East Lancashire Hospitals NHS Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

Personal

Effective

Safe | Personal | Effective

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD PART 1 MEETING

27 JULY 2016, 14:00, SEMINAR ROOM 6, ROYAL BLACKBURN HOSPITAL

AGENDA

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

OPENING MATTERS				
TB/2016/204	**Chairman's Welcome**	Chairman	v	
TB/2016/205	**Open Forum** To consider questions from the public	Chairman	v	
TB/2016/206	**Apologies** To note apologies.	Chairman	v	
TB/2016/207	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 29 June 2016	Chairman	d✓	
TB/2016/208	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2016/209	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	
TB/2016/210	**Declarations of Interest** To note any new declarations of interest from Directors.	Company Secretary	v	
TB/2016/211	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	
TB/2016/212	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	
QUALITY AND SAFETY				
TB/2016/213	**Patient Story** To receive and consider the learning from a patient story.	Director of Nursing	p	
TB/2016/214	**Board Assurance Framework** To receive an update on the Board Assurance Framework and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Medical Director	d✓	
TB/2016/215	**Corporate Risk Register** To receive an update on the Corporate Risk Register and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Medical Director	d✓	
TB/2016/216	**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 aware of the associated learning. Including Never Events from 2015/16	Medical Director	d✓	
TB/2016/217	**Professional Judgement Review** To receive the report and approve the recommendations in the report.	Director of Nursing	d✓	
ACCOUNTABILITY AND PERFORMANCE				

TB/2016/218	**Integrated Performance Report** To note performance against key indicators and actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed: • Performance • Quality • Finance • HR • Safer Staffing	Director of Operations	d✓	
GOVERNANCE				
TB/2016/219	**Quality Committee Update Report** To note the matters considered by the Committee in discharging its duties (July 2016)	Committee Chair	d✓	
TB/2016/220	**Finance and Performance Committee Update Report** To note the matters considered by the Committee in discharging its duties (May and June 2016)	Committee Chair	d✓	
TB/2016/221	**Audit Committee Update Report** To note the matters considered by the Committee in discharging its duties (June and July 2016)	Committee Chair	d✓	
TB/2016/222	**Audit Committee Terms of Reference** To approve the revised terms of reference	Company Secretary	d✓	
TB/2016/223	**Remuneration Committee Update Report** To note the matters considered by the Committee in discharging its duties (May and June 2016)	Committee Chair	d✓	
TB/2016/224	**Trust Board Part Two Update Report** To note the matters considered by the Committee in discharging its duties (May and June 2016)	Chairman	d✓	
FOR INFORMATION				
TB/2016/225	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2016/226	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2016/227	**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? • Has the Board agenda the correct balance between formulating strategy and holding to account? • Is the Board shaping a healthy culture for the Board and the organisation? • Is the Board informed of the external context within which it must operate? • Are the Trust's strategies informed by the intelligence from local people's needs, trend and comparative information? • Does the Board give enough priority to engagement with stakeholders and opinion formers within and beyond the organisation?	Chairman	v	
TB/2016/228	**Date and Time of Next Meeting** Wednesday 28 September 2016, 15.00, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.	Chairman	v	16:40

East Lancashire Hospitals NHS Trust

TRUST BOARD PART ONE REPORT

Item 207

27 July 2016

Purpose Action

Title	Minutes of the Previous Meeting
Author	Miss K Ingham, Minute Taker
Executive sponsor	Professor E Fairhurst, Chairman

Summary:

The draft minutes of the previous Trust Board meeting held on 29 June 2016 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

(207) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST
TRUST BOARD MEETING, 29 JUNE 2016
MINUTES

PRESENT

Professor E Fairhurst	Chairman	Chair
Mr K McGee	Chief Executive	
Mr S Barnes	Non-Executive Director	
Mrs M Brown	Acting Director of Finance	
Mrs C Pearson	Director of Nursing	
Dr D Riley	Medical Director	
Mr P Rowe	Non-Executive Director	
Mrs E Sedgley	Non-Executive Director	
Mrs G Simpson	Director of Operations	
Mr D Wharfe	Non-Executive Director	

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Company Secretary	
Mr K Cockerill	Staff Governor	Observer/Audience
Mr M Hodgson	Director of Service Development	
Mrs C Hughes	Director of Communications and Engagement	
Miss K Ingham	Company Secretarial Assistant (minutes)	
Mrs S Moorcroft	Pfizer Representative	Observer/Audience
Mr K Moynes	Director of HR and OD	
Mr M Wedgeworth	Healthwatch Lancashire	Observer/Audience

APOLOGIES

Mr R Slater	Non-Executive Director

TB/2016/180 CHAIRMAN'S WELCOME

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

TB/2016/181 OPEN FORUM

Mr Wedgeworth asked whether the Trust had considered the development of a step down

facility, similar to the Beachwood facility that currently operates in the Preston area.

Mrs Simpson reported that the Trust already had in excess of 120 community beds which were used for step down care. The Trust continues to work closely with the local Clinical Commissioning Groups (CCGs) to look at future modelling of the service for patients who require intermediate care. Mrs Simpson confirmed that the Trust was currently taking part in a collaborative project relating to delayed transfers of care. Directors noted that work was also being carried out to provide additional support to those patients who were classed as medically fit for discharge but were unable to be discharged home due to their enhanced care requirements in the short term. The additional support would take place in the patients' own home.

Mr Wedgeworth asked whether there was still an issue in relation to delayed transfers of care within the Trust. Mrs Simpson confirmed that there were still a number of issues and would be happy to discuss these outside of the meeting with Mr Wedgeworth.

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

Mrs Simpson to liaise with Mr Wedgeworth to discuss issues relating to delayed transfers of care.

TB/2016/182 APOLOGIES

Apologies were received as recorded above.

TB/2016/183 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 25 May 2016 were approved as a true and accurate record.**

TB/2016/184 MATTERS ARISING

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

TB/2016/185 ACTION MATRIX

All items on the action matrix were reported as complete or were to be presented as agenda items today or at subsequent meetings. Updates were received as follows:

TB/2016/156: Fracture Clinic Relocation Report – Mr McGee confirmed that he had written to the local Clinical Commissioning Group to inform them about the recommendation made at the last Trust Board meeting and requested that they formally take the decision about the permanent relocation of the clinic to the Royal Blackburn site. Directors noted that

no response had been received to date and Mr McGee agreed to follow up this matter should a response not be received by the end of the week.

TB/2016/165: Board Performance and Reflection – Mr Moynes confirmed that following discussions at a recent Executive Team meeting, an item will be added to the October agenda to provide a comprehensive update regarding workforce issues.

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

TB/2016/186 **DECLARATIONS OF INTEREST**

Directors noted that there was one item to be added to the Directors' Register of Interests. Mrs Bosnjak-Szekeres confirmed that Professor Fairhurst made a declaration that she would be undertaking work for NHS England. There were no declarations in relation to agenda items.

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

TB/2016/187 **INTEGRATED PERFORMANCE REPORT**

Mrs Simpson presented the Integrated Performance Report for the month of May highlighting the continued good performance against Cancer targets and confirmed that there had been no patients treated outside of the 104 day limit. The Hospital standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Indicator (SHMI) indicators remain in the expected range and the Friends and Family survey results continue to show high levels of positive responses. Directors noted that there had been no cases of Methicillin-resistant Staphylococcus Aureus (MRSA) identified in the last month but there had been two cases of Clostridium Difficile diagnosed against a trajectory of three.

Performance against the four hour Emergency Department (ED) standard remains a significant challenge, with performance for the month at 85.4%. Mrs Simpson confirmed that a thorough analysis has been undertaken since January 2016 regarding performance against this indicator. She reported that there had been the anticipated increase in the early part of the year, but there had been a reduction in overall admissions, due in part to the development of the Medical Assessment Unit (MAU). Directors noted that there has been an increase in the number of patients with a length of stay over 30 days. It is anticipated that this has negatively impacted the delayed transfers of care. In addition, the Trust has reduced its overall bed stock back to the funded establishment with the closure of ward 23 at Burnley General Hospital and ward C3 at the Royal Blackburn Hospital. Directors noted that subsequently ward C3 had to be reopened due to increased demand on the emergency care pathway. Directors were informed that there had been a small increase in patients being

admitted to the Trust from Chorley and South Ribble postcodes following the closure of the Emergency Department at Chorley hospital. The Trust has continued to experience staffing related issues which have also negatively affected performance.

Mrs Simpson provided an overview of the actions that will be undertaken to improve performance, including improving the current bed management system and allocation of a senior flow team for an initial three month period which will come into effect on 4 July together with other initiatives. The Trust will continue to hold twice weekly meetings to identify patients who are medically fit for discharge and facilitate their return to their place of residence. Mrs Simpson reported that she and Mr McGee attended a regional meeting with NHS Improvement earlier in the month where issues in relation to the four hour standard were recognised, but the emphasis remains on achieving the target in order to ensure high quality of service.

Directors noted that there had been eight 12 hour breaches within the ED during the month, all of which were patients awaiting mental health assessment beds. Mrs Simpson confirmed that an external review has been commissioned by the Trust and partner agencies.

Delayed transfers of care remain above threshold with 44 patients delayed on the last Thursday of the month with 116 patients delayed across the month.

Mrs Pearson confirmed that safer staffing figures remained a challenge however there had been a small improvement last month. She went on to report that the Carter review had looked at staff efficiency and therefore reporting of staffing figures also showed care provided to patients in hours, which had been reported as 6.33 hours per patient day. Directors noted that this information would become more relevant and meaningful in the coming months. Mrs Pearson reported that five of the recently recruited nurses from the Philippines had commenced in their posts, with a further 8 to follow in the coming weeks. Mrs Pearson highlighted that there had been no pressure ulcers reported in month. Directors expressed their thanks to the ward based teams for their continued hard work in this area.

Mr Rowe asked how many nurses would be brought into the Trust from the recent international recruitment exercise should the language test pass mark be revised. Mrs Pearson confirmed that there would be around 70 nurses who could immediately be brought into post should the test pass mark be revised.

In response to Mrs Sedgley's question concerning the outcome of the recent EU Referendum vote, Mr McGee confirmed that there had been reports from other providers that a small number of recently recruited staff who had rejected offers of employment following the outcome of the referendum. Mrs Hughes confirmed that there had been a number of messages cascaded to staff as a result of the outcome of the referendum to

emphasise how all staff are valued by the Trust irrespective of their country of origin.

Mrs Brown provided an overview of the financial position at the end of month two and confirmed that it was broadly in line with the forecast position. Income remains in line with the projected position, however non-elective activity had increased whilst elective activity had reduced. The Trust remains in line with the forecast plan in relation to expenditure. Capital expenditure was currently slightly behind plan.

In response to Mr McGee's question Mrs Brown reported that there had been a number of suppliers who had been in touch to confirm price increases as a result of recent fluctuations in the exchange rate and daily monitoring of this situation is taking place within the finance team.

Mr Moynes reported that there were over 2500 staff members who have not had a single day of sickness in the last 12 months. He confirmed that five posts were currently being advertised in relation to the staff mental health and wellbeing service that was recently approved at operational level. Directors noted that the Trust will seek to recruit to the vacant Emergency Department consultant posts from India and possibly Dubai. This work will commence in September 2016. Mr Moynes confirmed that an email had been received to confirm that the Trust had been asked to submit a bid to be a Trust involved in the development and trial of Associate Nurse roles across the Pennine Lancashire area.

In response to Mr Barnes's question relating to the 12 hour breaches for patients awaiting mental health assessments, Mrs Simpson confirmed that the breach is allocated to the Trust where the patient is waiting and cannot be transferred to a different organisation. Mr McGee provided a brief overview of the two pieces of work that would be undertaken with partners to improve patient care for patients requiring mental health assessments. Dr Riley confirmed that the terms of reference had been agreed for the review, but the work was likely to take a number of months to complete.

RESOLVED: **Directors received the report and noted the work undertaken to address areas of underperformance.**

TB/2016/188 **RECENT DEVELOPMENTS IN NHS STRATEGY AND SUSTAINABILITY**

Mr McGee provided an overview of the recent developments. He confirmed that he and a number of colleagues had been in attendance at the NHS Confederation Annual Conference earlier in the month, where there had been a clear emphasis on the delivery of financial targets and delivering efficiency savings across the NHS as a whole. Directors noted that the public announcement concerning financial control totals for every provider had been mooted at the conference. The announcement on this is expected in the coming weeks.

Mr McGee confirmed that it was unclear what the impact on the NHS would be from the outcome of the recent EU referendum. He reported that issues in relation to staffing and supplier finances were reported by providers, both of which had been discussed earlier in the meeting.

Mr McGee reported that there was a clear drive across the NHS for concentration on development and delivery of the Sustainability and Transformation Plans (STPs). Directors noted that there were 44 STP areas across England, with East Lancashire Hospitals NHS Trust being part of the Lancashire and South Cumbria STP. Directors noted that the draft STP is in the process of being finalised prior to submission at the end of the month. It will cover five key areas: investment in primary care services, investment in prevention, review of emergency and urgent care services, mental health services and review of acute services. Within the development of the STP there is a drive towards working together as a system to become sustainable and address workforce pressures.

Mr McGee confirmed that the Trust would ensure that it did what was right for the population of East Lancashire; however there is debate to be undertaken in terms of responsibilities of the Board for both the Pennine Lancashire work and delivery of the STP across the Lancashire and South Cumbria area. Mr McGee went on to comment that the Trust would be looking at the Accountable Care System model and as a result there would be a significant amount of work carried out with partners on this issue.

Mr Rowe commented that there would be significant amounts of money that needed to be saved across the STP footprint but this must not be at the expense of patient care. He went on to suggest that the emphasis on prevention and self-care were crucial to the delivery of these savings.

Mr Barnes commented that the Trust must work closely with partners across the STP area to support the population of East Lancashire. He recognised that there may be a benefit to patients if some services were consolidated on one site across the locality; however it was noted that these services may not be sited in easily accessible areas for the local population served by the Trust.

Professor Fairhurst, in recognition of the importance of the subject matter, opened up the discussion for questions from the audience. Mr Cockerill, Shadow Staff Governor commented that many community services providers throughout the country work closer with GPs than the Trust currently does and asked whether there was a possibility of developing closer links with the GP practices. Dr Riley confirmed that discussions were taking place with a number of GP practices/federations within the area to develop closer ways of working.

Mr Wedgeworth, Healthwatch Lancashire requested that the technical discussions that are taking place at regional level through Trust Boards eventually be filtered down to the public

as it is crucial that they understand the changes that will be taking place and the reasons for the changes.

Professor Fairhurst suggested that organisations such as Healthwatch would be welcomed in terms of helping the Trust to communicate with the local population and suggested that Mrs Hughes and Mr Wedgeworth meet to discuss the possible ways that the organisation can be involved. Mrs Hughes confirmed that a comprehensive communications plan was being developed across the STP area; however this would not be ready for launch until later in the summer.

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

Mrs Hughes to liaise with Mr Wedgeworth to discuss possible ways in which Healthwatch Lancashire could be involved in the STP related communication with the population.

TB/2016/189 ANY OTHER BUSINESS

There were no further items of business to report.

TB/2016/190 OPEN FORUM

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

TB/2016/191 DATE AND TIME OF NEXT MEETING

The next Trust Board meeting will take place on Wednesday 27 July 2016, 14:00, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 209

27 July 2016

Purpose Action

Title	Action Matrix
Author	Miss K Ingham, Minute Taker
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The outstanding actions from previous meetings are presented for discussion.

Members 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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver anticipated benefits The Trust fails to deliver and develop a safe, competent workforce Partnership working fails to support delivery of sustainable safe, personal and effective care The Trust fails to achieve a sustainable financial position The Trust fails to achieve required contractual and national targets and its improvement priorities Corporate functions fail to support delivery of the Trust's objectives

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

East Lancashire Hospitals NHS
NHS Trust

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
2015/66: Talent Management	Update report to be provided in early 2016 *(this will be covered as part of the Board presentation on workforce in October 2016)*	Director of HR and OD	To be advised	Agenda Item October 2016
2016/023: Safer Staffing Report	The professional judgement review report on beds in ward areas to be presented to a future Trust Board meeting.	Director of Nursing	July 2016	Agenda Item July 2016 incorporated in the IPR
2016/133: Action Matrix	Update to be provided in relation to progress with the population centred workforce development *(this will be covered as part of the Board presentation on workforce in October 2016, same as action number 2015/66)*	Director of HR and OD	October 2016	Agenda Item October 2016
2016/154: Serious Untoward Incidents Requiring Investigation Report	Report concerning the four never events in last year and learning from them to be brought to the next Board meeting	Medical Director	July 2016	Agenda Item July 2016
2016/155: Information Technology Management Strategy	Regular progress reports on implementation of the Strategy to be presented to the Board to ensure that the Board has a timely debate about the allocation of resources.	Acting Director of Finance	To be advised	Agenda Item November 2016 (indicative)

Item Number	Action	Assigned To	Deadline	Status
TB/2016/181: Open Forum	Mrs Simpson to liaise with Mr Wedgeworth to discuss issues relating to delayed transfers of care.	Director of Operations	July 2016	Oral Report
TB/2016/185: Action Matrix	Mr McGee to update the Board regarding the outcome of the follow up in relation to the response from the CCG regarding the Fracture Clinic relocation.	Chief Executive	July 2016	Oral Report
TB/2016/188: Recent Developments in NNS Strategy and Sustainability	Mrs Hughes to liaise with Mr Wedgeworth to discuss possible ways in which Healthwatch Lancashire could be involved in the STP related communication with the population.	Director of Communications and Engagement	July 2016	Oral Report

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 212

27 July 2016

Purpose Information

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

Summary:

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

Recommendation:

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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of

failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

National Updates

1. **A New national framework for nursing, midwifery and care staff - Leading Change, Adding Value** - On 18 May 2016, Professor Jane Cummings, Chief Nursing Officer for England, launched Leading Change, Adding Value - a framework for nursing, midwifery and care staff. The framework sets out how to lead on delivering better outcomes, better experiences for patients and staff, in addition to making better use of resources. The framework is also intended to help staff close the three gaps identified in the NHS Five Year Forward View - the health and wellbeing gap, the care and quality gap, and the funding and efficiency gap.
2. **Achieving world class cancer services -** The NHS in England has set out its plan to deliver world class cancer services, which includes a fund to find new ways of speeding up diagnosis with the potential to save thousands more lives every year. The plan, published by the National Cancer Transformation Board which is led by Cally Palmer, National Cancer Director for NHS England, is designed to increase prevention, speed up diagnosis, improve the experience of patients and help people living with and beyond cancer. This will include the rollout of a recovery package throughout the county to ensure that the individual needs of all people going through cancer treatment and beyond are met by tailored support and services.
3. **NHS Providers Summary of Statutory Board Papers June 2016 –** The Trust received a copy of the CQC's Summary of Statutory Board Papers for June 2016. The board papers included an update from the chief executive, including recent inspection ratings, WRES publication and CQC appointments and departures, and an update on Healthwatch England.
4. **Simon Stevens launches fast track funding at NHS Confederation 2016 -** In his keynote speech to around 1,000 NHS leaders at the NHS Confederation Conference in Manchester on 17 June 2016, Simon Stevens, NHS England Chief Executive, announced, for the first time, the NHS will provide a national reimbursement route for new medtech innovations. This will accelerate uptake of new medtech devices and apps for patients with diabetes, heart conditions, asthma, sleep disorders, and other chronic health conditions. Simon Stevens spoke openly about current pressures on the health care system, stabilising finances and implementing the Sustainability and Transformation plans. Read Simon Stevens' speech in full on the NHS England website.
5. **Celebration of SS Windrush and diversity in the workforce** - NHS England hosted its second Windrush event earlier this month, which marked a new chapter in the birth of the NHS and the growth of multicultural Britain. However, seven decades later, colleagues from black and minority ethnic (BME) backgrounds are still under-

represented at senior levels in the NHS workforce. This annual event provides the NHS with the opportunity to examine the challenges we currently face to address this, as well as highlighting and celebrating the progress on this important agenda, including the first NHS Workforce Race Equality Standard (WRES) report published earlier this month by the NHS Equality and Diversity Council. The report highlights NHS England's commitment to applying the principles of the WRES to ensure employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

6. **New guidance for improving NHS staff health and wellbeing -** NHS England has published guidance offering financial incentives to improve the health and wellbeing of NHS staff in England, as part of the Healthy Workplaces scheme. The offer introduces health and wellbeing schemes covering mental health, physical activity and physiotherapy, improving flu vaccination uptake rates and taking action on junk food. The guidance comes in the form of a new Commissioning for Quality and Innovation (CQUIN), which has been driven by commitments made in the Five Year Forward View. For further information, please email e.cquin@nhs.net.

7. **First 10 sites of the NHS Diabetes Prevention Programme ready to make referrals** - NHS England has announced the 10 areas that will benefit from the first national NHS Diabetes Prevention Programme. The Healthier You: NHS Diabetes Prevention Programme will initially roll out to 27 areas this year, covering 26 million people which is around half of the population. Patients who are referred will receive personalised help to reduce their risk of Type 2 diabetes, including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes, all of which together have been proven to reduce the risk of developing the disease.

