	01:27	01:27	01:27	01:27
	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	Bank Usage 5.8WTE	Bank Usage 7.0WTE	Bank Usage 4.8WTE	Bank Usage 6.3WTE

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 - 31/03/19

SAFE

Family Care Staffing Red Flag Events

On reviewing Datix, 6 incidents were reported overall as Red Flag events in Family Care Division in March 2019
Of these 6 incidents reported, 1 has been excluded as it related to outpatient services.
Of the remaining 5 incidents reported, 4 of them occurred within Maternity Services and 1 related to Gynaecology Services. 3 incidents related to staffing issues and 2 to missed or delayed care.

The incidents were reported under the following category and sub-categories:

Maternity Services - 2
2 staffing issue – staff shortage midwives. *No harm, impact prevented*
1 missed or delayed treatment. *No harm impact prevented*
1 missed or delayed treatment. *No harm impact not prevented*

Gynaecology Services
1 staffing issue – staff shortage nursing. *No harm, impact not prevented*. (detail above)

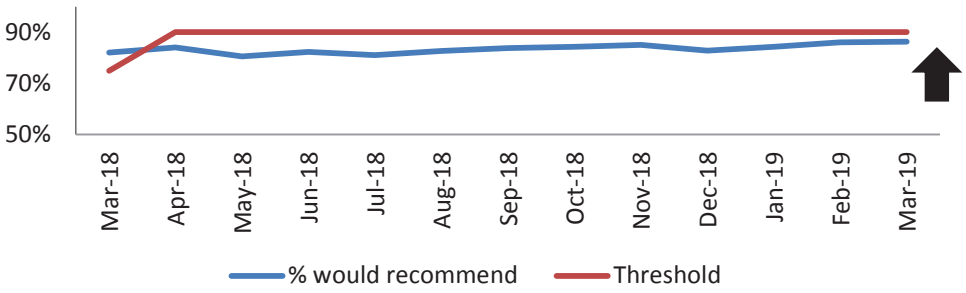
No harm was caused.

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 with all disciplines involved in care and service delivery was excellent throughout.

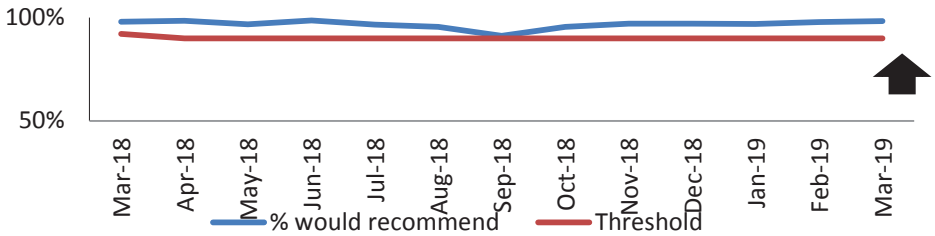
Paediatrics
Paediatrics has had an increase in the use of bank and agency nurse staffing to care for a number of children requiring 1-1 care. There has also been an increase in sickness absence which has been managed within the rosters. Acuity is closely monitored and recorded 3 times throughout the day on safe staffing.

CARING

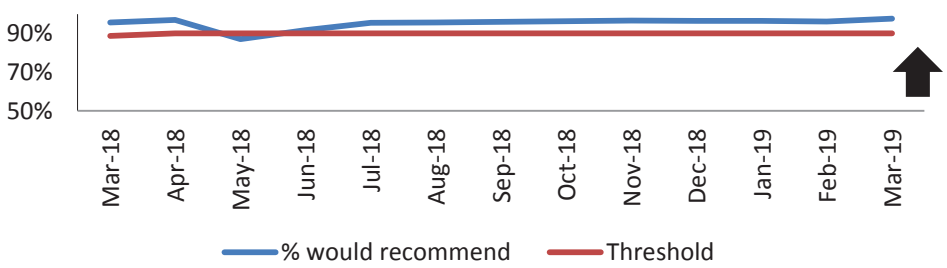
Friends & Family A&E



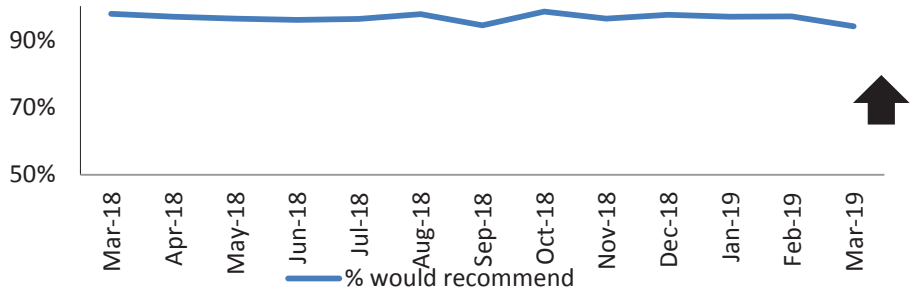
Friends & Family Inpatient



Friends & Family Community



Friends & Family Maternity



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 improved in March to 86.4% with a response rate of 19.2%

The proportion that would recommend inpatient services has improved on last month to 98.3% in March. The response rate was 45.4%

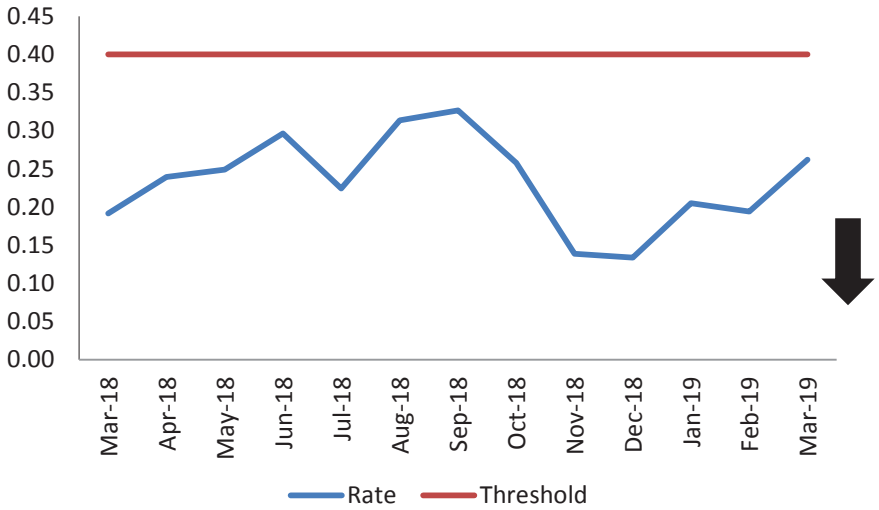
Community services would be recommended by 97.6% in March.

Maternity services would be recommended by 94.0% in March.

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

CARING

Complaints per 1000 contacts



The Trust opened 31 new formal complaints in March. The number of complaints closed was 28.

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 March the number of complaints received was 0.3 Per 1,000 patient contacts.

Patient Experience

March 2019 Totals	Dignity	Information	Involvement	Quality	Overall
	Average Score %	Average Score %	Average Score %	Average Score %	Average Score %
Trust	95	91	93	92	93
Integrated Care Group – Acute	95	90	93	91	92
Integrated Care Group – Community	95	94	93	96	94
Surgery	94	90	93	94	92
Family care	98	96	97	97	97
Diagnostic and Clinical	96	93	91	78	90

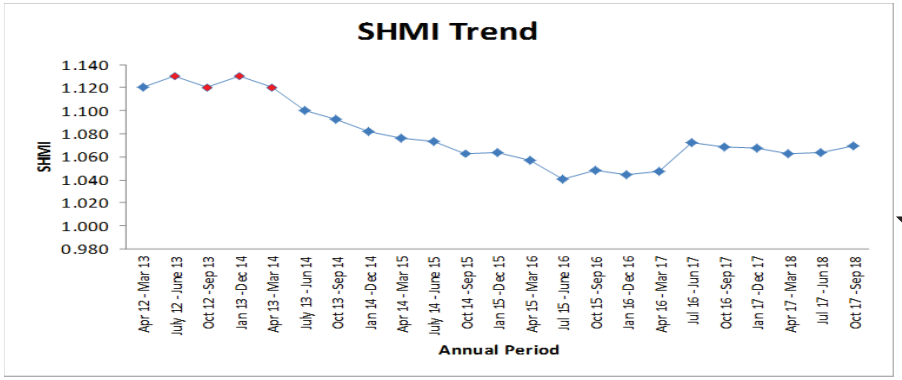
The table demonstrates divisional performance from the range of patient experience surveys in March 2019. The threshold is a positive score of 90% or above for each of the 4 competencies.

The overall Trust performance from the range of patient experience surveys is above the threshold of 90% for all of the 4 competencies in March 2019.

One divisional area fell below threshold in March - the Quality competency in Diagnostic & Clinical Support.

EFFECTIVE

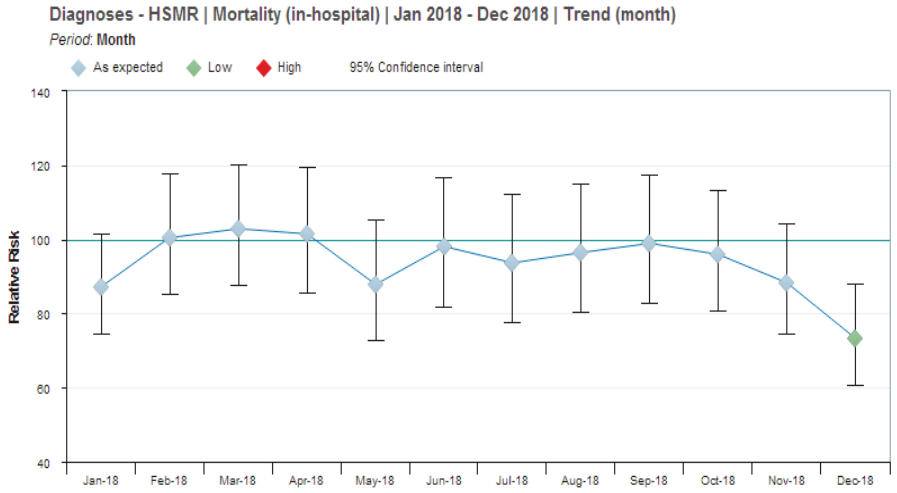
SHMI Published Trend



Dr Foster HSMR rolling 12

	HSMR Rebased on latest month Jan 18 – Dec 18 (Risk model Sep 18)
TOTAL	93.3 (CI 88.9 – 98.0)
Weekday	92.6 (CI 87.4 – 97.9)
Weekend	95.5 (CI 86.7 – 105.0)
Deaths in Low Risk Diagnosis Groups	90.7 (CI 54.6 – 141.6)

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 Oct 17 to Sep 18 has increased slightly to 1.069 and is still within expected levels, as published in January 19.

The latest indicative 12 month rolling HSMR (January 18 – December 18) remains 'significantly better than expected' at 93.3 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.

One further learning disability death was reviewed through the Learning Disability Mortality Review Panel in March. 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	Dec-18	Jan-19	Feb-19	Mar-19	TOTAL
Deaths requiring SJR (Stage 1)	46	50	35	28	34	29	36	40	26	21	26	19	27	22	14	14	18	4	6	495
Allocated for review	46	50	35	28	34	29	36	40	26	20	26	19	27	22	11	11	16	1	1	478
SJR Complete	46	50	35	28	34	29	36	40	24	19	25	19	27	20	10	9	12	1	1	465
1 - Very Poor Care	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
2 - Poor Care	8	4	4	4	4	2	1	2	2	3	2	0	1	3	0	1	1	0	0	42
3 - Adequate Care	14	16	8	10	10	10	14	9	9	0	9	7	10	4	4	2	2	0	1	139
4 - Good Care	20	26	21	9	19	13	18	26	9	13	11	9	14	12	5	4	8	1	0	238
5 - Excellent Care	3	4	2	4	1	4	3	3	4	3	3	3	2	1	1	2	1	0	0	44
Stage 2																				
Deaths requiring SJR (Stage 2)	9	4	4	5	4	2	1	2	2	3	2	0	1	3	0	1	1	0	0	44
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	0	0	0	0	5
Allocated for review	6	4	3	4	4	2	1	2	2	3	2	0	1	3	0	1	1	0	0	39
SJR-2 Complete	6	4	3	4	4	2	1	2	2	3	2	0	1	2	0	1	1	0	0	38
1 - Very Poor Care	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	3
2 - Poor Care	3	1	2	1	1	1	0	1	0	0	0	0	1	0	0	1	1	0	0	13
3 - Adequate Care	2	3	1	3	2	1	0	1	1	3	2	0	0	2	0	0	0	0	0	21
4 - Good Care	0	0	0	0	0	0	1	0	0	0	0	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	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	Dec-18	Jan-19	Feb-19	Mar-19	Total
stage 1 requiring allocation	0	0	0	0	0	0	0	0	0	1	0	0	0	0	3	3	2	3	5	17
stage 1 requiring completion	0	0	0	0	0	0	0	0	2	1	1	0	0	2	1	2	4	0	0	13
Backlog	0	0	0	0	0	0	0	0	2	2	1	0	0	2	4	5	6	3	5	30
stage 2 requiring allocation	0	0	0	0	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	0	0	0	1	0	0	0	0	0	1
Backlog	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1

Commissioning for Quality and Innovation

EFFECTIVE

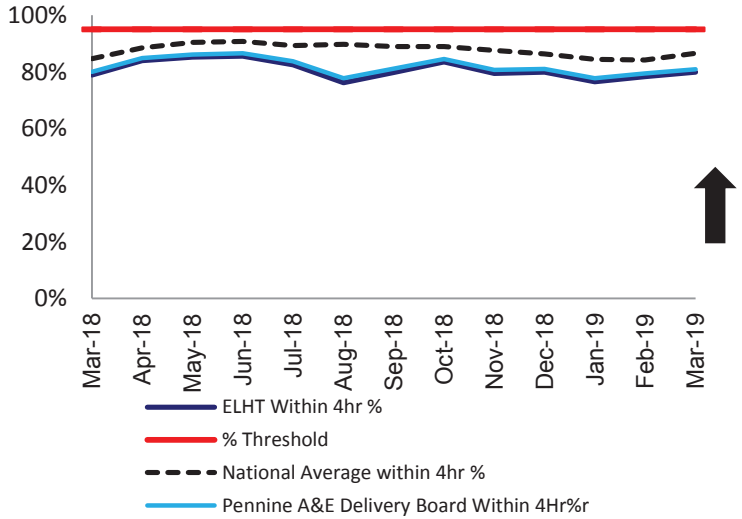
in 2018/19 the Trust is participating in the following 5 national CQUIN schemes as agreed with the CSU in 2017/18:

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

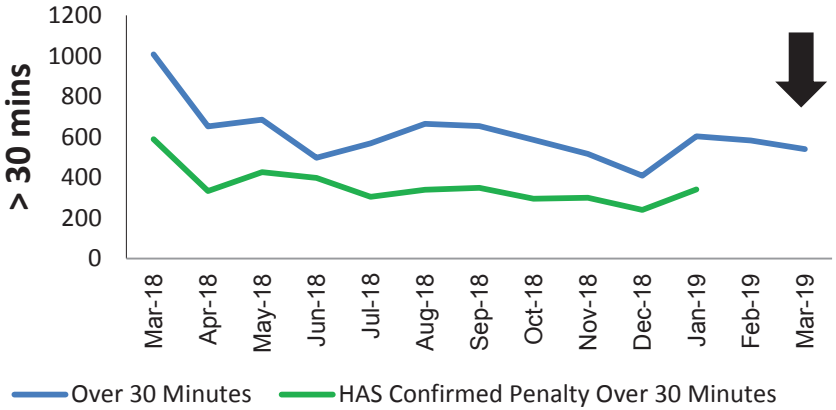
CQUIN Scheme		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Q1	Q2	Q3	Q4
national	**NHS STAFF HEALTH & WELLBEING** - Flu Vaccine Uptake	**75%**									**85.6%**	**93%**	**94%**	**94%**			85.6%	94%
national	**SEPSIS PART A- IDENTIFICATION**- TOTAL %	**90.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**				**100%**	**100%**	**100%**	
national	**SEPSIS PART B - ANTIBIOTIC ADMINISTRATION - TOTAL %**	**90.0%**	**90.4%**	**93.4%**	**90.6%**	**92.2%**	**100.0%**	**96.9%**	94.4%	97.1%	96.2%				**91.5%**	**96.4%**	95.9%	
national	**SEPSIS PART C - ANTIBIOTIC REVIEW -** % Prescriptions Reviewed within 72 Hrs	**Q1 25% Q2 50% Q3 75% Q4 90%**		**100%**			**90%**			**96%**					**100%**	**90%**	**96%**	
national	**REDUCTION IN ANTIBIOTIC CONSUMPTION- PART D**- Total antiobiotic consumption per 1000 admissions	**4845.1**		**5107.3**			**5,110.3**			**5,258.2**					5,107	5,110	5,258	
national	-Antibiotic % Reduction on 2016 baseline	**-2.0%**		**5.4%**			**5.5%**			**8.5%**					5.4%	5.5%	8.5%	
national	- Total consumption of carbapenem per 1000 admissions	**31.9**		**42.1**			**38.0**			**40.7**					42.1	38	41	
national	-Carbapenam % Reduction on 2016 baseline	**-3.0%**		**32.2%**			**19.2%**			**27.8%**					32.20%	19.20%	27.8%	
national	- Increase proportion of antiobiotic usage within the Access group of the AWaRe category	***>=55%***		**58.4**			**59.1**			**58.3**					58.4	59	58	

RESPONSIVE

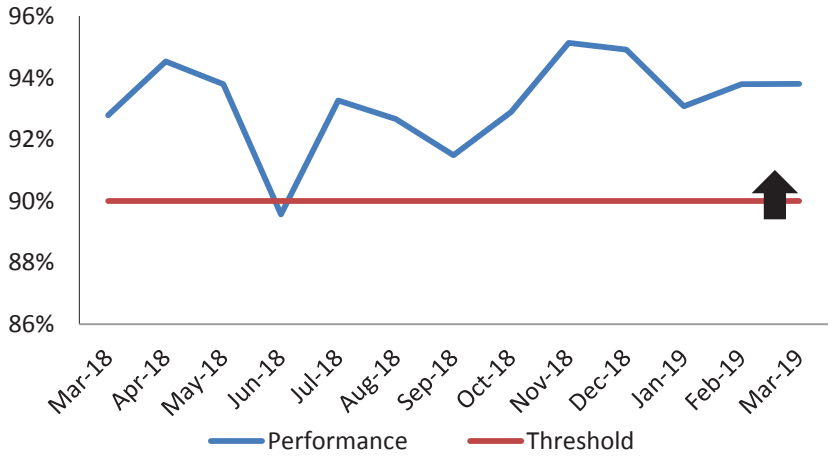
A&E 4 hour standard % performance



Ambulance Handovers



HAS Compliance



Overall performance against the ELHT Accident and Emergency four hour standard improved in February to 79.9%, which remains below the 95% threshold. The performance against the Pennine A&E Delivery Board four hour standard has also improved to 81.0% in March.

The number of attendances during February was 16,634 and of these 13,465 were treated and left the department within 4 hours. (Pennine A&E Delivery Board)

The national performance improved to 86.6% in March (All types) with 15 out of 134 reporting trusts with type 1 departments achieving the 95% standard.

There were 23 reported breaches of the 12 hour trolley wait standard from decision to admit during March. 22 were mental health breaches and 1 was a physical health breach. 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 540 in March compared with 583 for February.

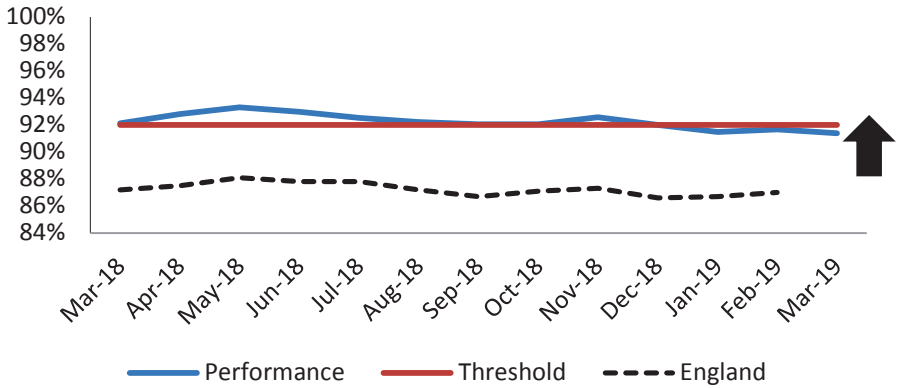
The validated NWAS penalty figures are reported as at January as;- 134 missing timestamps, 292 handover breaches (30-60 mins) and 50 handover breaches (>60 mins).

The ambulance handover compliance indicator measures the compliance with PIN entry on completion of patient handover. This was achieved at 93.8% in March, 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 not achieved in March with 91.4% patients, waiting less than 18 weeks to start treatment at month end.

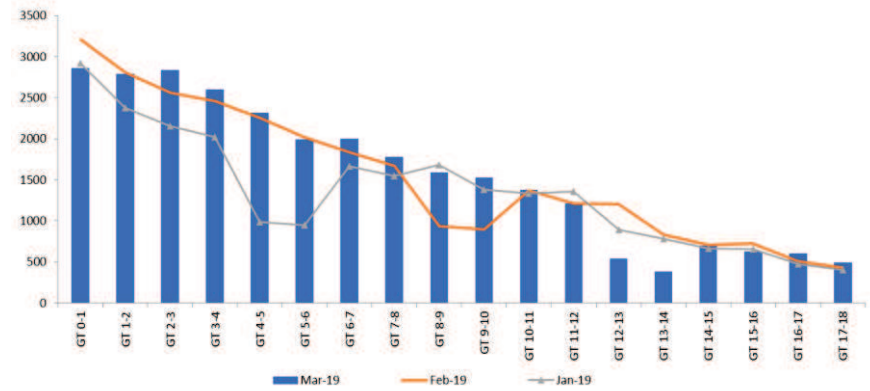
There were no patients waiting over 52 weeks at the end of March.

The total number of on-going pathways has increased in March to 30,898 from 30,144 in February.

There has been an increase in patients waiting over 18 weeks at the end of March to 2659 from 2507 in February.

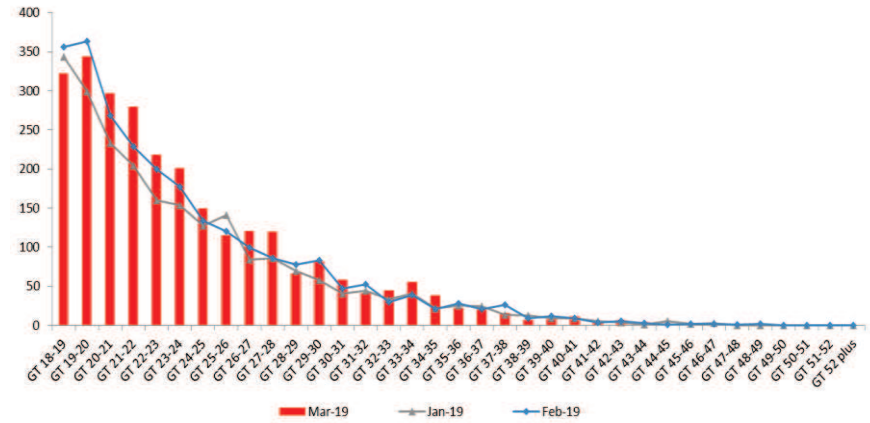
The median wait has been maintained at 6.3 weeks for ongoing patients at the end of March.

RTT Ongoing 0-18 Weeks



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

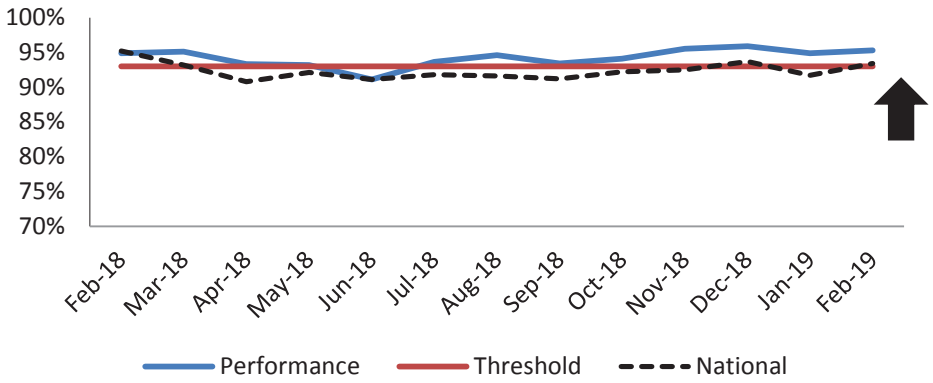
RTT Over 18 weeks



The latest published figures from NHS England show continued failure of the ongoing standard nationally (reported 1 month behind), with 87.0% of patients waiting less than 18 weeks to start treatment in February.

RESPONSIVE

Cancer 2 Week

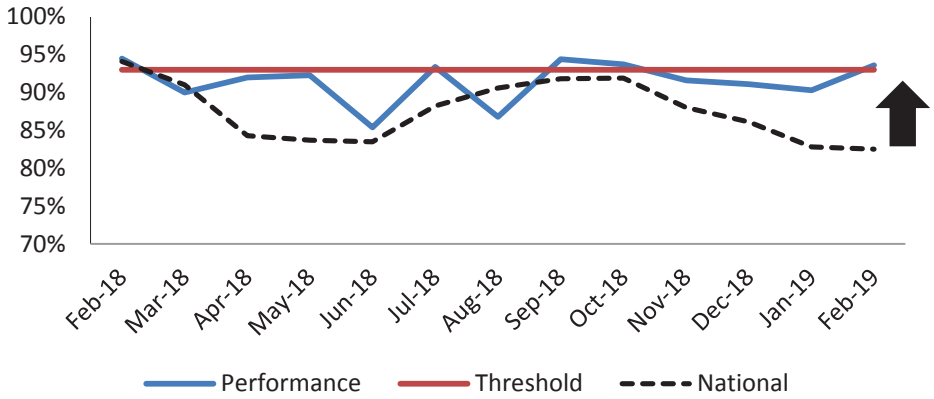


The cancer 2 week wait for GP referrals standard was achieved in February at 95.3%, above the 93% standard.

Quarter 3 performance was also above threshold at 95.1%

National performance also met the standard in February.