8. **Staff at the heart of new care models NHS Confederation**, NHS Clinical Commissioners, NHS Providers and the Local Government Association, have published a short guide about the work vanguards are doing to engage their staff in the design and delivery of new care models. The publication – New care models and staff engagement: All Aboard aims to help spread the learning from the vanguard programme across the health and care sector.

9. **National Guardian Appointment –** The Trust received a joint letter from David Behan, CEO of the CQC and Sir Robert Francis QC announcing the appointment of Dr Henrietta Hughes as the new National Guardian for the NHS

Local Developments

10. **Use of the Trust Seal** - The Trust seal has been applied on the 28 June 2016 to the deed of novation relating to the Accounts Agreement dated 9 July 2003 on the Blackburn Hospital PPP Project. Parties to the deed are Consort Healthcare (Blackburn) Limited, Consort Healthcare (Blackburn) Funding Plc, Deutsche Trustee Company Limited (as 'Security Trustee'), Deutsche Trustee Company Limited (as 'Bond Trustee'), Deutsche Bank AG London, Ambac Assurance UK Limited, European Investment Bank, Lloyds Bank Plc and East Lancashire Hospitals NHS Trust. The deed has been signed by the Chairman and the Chief Executive.

11. **ELHT scoring in the Training Evaluation Form (TEF) 2016 Obstetrics and Gynaecology** - The Training Evaluation Form (TEF) is a survey completed by Obstetrics and Gynaecology doctors in training which is then published across each Local Education Training board (LETB). It facilitates benchmarking with other Trusts, it shows where we do well, and also highlights areas for improvement. In addition to assessing training, as the Francis report suggested, it utilises Trainees as the eyes and ears of an organisation to rate their views on governance, working environment, behaviours experienced and if the doctor would recommend the placement. ELHT score highly across a significant number of fields. We score a Green RAG rating across ten of the 13 potential indictors, and whilst comparisons are difficult due to the different stages of training offered at various units, and the differing sizes of unit within the LETB, overall we narrowly beat all the other units in Mersey and the North West to secure the highest score in overall recommendation. The survey shows that our doctors have not experienced any negative behaviours, and for areas highlighted for improvement, notably scan training (which is a nationwide issue), we have an action plan to make sure that we improve. This is further testament to the great training provided by our senior Obstetrics and Gynaecology consultant staff to their trainees and the great educational experience that ELHT can offer.

12. **ELHT Outline Business Case Approval Letter for Phase 8 at Burnley General Hospital** – The Trust is pleased to announce that it received a letter from Elizabeth O'Mahoney, Director of Finance at NHSi confirming the approval of Phase 8 at BGH at a cost of £18.02 Million.

13. **Elective Care Centre at Burnley General Hospital** - Work is scheduled to begin this month on the re-development and expansion of the Surgical Day Unit to create a new East Lancashire Elective Centre. The East Lancashire Elective Care will also feature an **additional Endoscopy room** to aid in the rapid diagnosis of both respiratory and gastrointestinal cancers. Remodelling will allow for more spacious

waiting areas and better facilities for patients within a self-contained unit. As you will have seen in the recent press, we have also agreed plans on the new East Lancashire Cancer Centre which will see its current Haematology and Chemotherapy services increase in size and be brought together in one unit with our Breast Care Service. This is a big step forward in delivering Cancer care in East Lancashire and will improve the patient experience immensely. The Trust has worked alongside the Rosemere Foundation and they have raised funds of 100k to help deliver the project due later this year. The Trust is also finalising development on the Burnley site which will see Children's out patients move within the site to a much better location alongside Children's Recover.

14. **Patient Safety Congress & Awards** – The Trust won the **Emerging Patient Safety Technology and IT Award** which was in relation to a simple IT solution that was developed to improve discharge to the community

Summary and Overview of Board Papers

15. **Patient Story** - These stories are an important aspect for the Trust Board and help to maintain continuous improvement and to build communications with our patients.

Summary of Chief Executive's Meetings for May 2016

04/05/16	Primary Care and ELHT Meeting
04/05/16	Mark Hindle, Calderstones Partnership NHS Foundation Trust
05/05/16	NHS Improvement Integrated Delivery Meeting
10/05/16	Rothwell Douglas Workshop
10/05/16	Visit to AVH with the Director of Nursing
11/05/16	Board Development Session
11/05/16	Employee of the Month
12/05/16	Post Graduate Education Monitoring Visit by HENW
16/05/16	Patient Safety Walk round with the Director of OD & HR – RBH
18/05/16	GGI Leaders Forum – Leeds
19/05/16	GGI Leaders Forum – Leeds
23/05/16	Meeting between ELHT/ELCCG Chairs and Chief Executives
23/05/16	Dale Williams - KPMG
24/05/16	HSJ Awards – Manchester
25/05/16	Trust Board
26/05/16	Meeting Professor StJohn - UCLAN
27/05/16	Team Brief RBH

Summary of Chief Executive's Meetings for June 2016

08/06/16	Board Development Session – GGI
13/06/16	Russ McLean
14/06/16	Meeting with Chief Officer – Bury CCG
15/06/16	NHS Confederation Annual Conference - Manchester
16/06/16	NHS Confederation Annual Conference - Manchester
17/06/16	NHS Confederation Annual Conference - Manchester
21/06/16	Health and Wellbeing Board – Blackburn
22/06/16	Healthier Lancashire & South Cumbria Programme Board - Leyland
22/06/16	Meeting with Trust CEO's, Graham Urwin and Amanda Doyle
23/06/16	Meeting with Burnley College
24/06/16	A&E Regional Workshop - Leeds
29/06/16	Trust Board
30/06/16	Roundtable with CQC to develop a Single View of Quality – London

Summary of Chief Executive's Meetings for July 2016

01/07/16	CEOs Follow Up Development Workshop - Preston
01/07/16	Meeting with Harry Catherall – Town Hall, Blackburn
01/07/16	Meeting with Sally McIvor, ELCCG
04/07/16	MIAA Introduction
04/07/16	Meeting with Mike Burrows, GMAHSN – Manchester
05/07/16	STP Assurance Meeting - Preston
07/07/16	NHSI IDM Meeting
07/07/16	Pennine Lancashire System Resilience Group
12/07/16	Meeting with Chair and CEO - Blackpool Hospitals NHS Trust
13/07/16	Board Development Session
15/07/16	Meeting with Julie Cooper MP
18/07/16	Team to Team meeting with LCFT
19/07/16	Meeting with The Christie - Manchester
20/07/16	STP meeting with Simon Stevens – Leeds
20/07/16	Lancashire and South Cumbria Programme Board
21/07/16	Visit to Barnoldswick Clinic
22/07/16	Health System Leaders Briefing
25/07/16	Finance and Performance Committee
26/07/16	Health and Wellbeing Board Summit – Preston
26/07/16	Lancashire CEO's Meeting - Preston
27/07/16	Trust Board – RBH

28/07/16	Back to the Floor – Quality and Safety
29/07/16	Team Brief – BGH & RBH
29/07/16	Shadow Council of Governors Meeting

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

27 June 2016

Item 214

Purpose Information
Action

Title	Board Assurance Framework (BAF) Review
Author	Mrs A Bosnjak-Szekeres, Company Secretary
Executive sponsor	Dr D Riley, Medical Director

Summary:
The Executive Directors have reviewed the risks monitored on the BAF and updated the controls, assurances and actions in relation to each risk.

As requested by the Board it can be confirmed that, in preparing this report the external context has been taken into account, such as legislative and regulatory requirements placed on NHS providers. Other elements such as local needs, trends and engagement with stakeholders have been considered and have influenced the review of the BAF risks.

Recommendation:

The Board is asked to discuss the BAF risks and the risk scores and agree the recommendation to increase the risk score in relation to risk 6.

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 Become a successful Foundation Trust

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: by the Operational Delivery Board (June 2016) and the Medical Director.

1. The Executive Directors have revised the BAF risks and the following changes have been made since the document was last presented to the Board.

a) **Risk 1** – the **risk score remains** 12 (likelihood 3 x consequence 4). New potential sources of assurance identified include the Quality Committee presentation about the quality element of the transformation programme and a presentation to the Board about the stroke transformation project. Work is on-going on providing assurance about the delivery of the programme and its benefits. The completed actions include implementation of the new reporting format for the transformation programme, successful recruitment to 2 transformation posts, early engagers to deliver service design identified and a methodology presented to the June Transformation Board which also forms part of the Pennine Lancashire transformation plan.

b) **Risk 2 –** the **risk score remains** 12 (likelihood 3 x consequence 4). The controls and potential sources of assurance have been revised and they remain the same. The transformation projects are now monitored through the Transformation Board and the workforce transformation pilots will start on 3 wards, with the results of the pilots and subsequent action plans reported to the Quality Committee.

c) **Risk 3** – the **risk score remains** 9 (likelihood 3 x consequence 3). Progress since the last review includes agreement about a number of clinical priorities and development of work streams at Pennine Lancashire level, quick wins initiative covering stoma, devices and procedures of limited value, Chronic Obstructive Pulmonary Disease (COPD), diabetes, locality working for new paediatric model in Rossendale, locality working for a new community model Ribblesdale, partnership working with GP practices for running primary care services and frailty pathway. At Healthier Lancashire level the Medical Directors of the four Trusts discussed the big ticket items and agreed to focus on urology, vascular services, stroke, emergency department, interventional radiology and gastrointestinal bleed.

d) **Risk 4** – the **risk score remains** 16 (likelihood 4 x consequence 4). New potential sources of assurance include the establishment of the case for change at Pennine Lancashire level and feedback has been sought on the case. The next phase will be the solution design case and the Trust is actively involved in the programme. The Pennine Lancashire Memorandum of Understanding is being presented to the Trust Board at the end of July.

e) **Risk 5 –** the **risk score remains** 16 (likelihood 4 x consequence 4). Changes to the strategic risk have been made as continuity of service risk rating has been

replaced with risk rating in line with the single definition of success criteria. The key controls have been updated to define the measures for closing the financial gap (effective monitoring of the transformation and Safely Releasing Costs Programme (SRCP) schemes by the Programme Management Office (PMO) and the Finance department). The additional workforce controls are to remain in place and divisions to be held to account for the delivery of the transformation and SRCP schemes.

f) **Risk 6 –** following a review it is recommended to **increase the risk score** from 15 (likelihood 5 x consequence 3) to 20 (likelihood 5 and the consequence score increasing from 3 to 4). The suggested increase is mainly a result of the challenges the Trust is currently facing in relation to the 4 hour Accident and Emergency (A&E) standard. The Trust has put in place a number of measures in order to address performance and these have resulted in improvements during last week. Work is on-going on the action plan that will be submitted to NHS Improvement and to ensure that the improvements in performance are sustained in the long term and built upon. The Board will at its July meeting receive an update on the actions taken to address the 4 hour performance. New potential sources of assurance identified under this risk include the development of the action plan from the last Care Quality Commission (CQC) inspection that is owned at divisional level with progress reported to the Quality Committee. The update to the planned actions is about the Trust being on track to achieve its target on reducing the number of complaints that are over 50 days.

2. Work that will be carried out in this quarter includes aligning the BAF with the Corporate Risk Register and starting the process of reporting on individual BAF risk to the sub-committees of the Trust Board, with the Finance and Performance Committee focusing on BAF risks 1, 2, 4 and 5 and the Quality Committee on BAF risks 3 and 6. The work on developing the risk appetite statement for the organisation will continue at Board level.

3. NHS Improvement has issued for consultation the document about the Single Oversight Framework. Consultation closes on 5 August 2016 and changes relating to the BAF following the implementation of the Single Oversight Framework will be taken into account during the next review.

4. The Board is asked to note the changes to the Board Assurance Framework and agree the recommendation to increase the risk score for risk 6 from 15 to 20.

Angela Bosnjak-Szekeres, Company Secretary, 20 July 2016

Board Assuran Board Assurance Framework

Ref	Ref No	Principle Director	Strategic Risk *What could prevent these objectives being achieved.*	Risk related to strategic objectives	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 2015/16				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.*
											Q1	Q2	Q3	Q4			
BAF/16/01	BAF/16/01	Director of Service Improvement	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives	Aligned to Strategic Objectives 1,2,3 and 4.	Integrated transformation plans agreed at organisational level, overarching tracker for transformation and SRCP, Transformation Board meetings (internal and external stakeholders), divisional Transformation Boards report into the Transformation Board that reports into the Finance & Performance Committee. Membership of the Pennine Lancashire Transformation Board (6 workstreams). Transformation/business plans linked to the clinical strategy, high level workforce and estate interdependencies identified.	Monthly report demonstrating progress against key targets reported to the Transformation Board and the Finance & Performance Committee Presentation to the Quality Committee om the quality aspect of the transformation programme Board presentation on the stroke transformation plan	15	10	12	3x4	12	12			Capacity for delivery of transformation programme Service redesign methodology developed by the Trust (accepted by Pennine Lancashire) but ownership and training in relation to service redesign is outstanding.	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.	New reporting format agreed following meeting with the NED's Using the Transformation Board meetings and our membership on Pennine Lancashire to influence delivery of transformation - update in July. Update - case for change at Pennine Lancashire level agreed, Trust senior leadership involved in the solution design phase. Resources allocated for the delivery of the transformation programme, but further resources needed. Update: two PMO posts recruited. Ownership/training in relation to the service redesign to be driven by the clinical leadership and by identifying early engagers to deliver the service redesign. Update - early engagers identified, methodology presented to the Transformation Board and accepted for inclusion into the Pennine Lancashire Transformation Plan.
BAF/16/02	BAF/16/02	Director of HR/OD	Recruitment and workforce planning fail to deliver the Trust objectives	Aligned to Strategic Objectives 2, 3 and 4.	Transformation plans relating to workforce in place monitored through Transformation Board. Divisional Workforce Plans aligned to Business & Financial Plans, Divisional Performance Meetings, Reports to Finance & Performance Committee, Workforce Controls Group, Population/Person Centric Workforce Planning Methodology	Performance measures, time limited focus groups with action plans, board and committee reports, regulatory and inspection agencies, stakeholders, internal audit	16	10	12	3x4	12	12			National recruitment shortages, capacity for delivery of transformation programmes, financial restrictions	Further work required on assurance reporting	PIDS and project plans agreed for transformation programmes. Overseas recruitment campaigns continue. 3 distinct Workforce Transformation (WFT) Pilots identified. Update: pilots on three wards start at the end of the month re person centric workforce planning methodology. Results of the pilot and actions will be presented to the Quality Committee. October Board will receive a presentation on workforce under the strategy item.
BAF/16/03	BAF/16/03	Medical Director	Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways	Aligned to strategic objectives 3 and 4.	New clinical pathways agreed at Care Professional Group of Pennine Lancashire and reporting to the Transformation Steering Group. Governance controls in place feeding into the Clinical Effectiveness Committee and into the Quality Committee	Clinical Effectiveness Committee acting as a governance mechanism for the agreement of the internal pathways and guideline. Stroke pathway already included in the transformation programme. ELHT Transformation Board has urgent care pathway reporting process.	9	6	9	3x3	9	9			Not all pathway developments linked in fully with the transformation programme	No separate programme is place to consolidate internal clinical pathways. Mechanism for prioritisation of pathway development not in place at divisional/organisational level	Prioritisation mechanism to be resolved at 2 levels - internally as part of the transformation programme & externally as part of the Pennine Lancashire. Work at Pennine Lancashire level to establish clinical priorities due to be signed off by June. Update: agreement about a number of clinical priorities and development of work streams at Pennine Lancashire level, quick wins initiative covering stoma, devices and procedures of limited value, COPD, diabetes, locality working for new paediatric model in Rossendale, locality working for a new community model Ribblesdale, partnership working with GP practices for running primary care services and frailty pathway. At Healthier Lancashire level the Medical Directors of the four Trusts discussed the big ticket items and agreed to focus on urology, vascular services, stroke, emergency department, interventional radiology and gastrointestinal bleed.

Ref	Ref No	Principle Director	Strategic Risk *What could prevent these objectives being achieved.*	Risk related to strategic objectives	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 2015/16				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.*
											Q1	Q2	Q3	Q4			
BAF/16/04	BAF/16/04	Chief Executive/ Director of Finance/ Director of Service Improvement	Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust	3,4,5	Senior Leaders' Forum meets to discuss strategy. Engagement by senior leaders in wider transformation programmes. Regular Board updates and decisions on key actions. Strengthen links between internal transformation and external change processes.	Verbal and written updates, where appropriate Board approvals will be established and permissions will be provided by the Board to let Executives to progress the generations of ideas and options with external stakeholders. At Pennine Lancashire level a case for change established and in process of seeking feedback on it. Moving onto the solution design phase, senior leaders from Trust involved at a strategic level	16	12	16	4x4	16	16				Concise summarisation of discussions and decisions	Regular updates provided to Board Pennine Lancashire Memorandum of understanding to be presented to the July Trust Board. Pennine Lancashire project entering solution design phase.
BAF/16/04	BAF/16/05	Director of Finance	The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with a single definition of success criteria.	3,4,5	Ensure suitable controls are in place to maintain budgetary control (income and expenditure). These controls need to extend to effective workforce arrangements. In addition to controls the Trust must ensure that measures are in place to close the financial gap (SRCP), via the Transformation and SRCP schemes effectively monitored by the PMO and the Finance Department.	Monthly reporting to Finance and Performance reports and the Board to reflect financial position. Separate reporting available to support assurances on the transformation programme.	16	12	16	4x4	16	16			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.	Utilise the internal audit programme to test for assurance on core controls and SRCP.	Regular updates to Board and Finance and Performance Committee
BAF/16/06	BAF/16/06	Director of Operations/ Director of Nursing/Medical Director	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements	Aligned to strategic objectives 1, 3 and 4.	Divisional business plans, weekly operational performance meetings, quarterly divisional performance meetings feeding into the ODB and Finance and Performance Committee, emergency pathway and elective pathway work linking into the broader Trust wide transformation. Engagement meetings with CQC, quality and safety compliance assessed by each division, divisional assurance boards feeding into the operational sub-committees and the Quality Committee.	IPBR reporting to the ODB and at Board/Committee level, regular reporting to the NHSI, monthly integrated delivery meeting with the NHSI and system resilience group (SRG). Positive feedback from the last CQC visit, no active action notices from the CQC since April 2014, 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. Action plans developed for the must do's and should do's from the last inspection, owned by the Divisions and reporting on progress to the Quality Committee.	15	9	15	5x4	15	20			Timelines for the delivery of the transformation projects not in place. Staffing not sufficient to deal with the impact of external environment & high demand, difficulties with discharges. Staff guardian role not yet fully embedded across the Trust, complaints are a potential source of action by the CQC. Work needed on improving standardised clinical multiprofessional care.		Timeline for the transformation of the emergency pathway plan to be agreed by July. Working as part of the SRG to resolve demand issues and participating in the delayed discharge collaborative with the NHSI. Work on-going on publishing the staff guardian role. Work on reducing the number of complaints, 50+ days complaints, still on target to be completed by the end of July. Work on the AMU/urgent care centres/model wards continues. Challenges of achieving the four hour standard addressed, measures put in place to address performance and action plan being drafted for submission to NHSI with a view to improve performance and sustain it in the longer term. Board will receive a presentation on the challenges surrounding the four hour standard at the July meeting.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 215

27 July 2016

Purpose Action

Title	Corporate Risk Register
Author	Mr D Tansley, Associate Director of Quality and Safety
Executive sponsor	Dr D Riley, Executive Medical Director

Summary:

This paper reviews the current Corporate Risk Register

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 have also been considered where appropriate.

Recommendation:

It is recommended that the Committee:

a. Note the Corporate Risk Register

b. Note the new risks identified that are awaiting PS&RA Committee approval

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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical

pathways

Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust

The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Introduction

1. There have been no additional risks incorporated into the Trusts Corporate Risk Register during May / June 2016.
2. A Risk Assurance Group has been introduced as a formal sub-committee of the Patient Safety and Risk Assurance Committee.
3. The current risk register of those items scored at 15 and above is attached as Appendix 1.

New risks that have been identified awaiting committee approval

6910 – Inadequate staffing for litigation function

4. Hazard - Inadequate staffing for litigation function impacting on the Trusts ability to put safety and quality at the heart of everything we do.
5. Risks - Litigation claims are not submitted to NHSLA within the required timeframe resulting in the Trust being financially liable for the payment of clinical negligence claims if proven.
6. Deadlines for litigation are not met resulting in financial penalties as a result of cases being referred to court for mandatory action**.**
7. Reputational risk to the Trust with the stakeholders and regulatory bodies
8. Withdrawal of specialist support due to high risk
9. Inadequate oversight of on-going litigation cases leading to missed opportunities for early settlement and reduced costs.
10. Potential adverse impact on claimants from delayed processing of claims leading to higher award of costs / damages.
11. Adverse impact on current staffing and low staff morale and depletion of resources within other functions to support case management leading to increased levels of sickness through work related stress.

6912 – ICO intervention

12. Hazard – Insufficient resources to support current demand for Data Protection / Freedom of Information / Information Governance (including potential litigation) requests have resulted in a number of ICO decision notices over the last six months
13. Risk – Current involvement by ICO in a number of FOI and DPA requests escalates to enforcement action / sanctions resulting in potential fines
14. Further decision notices being issued due to poor information governance practice across the Trust
15. Contract based negotiations have taken place with the CCG regarding the

Information Governance Toolkit.