Cancer 2 Week - breast

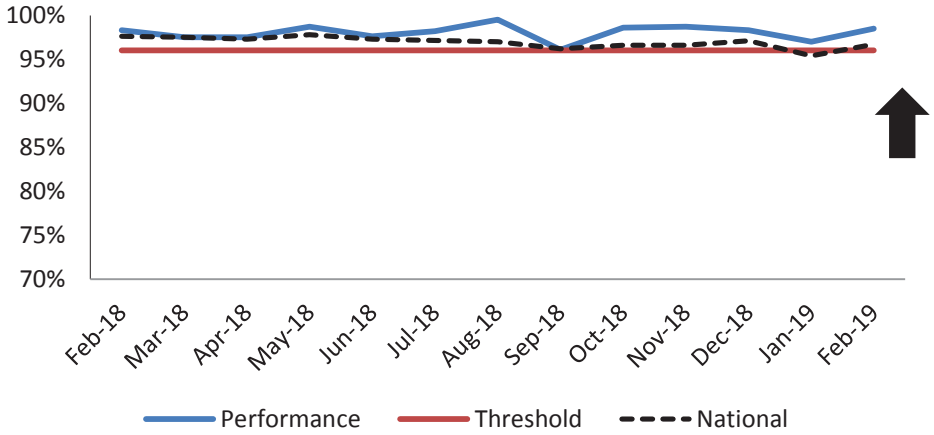


The 2 week breast symptomatic standard was achieved in February at 93.6%, above the 93% standard.

The quarter 3 performance was below threshold at 92.1%

National performance remains below the standard in February.

Cancer 31 day

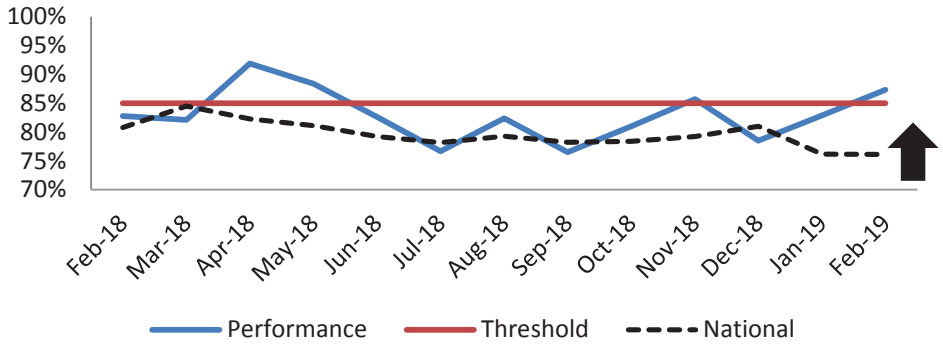


The 31 day target was achieved in February at 98.5%, above the 96% standard.

The standard was also met for quarter 3 at 98.6%

RESPONSIVE

62 Day Cancer

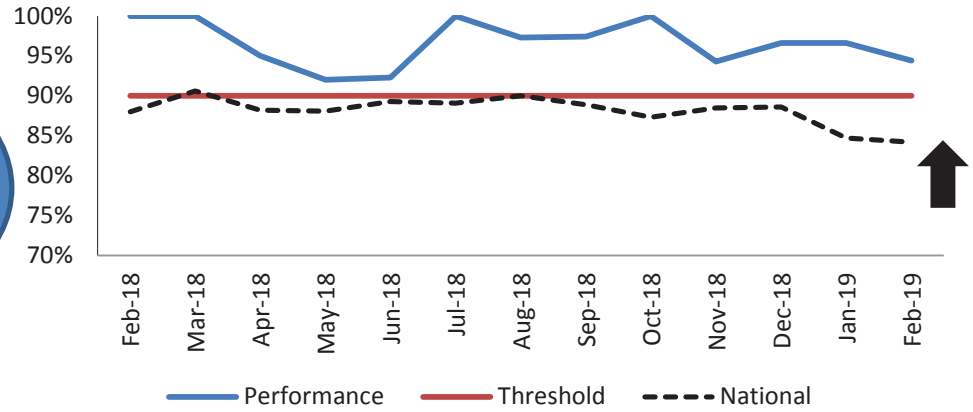


62 day performance was achieved in February at 87.3%, above the 85% threshold.

Quarter 3 performance was below threshold at 82.0%

National performance has been consistently below the standard.

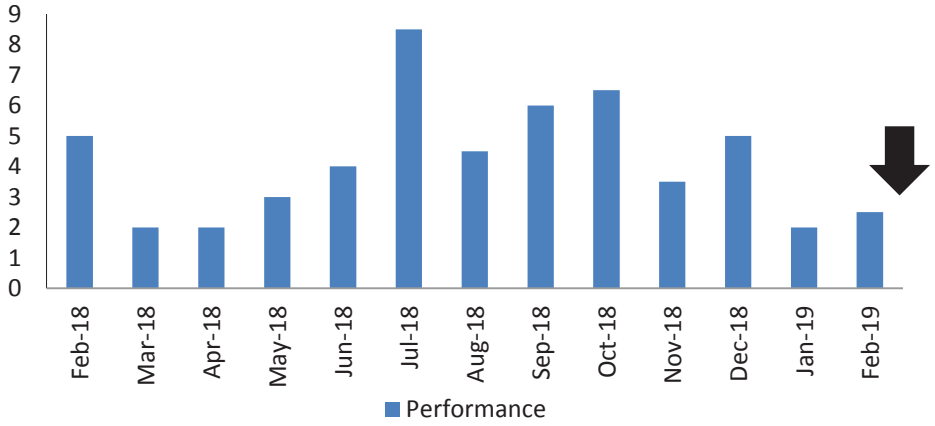
62 Day Screening



The 62 day screening standard continued to be achieved in February at 94.4%

Quarter 3 was also acheived at 97.3%

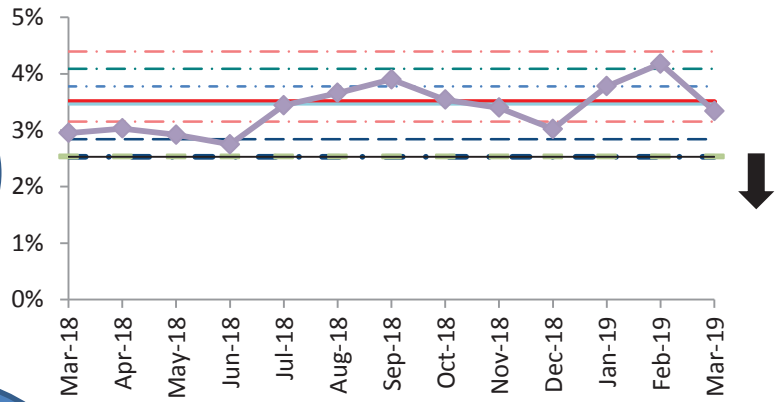
Cancer Patients Treated > Day 104



There were 2.5 breaches allocated to the Trust, treated after day 104 in February 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

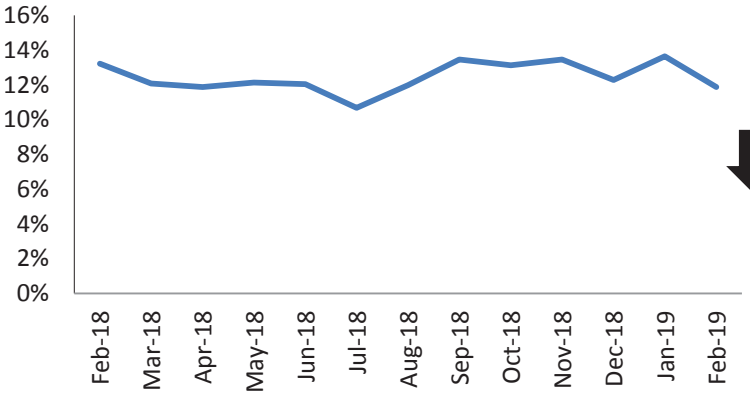


The proportion of delays reported against the delayed transfers of care standard has reduced during March to 3.34% which is below the threshold of 3.5%.

This equates to an average of 27 beds lost per day in March. The top three reasons for the bed days lost due to delayed discharge are; 'Awaiting completion of assessment' (39%), 'Patient or family choice' (18%), 'Awaiting domicilliary package of care' (19%), The achievement of this target is multi-factorial, linked to complex discharge processes involving ELHT and partners.

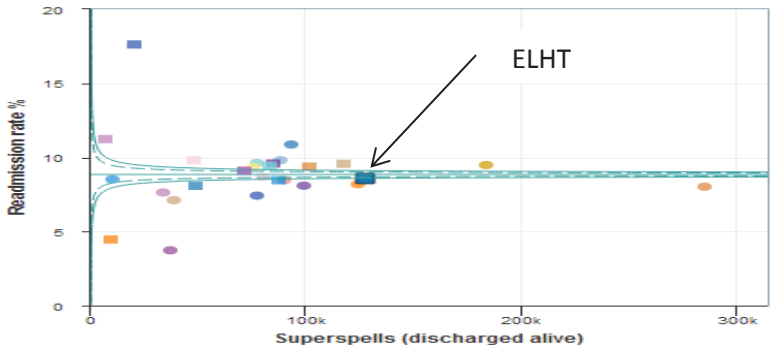
There is a full action plan which is monitored through the Finance & Performance Committee.

Emergency Readmissions

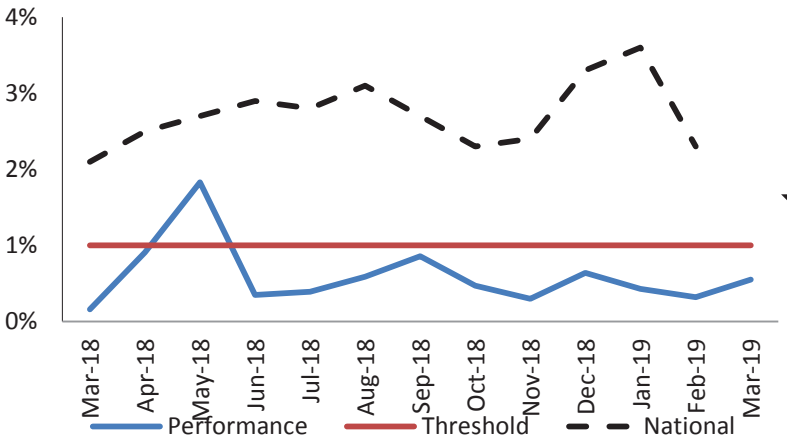


The emergency readmission rate has reduced to 11.3% in February 2019 (reported 1 month behind) compared to 13.2% in February 2018. Dr Foster benchmarking shows the ELHT readmission rate is below the North West average.

Readmissions within 30 days vs North West - Dr Foster
July 2017 - June 2018



Diagnostic Waits



In March 0.6% 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 February (reported 1 month behind), compared with 3.6% in January.

RESPONSIVE

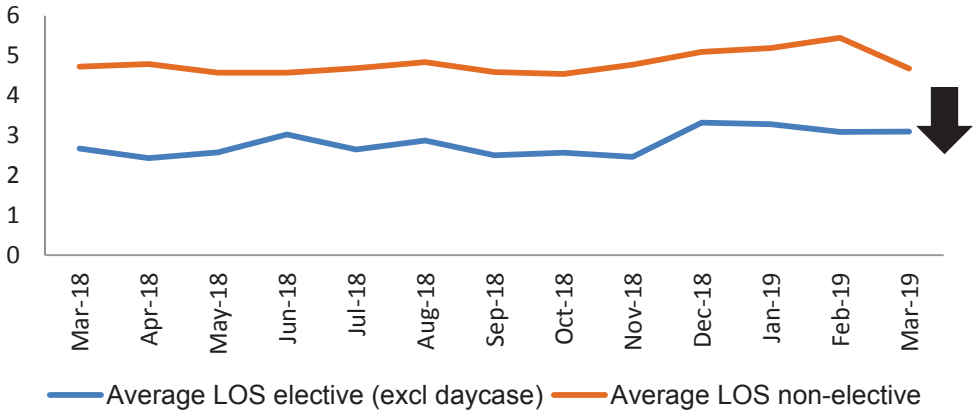
Average Length of Stay Benchmarking

Dr Foster Benchmarking December 17 - November 18

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	61,712	9,464	52,248	3.4	2.6	-0.8
Emergency	55,898	55,898	0	4.6	4.7	0.0
Maternity/ Birth	13,363	13,363	0	2.1	2.4	0.2
Transfer	204	204	0	10.9	26.7	15.7

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

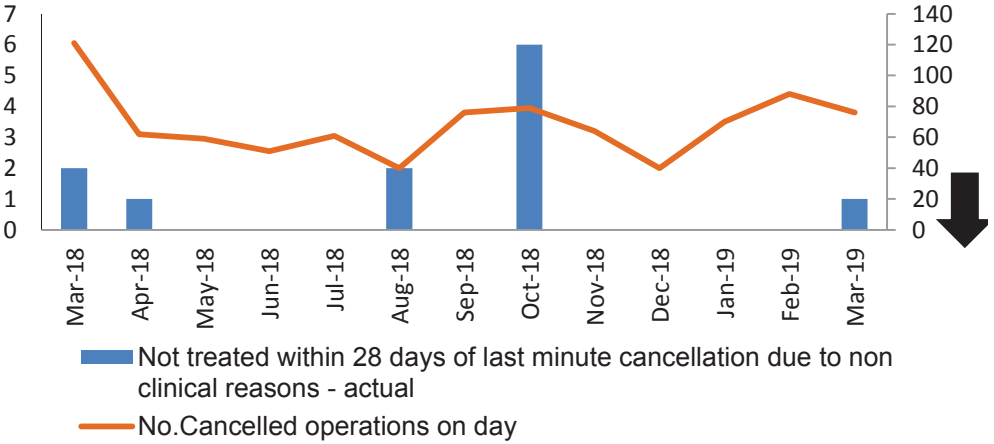
Average Length of Stay



The Trust non elective average length of stay decreased to 4.7 days in March, compared to 5.4 in February.

The elective length of stay (excluding day case) has remained at 3.1 days in March, however remains higher than March 18 (2.7)

Operations cancelled on day - 28 day standard

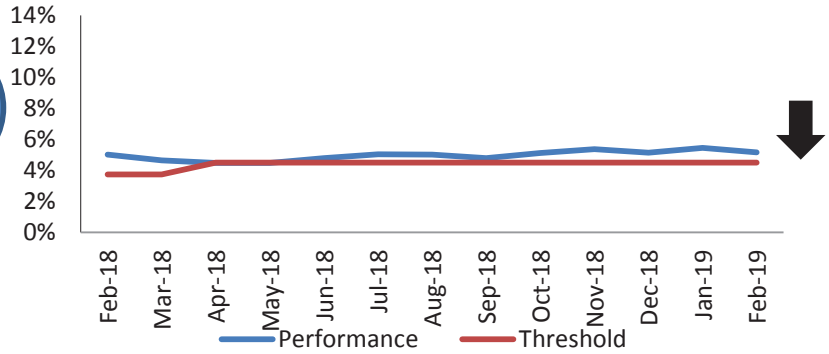


There were 76 operations cancelled on the day of operation - non clinical reasons, in March. There was one 'on the day' cancelled operation not rebooked within 28 days in March.

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

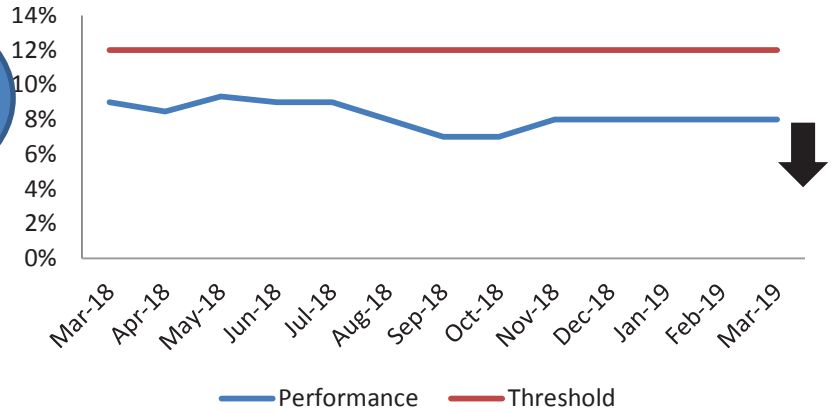


The sickness absence rate has decreased from 5.45% in January to 5.16% in February 2019. The current rate is higher than the previous year and still above threshold.

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

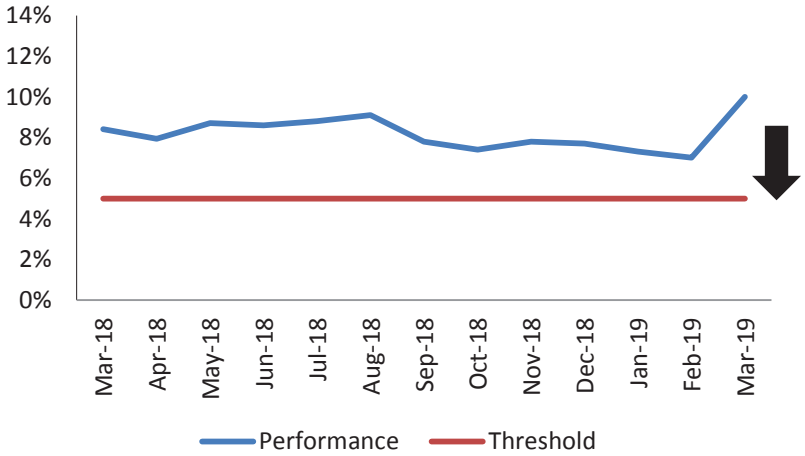


The trust turnover rate has remained at 8% in March and the vacancy rate has increased to 10.0% in March from 7.0% in February.

Overall the Trust is now employing 7459 FTE staff in total. This is a net decrease of 25 FTE from the previous month. The number of nurses in post at March 2019 stood at 2280 FTE which is 38 lower than last month and a net increase of 231 FTE since 1st April 2013.

As at 2nd April 2019 there are 113 external/R&R nurses in the recruitment pipeline, scheduled to start between now and March 2020 and 24 changing posts internally. These figures include 3 overseas nurse through the HEE Global Learners Programme (GLP) who is predicted to start with the trust before June. This, together with the 13 already in post, will bring the total to 16 arrived in trust

Vacancy Rate



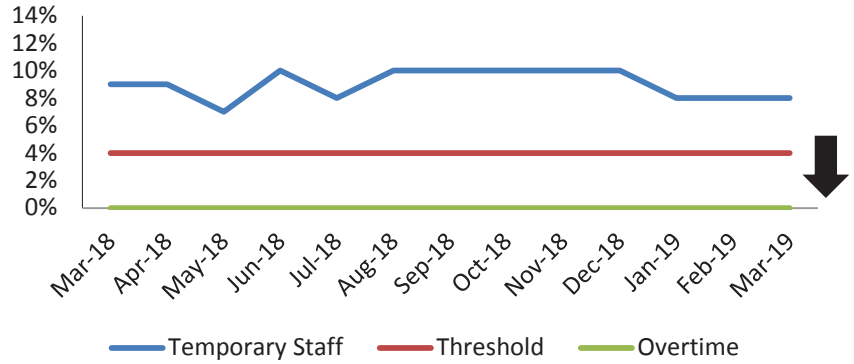
The vacancy rate for nurses now stands at 17.6% (486 FTE)

As of April 2019 there are 107 FTE Medical Posts vacant of which 42 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 10.1% (66 FTE).

WELL LED

Temporary costs and overtime as % total pay

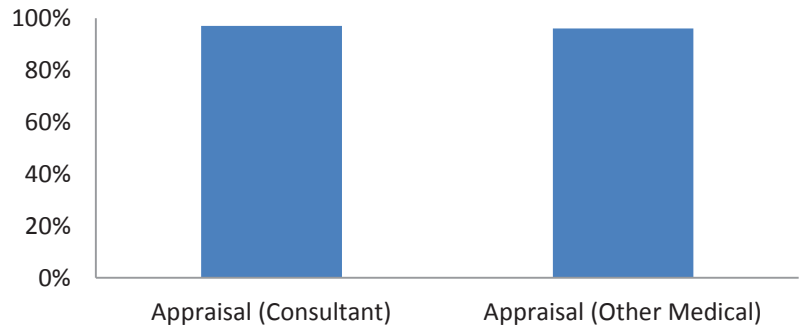


In 2017/18 East Lancashire Hospitals NHS Trust spent £27.4m on temporary staffing for the year. (£12,832,971 agency; £14,626,488 bank).

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 April to March 2019 £32 million was spent on temporary staff. £13.2 million expenditure on agency staff and £18.8 million expenditure on bank staff. Wte staff worked (8,262 wte) was 69 wte less than is funded substantively (8,331 wte). Pay costs are £480k more than budgeted establishment in March.

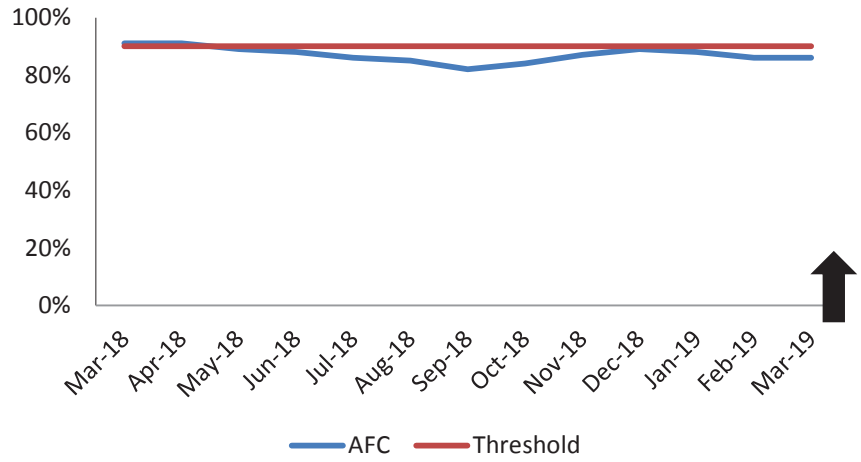
Appraisals, Consultant & Other Medical



At the end of March 19 there were 832 vacancies

The appraisal rates for consultants and career grade doctors are reported cumulative year to date, April – March 2019 and reflect the number of reviews completed that were due in this period. The consultant and medical staff appraisal rates are above threshold at 97% and 96% respectively.

Appraisals AFC



The AFC appraisal rate continues to be reported as a rolling 12 month figure and remains below threshold at 86% in March.

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

WELL LED

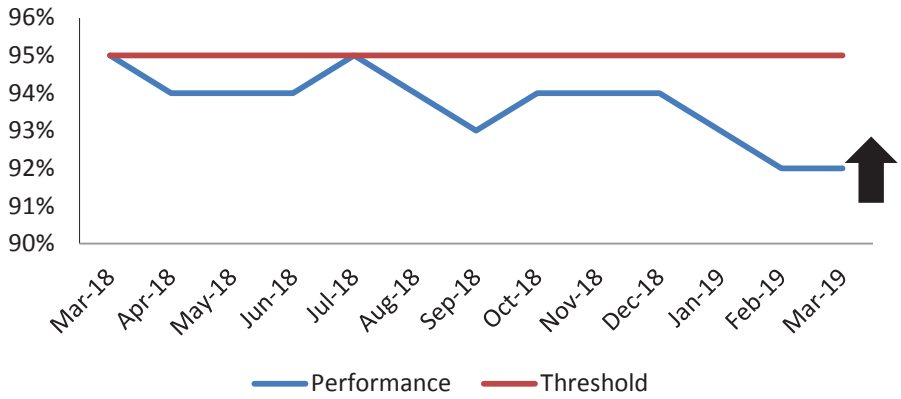
Job Plans

Stage	Consultant	SAS Doctor
With consultant to review	1	
In discussion with 1st stage manager	229	26
1st stage sign off by consultant	10	
1st stage sign off by manager	23	1
2nd stage sign off	22	
Signed Off	4	

There are 289 Consultants and 27 SAS doctors registered with a job plan on Allocate.

The 2019 planning round has been opened since January to be completed by 31 March.

Information Governance Toolkit



Information governance toolkit compliance has remained at 92% in March below the 95% threshold.

Core Skills Training % Compliance

	Target	Compliance at end March
Basic Life Support	90%	92%
Conflict Resolution Training Level 1	90%	97%
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%	92%
Prevent Healthwrap	90%	96%
Safeguarding Adults	90%	97%
Safeguarding Children	90%	96%
Safer Handling Theory	90%	97%

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%

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

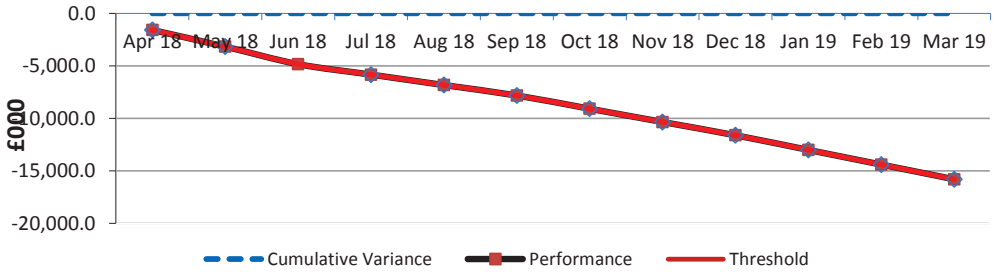
Divisional actions plans to address non-compliance are in place and are being monitored through divisional meetings. Furthermore, a range of Trust-wide measures to support staff to be fully compliant are in place. These include facilitated e-Learning sessions, bespoke training for wards and departments,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

WELL LED

Finance & Use of Resource metrics

Area	Metric	Actual YTD Performance	Actual YTD Score	Forecast outturn Performance	Forecast outturn Score
Financial sustainability	Capital service capacity	0.7	4	0.7	4
	Liquidity (days)	(9.3)	3	(11.7)	3
Financial efficiency	I&E margin	(2.0%)	4	(2.0%)	4
Financial control	Distance from financial plan	(0.4%)	2	(0.4%)	2
	Agency spend	39.9%	3	42.0%	3
Total			3		3

Adjusted financial performance



* - excludes PSF allocation

The Trust is reporting that it has met the 2018-19 financial plan and is reporting an underlying £15.8 million deficit; and a £10.2 million deficit after receipt of the Provider Sustainability Funding (PSF) monies.

70% of the available PSF has been achieved relating to the achievement of the financial plan; £5.6 million of an available £8.0 million.

While we have seen higher than planned expenditure pressures during the financial year, we have achieved the full £18.0 million Safely Releasing Cost Programme (SRCP) for 2018-19. £8.8 million has been achieved recurrently and £9.2 million non-recurrently.

The Better Payment Practice Code (BPPC) targets have been achieved.

The 'Finance and use of resources metrics score' remains at 3 for the financial year.

The cash balance as at the 31st March 2019 was £12.1 million.