Recommendations

16. It is recommended that the Board:

a) **Note** the Corporate Risk Register and the discrepancies highlighted with register entries.

b) **Support** the development of the Risk Assurance Group and Risk Register through training to governance and divisional leads.

David Tansley, Associate Director of Quality and Safety, 20 June 2016

Appendix 1 - Corporate Risk Register as at 20/06/2016

ID	Opened	Due for review	Title	Controls in place	Risk Lead	Lead Division	Rating (initial)	Rating (current)	Rating (Target)	Action summary	Open actions / comments
5790 Linked to divisional risks **4488** **5702** **908** **6487**	11/09/2015	30 June 2016	Aggregated risk - high usage of medical locums resulting in risk of increased costs	Use of Framework Use of Staff-Flow management Refreshed advertising for ED posts GP advertisements Engaging a recruitment agency Consultants current do cross cover at times of need Requiring agency override forms to be signed by	Kevin Moynes	Trust-wide	15	**15** NO CHANGE SINCE LAST REPORT	9	Local Plans in place to manage medical vacancies but national shortages of some specialists, and locum agency cap deters some applicants.	Due review

				MD. Only authorising on grounds of patient safety. Ward based competencies programme underway							
5791 Linked to divisional risks **3804** **4640** **4708** **5789**	11/09/2015	30 June 2016	Aggregated risk - Nursing shortages requiring high agency spend	Daily staffing teleconference each morning to ascertain staffing "hot spots" and reallocation of staff Corporate Safer Staffing steering group Planned duty rosters set out to deliver numbers and skill mix, aiming to ensure	Chris Pearson	Trust-wide	15	**15** NO CHANGE SINCE LAST REPORT	8	Local plans in place to manage and fill vacancies but national shortages of some nurse groups, and locum agency cap deters some applicants	Due review

				appropriate senior nurse with skills and experience on duty to achieve 1:8 (daylight hours); All supervisory management time has been identified and is utilised to deliver 'hands on' nursing care. E-rostering utilised Robust systems implemented to manage and monitor the utilisation of temporary staff, and overtime;							

				A strategic recruitment campaign and improved processes has resulted in a significant reduction in unfilled vacancies, and monitoring of same Reduced bed base and increased efficiency in managing length of stay to make more effective and safe use of staffing resource:								

2310	23/04/2014	30 June 2016	Failure to deliver 18 week Referral to treatment waiting times	Performance management meetings with the surgical division. Individual specialties being examined and plans put in place to improve waiting time performance	Gill Simpson	Trust-wide	3	**15** NO CHANGE SINCE LAST REPORT	10	-	Divisional General Managers leading. Due review
6828 Linked to divisional risks 2256 2051	03/05/2016	30 June 2016	Aggregated risk - Failure to deliver stroke care within national guidance and to meet at least "C" in SSNAP audit	Rectification action plan in place Care pathways and bundles be improved Improving patient flow Healthier Lancashire priority discussions	(Medicine CD)Roberts, Dr Nick	Medical	15	**15** NO CHANGE SINCE LAST REPORT	10	Pan Lancashire group being established to address challenges. New Stroke care booklet launched in ELHT for improved coding	John Bannister and Johanne Deegan Due review

5180	29/04/2015	30 Nov 2016	Failure to meet the HIMOR standards of living in the Staff residence buildings at RBH	Faults are reported to BBW. Highlighted to head of Estates that action needs to be taken to rectify these faults immediately.	James Maguire	Corporate	20	**16** NO CHANGE SINCE LAST REPORT	8	Works planed for upgrades by November 2016	(Facs) Henderson, Heather
1660	17/10/2012	3 May 2017	Risk of unsuitable ward areas due to cancelling Statutory refurbishment programme	No controls available - All works have to be suspended as no decant ward area available on site to continue with programmed works.	James Maguire	Corporate	20	**16** NO CHANGE SINCE LAST REPORT	12	As wards become available works are being commenced and further work is being done to identify ward flows to free wards for works to take place	(Facs) Grendall, Lisa

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD REPORT

Item 216

27 July 2016

Purpose Information
Action
Monitoring

Title	Serious Incidents Requiring Investigation Report
Author	Mrs D Hunter, Assistant Director of Safety and Risk Assurance
Executive sponsor	Dr D Riley, Medical Director

Summary: This report provides a summary of the Serious incidents that have occurred within the Trust in May and June 2016, a status report on the delivery of Duty of Candour and assurance on actions taken following a number of Never Events that have occurred since July 2015.

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.

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice Become a successful Foundation Trust
Related to key risks identified on assurance	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the

framework	organisation's corporate objectives
	Recruitment and workforce planning fail to deliver the Trust objectives
	Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways
	Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust
	The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.
	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

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

Previously considered by: NA

Introduction

1. This paper provides the Board with:

- **Part 1:**
  An overview of all Serious Incidents Requiring Investigation (SIRIs) that have been reported during May and June 2016

- **Part 2:**
  A Duty of Candour performance report

- **Part 3:**
  A Never Event assurance report

Part 1: Overview of SIRIS reported

STEIS SIRIs reported in May and June 2016

2. There have been 8 Strategic Executive Information System (STEIS) events reported in May and June 2016 which is a decrease of 9 compared with the last reporting period. All will undergo Root Cause Analysis (RCA) which will be performance managed by the Trust's SIRI Panel and East Lancashire Clinical Commissioning Group.

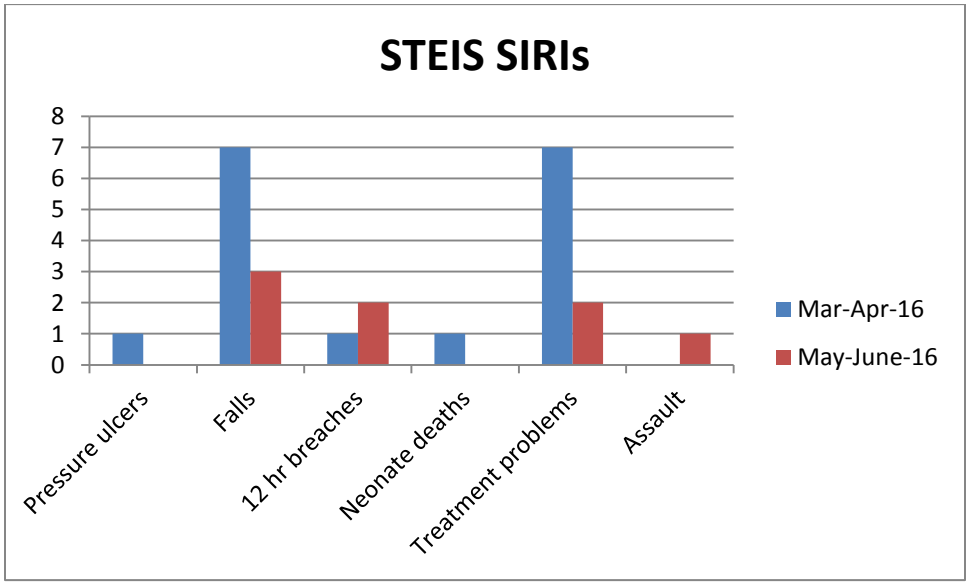
No	Eir1	Division	Ward/ dept.	Description
1	107710	DCS	Radiology	Missed cerebral aneurysm on CT brain scan
2	100833	SAS	C22	Failure to prescribe and administer anti-epileptic medication
3	106885	ICG	D1	# Neck of Femur
4	108368	ICG	ED	12 hour mental health breach
5	108463	ICG	ED	12 hour mental health breach
6	109116	ICG	C7	# Neck of Femur
7	109296	ICG	Reedyford	# Neck of Femur
8	109610	ICG	AMU B	Alleged sexual assault

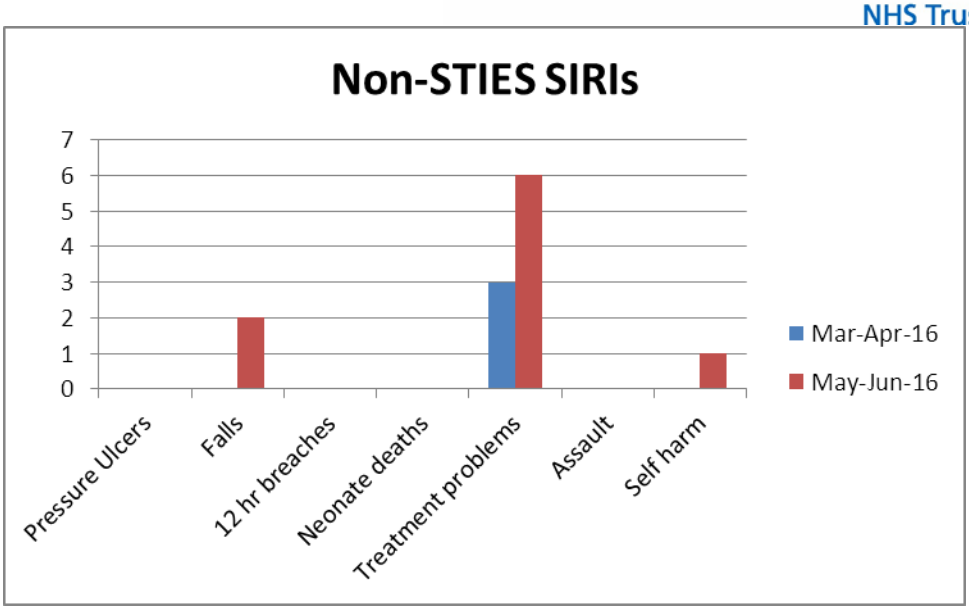
Non STEIS SIRIs reported in May and June 2016

3. There were 9 non STEIS incidents deemed to be serious incidents requiring investigation in May and June 2016 compared with 3 in the previous reporting period. All will undergo RCA and will be performance managed by the Serious Incident Review Group (SIRG).

No	Eir1	Division	Ward/ dept.	Description
1	104957	ICG	AMU A	Serious Fall
2	107199	ICG	ED	Diagnosis failure
3	107844	SAS	B22	Medication error
4	108008	ICG	AMU A	Self-harm
5	107452	Estates and facilities	Out patients Burnley General	Serious Fall
6	108002	ICG	B4	Medication Error
7	108245	SAS	Critical Care	Dislodged tracheostomy
8	108635	FC	Birth Suite Burnley General	Undiagnosed breach birth
9	109688	ICG	Ambulatory Care	Missed VTE prophylaxis

4. *STEIS and non STEIS SIRIs reported above compared with previous months in graphical format*





Part 2: Duty of Candour (DOC) performance report

5. 39 patient safety incidents graded as moderate or above were reported in May and June 2016 which was a decrease on the 49 that were reported in the previous reporting period.

   These incidents were subject to the DoC regulations which dictate that DoC should be served within a 10 day timeline.

   At the time of writing this report, there are 2 incidents where Duty of Candour has not been served within the 10 day timeline.

   An update report setting out the rationale for the non-completion of DoC is shared with the Deputy Medical Director on a daily basis. The aim of this report is to facilitate a discussion between the Deputy Medical Director and the senior lead clinician responsible for each of the DoC cases to resolve any perceived difficulties

   In addition, a weekly meeting is held with the divisional governance leads to review any outstanding DoC cases and to agree plans to bring them back on track.

   Performance in adherence to the DoC regulations has improved significantly across the Trust during this reporting period

Part 3: *Never Events assurance report*

6. Since July 2015, the Trust has reported 5 Never Events as follows:

Date	Type of Never Event
10th July 2015	Misplaced NG Tube
13th November 2015	Wrong site nerve block
3rd December 2015	Wrong site surgery
27th December 2015	Retained foreign object
30th June 2016	Retained foreign object

The Never Events are not connected, they occurred in different teams, and these teams have not had a repeat of the Never Events since.

The retained foreign object incident of 27th December 2015 has now been downgraded following investigation and is now no longer deemed to be a Never Event

Due to the high number of Never Events reported, the Trust was contacted by the Trust Development Authority (TDA) with a request to provide assurance on actions implemented and an overview of the audit processes in place to prevent re occurrence.

The following tables provide an overview of the 5 Never Events, an update on their progression through the Trusts SIRI process including where available a summary of the lessons learned and actions taken / planned and evidence of audit and assurance as requested by the TDA.

Never Events update

STEIS number	2015/23925
Date reported	10th July 2015
Event description	Misplaced NG tube
Investigation status	• Rapid Review shared with CCG • RCA presented to SIRI panel and closed in October 2015 by CCG
Lessons learned	• Mis-reporting of X-ray can occur even with experienced staff if the focus is given to the position of the tip of the NG tube rather than the relationship of the tube to the central airways. • The practice of flushing tubes with water prior to obtaining aspirate should be avoided • PH strips buffered for water should only be available for use in the Trust. The non-buffered pH strips were masked off the electronic supply chain ordering system for the Trust however they have since been found in the Trust. The expiry date has been checked and some have an expiry of 2017 which indicates that they have recently come into the Trust. There could be a possibility that even though the correct pH strips are ordered the Trust may be being sent un -buffered strips if not in stock. This needs further investigation. (NB the pH strips are not marked as buffered or un-buffered therefore and the only way of knowing was by undertaking tests internally which led to the masking of non-buffered strips in the Trust)
Actions agreed	• Amend the Naso-gastric Care Bundle to specify that water should not be used to flush the tube prior to obtaining aspirate. • Ensure the Naso-gastric Care Bundle trialled and rolled out across Trust • Ensure all non-buffered pH strips are removed from all wards • Ensure all non-buffered pH strips are masked and cannot be purchased. • Audit if any non-buffered pH strips have been ordered within the Trust when they should have been masked and identify wards who may have ordered them to remove. • Distribute a “message of the day” regarding the use of the correct pH paper and include in the Share 2 Care bulletin • Use anonymised case study of X-ray reporting as a learning aid • Amend the training tools for X-ray reporting for NG tube placement. • Amend the enteral feeding policy to make it very clear that confirmation of placement is by drainage of

	gastric content and that feeding must not be attempted via a drainage tube • As part of the re tendering process, explore the possibility of the Care Bundle paperwork being included in the feeding tube packaging • Amend the Naso-gastric Care Bundle to ensure that medical teams requesting feeding tube insertion are clear about their roles and responsibilities ie reviewing associated xrays / escalation to radiology if necessary / request assistance if not confident that the tube is in the correct place
Audit and assurance	• The Trust audited the use of enteral feeding tubes in 2015. • Thereafter a NG tube care bundle was introduced and the audit was repeated in Q1 of 2016. • The preliminary results of the audit have now been reviewed and an action plan developed to support the findings as follows: – Refine the audit tool and repeat the re-audit as some elements of the audit tool are not wholly suitable now that the Care Bundle is in place – Further educate medical staff is to ensure x-ray element of the Care Bundle is completed fully. – Further educate nursing staff to ensure repositioning techniques are undertaken prior to request for x-ray confirmation of positioning. • Further assurance on the audit process and implementation of actions will be managed by the Patient Safety and Risk Assurance Committee

STEIS number	2015/37934
Date reported	3rd December 2015
Event description	Wrong site surgery
Investigation status	• Rapid Review shared with CCG • RCA presented to SIRI panel and submitted to CCG for closure in March 2016 • Discussion re Trust's proposal to de STEIS held with CCG as incident deemed not to be a Never Event following investigation. • Agreement not reached • Arbitration to be pursued
Lessons learned	• An agreed system is required for effective and reliable communication of the required biopsy site(s) when listing to minor operations clinic. This system should be linked to the surgical checklist used prior

	to the procedure
Actions agreed	• Share learning from the incident with Dermatology Directorate • Agree and implement an ELHT standard for utilisation of the British Association of Dermatologists pre-printed anatomical numerical diagrams. • Agree identity/version control for the anatomical numerical diagram • Implement a surgical checklist for use in minor operations clinics to ensure that operators check biopsy sites • Review biopsy listing processes • Establish an agreed list for operators approved to undertake head and neck skin biopsies • Implement an audit program for assurance relating to all standards adopted
Audit and assurance	• The Trust is compliant with the WHO documentation check list audit • Further work is underway to audit the Quality of the completion of the WHO checklist

STEIS number	2016/425
Date reported	27th December 2015
Event description	Retained foreign object
Investigation status	• Rapid Review shared with CCG • RCA presented at SIRI panel on 21st April 2016 and submitted to CCG • Amendments to RCA requested by CCG on 31st May 2016 • Amended RCA submitted to CCG on 29th June 2016 – downgraded from a Never Event • Awaiting final decision on closure by CCG
Lessons learned	• All gauze swabs / balls used as part of any procedure at birth eg instrumental birth, suturing, normal birth etc must vbe x-ray detectable and be counted pre and post procedure and mid procedure if there is a change of staff • Delivery and suture packs must not contain non x-ray detectable gauze swabs / balls
Actions agreed	• All delivery areas have stopped using the pre packed delivery packs which contained non x-ray detectable gauze swabs / balls • All delivery packs are now self-assembled and only contain x-ray detectable gauze swabs / balls • Introduce a swab / instrument count when there is a change of staff during a procedure. This will be recorded on the white board

	• A blue light alert will be circulated regarding the cessation of the use of pre packed birth packs • Use of a purple wrist band for all patients with intended retained swabs in situ
Audit and assurance	• The use of gauze swabs / balls in maternity services is contained within three policies as follows: – ELHT maternity services clinical guideline 3: Care of women in labour – ELHT maternity services clinical guideline 12: Operative vaginal delivery – ELHT maternity services clinical guideline 44: Perineal trauma • Guidance on the use of gauze balls / swabs to be removed from the above 3 policies and become a standalone policy • These guidelines have been compared with equivalent international best practice guidelines in so far as managing the risk of a Never Event and they are compliant • A retrospective audit has been undertaken and has shown 100% compliance for pre and post procedure swab count • Further audits are planned for the birth centres

STEIS number	2016/8389
Date reported	13th November 2015
Event description	Wrong site nerve block
Investigation status	• Rapid Review shared with CCG • RCA submitted to SIRI panel 19th May 2016 • Amendments required • RCA submitted to CCG on 21st June 2016 • Closed by CCG
Lessons learned	• The process of "Stop before you Block" is essential to prevent this type of incident re occurring
Actions agreed	• Promote adherence to "Stop before you Block" to all anaesthetic clinicians, nurses and ODPs • Circulate new "Stop before you Block" posters to theatres and anaesthetic rooms • Pursue a programme of audit using the new NATSSIPs checklist when it is rolled out
Audit and assurance	• The Trust has implemented the "Stop before you Block (SBYB)" process which is supported by the Royal College of Anaesthetists and has been championed by the Safe Anaesthesia Liaison Group • The Trust is currently adhering to the relevant best practice guidelines issued by Regional Anaesthetics

	UK and the Safe Anaesthesia Liaison Group. These national guidelines do not as yet include reference to the SBYB process • Despite this, the Trust is working to include the SBYB process into the WHO checklist and the anaesthetic chart. Once this has been completed a programme of audit will commence • Risk assurance audit under taken by the Governance lead in Anaesthetics

STEIS number	2016/18659
Date reported	30th June 2016
Event description	Retained swab
Investigation status	• Rapid Review received • STEIS reported • RCA requested • Due at SIRI panel in September 2016
Lessons learned	• Awaiting outcome of investigation
Actions agreed	• Awaiting outcome of investigation
Audit and assurance	• Awaiting outcome of investigation

Debbie Hunter, Assistant Director of Safety and Risk Assurance, 20th July 2016

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD REPORT

Item 217

27 July 2016

Purpose Monitoring

Title	Professional Judgement Review
Author	Mrs J Molyneaux, Deputy Chief Nurse Ms C Henson, Assistant Director of Finance
Executive sponsor	Mrs Christine Pearson, Director of Nursing

Summary:

The paper details the outcome of the professional judgment review of registered and non-registered nurse staffing. The financial implications are presented in detail within the body of the report.

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 have been taken into account where applicable.
.

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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the

delivery of sustainable services by the Trust

The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.

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	Yes

Previously considered by: NA

Introduction & Background Information

1. This paper will provide an update to the Trust Board in respect of the expectations set out by the National Quality Board (NQB) in November 2013, contained within "How to ensure the right people, with the right skills, are in the right place at the right time" *A guide to nursing, midwifery and care staffing capacity and capability*
2. Expectation 3 of the above report stipulates that as a wider assessment of workforce requirements, evidence based tools, in conjunction with professional judgments and scrutiny are used to inform staffing requirements. The report goes onto specify that the Board receives papers on establishment reviews, and that they are carried out every six months.
3. The Board has agreed previously that whilst the organisation is in the process of rolling out the Safer Care Module of the Allocate E-Rostering system, (which will enable 3 points throughout the day real time acuity and dependency against the staffing available) that the 6 monthly acuity and dependency audit will forgo and a professional judgment review be undertaken in the interim.
4. The acuity and dependency audit (over a three week period) was due to take place in September 2015, in its place a professional judgment review was undertaken. Unfortunately due to the reconfiguration of several services (MAU and within SAS) the report has been delayed to this point.
5. The professional judgment review encompassed all ward areas, across all 5 sites, looking at both registered and non-registered nursing workforce.
6. The establishment reviews for the Emergency Department and the Neonatal Intensive Care Unit will be presented as separate paper.

Purpose of the report

7. To inform the Trust Board of the findings of the nurse staffing, registered and non-registered professional judgment review.

Process

8. The review was undertaken per division and per directorate led by the Deputy Director of Nursing and the Assistant Director of Finance. The Divisional Directors of Nursing, Assistant Director of Nursing, Matron and Divisional Accountants attended the meetings and by way of professional debate and challenge safe staffing levels for each ward were agreed and or confirmed based on previous iterations of the process. For the first time health care support workers ratio's were reviewed

Summary Headlines

Surgical & Anaesthetic Services (SAS)

9. Registered nurse establishments on the whole remained as per previous professional judgment review (August 2014), the only exceptions being to:

   a) Ward B20, the new vascular ward, due to reconfiguration of services. The professional judgment review concluded an additional 1.71wte would be necessary to meet the requirements of safe staffing. The posts have been funded out of the income attribution relating to Vascular Services.

   b) Ward C22, Urology and head and neck, have a shortfall of 1.00wte from the initial exercise when an advanced nurse practitioner was mistakenly classed as a staff nurse, this is shown in table 1

Table 1

Division	Ward	Wte	£'000
SAS	C22 - Urology / H&N	1.0	23.0
Total		1.0	23.0

10. A review of health care support worker establishment determined the following additional requirements as identified in table 2

Table 2

Division	Ward	Wte	£'000
SAS	C18 - General Surgery	1.0	23.5
	Surgical Triage Unit	2.9	65.5
	B22 - Orthopaedics	6.1	139.6
	B24 - Orthopaedics	1.5	35.0
Total		11.5	263.6

11. The forecast spend within the Surgery and Anaesthetic Services division in 2015-16 for health care support bank staff is £0.8m and £0.2m on health care support agency staff.

12. The qualified nurse shortfall of 1.0wte will be funded via the 2016-17 budget setting process and it is recommended that the Health Care Support Staff shortfall of 11.5wte is addressed by the division by realigning the income attribution budget received in 2015-16 as the spend on temporary staff is currently above the cost of the substantive staff.

Family Care

13. NICU establishment review will be presented as separate paper

14. Based on the birth rate for Jan 2015 to December 2015 the midwifery funded establishment/birth ratio is 1:29:7. The division is not requesting any changes to the midwifery based establishments. However it should be noted due to vacancies, maternity leave and sickness birth ratio varies between 1:30 to one to 1:33. Recruitment is on going and new starters are due to commence over the next few months.

15. There has been a substantial request in respect of increasing the registered nurse establishment (from the previous August 2014 review) for children's services as identified in Table 3

Table 3

Division	Ward	Wte	£'000
Family Care	COAU	0.5	10.6
	Childrens ward	8.5	196.4
Total		9.0	207.0

16. The requested increase remains significantly lower than RCN guidance which would suggest 36.67 WTE. The increase of 9.0 WTE using professional judgment is being asked for due to the following reasons:

a) Increase in activity

b) To provide a supervisory coordinator during the day for the 51 bedded unit

c) Operational challenges, due to the geographical lay out of the unit, 20 cubicles and rapid changes to the activity

d) To provide a member of staff for the high activity, acuity and dependency of the High Dependency Unit. (3 HDU beds – the recommended registered nurse ratio is either 1:2 or 1:1, depending on acuity and severity of illness) This has been forward as in the 2016-17 contract negotiations to the commissioners as a code of conduct variation. To date this has not yet been agreed.

17. A review of health care support worker establishment for children's ward determined the following additional requirements as identified in table 4 and are to support the registered nurses manage the increase in activity and operational issues discussed above.

Table 4

Division	Ward	Wte	£'000
Family Care	COAU	4.6	105.6
	CMIU	1.1	25.5
Total		5.7	131.1

18. The forecast spend within the Family Care division in 2015-16 for health care support bank staff is £0.4m and £0.01m on health care support agency staff.

19. The qualified nurse staffing levels (9.0wte) will be funded via the 2016-17 budget setting process and the recommendation is that the health care support staff shortfall of 5.7wte is addressed by the division by realigning the income attribution budget received in 2015-16 as the spend on temporary staff is currently above the cost of the substantive staff.

Integrated Care Group

20. The Emergency Department establishment review will be presented as separate paper.

21. Registered nurse establishments on the whole remained as per previous professional judgment review (August 2014), the only exceptions being to the acute stroke unit as displayed in table 5

Table 5

Division	Ward	Wte	£'000
ICG	B2 Acute Stroke Unit	3.4	78.4
Total		3.4	78.4

22. A review of health care support worker establishment determined the following additional requirements as identified in table 6

Table 6

Division	Ward	Wte	£'000
ICG	B2 Acute Stroke Unit	4.6	106.7
	B4	1.8	41.2
	C9	1.7	39.3
	B18	3.0	68.8
	C4	4.0	92.0
	C5	1.4	31.0
	C6	2.2	49.9
	C7	2.2	50.4
	C10	4.5	103.0
	C1	2.2	50.4
	D3	3.2	73.4
	D1	2.7	62.8
	Hartley PCH	1.1	26.0
	Ward 2 AVH	2.2	50.6
Total		38.2	878.1

23. The forecast spend within the ICG in 2015-16 for health care support bank staff is £2.4m and £0.5m on health care support agency staff.

The qualified nurse staffing level on ward B2 are to be funded via the 2016-17 budget setting process and the recommendation is that the health care support staff shortfall of 38.2wte is addressed by the division by realigning the income attribution budget received in 2015-16 as the spend on temporary staff is currently above the cost of the substantive staff.

Financial Summary

24. The qualified nurse shortfall is on ward B2 stroke ward, ward C22 and within Family care on the children's observation assessment unit (COAU) and the children's ward, this equates to 13.4wte, a cost of **£308,400**.

25. The health care assistant shortfall on the wards is across the Integrated Care Group, Surgery and Anesthetics Services division and the Family Care Division. This equates to 53.9wte posts a cost of **£1,240,000**.

Recommendation

26. The recommended qualified nurse levels are to be funded out of the 2016-17 budget setting process at a cost of £308,400.

27. The health care assistant shortfall should be reviewed by the divisions by realigning the income attribution budget received in 2015-16 as the spend on temporary staff is

currently above the cost of the substantive staff within the divisions and an agreed budgeted establishment should be reached at divisional level in line with the findings of the report.

28. To note work is ongoing to agree staffing levels for the Emergency Department and the Neo-natal intensive care unit. Once completed this will be presented to the Trust board.

East Lancashire Hospitals NHS Trust

TRUST BOARD PART ONE REPORT

Item 218

27 July 2016

Purpose Monitoring

Title	Integrated Performance Report (for the period to June 2016)
Author	Mr M Johnson, Associate Director of Performance and Informatics
Executive sponsor	Mrs G Simpson, Executive Director of Operations

Summary:

This paper presents the corporate performance data at June 2016 against the Trust Development Authority Standards and other key areas.

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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.

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	Yes

Previously considered by: Operational Delivery Board and Finance and Performance Committee (June 2016)

Board of Directors, Update

Corporate Report – July 2016

Key Messages of this Report

Referral to treatment 18 week ongoing pathways continue to achieve.
Accident and emergency four hour failed in June 2016 alongside the number of ambulance handover over 30 minutes
The number of delayed transfers of care remains above threshold.
The 62 day cancer treatment measure is below threshold (85%) in May at 82.8%. All other cancer measures were achieved.
The Trust is reporting a deficit of £0.9m at 30th June 2016, this position is in line with the planned forecast deficit.
The Trust is reporting underperformance on activity levels due to operational pressures which have resulted in some cancelled activity.
Continued usage of agency and locum staff over and above the resources available.

Introduction/Background

1. This paper presents the corporate performance data for June 2016 against the Trust Development Authority Standards and other key measures.
   Except:
   - Mortality – March 2016
   - Cancer performance – May 2016
   - Sickness rates – May 2016
   - Ambulance indicators – May 2016

Achievements

2. **Main achievements for June 2016:**

- No MRSA infections since December 2015, over six months.
- There were three Clostridium difficile toxin positive isolates identified in June 2016 against a trajectory of two. The year to date cumulative figure is 6 against the trust target of 28.
- Complaints remain below the 0.4 per 1000 contacts threshold with 23 new complaints in June.
- The latest Trust SHMI continues to be within expected levels, as published in June 2016 at 1.06
- The latest indicative 12 month rolling HSMR (Apr 15 – Mar 16) is reported 'as expected' at 96.58 against the monthly rebased risk model.
- The Trust continues to receive a high response rate and positive scores for the friends and family test.
- The Trust continues to achieve the hospital ambulance screen data quality compliance measure.

- Referral to treatment incomplete pathways remains above the 92% threshold.
    - There are two patients waiting over 52 weeks at the end of May 2016, both waits due to patient choice.
- The Trust is reporting a deficit of £0.9m at 30th June 2016. This position is in line with the planned forecast £3.7m deficit for the financial year 2016-17.

Key Issues

3. **Main issues for June 2016:**

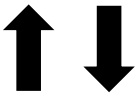
- Overall performance against the Accident and Emergency four hour standard continues to under achieve with 85.47% in June 2016.
- The two 12 hour trolley waits in June 2016 were all due to wait for mental health beds. There has now been ten 12 hour trolley waits since November 2015. These occurred in November (1), December (2), February (1), April (1), May (3) and June (2). A root cause analysis is completed for each breach.
- There were 423 validated over 30 minute handover breaches in May 2016.
- The number of delayed transfers of care remains above threshold with 4.2%. This equates to 117 patients delayed in month with 37 patients still delayed at the month end.
- The 62 day treatment measure is below threshold in May at 82.8%. At tumour site level, four groups did not meet the 62 day target in May; Colorectal, haematology, head & neck and upper GI.
- There were seven patients in May treated after day 104.
- Sickness rates remain above the target absence rate of 3.75% at 4.5% in May 2016.
- Payment for 2015/16 was made in full for Quarter 4 with the exception of the national sepsis and acute kidney injury schemes. Commissioners have agreed partial payment for both schemes based on underperformance against the nationally set targets for achievement in Quarter 4.
- The Trust is reporting underperformance on activity levels due to operational pressures which have resulted in some cancelled activity. The Trust has a planned funding stream of £12.5m through Sustainability and Transformation Funding. We are awaiting specific final guidance on how these funds will transfer and how they will be affected by any performance issues.
- Expenditure pressures are continuing and are due to slippage against the in year efficiency savings and the use of temporary staffing at a premium rate. Increased controls around non-essential spend and the temporary workforce introduced in 2015-16 remain in place
- Non-achievement of the new agency maximum threshold of £10.5m, forecast £13.2m. Agency expenditure to date is £3.3m against a target of £2.6m for the first quarter
- Non-achievement of the Safely Releasing Cost Programme (SRCP) £2.2m gap as at month 3 under achieved.

- The new Trust core skills training package has been implemented replacing the core mandatory training. The majority of areas are underachieving the local compliance target.

Key

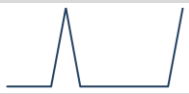
4. The information assurance framework provides detail on the main key performance indicators detailed in this report and is intended to serve as a point of reference for Board members, but it will also provide a useful document for staff who may view the performance report or other similar indicators in other business unit level reports.

The data for this measure is not currently available for this period.

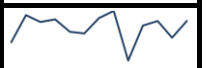


These arrows identify whether high or low performance is required to achieve the standard.

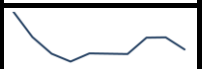
Safe

		Threshold 16/17	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Monthly Sparkline
M64	CDIFF	28	1	1	2	4	4	5	3	3	1	2	1	2	3	
M65	MRSA	0	0	0	0	0	0	0	1	0	0	0	0	0	0	
M66	Never Event Incidence	0	0	1	0	0	0	0	1	1	0	1	0	0	0	
M67	Medication errors causing serious harm	0	0	0	0	0	0	0	0	0	0	0	0	0	1	
C28	Percentage of Harm Free Care	92%	99.42%	98.69%	98.77%	99.37%	98.96%	99.11%	99.20%	99.14%	99.37%	99.06%	99.74%	98.77%	99.15%	
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%	99.39%	98.89%	98.44%	97.39%	98.94%	98.69%	99.08%	99.40%	99.34%	99.07%	99.50%	98.20%		
M69	Serious Incidents (Steis)		5	10	8	3	3	8	10	7	9	7	10	2	6	
M70	CAS Alerts - non compliance	0	0	0	4	0	0	0	1	0	0	0	0	0	0	
M146	Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80%	89%	88%	86%	87%	91%	92%	90%	89%	89%	86%	88%	89%	87%	
M147	Safer Staffing -Day-Average fill rate - care staff (%)	80%	106%	107%	106%	105%	105%	109%	105%	105%	105%	107%	110%	114%	116%	
M148	Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80%	99%	99%	98%	98%	99%	98%	97%	97%	97%	97%	97%	99%	98%	
M149	Safer Staffing -Night-Average fill rate - care staff (%)	80%	108%	109%	109%	114%	112%	117%	116%	120%	120%	121%	124%	122%	129%	
M150	Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80%	0	8	12	18	10	6	3	9	8	12	19	16	11	17	
M151	Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80%	0	0	0	0	0	1	0	0	0	0	0	0	0	1	
M152	Safer Staffing - Day -Average fill rate - care staff- number of wards <80%	0	4	4	5	4	1	1	2	3	4	3	2	0	0	
M153	Safer Staffing - Night -Average fill rate - care staff- number of wards <80%	0	1	1	2	2	1	1	1	3	2	3	2	1	1	

Caring

		Threshold 16/17	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Monthly Sparkline
C38	Inpatient Friends and Family - % who would recommend	91.76%	97.71%	98.90%	98.59%	98.71%	98.16%	98.10%	98.77%	99.08%	96.90%	98.44%	98.63%	97.91%	98.64%	
C40	Maternity Friends and Family - % who would recommend		95.38%	95.68%	94.15%	94.90%	94.09%	95.80%	92.60%	93.37%	95.50%	96.60%	96.42%	96.68%	95.87%	
C42	A&E Friends and Family - % who would recommend	77.83%	82.88%	77.42%	84.42%	84.66%	83.20%	83.90%	85.14%	78.28%	80.80%	76.52%	80.44%	75.73%	76.25%	
C44	Community Friends and Family - % who would recommend		92.07%	93.52%	93.51%	91.57%	94.59%	93.90%	93.67%	94.37%	93.70%	93.70%	93.95%	94.94%	94.34%	
C15	Complaints – rate per 1000 contacts	0.4	0.26	0.23	0.25	0.20	0.22	0.21	0.18	0.28	0.30	0.18	0.26	0.24	0.20	
M52	Mixed Sex Breaches	0	0	0	0	0	2	0	0	0	0	0	0	0	0	

Effective

		Threshold 16/17	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Monthly Sparkline
M73	Deaths in Low Risk Categories - relative risk	Outlier	86.54	75.82	68.69	65.22	68.76	68.60	68.50	75.49	75.59	70.40				
M74	Hospital Standardised Mortality Ratio - Weekday (DFI Indicative)	Outlier	104.29	102.78	102.01	103.06	100.25	100.94	98.64	96.36	94.82	94.88				
M75	Hospital Standardised Mortality Ratio - Weekend (DFI Indicative)	Outlier	106.57	105.33	106.92	106.47	106.88	104.01	101.63	101.91	101.73	101.56				
M54	Hospital Standardised Mortality Ratio (DFI Indicative)	Outlier	104.90	103.51	103.35	104.02	101.94	101.72	99.40	97.76	96.58	96.59				
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Outlier	1.07			1.06										
C16	Emergency re-admissions within 30 days		13.10%	13.01%	12.75%	12.65%	12.69%	13.44%	13.33%	13.34%	12.56%	12.76%	12.26%			
M89	CQUIN schemes at risk	0				0			3			2				

Responsive

		Threshold 16/17	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Monthly Sparkline
C2	Proportion of patients spending less than 4 hours in A&E	95%	94.78%	93.36%	93.32%	94.79%	93.56%	94.42%	94.49%	88.15%	89.95%	87.77%	88.50%	85.47%	85.47%	
M62	12 hour trolley waits in A&E	0	0	0	0	0	0	1	2	0	1	0	1	3	2	
C1	RTT admitted: percentage within 18 weeks	95%	94.0%	91.1%	89.9%	85.0%	85.3%	85.0%	86.3%	82.5%	83.2%	81.2%	78.5%	80.4%	79.2%	
C3	RTT non- admitted pathways: percentage within 18 weeks	90%	98.0%	97.6%	97.5%	97.5%	96.3%	97.5%	95.9%	95.3%	95.6%	96.3%	94.4%	94.4%	95.0%	
C4	RTT waiting times Incomplete pathways	92%	97.5%	97.5%	97.9%	96.7%	95.9%	94.6%	93.9%	94.5%	95.2%	95.6%	94.8%	93.7%	94.7%	
C37.1	RTT 52 Weeks (Ongoing)	0	0	0	0	0	0	0	0	0	0	0	1	2	1	
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1%	0.04%	0.01%	0.09%	0.11%	0.02%	0.1%	0.08%	0.19%	0.15%	0.15%	0.22%	0.16%	0.26%	
C18	Cancer - Treatment within 62 days of referral from GP	85%	85.40%	85.10%	86.6%	85.90%	93.2%	89.2%	91.0%	93.7%	86.6%	88.4%	85.6%	82.8%		
C19	Cancer - Treatment within 62 days of referral from screening	90%	93.8%	100.0%	93.9%	95.70%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
C20	Cancer - Treatment within 31 days of decision to treat	96%	98.9%	98.9%	98.1%	100.00%	100.0%	100.0%	100.0%	98.3%	100.0%	98.9%	100.0%	98.4%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98%	100.0%	100.0%	100.0%	100.00%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94%	97.1%	97.1%	100.0%	100.00%	97.4%	100.0%	100.0%	99.0%	97.3%	94.1%	97.1%	100.0%		
C24	Cancer - seen within 14 days of urgent GP referral	93%	96.90%	96.60%	96.0%	96.40%	96.3%	96.7%	96.7%	97.6%	95.5%	95.6%	95.2%	95.1%		
C25	Cancer - breast symptoms seen within 14 days of GP referral	93%	96.30%	94.90%	94.6%	94.70%	97.1%	93.0%	97.2%	96.4%	97.3%	93.6%	95.2%	94.1%		
M9	Urgent operations cancelled for 2nd time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C27	Not treated within 28 days of last minute cancellation due to non clinical reasons	0	0.00%	0.00%	1.92%	0.00%	0.00%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	1.92%	0.00%	
M55	Proportion of delayed discharges attributable to the NHS	3.5%	3.84%	4.75%	3.69%	3.62%	3.64%	3.0%	4.16%	4.42%	4.75%	4.76%	4.02%	4.20%	4.37%	
M90	Average LOS elective and daycase		2.9	3.2	3.5	2.8	2.4	2.9	2.8	2.9	3.0	2.8	2.8	2.6	2.9	
M91	Average LOS non-elective		4.6	4.7	4.7	4.4	4.6	4.6	4.6	4.6	4.6	4.9	4.8	5.0	5.0	