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	4,380	0	0	4,380	(1,226)	139%	1,136	3,244	4,380
SAS	3,720	2,845	0	0	2,845	875	76%	1,903	942	2,845
Family Care	2,423	1,699	0	0	1,699	724	70%	1,299	400	1,699
DCS	1,103	2,528	0	0	2,528	(1,425)	229%	1	2,527	2,528
Estates & Facilities	1,440	1,454	0	0	1,454	(14)	101%	594	860	1,454
Corporate Services	536	1,190	0	0	1,190	(654)	222%	817	373	1,190
Cross divisional	0	0	0	0	0	0		0	0	0
Targetted Transformation	5,624	3,877	0	0	3,877	1,747	69%	3,459	417	3,877
Total	**18,000**	**17,973**	**0**	**0**	**17,973**	**27**		9,209	8,763	17,973

APPENDIX 1

Safe		Threshold 18/19	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Monthly Sparkline
M64	CDIFF	27	5	2	3	4	1	5	1	3	2	0	2	2	1	
M64.1	Cdiff Cumulative from April	27	37	2	5	9	10	15	16	19	21	21	23	25	26	
M65	MRSA	0	0	0	0	1	0	0	0	0	0	0	0	0	0	
M124	E-Coli (post 2 days)	48	3	5	5	2	6	8	4	7	6	7	3	7	6	
M154	P. aeruginosa bacteraemia (total pre 2 days)		2	1	1	1	1	1	3	2	1	2	1	1	0	
M155	P. aeruginosa bacteraemia (total post 2 days)	4	1	2	0	0	0	1	1	1	0	1	0	1	1	
M156	Klebsiella species bacteraemia (total pre 2 days)		5	8	10	4	2	3	7	5	5	4	7	6	3	
M157	Klebsiella species bacteraemia (total post 2 days)	16	3	1	2	1	2	4	3	2	1	4	3	0	0	
M66	Never Event Incidence	0	1	1	0	0	0	0	0	0	0	1	0	0	0	
M67	Medication errors causing serious harm (Steis reported date)	0	0	0	0	0	0	0	0	0	0	0	0	0	1	
C28	Percentage of Harm Free Care	92%	99.6%	99.3%	99.2%	99.6%	98.9%	98.9%	99.6%	98.8%	99.3%	98.7%	99.0%	99.4%	99.1%	
M68	Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	99.2%	99.4%	99.5%	99.3%	99.4%	99.5%	98.8%	99.2%	99.1%	99.1%	99.3%	99.2%		
M69	Serious Incidents (Steis)		6	9	8	10	6	9	6	10	9	4	13	7	19	
M70	CAS Alerts - non compliance	0	0	2	0	0	0	0	0	0	0	0	0	0	0	
M146	Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80%	88%	91%	91%	91%	89%	89%	90%	91%	92%	89%	91%	90%	90%	
M147	Safer Staffing -Day-Average fill rate - care staff (%)	80%	103%	106%	104%	104%	99%	102%	102%	104%	104%	101%	104%	102%	103%	
M148	Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80%	97%	99%	101%	99%	98%	97%	100%	97%	101%	99%	98%	98%	98%	

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

Caring

		Threshold 18/19	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Monthly Sparkline
C38	Inpatient Friends and Family - % who would recommend	90%	97.9%	98.5%	96.8%	98.7%	96.6%	95.6%	91.2%	95.5%	97.1%	97.1%	96.9%	97.9%	98.3%	
C31	NHS England Inpatients response rate from Friends and Family Test		47.8%	49.3%	36.2%	41.5%	48.6%	50.5%	47.9%	54.2%	47.3%	43.3%	46.3%	44.7%	45.4%	
C40	Maternity Friends and Family - % who would recommend	90%	97.7%	96.8%	96.3%	95.9%	96.2%	97.6%	94.3%	98.4%	96.3%	97.4%	96.8%	97.0%	94.0%	
C42	A&E Friends and Family - % who would recommend	90%	82.1%	84.1%	80.5%	82.3%	81.1%	82.7%	83.9%	84.3%	85.1%	82.8%	84.4%	86.1%	86.4%	
C32	NHS England A&E response rate from Friends and Family Test		22.4%	23.1%	17.1%	20.8%	19.7%	20.0%	22.9%	20.6%	20.2%	19.9%	19.7%	20.3%	19.2%	
C44	Community Friends and Family - % who would recommend	90%	95.6%	97.0%	87.1%	91.7%	95.5%	95.6%	96.0%	96.3%	96.7%	96.5%	96.5%	96.2%	97.6%	
C15	Complaints – rate per 1000 contacts	0.4	0.2	0.2	0.2	0.3	0.2	0.3	0.3	0.3	0.1	0.1	0.2	0.2	0.3	
M52	Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Effective

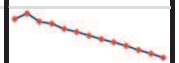
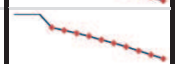
		Threshold 18/19	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Monthly Sparkline
M73	Deaths in Low Risk Categories - relative risk	Outlier	43.5	51.6	52.0	57.6	61.9	52.6	62.9	67.2	76.3	90.7				
M74	Hospital Standardised Mortality Ratio - Weekday (DFI Indicative)	Outlier	89.8	92.2	91.7	91.1	90.6	91.1	93.0	94.7	94.4	92.6				
M75	Hospital Standardised Mortality Ratio - Weekend (DFI Indicative)	Outlier	91.1	90.3	90.5	91.2	95.8	96.6	95.5	94.4	95.2	95.5				
M54	Hospital Standardised Mortality Ratio (DFI Indicative)	Outlier	90.2	91.7	91.4	91.1	91.9	92.5	93.7	94.6	94.6	93.3				
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Outlier	1.06			1.06			1.07							
M159	Stillbirths	<5	4	3	1	4	2	2	3	3	3	1	0	2	1	
M160	Stillbirths - Improvements in care that impacted on the outcome		1													
M89	CQUIN schemes at risk	0														

Responsive

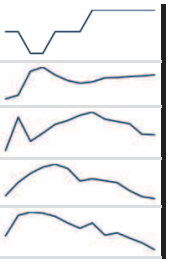
		Threshold 18/19	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Monthly Sparkline
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95%	78.9%	84.0%	85.3%	85.6%	82.5%	76.1%	79.8%	83.5%	79.5%	80.0%	76.5%	78.3%	79.9%	
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95%	80.1%	84.9%	86.1%	86.6%	83.8%	77.8%	81.2%	84.6%	80.7%	81.0%	77.8%	79.5%	81.0%	
M62	12 hour trolley waits in A&E	0	23	9	3	34	37	36	20	30	22	18	16	14	23	
M81	HAS Compliance	90%	92.79%	94.53%	93.79%	89.57%	93.26%	92.66%	91.49%	92.88%	95.13%	94.91%	93.07%	93.79%	93.80%	
M82	Handovers > 30 mins ALL	0	1008	652	685	497	568	665	654	586	517	410	604	583	540	
M82.6	Handovers > 30 mins ALL (NWAS Confirmed Penalty)	0	589	334	426	399	305	340	349	296	300	241	342			
C1	RTT admitted: percentage within 18 weeks	N/A	73.1%	69.7%	71.9%	71.6%	73.0%	72.9%	71.9%	72.9%	67.6%	76.2%	64.6%	64.9%	64.2%	
C3	RTT non- admitted pathways: percentage within 18 weeks	N/A	92.1%	90.6%	93.5%	93.2%	92.4%	90.9%	89.5%	89.3%	89.6%	90.8%	89.9%	89.5%	89.8%	
C4	RTT waiting times Incomplete pathways %	92%	92.1%	92.8%	93.3%	93.0%	92.5%	92.2%	92.1%	92.1%	92.6%	92.0%	91.5%	91.7%	91.4%	

C4.1	RTT waiting times Incomplete pathways Total	<25,920	24,124	23,754	24,320	24,418	25,086	26,690	26,986	26,858	26,728	26,677	26,502	30,144	30,898	
C4.2	RTT waiting times Incomplete pathways -over 40 wks		34	25	25	25	9	19	15	12	10	23	29	29	32	
C37.1	RTT 52 Weeks (Ongoing)	0	0	0	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%	0.9%	1.8%	0.4%	0.4%	0.6%	0.9%	0.5%	0.3%	0.6%	0.4%	0.3%	0.6%	
C18	Cancer - Treatment within 62 days of referral from GP	85%	82.1%	91.9%	88.4%	82.6%	76.7%	82.4%	76.5%	81.0%	85.7%	78.5%	82.9%	87.3%		
C19	Cancer - Treatment within 62 days of referral from screening	90%	100.0%	95.0%	92.0%	92.3%	100.0%	97.3%	97.4%	100.0%	94.3%	96.6%	96.6%	94.4%		
C20	Cancer - Treatment within 31 days of decision to treat	96%	97.5%	97.5%	98.7%	97.6%	98.2%	99.5%	96.1%	98.6%	98.7%	98.3%	97.0%	98.5%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94%	96.0%	89.2%	97.5%	92.7%	91.4%	96.0%	92.2%	87.0%	95.7%	94.7%	89.8%	95.7%		
C24	Cancer - seen within 14 days of urgent GP referral	93%	95.1%	93.3%	93.2%	91.1%	93.7%	94.6%	93.4%	94.1%	95.5%	95.9%	94.9%	95.3%		
C25	Cancer - breast symptoms seen within 14 days of GP referral	93%	90.0%	92.0%	92.3%	85.4%	93.4%	86.8%	94.4%	93.7%	91.6%	91.1%	90.3%	93.6%		
C36	Cancer 62 Day Consultant Upgrade	85%	92.3%	90.0%	90.4%	96.3%	90.0%	90.0%	89.3%	97.4%	91.7%	89.0%	87.8%	90.4%		
C25.1	Cancer - Patients treated > day 104		2	2	3	4	9	5	6	7	4	5	2	3		
M9	Urgent operations cancelled for 2nd time	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	2	1	0	0	0	2	0	6	0	0	0	0	1	
M138	No.Cancelled operations on day		121	62	59	51	61	40	76	79	64	40	70	88	76	
M55	Proportion of delayed discharges attributable to the NHS	3.5%	3.0%	3.0%	2.9%	2.8%	3.4%	3.7%	3.9%	3.5%	3.4%	3.0%	3.8%	4.2%	3.3%	
C16	Emergency re-admissions within 30 days		12.1%	11.9%	12.1%	12.0%	10.7%	12.0%	13.5%	13.1%	13.5%	12.3%	13.6%	11.9%	12.2%	
M90	Average LOS elective (excl daycase)		2.7	2.4	2.6	3.0	2.6	2.9	2.5	2.6	2.5	3.3	3.3	3.1	3.1	
M91	Average LOS non-elective		4.7	4.8	4.6	4.6	4.7	4.8	4.6	4.5	4.8	5.1	5.2	5.4	4.7	

Well led

		Threshold 18/19	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Monthly Sparkline
M77	Trust turnover rate	12%	9.0%	8.5%	9.3%	9.0%	9.0%	8.0%	7.0%	7.0%	8.0%	8.0%	8.0%	8.0%	8.0%	
M78	Trust level total sickness rate	4.5%	4.6%	4.5%	4.5%	4.8%	5.1%	5.0%	4.8%	5.1%	5.4%	5.1%	5.5%	5.2%		
M79	Total Trust vacancy rate	5%	8.4%	7.9%	8.7%	8.6%	8.8%	9.1%	7.8%	7.4%	7.8%	7.7%	7.3%	7.0%	10.0%	
M80.3	Appraisal (AFC)	90%	91.0%	91.0%	89.0%	88.0%	86.0%	85.0%	82.0%	84.0%	87.0%	89.0%	88.0%	86.0%	86.0%	
M80.3!	Appraisal (Consultant)	90%	97.0%	97.0%	97.0%	97.0%	97.0%	90.0%	95.0%	96.0%	95.0%	94.0%	96.0%	96.0%	97.0%	
M80.4	Appraisal (Other Medical)	90%	98.0%	98.0%	98.0%	98.0%	98.0%	85.0%	94.0%	92.0%	96.0%	94.0%	94.0%	93.0%	96.0%	
M80.2	Safeguarding Children	90%	96.0%	96.0%	96.0%	96.0%	97.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	
M80.2:	Information Governance Toolkit Compliance	95%	95.0%	94.0%	94.0%	94.0%	95.0%	94.0%	93.0%	94.0%	94.0%	94.0%	93.0%	92.0%	92.0%	
F8	Temporary costs as % of total paybill	4%	9%	9%	7%	10%	8%	10%	10%	10%	10%	10%	8%	8%	8%	
F9	Overtime as % of total paybill	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
F1	Adjusted financial performance (deficit) including PSF (£M)	(7.7)	(2.7)	(1.6)	(3.2)	(3.6)	(4.6)	(5.2)	(5.9)	(6.6)	(7.2)	(7.9)	(8.7)	(9.4)	(10.2)	
F1.1	Adjusted financial performance (deficit) excluding PSF (£M)	(15.8)				(4.8)	(5.8)	(6.8)	(7.8)	(9.1)	(10.3)	(11.6)	(13.0)	(14.4)	(15.8)	
F2	SRCP Achieved % (green schemes only)	100.0%	107%	8%	17%	18%	29%	32%	50%	52%	55%	64%	69%	79%	100%	
F3	Liquidity days	>(14.0)	(10.5)	(5.4)	(9.4)	(5.7)	(8.4)	(10.0)	(9.3)	(10.2)	(11.4)	(12.2)	(9.4)	(9.3)	(11.0)	
F4	Capital spend v plan	85%	95%	38%	81%	67%	61%	80%	82%	81%	77%	83%	85%	83%	100%	
F16	Finance & Use of Resources (UoR) metric - overall	3	3	3	3	2	3	3	3	3	3	3	3	3	3	
F17	Finance and UoR metric - liquidity	4	3	4	4	2	3	3	3	3	3	3	3	3	3	
F18	Finance and UoR metric - capital service capacity	4	3	2	3	4	4	4	4	4	4	4	4	4	4	
F19	Finance and UoR metric - I&E margin	4	3	4	4	4	4	4	4	4	4	4	4	4	4	
F20	Finance and UoR metric - distance from financial plan	4	2	4	1	1	2	2	2	2	2	2	2	2	2	

F21 Finance and UoR metric - agency spend	1	2	2	1	1	2	2	2	3	3	3	3	3	3
F12 BPPC Non NHS No of Invoices	95%	95.0%	95.2%	96.3%	96.5%	96.2%	95.9%	95.7%	95.8%	96.0%	96.0%	96.1%	96.1%	96.1%
F13 BPPC Non NHS Value of Invoices	95%	95.1%	96.9%	95.6%	96.1%	96.5%	96.7%	97.0%	97.2%	96.8%	96.7%	96.6%	96.0%	96.0%
F14 BPPC NHS No of Invoices	95%	95.6%	96.6%	97.3%	97.8%	98.1%	97.7%	96.7%	96.9%	96.8%	96.6%	96.0%	95.5%	95.3%
F15 BPPC NHS Value of Invoices	95%	98.2%	99.3%	99.5%	99.4%	99.3%	98.9%	98.6%	98.9%	98.2%	98.4%	98.1%	97.8%	97.4%



Ward Staff Summary - Mar 2019

Executed on: 26/04/2019 at: 1:49:30 PM

Division: All 3 Available Divisions Selected
Directorate: All 17 Available Directorates Selected
Site: All 4 Available Hospital Sites Selected
This report is based on the 44 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	1,302	1,158	79.03%	744	720	119.89%	744	744	100.00%	372	624	145.16%	0	0	0	0	0	0	5.84	24.38%	13.00	2.40%
	5143	Ward C18A	1,302	1,206	79.03%	744	870	119.89%	744	744	100.00%	372	864	145.16%	0	0	0	0	0	0	-0.93	-3.86%	6.00	0.82%
	5144	Surgical Triage Unit	1,860	1,788	79.03%	1,488	1,428	119.89%	1,302	1,302	100.00%	1,116	1,152	145.16%	0	0	0	0	0	0	-4.41	-15.28%	71.24	7.25%
	5145	Ward C14B	1,302	1,158	79.03%	744	846	119.89%	744	744	100.00%	372	708	145.16%	0	0	0	0	0	0	5.48	22.88%	30.40	5.54%
	5146	Ward C18B	1,302	1,158	79.03%	744	846	119.89%	744	744	100.00%	372	552	145.16%	0	0	0	0	0	0	3.72	15.31%	17.00	2.75%
EC03: Urology																								
RBH	5128	Ward C22	2,232	2,154	79.03%	1,488	1,824	119.89%	1,116	1,212	100.00%	1,488	1,632	145.16%	0	0	0	0	0	0	1.76	5.85%	47.00	5.83%
EC04: Orthopaedic Services																								
BGH	4393	Ward 15	1,224	1,182	79.03%	936	918	119.89%	744	744	100.00%	612	684	145.16%	0	0	0	0	0	0	4.94	14.14%	44.79	4.82%
RBH	5366	Ward B24	1,488	1,266	79.03%	1,116	1,266	119.89%	744	744	100.00%	744	996	145.16%	0	0	0	0	0	0	3.75	12.10%	30.60	3.74%
	5367	Ward B22	1,488	1,248	79.03%	2,232	2,166	119.89%	744	744	100.00%	1,860	1,884	145.16%	0	0	0	1	0	0	3.47	7.44%	97.16	7.19%
EC05: Head & Neck																								
RBH	5119	Ward B20 Max Fac	1,488	1,224	79.03%	744	846	119.89%	744	744	100.00%	744	804	145.16%	0	0	0	0	0	0	4.01	14.57%	81.20	11.17%
EC09: Anaesth & Critical Care																								
RBH	5362	Elht Critical Care	6,900	6,834	79.03%	1,032	810	119.89%	6,702	6,594	100.00%	360	324	145.16%	1	2	0	0	0	0	24.84	18.47%	166.83	4.86%
ED: Family Care																								
ED07: General Paediatrics																								
RBH	5210	Inpatient	4,650	4,516	79.03%	1,116	1,050	119.89%	3,580.50	3,402	100.00%	336	325.50	145.16%	0	0	0	0	0	0	-0.98	-3.36%	38.92	4.30%
ED08: Gynae Nursing																								
BGH	4169	Gynae And Breast Care Ward	1,056	1,027.50	79.03%	558	564	119.89%	787.50	744.50	100.00%	325.50	332	145.16%	0	0	0	0	0	0	2.00	6.96%	72.92	8.77%
ED09: Obstetrics																								
BGH	4165	Birth Suite	4,092	3,996.13	79.03%	744	799.40	119.89%	4,092	4,032	100.00%	744	766	145.16%	0	0	0	0	0	0	-2.65	-3.65%	30.28	1.29%
	4192	Burnley Birth Centre	1,395	1,314.50	79.03%	372	378	119.89%	1,116	1,056	100.00%	372	372	145.16%	0	0	0	0	0	0	0.74	1.66%	10.40	0.76%
	4200	Antenatal Ward 12	1,656	1,622	79.03%	912	912	119.89%	1,116	1,080	100.00%	744	696	145.16%	0	0	0	0	0	0	-1.32	-4.01%	77.32	7.44%
	4203	Postnatal Ward 10	2,400	2,424	79.03%	1,116	1,152	119.89%	2,232	2,196	100.00%	1,488	1,368	145.16%	0	0	0	0	0	0	-6.01	-11.23%	146.40	7.85%
RBH	5256	Blackburn Birth Centre	930	954.75	79.03%	489	410	119.89%	666.50	666.50	100.00%	333.25	333.25	145.16%	0	0	0	0	0	0	6.79	14.32%	32.40	2.61%
ED11: Neonates																								
RBH	4215	Nicu	4,836	4,638	79.03%	372	384	119.89%	4,464	3,924	100.00%	0	180	-	0	0	0	0	0	0	-3.46	-4.33%	109.24	4.22%
EH: Integrated Care Group																								
EH05: Business Support Unit																								
RBH	6078	Ward C3	1,674	1,572	79.03%	1,488	1,596	119.89%	1,116	1,140	100.00%	1,116	1,500	145.16%	0	0	0	0	2	0	21.10	49.18%	11.24	1.56%

Ward Staff Summary - Mar 2019

Executed on: 26/04/2019 at: 1:49:30 PM

Division: All 3 Available Divisions Selected
Directorate: All 17 Available Directorates Selected
Site: All 4 Available Hospital Sites Selected
This report is based on the 44 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	3,720	3,612	79.03%	2,232	2,556	119.89%	3,348	3,240	100.00%	1,488	1,824	145.16%	0	0	0	0	0	0	13.71	16.66%	19.68	0.92%
	6092	AMU B	3,348	3,204	79.03%	2,232	2,196	119.89%	2,976	2,976	100.00%	1,860	1,836	145.16%	0	0	0	0	0	0	9.68	11.87%	106.36	4.88%
EH20: Respiratory																								
RBH	5063	Ward C6	1,488	1,212	79.03%	1,116	1,104	119.89%	1,116	1,104	100.00%	744	732	145.16%	0	0	0	0	0	0	3.54	10.73%	81.84	9.21%
	5064	Ward C8	1,860	1,584	79.03%	1,488	1,488	119.89%	1,116	1,116	100.00%	744	768	145.16%	1	0	0	0	0	0	5.88	15.34%	29.72	3.03%
	6027	Ward C7	1,488	1,272	79.03%	1,116	1,176	119.89%	744	804	100.00%	744	1,044	145.16%	0	0	0	0	0	0	3.12	10.39%	140.24	17.23%
EH25: Cardiology																								
RBH	5095	Coronary Care	1,488	1,260	79.03%	744	696	119.89%	1,116	1,116	100.00%	0	0	-	0	0	0	0	0	0	2.50	10.25%	26.36	3.88%
	5097	Ward B18	1,800	1,542	79.03%	1,116	1,194	119.89%	1,116	1,104	100.00%	744	1,020	145.16%	0	0	0	0	0	0	-0.36	-1.07%	45.96	4.34%
EH30: Gastroenterlogy																								
RBH	5050	Ward C2	1,488	1,212	79.03%	1,116	1,164	119.89%	1,116	1,092	100.00%	1,116	1,140	145.16%	0	0	0	0	0	0	11.68	32.77%	92.00	11.90%
	5062	Ward C4	1,488	1,182	79.03%	1,116	1,248	119.89%	1,116	1,116	100.00%	1,116	1,152	145.16%	0	0	0	0	0	0	8.44	23.69%	128.19	15.84%
	6103	Ward C11	1,488	1,194	79.03%	1,488	1,536	119.89%	744	744	100.00%	1,116	1,200	145.16%	0	0	0	2	0	0	8.19	22.68%	51.21	5.92%
	6106	C1 (Gastro)	1,860	1,656	79.03%	1,116	1,080	119.89%	744	744	100.00%	372	504	145.16%	0	0	0	0	0	0	13.87	42.03%	45.12	7.30%
EH35: Mfop & Complex Needs																								
BGH	4613	Rakehead Nursing Staff	1,116	852	79.03%	1,860	1,944	119.89%	744	744	100.00%	744	1,140	145.16%	0	0	0	0	0	0	2.46	7.46%	72.10	7.62%
	6094	Ward 16 Sept 13	1,860	1,518	79.03%	1,488	1,950	119.89%	744	744	100.00%	1,488	1,836	145.16%	0	0	0	0	0	0	4.19	10.17%	192.88	16.77%
PCH	4581	Marsden Ward	1,488	1,188	79.03%	1,860	1,890	119.89%	744	744	100.00%	744	1,116	145.16%	0	0	0	0	0	0	13.61	29.35%	7.64	0.75%
	4582	Reedyford Ward	1,488	1,140	79.03%	1,116	1,134	119.89%	744	744	100.00%	744	744	145.16%	1	0	0	0	0	0	3.07	10.50%	35.00	4.33%
	4583	Hartley Ward	1,488	1,182	79.03%	1,116	1,158	119.89%	744	744	100.00%	744	1,044	145.16%	0	0	0	0	0	0	19.21	43.44%	48.14	6.21%
RBH	5023	Ward D1	1,488	1,194	79.03%	1,116	1,152	119.89%	744	768	100.00%	744	876	145.16%	0	0	0	0	0	0	6.26	20.29%	94.64	13.13%
	5036	Acute Stroke Unit (B2)	1,860	1,590	79.03%	1,488	1,476	119.89%	1,116	1,116	100.00%	1,116	1,104	145.16%	0	0	0	0	0	0	25.80	39.72%	40.88	3.44%
	5037	Ward B4	1,488	1,260	79.03%	2,232	2,082	119.89%	744	744	100.00%	1,488	1,440	145.16%	0	0	0	0	0	0	17.98	32.87%	131.60	11.56%
	5048	Ward C10	1,488	1,266	79.03%	1,488	1,440	119.89%	744	744	100.00%	1,116	1,116	145.16%	0	0	0	0	0	0	4.34	11.75%	58.00	6.03%
	6096	Ward C5	1,116	846	79.03%	1,488	1,500	119.89%	744	744	100.00%	1,116	1,188	145.16%	0	0	0	0	0	0	3.73	11.26%	32.20	3.58%
	6105	Ward C9	1,488	1,182	79.03%	1,488	1,512	119.89%	744	756	100.00%	1,116	1,092	145.16%	0	0	0	0	0	0	3.32	9.27%	33.00	3.33%
EH44: Speciality Medicine																								
RBH	5040	Ward D3	1,488	1,176	79.03%	1,116	1,170	119.89%	744	744	100.00%	744	936	145.16%	0	0	0	0	0	0	2.40	8.14%	56.72	6.92%
EH70: Comm In Patient Care																								
CLI	R141	Ribblesdale Ward	1,860	1,602	79.03%	1,488	1,530	119.89%	1,116	1,116	100.00%	1,488	1,716	145.16%	0	0	0	1	0	0	3.00	6.83%	164.69	13.07%
Total for 44 wards shown					**90.16%**			**103.29%**			**98.33%**			**114.36%**	**3**	**2**	**0**	**4**	**2**	**0**	**258.30**	**13.97%**	**2,868.51**	**5.87%**