Well led

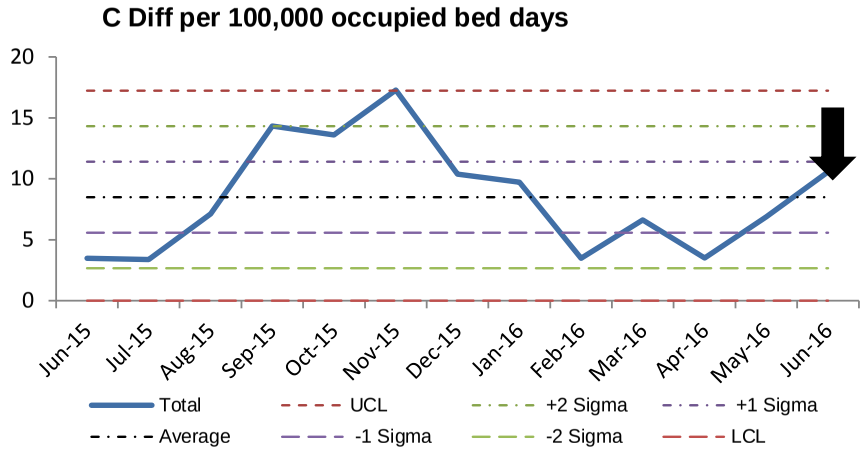
		Threshold 16/17	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Monthly Sparkline
C31	NHS England Inpatients response rate from Friends and Family Test	16%	59.79%	57.90%	55.12%	45.92%	49.05%	43.70%	49.81%	48.87%	48.50%	50.14%	45.89%	53.95%	50.48%	
C32	NHS England A&E response rate from Friends and Family Test	4%	25.52%	23.08%	25.44%	25.04%	25.42%	23.00%	23.69%	21.06%	21.71%	22.18%	21.80%	19.75%	19.65%	
M77	Trust turnover rate	12%	10.0%	9.9%	9.6%	9.7%	9.6%	9.5%	9.4%	9.3%	9.2%	8.7%	8.9%	8.9%	9.0%	
M78	Trust level total sickness rate	3.75%	4.79%	4.99%	4.87%	4.81%	4.91%	4.93%	4.74%	4.81%	4.74%	4.45%	4.5%	4.5%		
M79	Total Trust vacancy rate	5%	6.3%	6.3%	6.1%	5.2%	6.8%	6.5%	7.5%	7.8%	7.1%	7.3%	8.0%	6.7%	7.7%	
M80.1	Mandatory Training	95%	73.0%	81.0%	84.0%	89.0%	92.0%	93.0%	90.0%	89.0%	85.0%	82.0%				
M80.2	Safeguarding Children	80%	78.0%	81.0%	81.0%	84.0%	85.0%	86.0%	86.0%	87.0%	87.0%	88.0%	88.0%	88.0%	90.0%	
F8	Temporary costs as % of total paybill	4%	6%	8%	7%	8%	8%	8%	8%	8%	9%	9%	7%	7%	8%	
F9	Overtime as % of total paybill	0%	0%	0%	0%	1%	0%	1%	0%	0%	1%	0%	1%	0%	0%	
F1	Cumulative Retained Deficit for breakeven duty (£M)	(3.7)	(5.0)	(6.7)	(7.5)	(8.2)	(8.8)	(9.5)	(10.1)	(10.8)	(11.2)	(11.5)	(0.3)	(0.6)	(0.9)	
F2	SRCP Achieved % (green schemes only)	100.0%	20%	24%	33%	46%	49%	54%	60%	62%	64%	64%	52%	54%	56%	
F3	Liquidity days	>(14.0)	(7.7)	(8.4)	(10.8)	(13.2)	(12.7)	(13.2)	(13.5)	(14.0)	(14.4)	(5.0)	(5.3)	(5.9)	(5.6)	
F4	Capital spend v plan	85%	90%	77%	81%	75%	72%	71%	71%	72%	71%	90%	93%	91%	79%	
F5	FSSR (Continuity of risk rating)	3	2	2	2	2	2	2	2	2	2	3	2	2	3	
F6	FSSR - Liquidity rating	2	3	3	3	3	2	2	2	1	1	3	3	3	3	
F7	FSSR - Capital Servicing Capacity rating	1	1	1	1	1	1	1	1	1	1	3	1	1	2	
F10	FSSR - I&E Margin	3						1	1	1	1	4	2	2	2	
F11	FSSR - I&E Margin variance from plan	4						4	4	4	4	4	2	2	3	
F12	BPPC Non NHS No of Invoices	95%	96.5%	96.2%	96.2%	96.0%	96.0%	95.9%	95.9%	95.7%	95.5%	95.5%	96.8%	96.3%	96.0%	
F13	BPPC Non NHS Value of Invoices	95%	94.9%	95.1%	95.1%	94.5%	94.8%	94.8%	95.1%	95.3%	95.2%	95.4%	98.2%	96.7%	95.7%	
F14	BPPC NHS No of Invoices	95%	95.6%	95.6%	95.4%	95.4%	95.6%	95.5%	95.6%	95.2%	95.0%	95.0%	95.3%	95.3%	93.2%	
F15	BPPC NHS Value of Invoices	95%	96.4%	96.1%	96.4%	96.4%	97.0%	96.6%	96.6%	96.6%	96.6%	96.4%	99.5%	95.8%	95.9%	

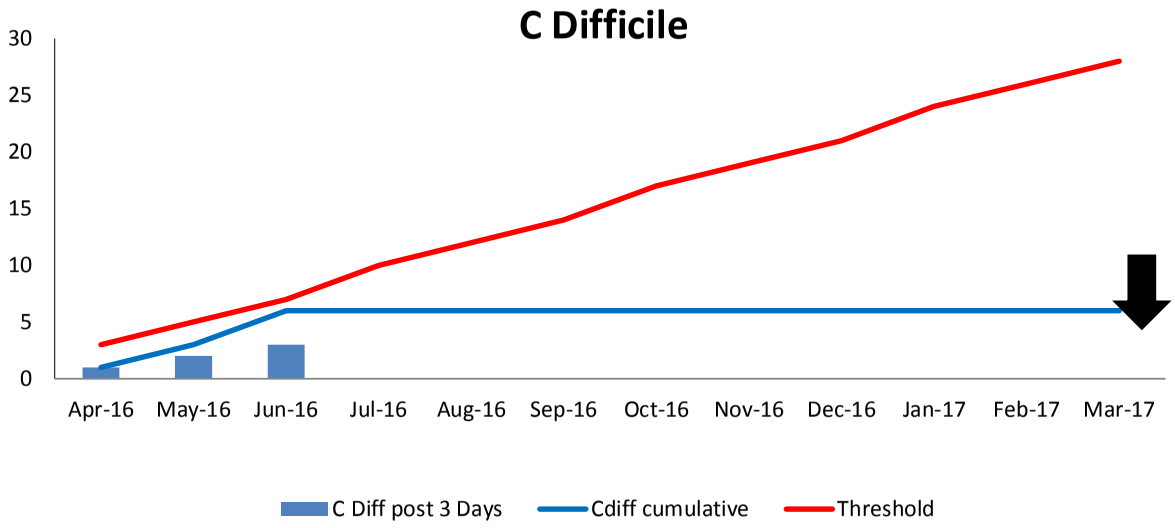
Safe – Infection Control (M64, M65)

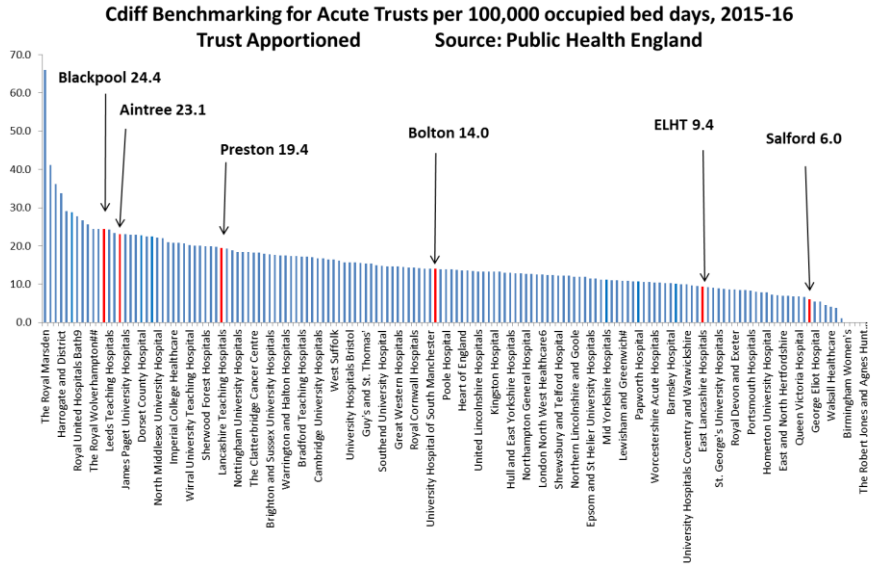
No MRSA infections detected in June post 2 days of admission. Zero attributed YTD against threshold of zero.

There were three Clostridium difficile toxin positive isolate identified in the laboratory in June which were post 3 days of admission. The year to date cumulative figure is 6 against the trust target of 28.

ELHT ranked 31st out of 154 trusts in 2015-16 with 9.4 clostridium infections per 100,000 bed days.







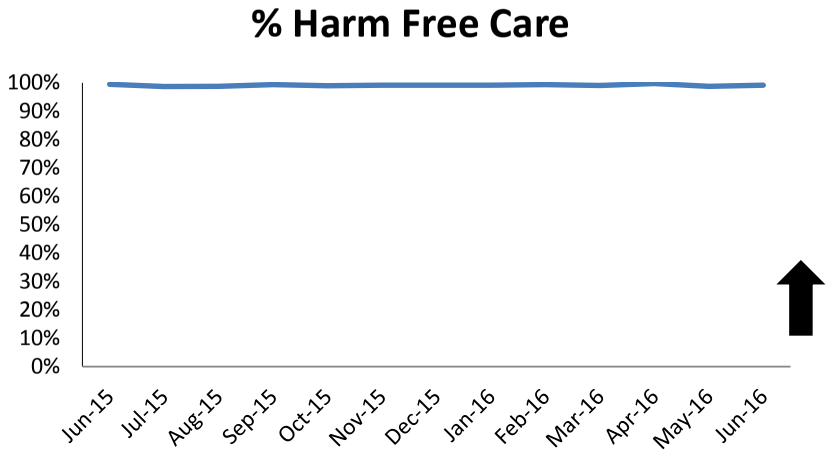
Safe – Harm Free Care

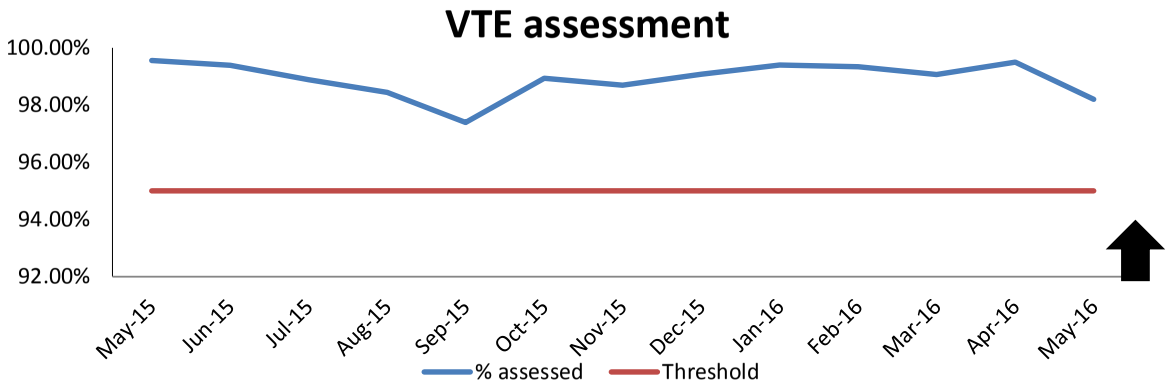
Never events
There were no never events reported to Steis in June.

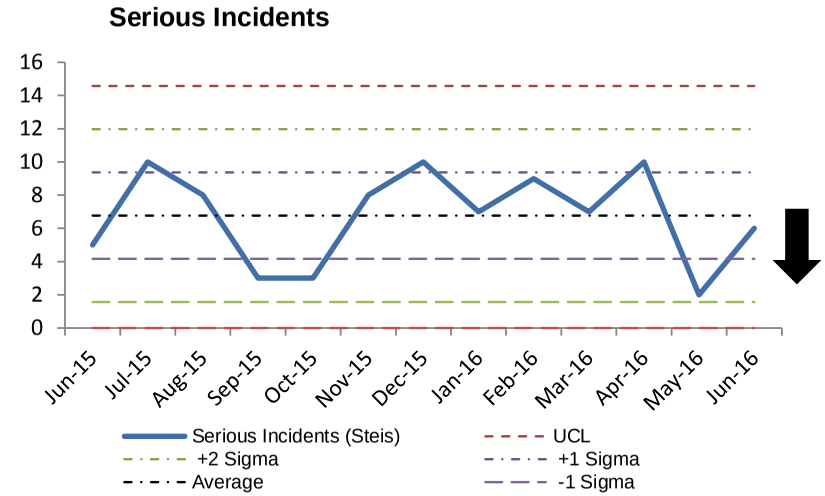
Serious Incidents
The Trust unverified position for incidents reported to the Strategic Executive Information System (StEIS) in the month of June was six incidents. These incidents were categorised as two slips, trips and falls, two commissioning incidents, one medication incident and one abuse/ alleged abuse of adult patient by staff.
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.

Harm free Care
The Trust remains consistent with the percentage of patients with harm free care at 99.15% for June 2016 using the National safety thermometer tool.

For June 2016 we are reporting the unverified position as one grade 2 community acquired pressure ulcer.







Safe – Safer Staffing

Nursing and midwifery staffing in June 2016 proved to be extremely challenging. Causative factors remain the same as in previous months further compounded by escalation areas.

17 areas fell below an 80% average fill rate for registered nurses on day shifts.

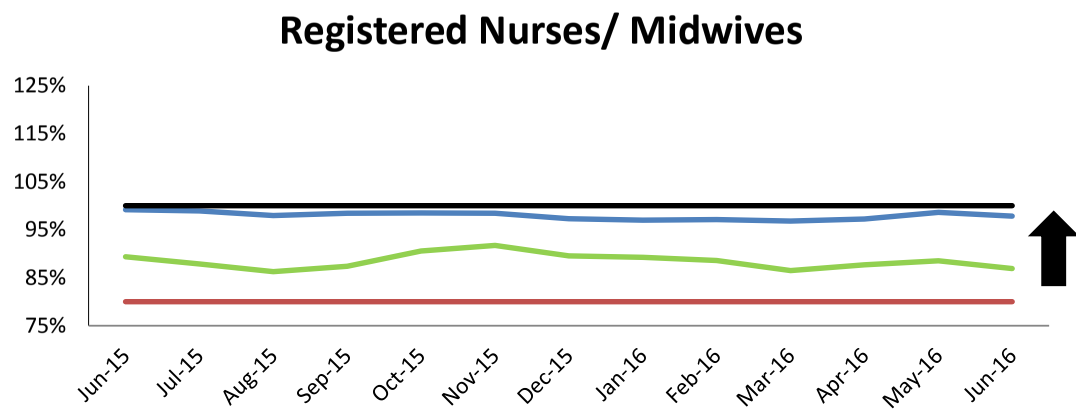
Care Hours per Patient Day (CHPPD) is reflective of last months. 8.40 in May and 8.41 in June.

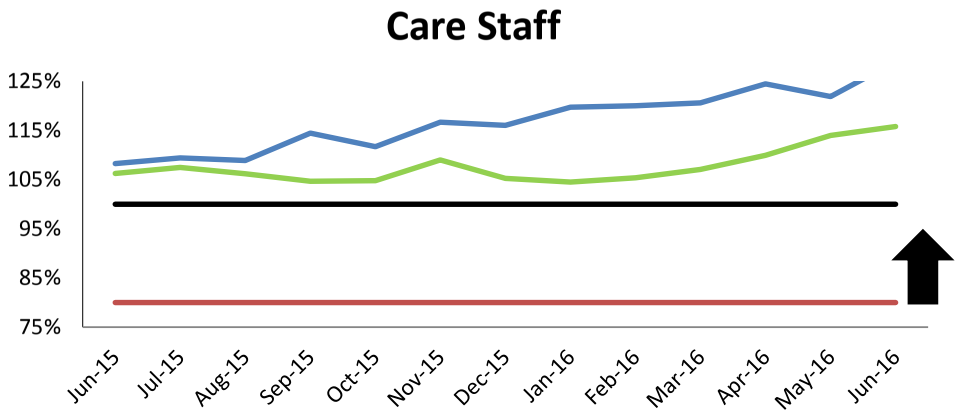
The divisions continually flex staffing resources to ensure safety is maintained. The roll out of safe care to all adult inpatient wards is almost complete and the matrons are gaining experience and confidence in using the system to determine the movement of staff based on acuity and dependency.

Of the DATIX incidents reported the divisions have given assurance that that no harm has been identified as a consequence of staffing. 3 wards entered DATIX, which flagged as a "red flag" incident highlighting less than 2 Registered nurses present on a shift, on investigation this was found not to be the case and incorrect information had been entered.

6 red flags were reported within maternity services, 3 were excluded as they didn't meet the "red flag" criteria. Of the three remaining, further interrogation determined that staffing did not impact on the missed/delayed care, or on the ability to provide 1:1 care as actions were taken to ensure that women within our care received the appropriate level of care. The division of Family Care have given assurance that no harm was caused.

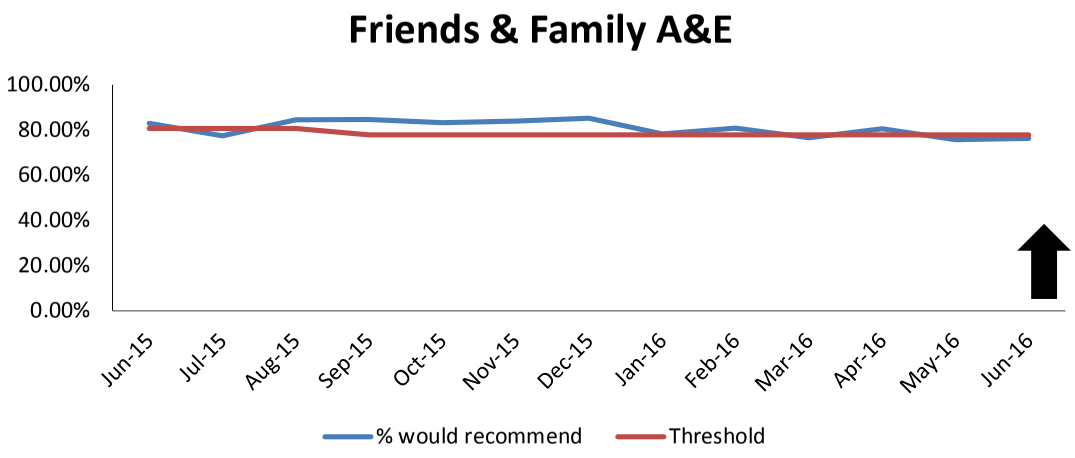
Please see Appendix 1 for UNIFY data and Appendix 2 for nurse sensitive indicator report.

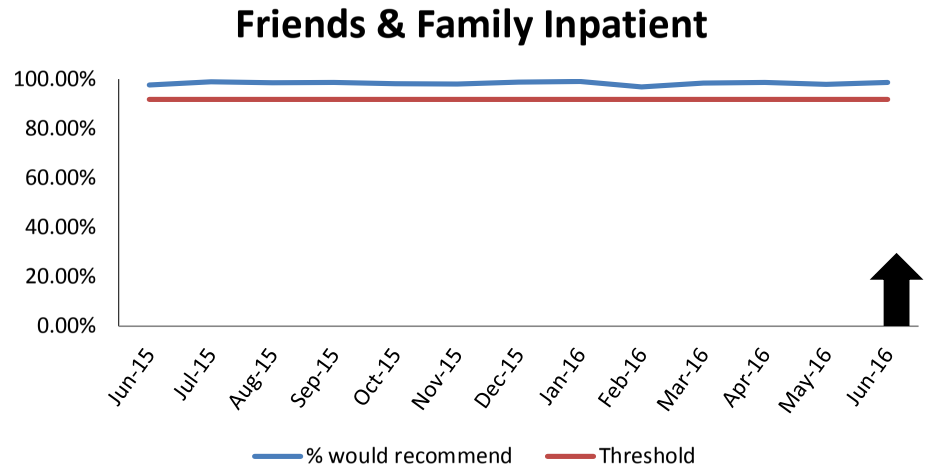


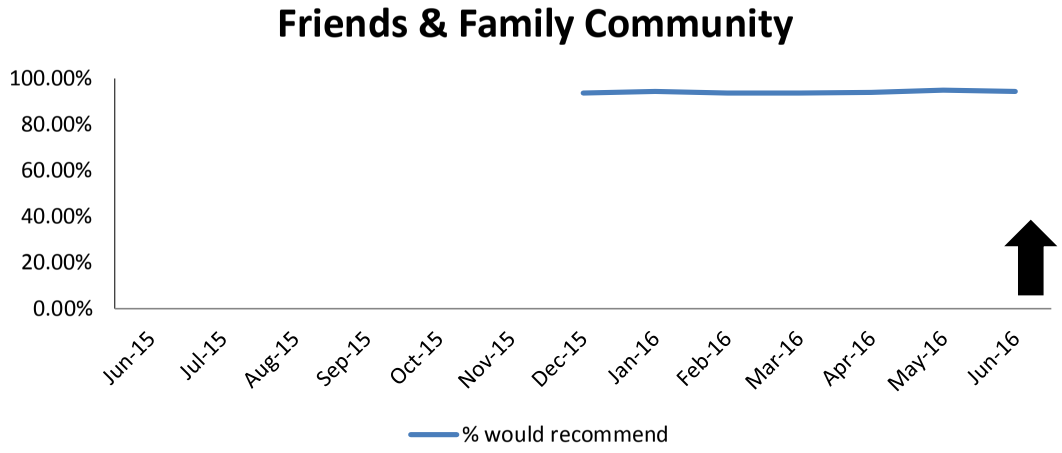


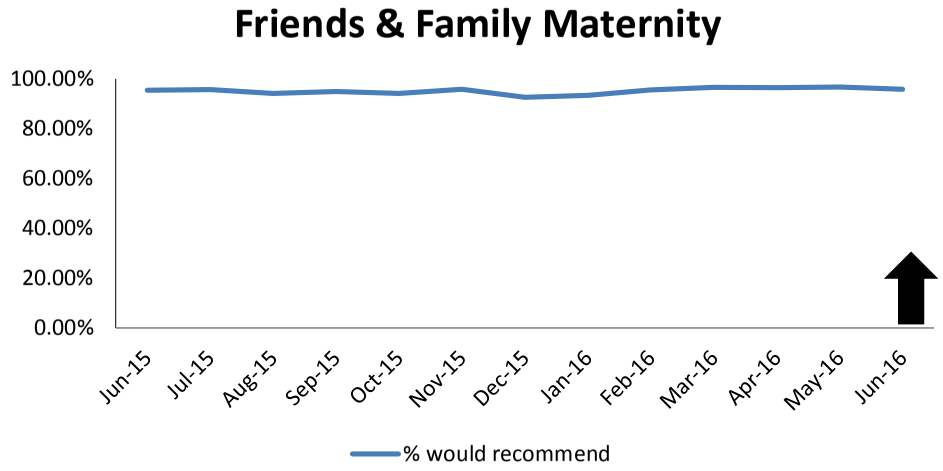
Caring – Friends and Family Test (C38, C42)

This report reflects national measurement methodology, which measures the proportion of patients that would recommend the Trust to friends and family. The latest Trust development authority thresholds have been included where available.
In June the number that would recommend A&E to friends and family increased to 76.3%, whilst the proportion that would recommend inpatient services, increased to 98.6%. Community services would be recommended by 94.3% and maternity 95.9%









Caring – Complaints and Patient Experience

Complaints
The Trust received 23 new complaints during June which is a reduction on last month.