Safe Staffing (Rota Fill Rates and CHPPD) Collection

Organisation : RXR East Lancashire Hospitals Trust
Month : Mar-19

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		-	-	-	-	-	-	-	-	0.0%	0.0%	0.0%	0.0%	0	#DIV/0!	#DIV/0!	#DIV/0!
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Acute Stroke Unit (ASU)	300 - GENERAL MEDICINE		1,860	1,590	1,488	1,476	1,116	1,116	1,116	1,104	85.5%	99.2%	100.0%	98.9%	707	3.83	3.65	7.48
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B18	320 - CARDIOLOGY		1,800	1,542	1,116	1,194	1,116	1,104	744	1,020	85.7%	107.0%	98.9%	137.1%	769	3.44	2.88	6.32
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B20	100 - GENERAL SURGERY		1,488	1,224	744	846	744	744	744	804	82.3%	113.7%	100.0%	108.1%	516	3.81	3.20	7.01
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B22	110 - TRAUMA & ORTHOPAEDICS		1,488	1,248	2,232	2,166	744	744	1,860	1,884	83.9%	97.0%	100.0%	101.3%	673	2.96	6.02	8.98
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B24	110 - TRAUMA & ORTHOPAEDICS		1,488	1,266	1,116	1,266	744	744	744	996	85.1%	113.4%	100.0%	133.9%	646	3.11	3.50	6.61
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B4	430 - GERIATRIC MEDICINE		1,488	1,260	2,232	2,082	744	744	1,488	1,440	84.7%	93.3%	100.0%	96.8%	749	2.68	4.70	7.38
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Blackburn Birth Centre	501 - OBSTETRICS		930	955	489	410	667	667	333	333	102.7%	83.8%	100.0%	100.0%	18	90.07	41.29	131.36
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C1	300 - GENERAL MEDICINE		1,860	1,656	1,116	1,080	744	744	372	504	89.0%	96.8%	100.0%	135.5%	358	6.70	4.42	11.13
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C10	300 - GENERAL MEDICINE		1,488	1,266	1,488	1,440	744	744	1,116	1,116	85.1%	96.8%	100.0%	100.0%	645	3.12	3.96	7.08
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C11	300 - GENERAL MEDICINE		1,488	1,194	1,488	1,536	744	744	1,116	1,200	80.2%	103.2%	100.0%	107.5%	675	2.87	4.05	6.92
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14A	100 - GENERAL SURGERY		1,302	1,158	744	720	744	744	372	624	88.9%	96.8%	100.0%	167.7%	508	3.74	2.65	6.39
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14B	100 - GENERAL SURGERY		1,302	1,158	744	846	744	744	372	708	88.9%	113.7%	100.0%	190.3%	503	3.78	3.09	6.87
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18A	100 - GENERAL SURGERY		1,302	1,206	744	870	744	744	372	864	92.6%	116.9%	100.0%	232.3%	533	3.66	3.25	6.91
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18B	100 - GENERAL SURGERY		1,302	1,158	744	846	744	744	372	552	88.9%	113.7%	100.0%	148.4%	511	3.72	2.74	6.46
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C2	301 - GASTROENTEROLOGY	MEDICINE	1,488	1,212	1,116	1,164	1,116	1,092	1,116	1,140	81.5%	104.3%	97.8%	102.2%	716	3.22	3.22	6.44
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C22	101 - UROLOGY	120 - ENT	2,232	2,154	1,488	1,824	1,116	1,212	1,488	1,632	96.5%	122.6%	108.6%	109.7%	965	3.49	3.58	7.07
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C3	300 - GENERAL MEDICINE		1,674	1,572	1,488	1,596	1,116	1,140	1,116	1,500	93.9%	107.3%	102.2%	134.4%	816	3.32	3.79	7.12
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C4	301 - GASTROENTEROLOGY	MEDICINE	1,488	1,182	1,116	1,248	1,116	1,116	1,116	1,152	79.4%	111.8%	100.0%	103.2%	746	3.08	3.22	6.30
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C5	430 - GERIATRIC MEDICINE		1,116	846	1,488	1,500	744	744	1,116	1,188	75.8%	100.8%	100.0%	106.5%	423	3.76	6.35	10.11
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C6	340 - RESPIRATORY MEDICINE	MEDICINE	1,488	1,212	1,116	1,104	1,116	1,104	744	732	81.5%	98.9%	98.9%	98.4%	748	3.10	2.45	5.55
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C7	340 - RESPIRATORY MEDICINE	MEDICINE	1,488	1,272	1,116	1,176	744	804	744	1,044	85.5%	105.4%	108.1%	140.3%	655	3.17	3.39	6.56
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C8	340 - RESPIRATORY MEDICINE	MEDICINE	1,860	1,584	1,488	1,488	1,116	1,116	744	768	85.2%	100.0%	100.0%	103.2%	522	5.17	4.32	9.49
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C9	300 - GENERAL MEDICINE		1,488	1,182	1,488	1,512	744	756	1,116	1,092	79.4%	101.6%	101.6%	97.8%	683	2.84	3.81	6.65
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Children's Unit	420 - PAEDIATRICS		4,650	4,516	1,116	1,050	3,581	3,402	336	326	97.1%	94.1%	95.0%	96.9%	268	29.54	5.13	34.68
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Coronary Care Unit (CCU)	320 - CARDIOLOGY		1,488	1,260	744	696	1,116	1,116	-	-	84.7%	93.5%	100.0%	0.0%	605	3.93	1.15	5.08
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Critical Care Unit	192 - CRITICAL CARE MEDICINE		6,900	6,834	1,032	810	6,702	6,594	360	324	99.0%	78.5%	98.4%	90.0%	639	21.01	1.77	22.79
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D1	300 - GENERAL MEDICINE		1,488	1,194	1,116	1,152	744	768	744	876	80.2%	103.2%	103.2%	117.7%	594	3.30	3.41	6.72
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D3	300 - GENERAL MEDICINE		1,488	1,176	1,116	1,170	744	744	744	936	79.0%	104.8%	100.0%	125.8%	1256	1.53	1.68	3.21
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUA)	300 - GENERAL MEDICINE		3,720	3,612	2,232	2,556	3,348	3,240	1,488	1,824	97.1%	114.5%	96.8%	122.6%	1203	5.70	3.64	9.34
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUB)	300 - GENERAL MEDICINE		3,348	3,204	2,232	2,196	2,976	2,976	1,860	1,836	95.7%	98.4%	100.0%	98.7%	726	8.51	5.55	14.07
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Neonatal Intensive Care Unit	420 - PAEDIATRICS		4,836	4,638	372	384	4,464	3,924	-	180	95.9%	103.2%	87.9%	18000.0%	660	12.97	0.85	13.83
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Surgical Triage Unit	100 - GENERAL SURGERY		1,860	1,788	1,488	1,428	1,302	1,302	1,116	1,152	96.1%	96.0%	100.0%	103.2%	144	21.46	17.92	39.38
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Antenatal Ward	501 - OBSTETRICS		1,656	1,622	912	912	1,116	1,080	744	696	97.9%	100.0%	96.8%	93.5%	51	52.98	31.53	84.51
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Burnley Birth Centre	501 - OBSTETRICS		1,395	1,315	372	378	1,116	1,056	372	372	94.2%	101.6%	94.6%	100.0%	242	9.80	3.10	12.89
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Central Birth Suite	501 - OBSTETRICS		4,092	3,996	744	799	4,092	4,032	744	766	97.7%	107.4%	98.5%	103.0%	304	26.41	5.15	31.56
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Gynaecology and Breast Care Ward	502 - GYNAECOLOGY		1,056	1,028	558	564	788	745	326	332	97.3%	101.1%	94.5%	102.0%	803	2.21	1.12	3.32
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Postnatal Ward	501 - OBSTETRICS		2,400	2,424	1,116	1,152	2,232	2,196	1,488	1,368	101.0%	103.2%	98.4%	91.9%	407	11.35	6.19	17.54
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Rakehead	314 - REHABILITATION		1,116	852	1,860	1,944	744	744	744	1,140	76.3%	104.5%	100.0%	153.2%	439	3.64	7.03	10.66
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 15	110 - TRAUMA & ORTHOPAEDICS		1,224	1,182	936	918	744	744	612	684	96.6%	98.1%	100.0%	111.8%	850	2.27	1.88	4.15
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 16	300 - GENERAL MEDICINE		1,860	1,518	1,488	1,950	744	744	1,488	1,836	81.6%	131.0%	100.0%	123.4%	692	3.27	5.47	8.74
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 19	430 - GERIATRIC MEDICINE	MEDICINE	1,482	1,272	1,488	1,554	744	744	744	1,092	85.8%	104.4%	100.0%	146.8%	925	2.18	2.86	5.04
RXR70	CLITHEROE COMMUNITY HOSPITAL - RXR70	Ribblesdale	314 - REHABILITATION		1,860	1,602	1,488	1,530	1,116	1,116	1,488	1,716	86.1%	102.8%	100.0%	115.3%	712	3.82	4.56	8.38
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Hartley	314 - REHABILITATION		1,488	1,182	1,116	1,158	744	744	744	1,044	79.4%	103.8%	100.0%	140.3%	711	2.71	3.10	5.81
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Marsden	314 - REHABILITATION		1,488	1,188	1,860	1,890	744	744	744	1,116	79.8%	101.6%	100.0%	150.0%	690	2.80	4.36	7.16
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Reedyford	314 - REHABILITATION		1,488	1,140	1,116	1,134	744	744	744	744	76.6%	101.6%	100.0%	100.0%	123	15.32	15.27	30.59
		Total			87,291	78,639	54,891	56,715	60,655	59,653	38,051	43,757	90.09%	103.32%	98.35%	115.00%	27129	5.10	3.70	8.80

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 70

8 May 2019

Purpose Approval

Title	NHS Improvement Annual Self-Certification
Author	Mrs A Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary

Summary: NHS providers need to self-certify after the end of the financial year as to whether they have:

1. Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have a regard to the NHS Constitution (condition G6)
2. Complied with governance arrangements (condition FT4) and
3. (for Foundation Trusts only) The required resources available if providing Commissioner requested services (CRS) (condition CoS7)

Although NHS Trusts do not need to hold a provider licence, they are legally subject to the equivalent of certain provider licence conditions and are required to self-certify under these licence conditions.

The attached documents provide the draft self-certification by ELHT for the financial year 2018/19 against the conditions G6 and FT4.

It is recommended that the Trust self-certifies as confirming compliance with both conditions. The narrative setting out the factors for confirming compliance is provided in the attached templates issued by NHS Improvement.

The Board is asked to review the draft self-certification and agree for it to be signed by the Chairman and the Chief Executive before its publication on the Trust website.

Recommendation: To Board is asked to agree the annual self-certification for signing by the Chairman and the Chief Executive before its publication on the Trust website.

Report linkages

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

Impact: Directions from the Secretary of State for Health and Social Care require NHS Improvement to ensure that NHS Trusts comply with conditions equivalent to those in the NHS provider licence. The Trust is required to carry out an annual self-certification against the set criteria and publish it on its website by the 30 June 2019.

Legal	Yes	Financial	Yes/No

Equality	No	Confidentiality	Yes/No

Previously considered by: Executive Directors

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | **2018/19** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Embedded Board and Committee structures; continuous effectiveness reviews; Board development programme; awarded 'good' rating by CQC overall and in the well-led domain following an inspection in September 2018 with some service areas rated 'outstanding'.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	As above; risk strategy reviewed; annual review of risk strategy as part of the Annual Governance Statement; Annual review of the BAF by the Audit Committee; regular review of the BAF and CRR at Board and operational level;	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	As response under statement 1 and effective operational structures; review of the divisional accountability framework; ODB acts as a senior operational decision body witih delegated authority, annual self-assessment of the Committees' effectiveness and summary reporting and escalation of matters to the Board.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Oversight of each of the matters under this statement is overseen by the Trust Board and where appropriate delegated to the relevant risk committee. In instances where matters require escalation then the Board has the final oversight and decision making authority on further mitigation and residual risks; awarded 'good' rating in the Value for Money (VFM) domain following inspection by the CQC in September 2018; no issues flagged by external auditors in relation to the 'going concern' statement.	#REF!

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**	Board composition reviewed as part of the Board development plan and concentrats on good governance and risk management. All Executive positions are held by full time employees of ELHT and the vacancies for NED positions are filled in a timely manner working with NHSI; the Quality Committee which is a subcommittee of the Board meets bi-monthly and receives reports from various risk committees in relation to patient care and quality of services and sends summary reports to the Board. The Trust received overall rating of 'good' by the CQC following an inspection in September 2018 with some services rated 'oustanding'.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	See response for statement 5 in relation to the Board composition; the Board members undertake an annual FPPT check and the Company Secretary reports annually to the Remuneration Committee on the outcome of the same. The appraisal process for all employees includes further personal and professional development, NEDs participate in personal development and this is recorded in their annual appraisals.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature **Signature**

Name **Name**

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A	The Trust continues to monitor its risks and review the action plans where perfromance of the national standards requires improvement (e.g. 4 hour standard)	**OK**

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2018/19 Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed — OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. — Please Respond

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. — Please Respond

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. — Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

ELHT is not a Foundation Trust, so we have not responded to question 3a, 3b and 3c as they are not applicable

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

N/A

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 71

8 May 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 25 February 2019.

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 25 February 2019 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 January 2019. The Trust achieved all cancer standards with the exception of the two week breast symptomatic indicator in the reporting month of December (Cancer standards report one month behind other indicators). Members of the Committee noted that this was due to the availability of patients. There were 16 patients who had a trolley wait of more than 12 hours; all were noted to be patients awaiting assessment by mental health services or mental health care beds. Members of the Committee noted that the Trust had not achieved the Referral to Treatment (RTT) indicator for January (91.5%). It was clarified that the main contributory factor was the number of operations being cancelled on the day of planned surgery in order to accommodate non-elective operations.
2. The members received the financial performance report for the month of January 2019 and noted that the Trust remained on course to meet the required financial year end position. Committee members noted that the Trust had forecast an over performance of £12,000,000 at the end of March 2019 with current over performance being £9,500,000 at the end of January 2019. The Committee were informed that discussions were taking place with local commissioners in relation to payment for the aforementioned over performance.
3. The Committee received an update on the development of the financial budget for 2019/20. The presentation included an overview of the guidelines and draft financial assumptions made for 2019/20; proposals relating to the revised payment mechanisms; overview of the work undertaken to date; key figures, including the increases to the tariff, reduction in the value of CQUIN schemes; loss of income, pay awards and employer pension contribution increases. Members noted the overview of the proposed financial control total that had been presented to the Trust by NHSI and the difficulties that the Trust were having in finding a workable solution to achieving the required year end figure. The Committee received confirmation that, at this time, the Trust was unable to sign up to the 2019/20 control total based on the shortfall between the Trust's draft submission and the proposed control total. The Committee noted that, in order to submit the documents in the required timeline,

there would be a need to request that the Board delegate authority to the Finance and Performance Committee for approval of the documentation prior to submission.