Patient Experience Surveys

The above table demonstrates divisional performance from the range of patient experience surveys for June 2016. The threshold is a positive score of 90% or above for each of the 4 competencies.

The Divisional performance from the range of patient experience surveys is above the threshold of 90% for all of the 4 competencies in June.

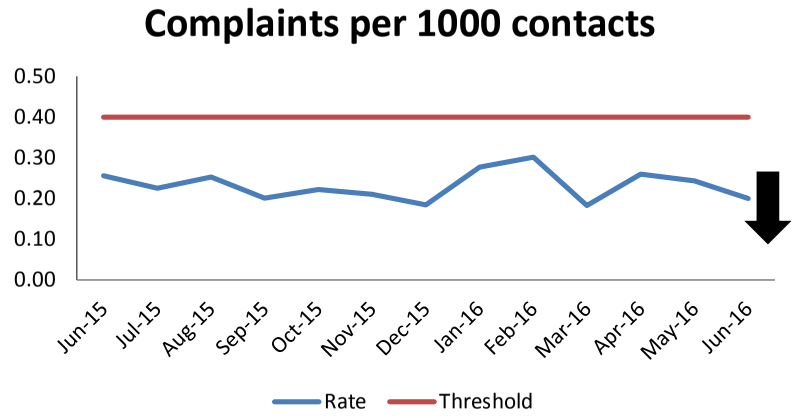
Performance by the Integrated Care Group – Acute against the information competency increased to 99% in June from 98% in May. Performance against all other competencies stayed the same as the previous month.

Performance by the Integrated Care Group – Community continues to be high with scores of 100% for Dignity, Involvement and Quality in June. Performance against the information competency decreased slightly to 98% in June from 99% in May.

Surgery - there were slight decreases in performance against the information and quality competencies during June.

The Family Care Division's overall performance fell to 93% in June from 97% the previous month and there were decreases in performance against the dignity, information and quality competencies in June. Performance against the involvement competency increased to 99%.

There was a slight increase in performance by the Diagnostic and Clinical Care Directorate against the dignity competency in June, however performance against involvement and quality decreased slightly.



June 2016 Totals	Overall		Dignity	Information	Involvement	Quality
	No.	%	%	%	%	%
Trust	2660	97%	98%	97%	99%	97%
Integrated Care Group - Acute	579	98%	99%	99%	99%	97%
Integrated Care Group - Community	477	99%	100%	98%	100%	100%
Surgery	552	97%	99%	97%	99%	98%
Family care	496	93%	95%	91%	99%	95%
Diagnostic and Clinical	554	95%	96%	96%	97%	95%

Effective - Mortality

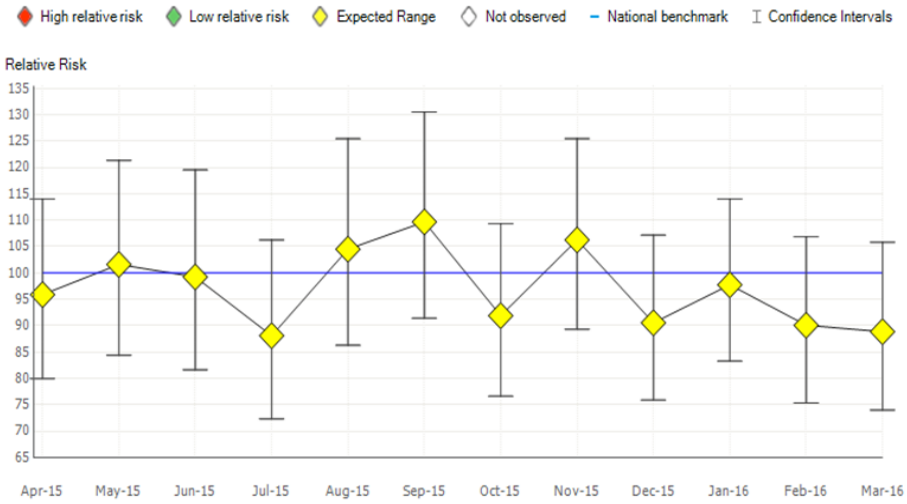
The latest Trust SHMI value as reported by the Health and Social Care Information Centre and Care Quality Commission is within expected levels, as published in June 2016 at 1.06

The TDA published HSMR is currently within expected levels at 103.03 (July 14 - June 15)

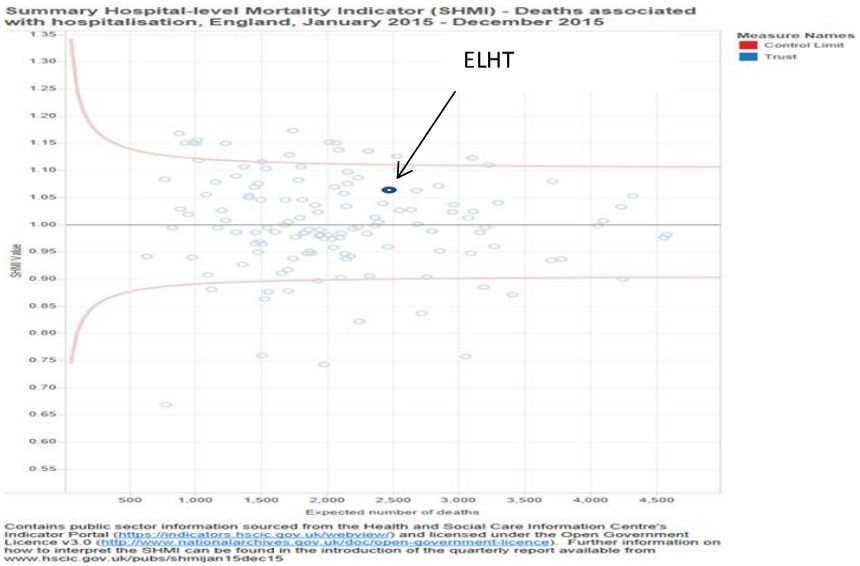
DFI Indicative HSMR - rolling 12 month - Green rating
The latest indicative 12 month rolling HSMR (Apr 15 – Mar 16) is reported 'as expected' at 96.58 against the monthly rebased risk model.

	TDA Reported HSMR July 14 – June 15	DFI Rebased on latest month Apr 15 – Mar 16 (Risk model Dec 15)
TOTAL	103.03	96.58 (CI 91.81 – 101.54)
Weekday		94.88 (CI 89.43 – 100.58)
Weekend	103.94	101.56 (CI 91.88 – 111.97)
Deaths in Low Risk Diagnosis Groups		70.4 (CI 42.37 – 109.95)

Dr. Foster Indicative HSMR monthly Trend



SHMI Published Funnel Plot

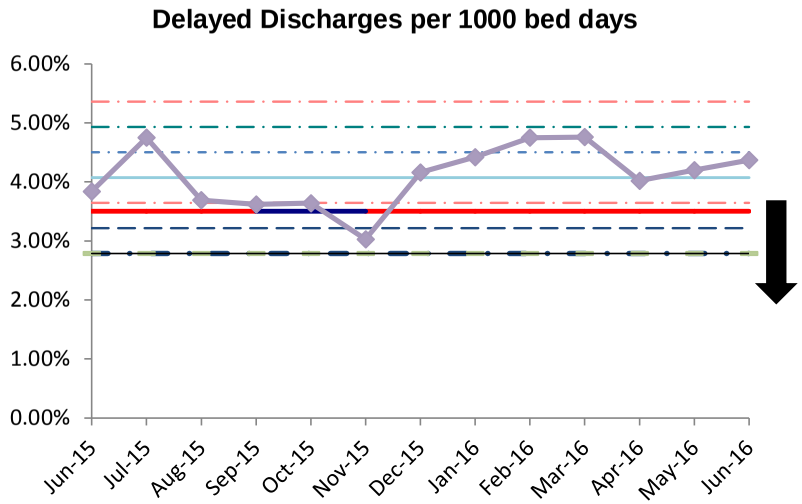


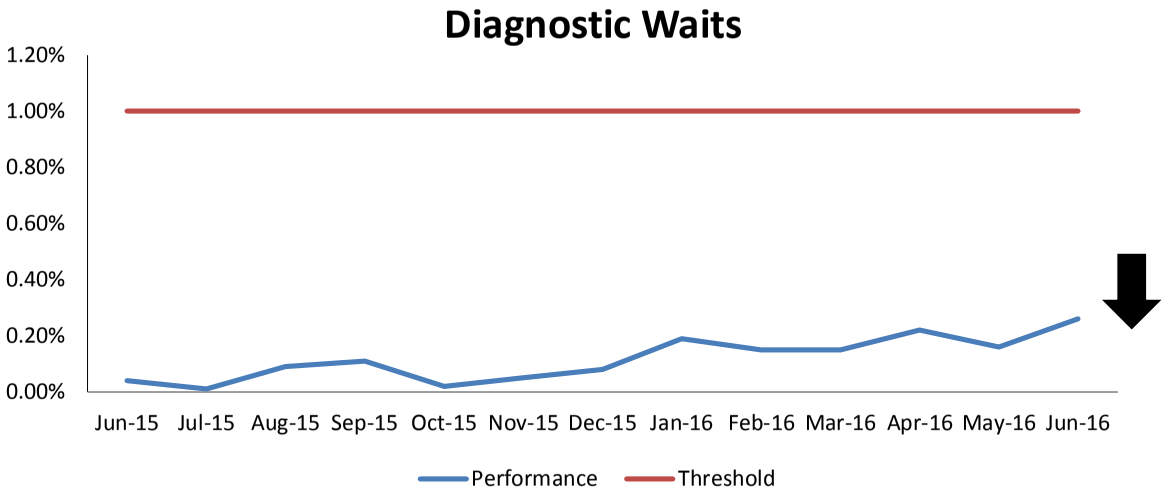
Effective/Responsive - Readmissions, Diagnostic Waits, Delayed Discharges

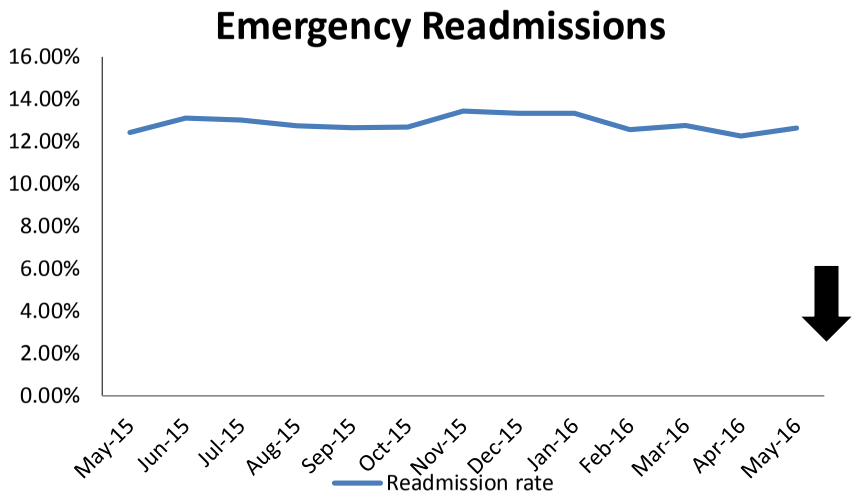
Delayed Discharges. The number of delays reported against the delayed transfers of care standard has remained above threshold at 4.37%.

Emergency Readmissions (Reported 1 month behind). The emergency readmission rate is reported at 12.46% in May 2016 compared with 12.42% in May 2015.

Diagnostic Waits. This measures the proportion of patients exceeding the 6 week target for a diagnostic procedure. In June, 0.26% waited longer than 6 weeks.







Effective - CQUIN

Commissioning for Quality and Innovation (CQUIN)

2015/16
Payment for 2015/16 was made in full for Quarter 4 with the exception of the national sepsis and acute kidney injury schemes. Commissioners have agreed partial payment for both schemes based on underperformance against the nationally set targets for achievement in Quarter 4.

The response challenging this decision that was sent to Commissioners in relation to both schemes has now been rejected. National data clearly shows the majority of Trusts were failing against the national thresholds as at Quarter 3 2015/16.

2016/17
The following CQUIN schemes have been agreed for 2016/17 and will be monitored and reported quarterley.

National Schemes

1. Staff Health & Wellbeing
    * Healthy food for NHS staff, visitors and patients – success judged by achieving a step-change in the health of the food offered on premises in 2016/17 and submitting to national data collection via UNIFY
    * Improving the uptake of flu vaccinations – success judged by achieving in excess of 75%.
    * Introduction of health and wellbeing initiatives for staff

2. Timely identification and treatment of sepsis
    * ED – timely identification and treatment of sepsis (includes children) – including 3 day review
    * Acute inpatient settings – timely identification and treatment of sepsis (includes children) – including 3 day review

3. Antimicrobial resistance and antimicrobial stewardship
    * Reduction in antibiotic consumption per 1,000 admissions
    * Empiric review of antibiotic prescriptions – success judged by the percentage of antibiotic prescriptions reviewed within 72 hours – achieve >90% by Q4.

Specialised Commissioning Schemes

1. Improving pathways for hepatitis C
2. Dose banding intravenous SACT
3. NICU – 2 year outcomes
4. Prevention of hypothermia in preterm babies

Public Health Scheme

1. Strengthening patient and public participation - DESP and breast screening

Local CCG Schemes

1. Saving Babies Lives Year 2
2. Frailty – a 2 part CQUIN
3. Local cancer scheme – improving communication for patients on a cancer pathway
4. Refer to Pharmacy

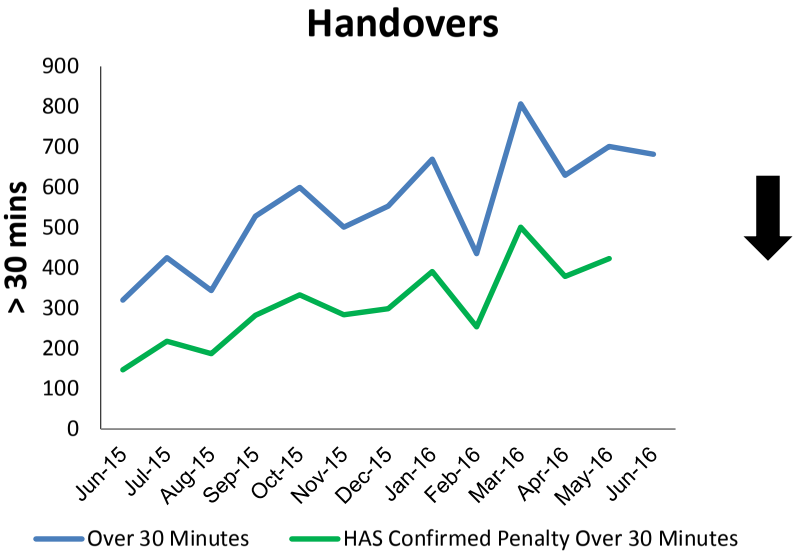
Responsive – A&E

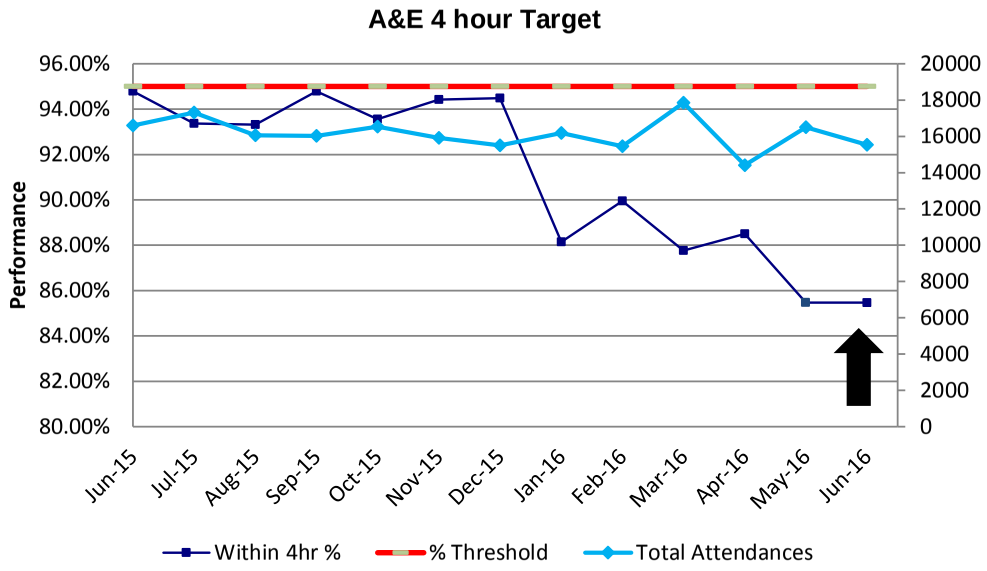
Overall performance against the Accident and Emergency four hour standard was reported as 85.5%, below the 95% threshold. The Trust saw 15,537 attendances in June.

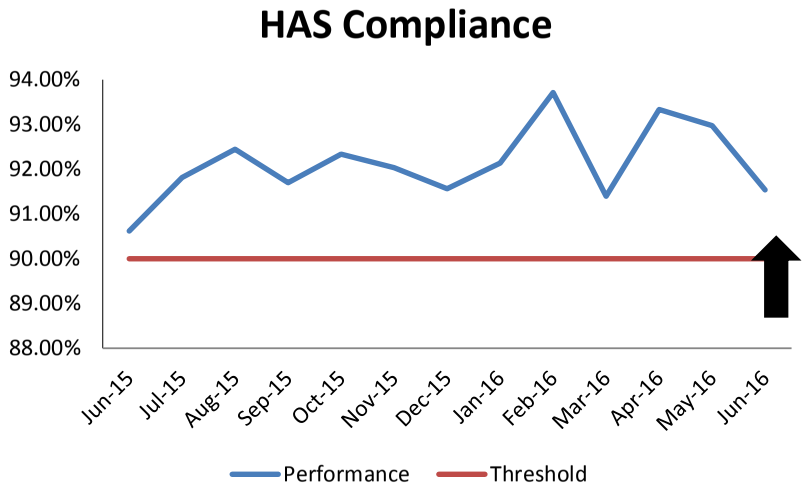
There have been two breaches of the 12 hour standard from decision to admit, in June. A root cause analysis is being completed for each breach.

The ambulance handover compliance indicator is reported at 91.5% in June, which is above the 90% threshold.
The number of handovers over 30 minutes has decreased to 682 for June compared to 701 for May.

The validated NWAS penalty figures for June are not available at the time of this report and so data is as at May. There are 157 missing timestamps, 366 handover breaches (30-60 mins) and 57 handover breaches (>60 mins).