4. The Committee members received a revised Workforce Report which focused on the development of key performance indicators (KPI's) within the remit of the workforce team. Members noted the increase in spend on bank staff and the associated reduction in spend on agency and locum staff. Members noted that there had been an increase in the number of Employee Relations cases but the team were hopeful that the revised 'Early Resolution Policy' would begin to bring down the number of such cases. The Committee Chair requested that a deeper dive into the workforce metrics and issues within the workforce team's remit be included in the next report. It was agreed that an outline of the next report to the Committee would be presented to the meeting scheduled for April with a formal report being presented to the Committee meeting scheduled for May 2019.
5. The Committee also received a review of the Board Assurance Framework risks associated with the Committee; an update on the development of the 2019/20 contract; the tenders report; and the minutes of the Financial Assurance Board for information.

At the meeting of the Finance and Performance Committee held on 25 March 2019 members considered the following matters:

1. The Committee received the Integrated Performance Report and noted that despite the average length of ambulance handovers increasing slightly, there had been an overall reduction in the number of handovers taking in excess of 30 minutes. There were 14 breaches of the 12 hour trolley wait standard, with 13 being patients awaiting suitable input from mental health services and one being a medical breach. Members noted that there had been an improvement in the 62 day cancer standard; however the standard was not met for the month of January, nor was the two week breast symptomatic standard. Members noted that the Trust failed to achieve the 92% RTT standard again in February at 91.7% and that the Trust had reached an agreement with NHSI/E that the integrated MSK service data would be included in RTT data from February 2019. The Committee members noted that the Trust remained on plan to meet the year-end financial requirements and the lifecycle of the Trust's PFI areas had been reviewed and revised to the benefit of the Trust.

2. The Committee members received a report detailing the statement of borrowing for the Trust in the 2018/19 financial year to date.
3. The Committee received the revised Business Planning submission for 2019/20 for approval prior to submission to NHSI/E via delegated responsibility from the Trust Board at its meeting in March 2019. Members noted that the finalised document also needed to be submitted to the Integrated Care System (ICS). The Committee discussed the various component parts to the plan, including: performance trajectories; activity, workforce, finance and capital plans; Cost Improvement/Efficiency Programmes; and contracting mechanisms. It was noted that the Trust's cost efficiency plan for 2019/20 totalled £15,600,000 and the Trust's capital plan totalled £33,600,000, of which £13,700,000 would be internally sourced funds. At this point in the year the Trust had been unable to sign up to the proposed financial Control Total, but it was confirmed that discussions were ongoing between the Trust, ICS and NHSI/E to reach a mutually agreeable figure. Following discussion and debate the Committee approved the business plan 2019/20 for submission to NHSI/E on behalf of the Trust Board.
4. The Committee received an update on the work taking place within the Lancashire Procurement Cluster and noted the significant improvements that had been made in relation to the Trust's ranking in the NHS Procurement League Table and plans for mitigating procurement risks as a result of Brexit.
5. The Committee also received the tenders report, and update on the Community Services Strategy; and the minutes of the Financial Assurance Board for information.

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 26 April 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 72

8 May 2019

Purpose Information Assurance

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

Summary: The report sets out the matters discussed and decisions made at the Audit Committee meeting held on 1 April 2019

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

Report linkages

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

Audit Committee Update

At the meeting of the Audit Committee held on 1 April 2019 members considered the following matters:

1. The internal audit reports listed below were presented to the Committee:
   a) Return to Work Process - **Limited Assurance**
   b) Medical Staffing – Substantial Assurance
   c) Estates Statutory Compliance – Substantial Assurance
   d) Data Security and Protection Toolkit Assurance – Substantial Assurance
   e) Mediation Services – Substantial Assurance

   Members noted that the management response to the Return to Work Process report would be presented to the meeting of the Committee that was scheduled for July 2019.
2. The Committee received the draft Internal Audit Plan for 2019/20 and noted that the fees for the service remained the same as those paid in 2018/19. It was confirmed that the plan had been developed from discussions with Board members and would be reviewed after the first six months of the 2019/20 financial year with a view to revising the plan if necessary.
3. The Committee received the management response update in relation to the recent review of Cyber Essentials Certification preparations. Members noted that significant work was underway to address the areas identified for improvement in the original review and was planned for completion by the end of June 2019. Committee members noted that there had been some issues with the supplier of some of the firewall technology being used within the Trust and the supplier is in the process of considering alternative options. Commercial discussions are taking place and it is anticipated that they will have come to a satisfactory conclusion in May 2019. The Committee also noted that the Trust is in the process of developing a business case to purchase a scanning solution to enable closer management of patches across the Trust.
4. Members of the Committee received an update from the Associate Director of Quality and Safety in relation to the management response for the recent audit relating to Policy Management. They noted that the Trust has strengthened its internal control processes and have devised a central point for the identification of policy leads and monitors timeframes for policy reviews. In addition, a process had been developed for the quality control of policies, including reviewing, reviewing within Division and

progression through to the Policy Council for ratification. The Committee members sought assurance regarding the application/implementation of policies by staff; it was confirmed that policies are reviewed to ensure that they meet best practice standards and regular spot checks take place to ensure that staff are compliant with the policies. It was agreed that a further update would be provided to the Committee in October 2019.

5. The Committee received an update in relation to the work being undertaken to address the recommendations from the MIAA audit of Risk Management Systems. Members noted that of the seven recommendations that were made in the original audit, only one of the thirty associated actions remained incomplete. It was confirmed that work was ongoing to cleanse and remove/consolidate duplicated actions across the live Divisional Risk Registers and improve the descriptions of the risks. The Committee members requested that a revised end date for this action be agreed and suggested that September 2019 would be a suitable and realistic timeframe, as it would be one year since the initial actions plan had been developed.

6. The Committee received the Trust's draft Costing Assurance Programme report 2017/18. Members noted that the Trust had submitted Reference Cost submissions to NHS Improvement/England for a number of years but had been required to submit the Patient Level and Costing System (PLICS) for the year 2017/18. The Trust purchased a PLICS system in 2018 in preparation for the 2017/18 reference/PLICS costs submission. The Committee members noted that PLICS submissions will become mandatory from 2018/19 submission onwards. The overall outcome of the report was limited assurance and contained four high level recommendations and four medium level recommendations in addition to a number of low level recommendations and opportunities for improvement. The high rated recommendations related to training on the new costing system; data matching; costing of Accident and Emergency and; critical care cost weightings.

7. The Committee members received the annual review of Going Concern and noted that discussions were ongoing with NHSI/E regarding the development of the Trust's financial Control Total for 2019/20 and ongoing contracting negotiations with commissioners.

8. The Committee received the progress report from external auditors and noted that the planning for the 2018/19 audit of the Trust's Financial Accounts had been completed and the interim audit was underway as was testing of the accounts.

Members briefly discussed the emerging issue of asset lives, the updated guidance that had been issued and the potential impact that it would have on depreciation charges against assets.

9. Members received the Anti-Fraud Service Progress Report and noted the progress being made in relation to referrals and investigations. The Committee noted that there had been no new referrals made since the last meeting.

10. In addition to the regular Anti-Fraud Progress Report the Committee received an update on the 2019 Counter Fraud Self-Referral Tool Submission. It was agreed that the areas where the Trust can show current compliance would include a short narrative to this effect and provide any relevant evidence. Members requested benchmarking information/confirmation that the Trust was in a similar position to others in terms of reporting of and overall numbers of potential fraud cases as criticism had been given in the response to a previous years' submission.

11. The Committee received the content of the external audit workplan for 2018/19 and noted the approach being taken to determining the 'value for money' statement and the approach being taken towards determining materiality in auditing the accounts for 2018/19.

12. The Committee reviewed the terms of reference, received an initial draft of the Trust's Annual Governance Statement and briefly discussed the governance arrangements associated with the Lancashire and South Cumbria Integrated Care System.

Kea Ingham, Assistant Company Secretary, 26 April 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 73

8 May 2019

Purpose Information

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 27 February 2019.

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 27 February 2019 members considered the following matters:

1. The Committee received the report from the Guardian of Safe Working Hours for Doctors and Dentists in training. Members noted that the report did not raise any matters of significant concern and that the Trust now has a policy in place for the management of exception reporting to the Guardian.
2. The Committee received the Maternity Services and Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme report which detailed the actions that have been undertaken to date to ensure compliance against the CNST scheme requirements. The members noted that additional resources would be sought in order to ensure full compliance against the requirements and in turn reduce stillbirths by 20% by 202 and a further 50% by 2025. It was noted that whilst the Committee members were supportive of the work being undertaken they were unable to approve the additional resources requested as it was outside the remit of the Committee and as such should be considered by the Trust Board as part of the overall financial plan for the Trust. The Committee members agreed that a gap analysis of the financial and staff resources required would be undertaken and presented to the next Committee for information.
3. In addition to the aforementioned report, a Non-Executive Director 'Maternity Champion' was sought and following discussion outside the meeting it was agreed that Mr Michael Wedgeworth would undertake this role.
4. The Committee received the Professional Judgement report relating to Nursing and Maternity staffing which detailed the expectations set out by the National Quality Board and the findings of the 2018/19 professional judgement review for all inpatient and community wards. Members noted the results of the review and the recommendations set out in the report. However, it was agreed, as per the previous item, that the Committee was unable to make any decision relating to the proposed investment in staffing of approximately £964,900 and it was recommended that the two requests for additional resources be incorporated in future strategic discussions at Trust Board as part of the overall financial plan for the Trust.
5. The Committee received the Serious Investigations Requiring Investigation (SIRI) report and noted the incidents that had been reported through the Strategic Executive Information System (StEIS), including a medication error, a surgical error,

patient falls, patient deterioration and pressure ulcers. The members also noted the incidents that had occurred that the Trust determined to be serious but did not meet the criteria for reporting on StEIS, including patient transfers, nutritional issues and misdiagnosis causing delays to treatment. The Committee also noted the learning improvements that had taken place as a result of incidents reported and investigated over the preceding 12 month period, including policy developments, changes to training, and advances in documentation and monitoring. The members also noted the further developments and improvements planned for the coming year, including incident triage processes, development of joint guidance with local commissioners and improved incident mapping.

6. Committee members received the Corporate Mortality Report and noted that both the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) remained within or better than the expected ranges. However, the Committee noted that there were two reporting groups within the SHMI indicators that had a high risk: Septicaemia and Other Liver Disease. It was confirmed that both of these areas are being closely monitored through the Trust's Mortality Steering Group. In addition the Committee were informed that the Trust had received a mortality outlier alert from the CQC in February 2019; as a result the Trust has reconvened the Sepsis Task Force to overview the resultant action plans from the CQC review that will take place.

7. Members received an update on the Trust's Patient Safety/Quality Walkrounds and spent time discussing the potential revision to the format of the visits. The Committee noted that the CQC had commented that the process was an area of good practice for the Trust and members agreed that they should continue. Members were asked to consider four options for the development of the walkrounds and agreed that the preferred option was for a total of four walkrounds to take place per month: two with an Executive Director and a Non-Executive Director and a further two with an Executive Director and a Public Participation Panel (PPP) member.

8. The Committee received the GMC Governance Handbook Self-Assessment and received an overview of its content and the Trust responses. The self-assessment is based on the following four principles:

   a) Organisations create an environment which delivers effective clinical governance for doctors

b) Clinical governance processes for doctors are managed and monitored with a view to continuous improvement

c) Safeguards are in place to ensure clinical governance arrangements for doctors are fair and free from bias and discrimination

d) Organisations deliver clinical governance processes required to support medical revalidation and the evaluation of doctors' fitness to practise

The self-assessment demonstrated that the systems and processes in place at the Trust for the effective clinical governance for the medical workforce are strong.

9. The Committee noted the results of the annual National Cancer Patient Survey and noted that they related to the 2017 survey, with the 2018 survey being undertaken in quarter four of the 2018/19 financial year. Members noted that the overall score for the Trust was 8.8 based on a sliding scale from 0 – 10 (0 being very poor and 10 being very good). Cancer specialty groups have been asked to review their specific results and develop appropriate action plans to address any issues raised. The monitoring of the action plans will take place at the Trust's Cancer Board.

10. The Committee received an update on CQC compliance, 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 (November 2018 and January 2019)

b) Infection Prevention and Control Committee (November and December 2018)

c) Health and Safety Committee (January 2019)

d) Internal Safeguarding Board (November 2018)

e) Patient Experience Committee (December 2018)

f) Clinical Effectiveness Committee (December 2018)

g) Education Directorate Strategic Board (October 2018)

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 29 April 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 74

8 May 2019

Purpose Information

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

Summary: The list of matters discussed at the Remuneration Committee held on 13 March 2019 are presented for Board members' information.

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Remuneration Committee Information Report

1. At the meeting of the Remuneration Committee held on 13 March 2019 members considered the following matter:
   a) Arrangements relating to the Deputy Chief Executive roles
   b) Director of HR and OD Arrangements
   c) Pension Arrangements

Kea Ingham, Assistant Company Secretary, 26 April 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 75

8 May 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 13 March 2019.

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 13 March 2019, the following matters were discussed in private:
   a) Round Table Discussion: ICS/ICP Update
   b) Round Table Discussion: Care Quality Commission Feedback
   c) Round Table Discussion: Community Neighbourhood Services Update
   d) Finance and Performance Update
   e) Planning for 2019/20
   f) Tender Update
   g) Committee Membership
   h) Serious Untoward Incident Report
   i) 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, 26 April 2019