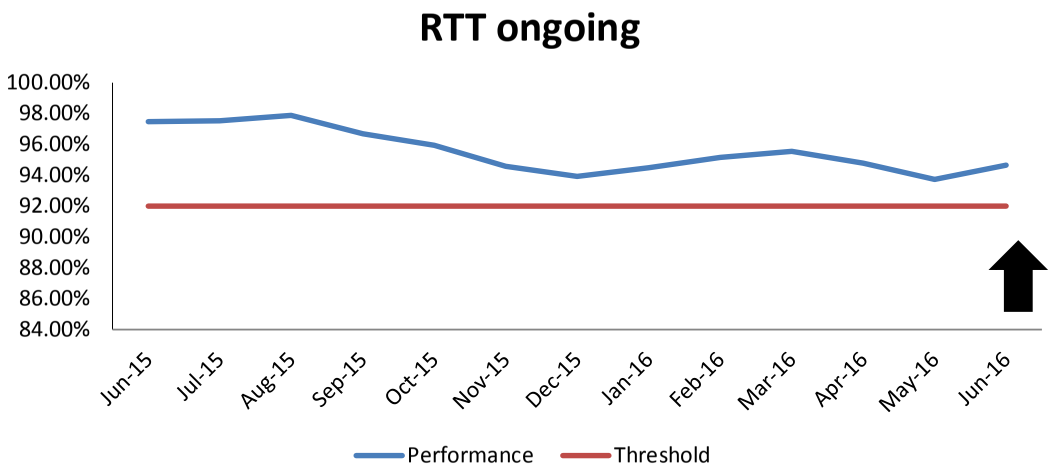


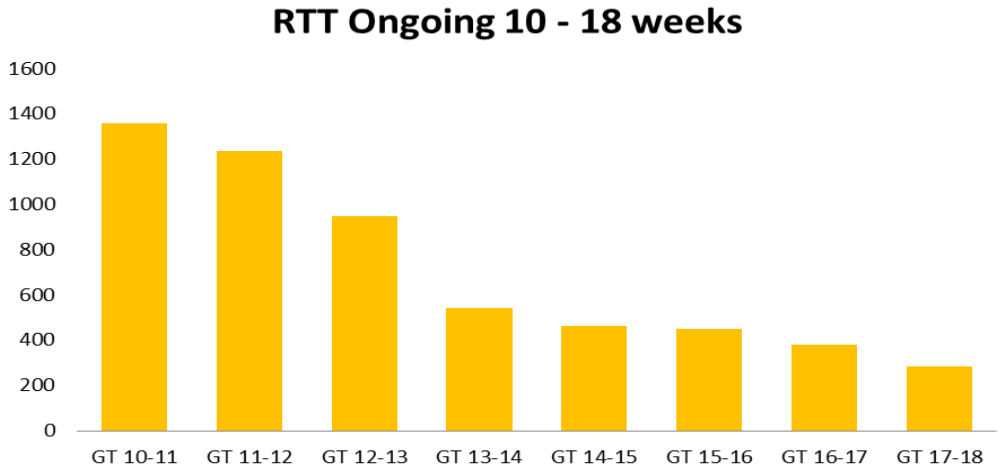


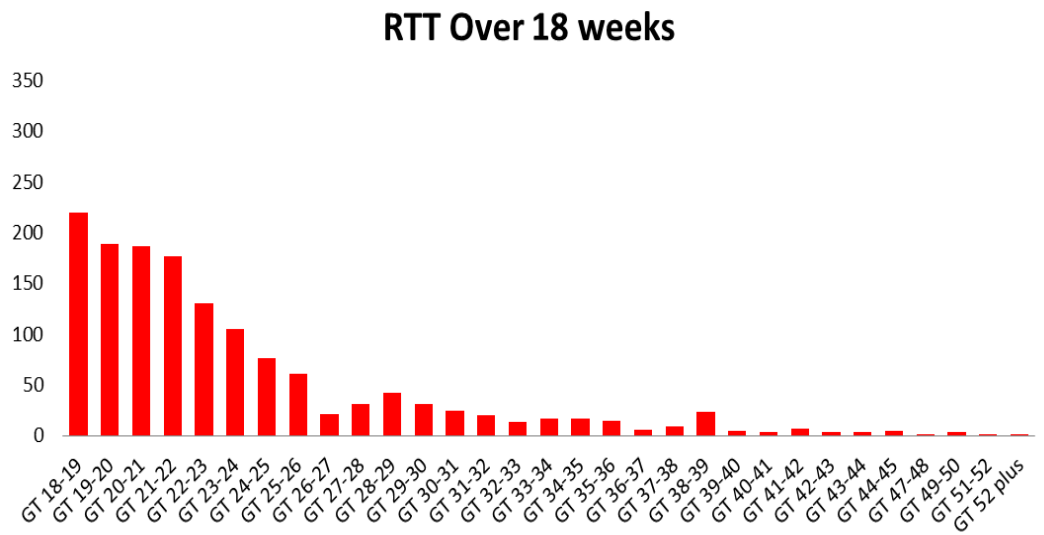
Responsive – Referral to Treatment (18 week target)

The 18 week referral to treatment % ongoing position is reported at 94.7% against the 92% threshold for June 2016.

There is one patient currently waiting over 52 weeks at the end of June. This is patient choice and is booked to have treatment in July.

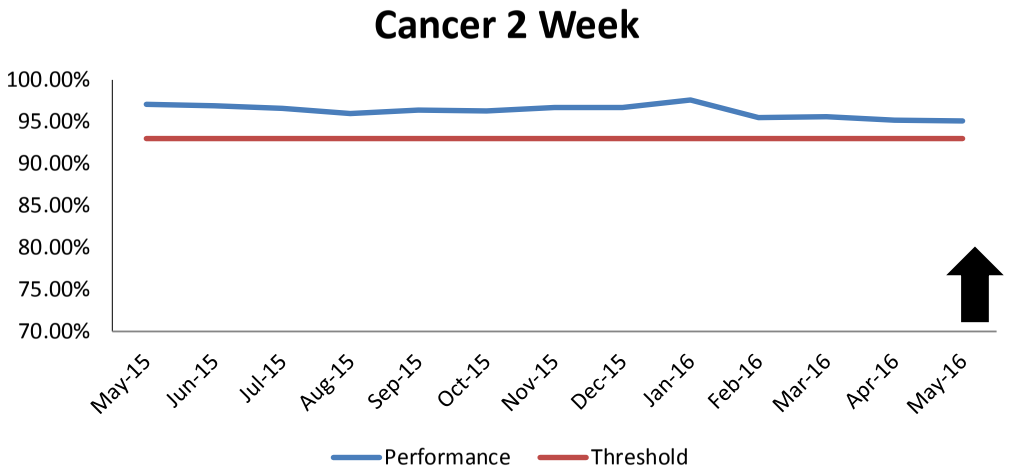


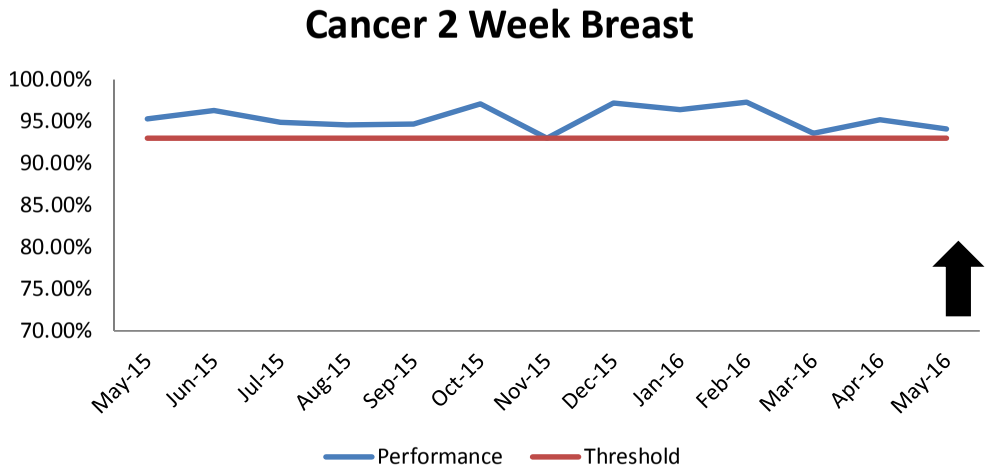


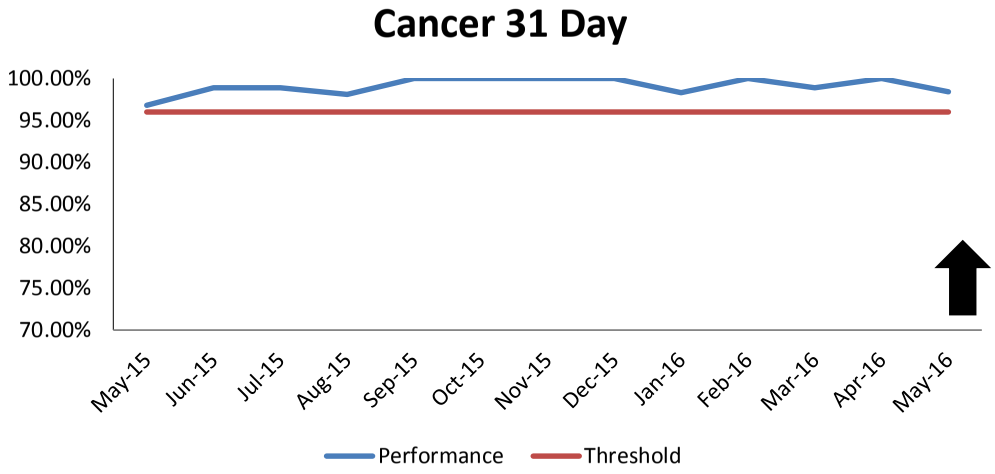


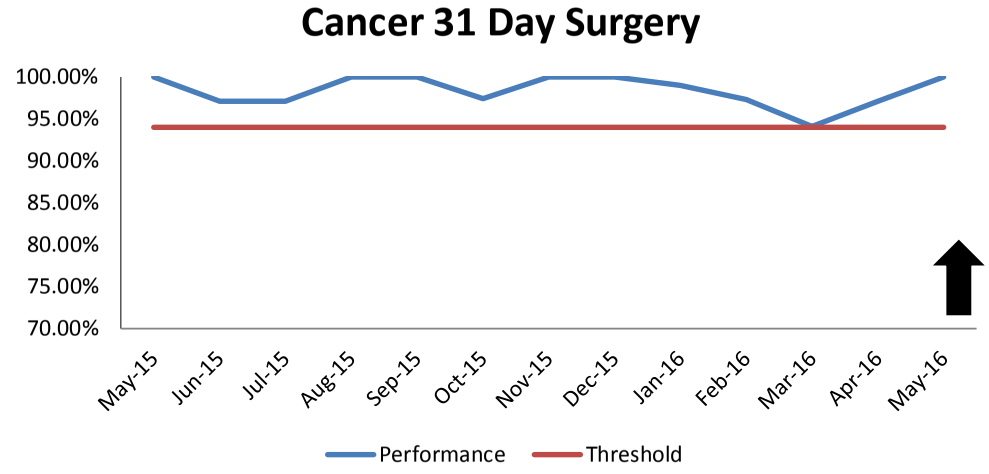
Responsive – Cancer Waits

The 62 day treatment measure is below threshold in May at 82.8%. At tumour site level, four groups did not meet the 62 day target in May; Colorectal, haematology, head & neck and upper GI. There were seven patients in May treated after day 104.

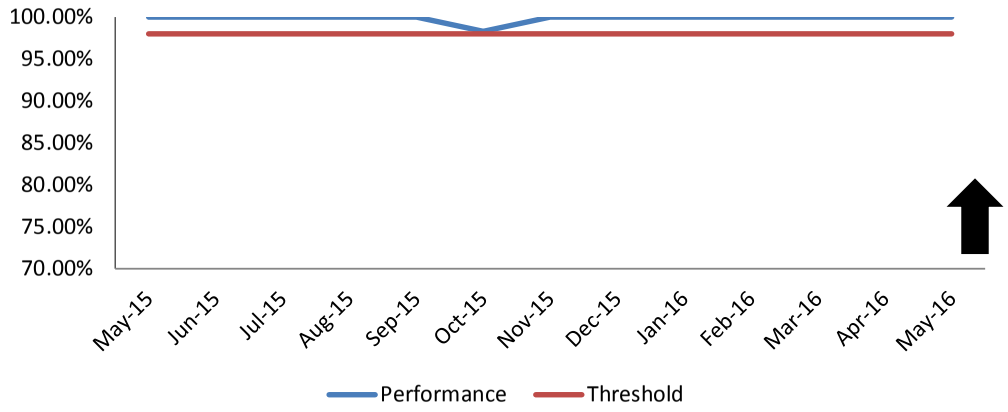




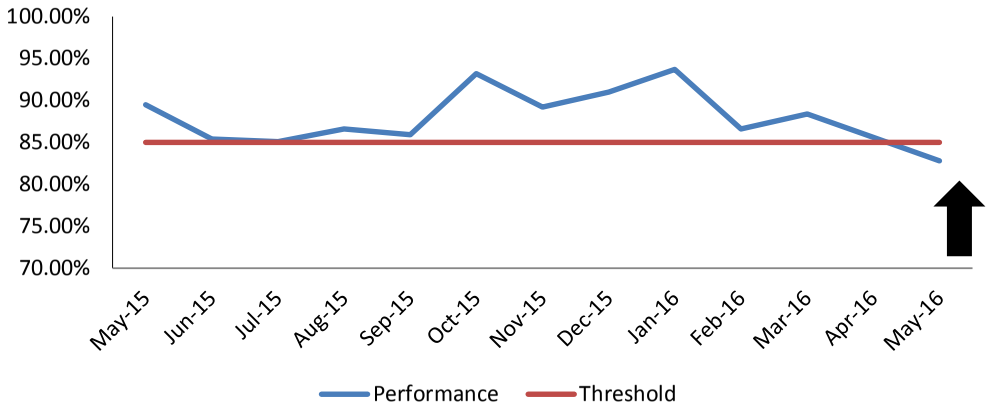




Cancer 31 Day Drug



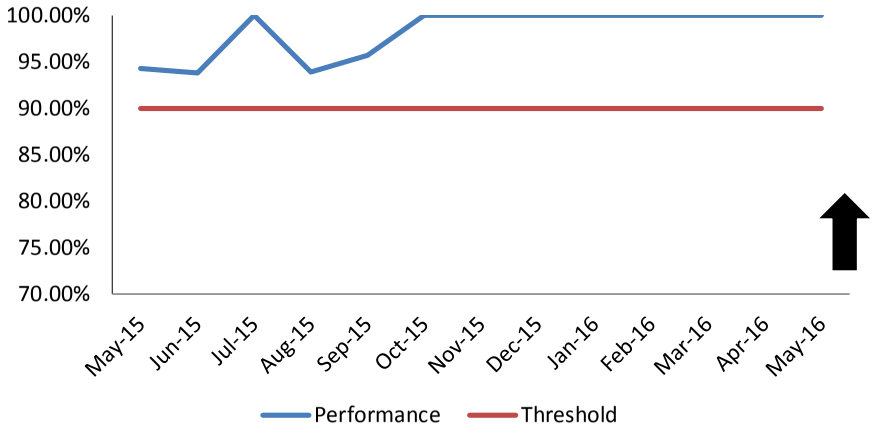
Cancer 62 Day

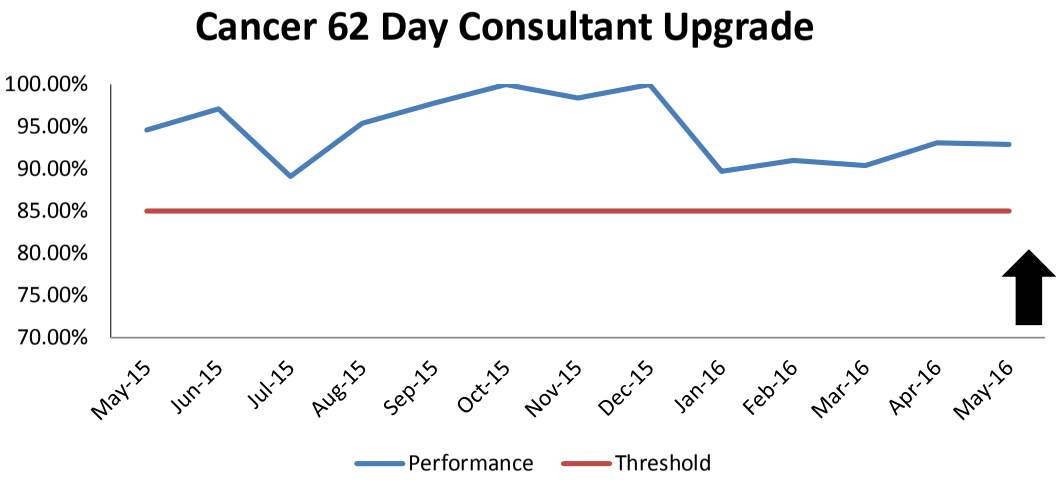


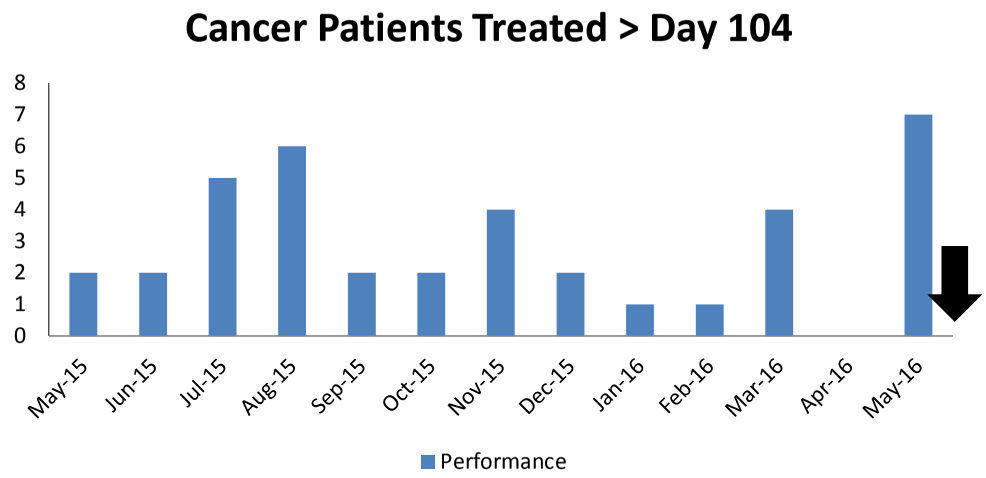
Cancer 62 Day by Tumour Site

Tumour Site	Apr-16	May-16
Breast	100.0%	100.0%
Colorectal	52.4%	75.0%
Gynaecology	72.7%	100.0%
Haematology	100.0%	71.4%
Head & Neck	64.3%	72.7%
Lung	87.0%	86.7%
Other	-	100%
Skin	94.1%	86.4%
Upper GI	80.0%	45.8%
Urology	96.2%	85.7%

Cancer 62 Day Screening




Cancer 62 Day Consultant Upgrade
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Performance
Threshold

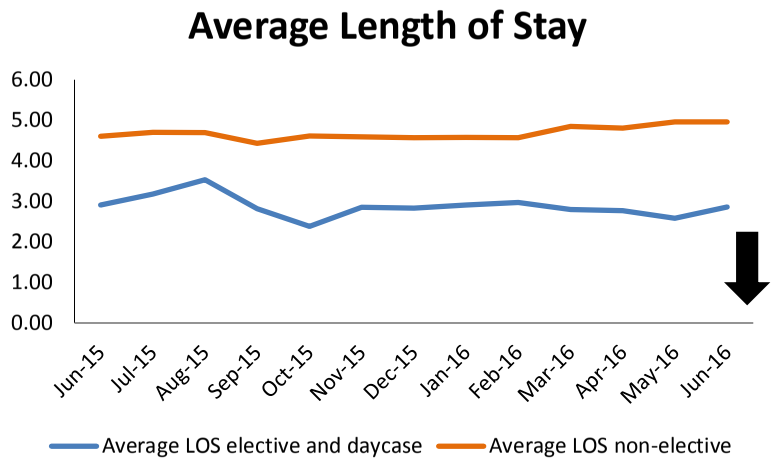

Cancer Patients Treated > Day 104
8
7
6
5
4
3
2
1
0
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Performance

Responsive – Average Length of Stay

Trust non elective average length of stay has remianed ther same as last month at 4.96 for June.

The elective length of stay has increased on last month to 2.86.

Dr Foster benchmarking shows the Trust length of stay to be below the expected when compared to national casemix adjusted, for elective and non-elective, however significantly higher for patients transferred to us.

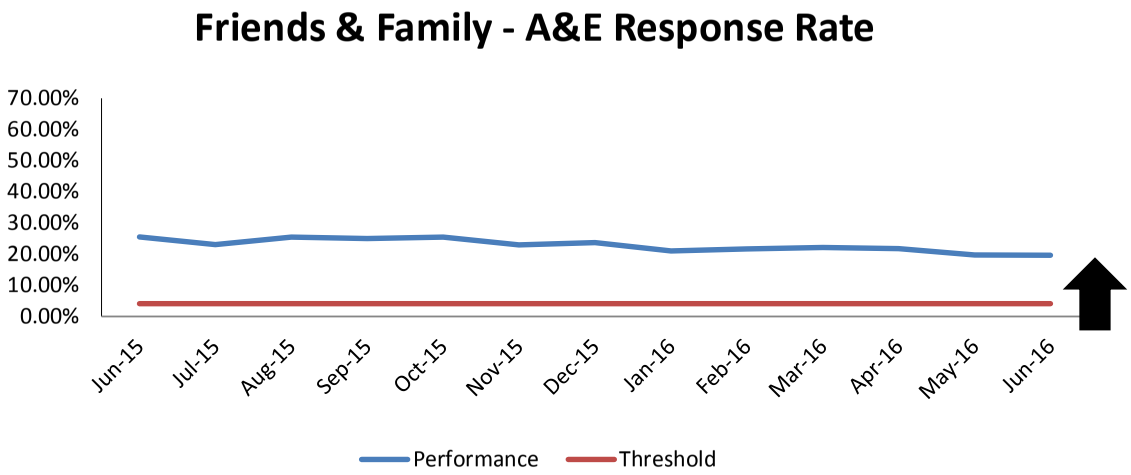


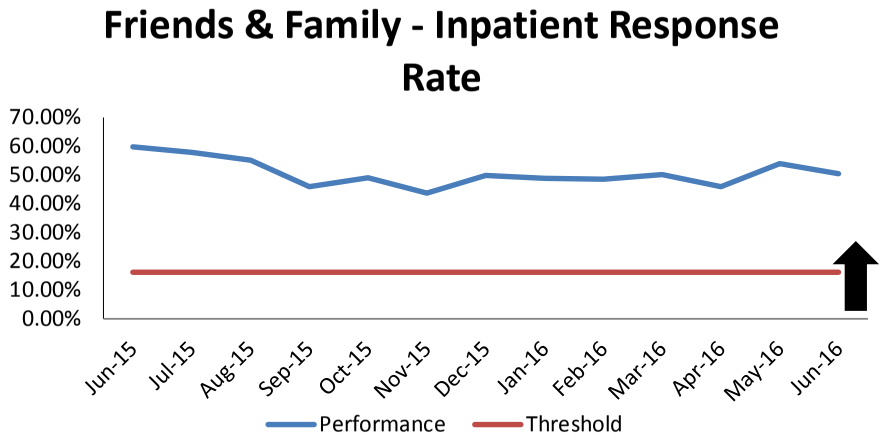
Average Length of Stay vs expected, Apr 15 - Mar 16, Dr Foster Information

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	56,955	9,906	47,049	3.3	2.9	-0.4
Emergency	55,057	55,057	0	4.8	4.8	0.0
Maternity/Birth	14,439	14,439	0	2.1	2.6	0.4
Transfer	208	208	0	11.0	31.0	20.0

Well Led – Response Rates from Friends & Family Test

Friends and family response rates continue to be above threshold for inpatients and A&E.

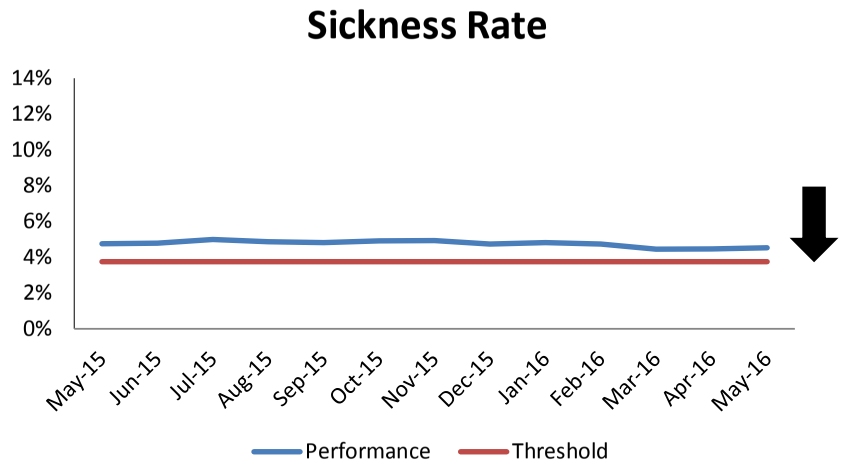




Well Led – Workforce - Sickness

Sickness rate - Amber rating
The sickness absence rate increased slightly from 4.46% in Apr 2016 to 4.53% in May 2016. This is higher than in the previous year (4.75%). The final average for 2015/16 is 4.50%.

Rates are highest in Estates (currently 8.40%) and ICG (currently 4.88%)
High levels of short term seasonal sickness (2.24%)
Long Term sickness (2.30%) attributed to anxiety/stress and musculoskeletal problems continue to be the main reasons for sickness absence.
See Exception reports for actions being taken to reduce sickness absence .



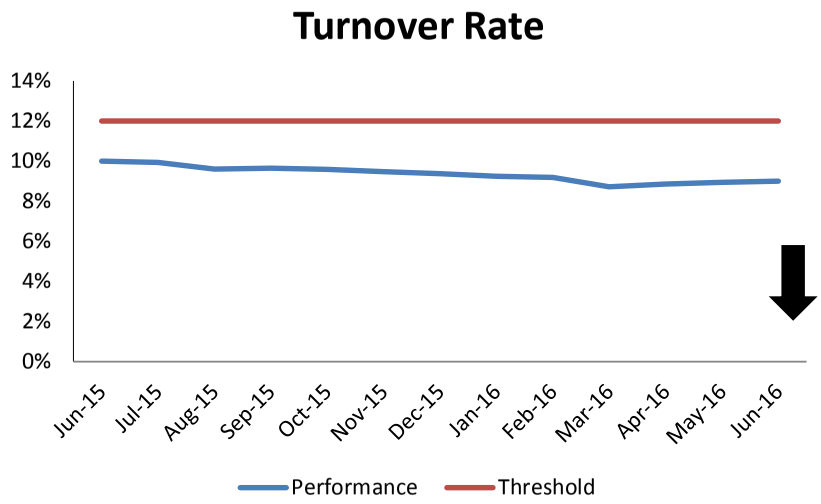
Well Led – Workforce – Staff in Post, Recruitment

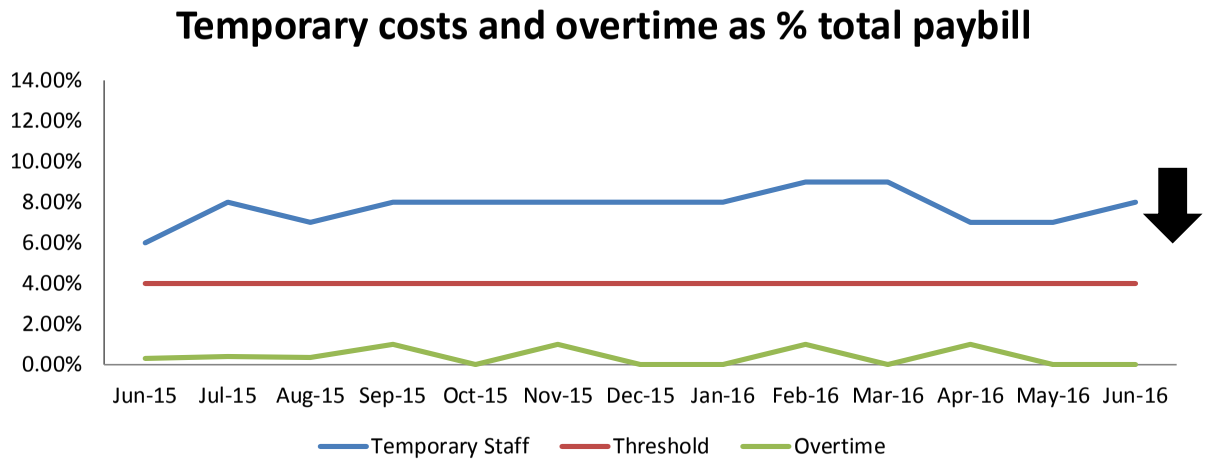
Turnover rate, Vacancy rate and temporary costs - Amber rating

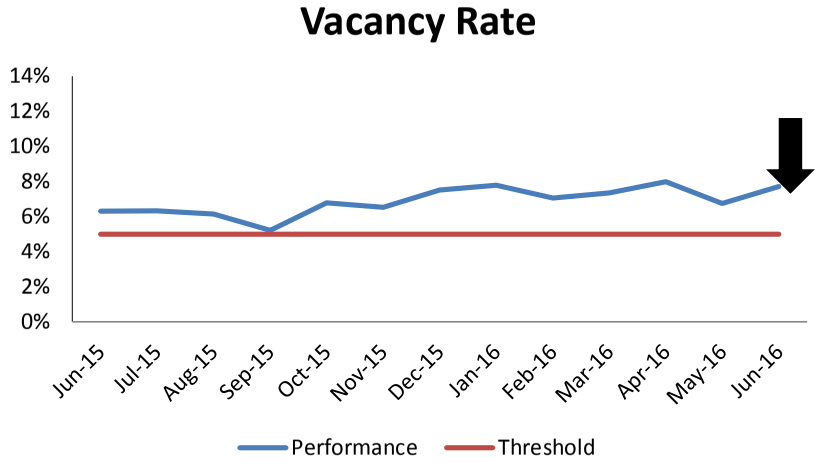
Overall the Trust is now employing 6849 FTE staff in total. This is a net decrease of 7 FTE from the previous month. The number of nurses in post at June 2016 stood at 2223 FTE which is a net decrease of 7 FTE since last month and a net increase of 169 FTE since 1st April 2013. There are a further 298 nurses in the recruitment pipeline. The vacancy rate for nurses now stands at 10.8% (269 FTE)

In 2015/16 East Lancashire Hospitals NHS Trust spent £24.6m on temporary staffing. This represented 8% of the overall pay bill. (9% 2014/15; 8% 2013/4; 5.5% 2012/13). For the year ending 2015/16 the Trust has spent £24,607,589 (£16,469,869 agency; £8,137,720 bank).

In June the Trust spent £2,031,341 on bank and agency. This is worse than in June 2015 (£1,981,488)



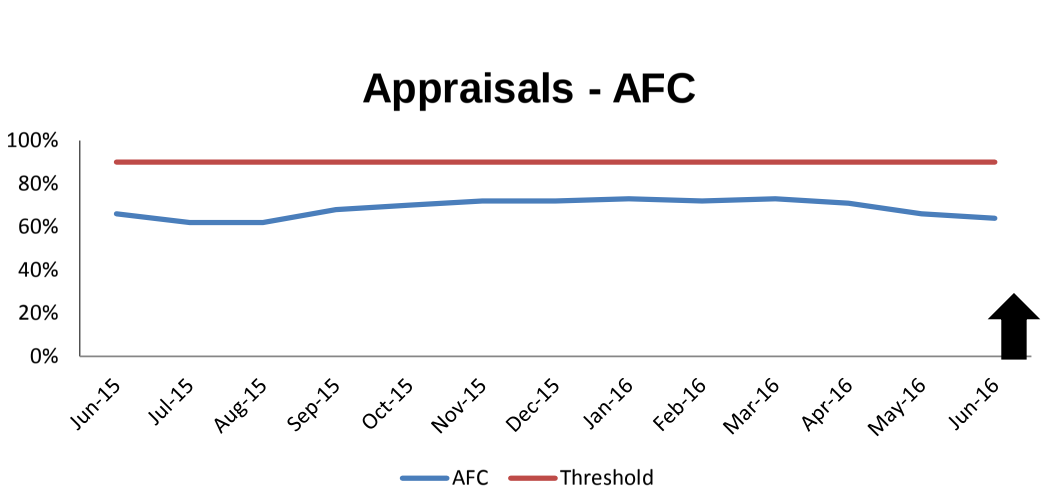


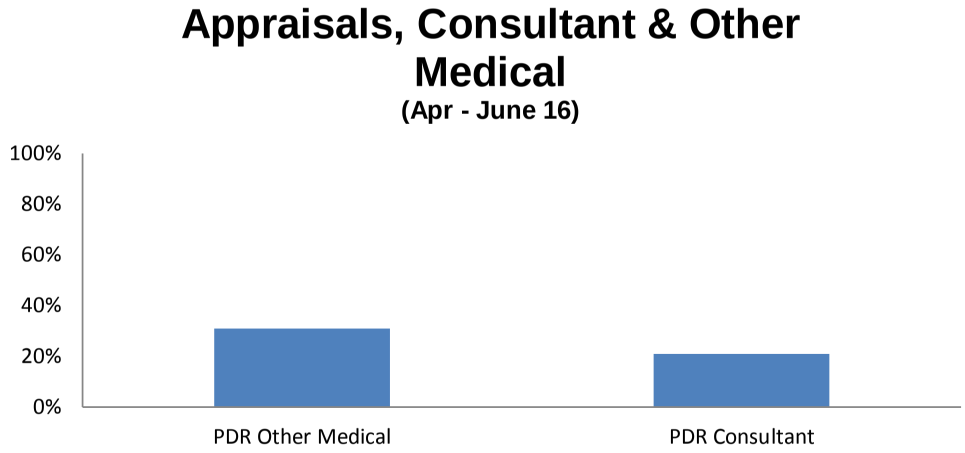


Well Led – Workforce – Appraisals & Job Plans

The 2015/16 year end job plan completion rate was 80%. The 2016/17 job planning round was re-launced in May, with a window of June to August to undertake the reviews. The current completion figure for 2016/17 at the end of May was 5%, including reviews that have taken place since January 2016.

There has been a new system implemented (MyL2P) to capture the appraisal rates for consultants and career grade doctors. The completion rates reported from this system are cumulative year to date, April - May 2016. The AFC appraisal rates continue to be reported as a rolling 12 month figure.



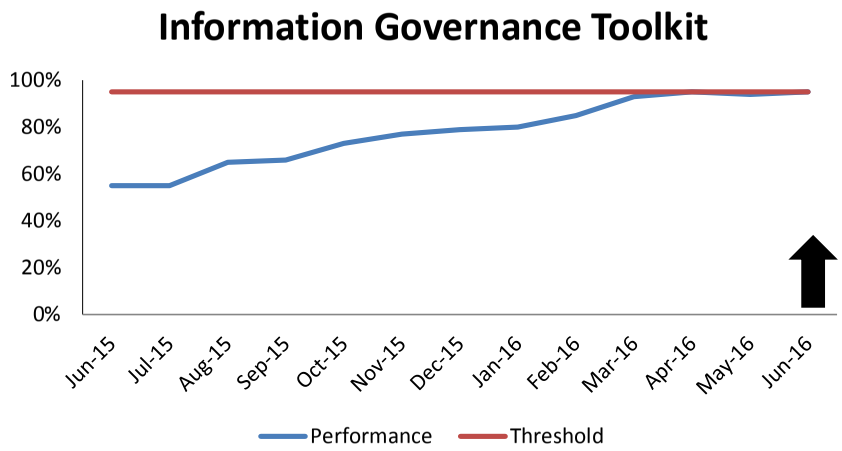


Job Plans

	2015	2016 (YTD)
Trust Total	80%	13%
Integrated Care Group	66%	0%
Surgery	75%	23%
Family Care	100%	0%
Diagnostics & Clinical Support	84%	23%

Well Led – Workforce – Core Skills Training

From April 2016, the core mandatory training has been replaced by a core skills framework consisting of eleven mandatory training subjects. Training is via a new suite of e-learning modules and knowledge assessments on the learning hub.



% Compliance

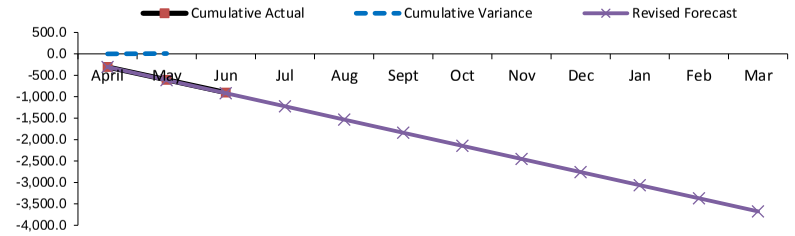
Corporate & Local Induction, Core Skills Training and PDR Compliance - Excluding New Starters Month ending 30th June 2016												
	Corporate Induction	Local Induction	Basic Life Support	Conflict Resolution Training Level 1	Equality, Diversity and Human Rights	Fire Safety	Health, Safety and Welfare Level 1	Infection Prevention	Information Governance	Prevent Healthwrap	Safeguarding Adults	Safeguarding Children
Target	**90%**	**90%**	**90%**	**90%**	**90%**	**90%**	**90%**	**90%**		**90%**	**90%**	**80%**
Chief Executive	82	36	-	69	60	64	16	16	Provided separately - see graph above	62	18	82
Diagnostics & Clinical Support	91	62	76	88	89	83	13	12		79	28	91
Estates & Facilities	93	57	-	76	66	58	17	19		51	18	86
Family Care	79	39	58	86	90	72	24	23		67	27	86
Finance & Informatics	92	40	-	91	91	87	10	11		89	19	95
Governance	88	63	-	93	98	82	30	30		93	30	95
HR & OD	100	59	74	89	88	85	30	28		78	37	87
Integrated Care Group	82	42	66	84	82	73	19	19		70	35	91
Research & Development	100	0	43	94	94	94	26	26		91	47	94
Surgical & Anaesthetics Services	76	36	61	82	82	72	19	19		58	29	90
Total	85	48	**65**	**84**	**84**	**74**	**18**	**18**		**68**	**29**	**90**

Well Led - Finance

East Lancashire Hospitals NHS Trust: Financial Overview as at 30th June 2016

Break-even duty

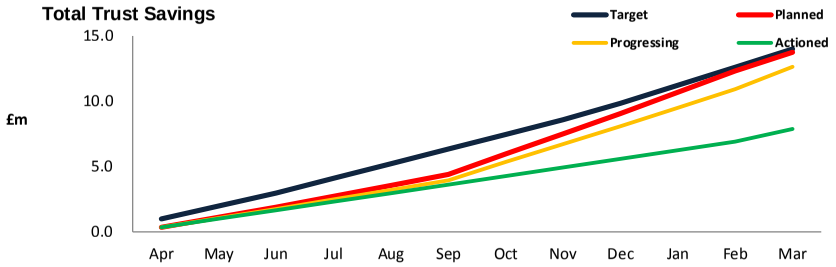
	Plan £m	Actual £m	Variance £m
Cumulative	(0.9)	(0.9)	**0.0**
In Month	(0.3)	(0.3)	0.0



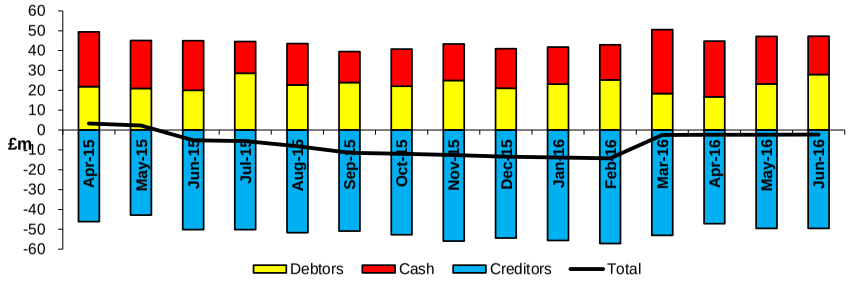
Statement of Comprehensive Income

	Annual Budget £m	In Month Budget £m	In Month Actual £m	In Month Variance £m	Cumulative Budget £m	Cumulative Actual £m	Cumulative Variance £m
Gross employee benefits	(298.7)	(25.3)	(25.3)	0.0	(74.8)	(75.0)	(0.2)
Other operating costs	(166.7)	(14.8)	(14.8)	(0.0)	(41.2)	(41.0)	0.1
Revenue from patient care activities	442.3	38.7	38.7	0.0	112.3	112.3	(0.0)
Other operating revenue	26.9	2.3	2.4	0.0	6.4	6.6	0.1
Operating Surplus	3.7	0.9	0.9	0.0	2.8	2.8	0.0
Investment Revenue	0.3	0.0	0.0	(0.0)	0.1	0.1	(0.0)
Other gains and (losses)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Finance Costs	(9.7)	(0.8)	(0.8)	0.0	(2.4)	(2.4)	0.0
(Deficit) for the year	(5.7)	0.1	0.1	0.0	0.4	0.4	0.0
Public Dividend Capital dividends payable	(5.6)	(0.5)	(0.5)	0.0	(1.4)	(1.4)	0.0
Retained (deficit) for the year	(11.3)	(0.3)	(0.3)	0.0	(1.0)	(1.0)	0.0
Impairment/donated asset adj	7.6	0.0	0.0	0.0	0.1	0.1	0.0
Adjusted retained (deficit) for breakeven duty	(3.7)	(0.3)	(0.3)	0.0	(0.9)	(0.9)	0.0

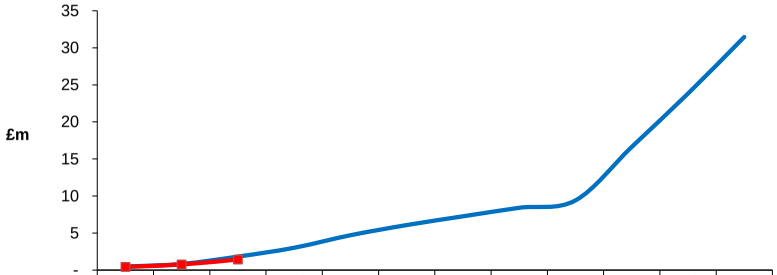
Safely Releasing Cost Programme Performance



Working Capital



Capital Expenditure



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Revised Plan	0.466	0.831	1.817	3.013	4.704	6.075	7.256	8.407	9.404	16.627	23.824	31.457
Actual	0.434	0.753	1.431									

Summary Balance Sheet

	YTD £m	Prior Month £m	Variance £m
Non-Current Assets	287.0	287.3	-0.3
Current Assets	51.6	51.9	-0.3
Total Assets	338.6	339.2	
Current Liabilities	-54.3	-54.3	0.0
Non-Current Liabilities	-116.1	-116.4	0.3
Total Liabilities	-170.4	-170.7	
Total Assets Employed	168.2	168.5	
Financed by:			
Total Taxpayers Equity	168.2	168.5	-0.3

Hospital Site Details		Ward name	! Specialties on eac	Day				Night				Day		Night		CHPPD			
				midwives/nurses		Care Staff		midwives/nurses		Care Staff									
Site code	Hospital Site name		Specialty 1	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 (%)	Sum of Midnight Counts of Patients	CHPPD: Nurses & Midwives	CHPPD: Care staff	Care Hours Per Patient Day (CHPPD) (cols (G+I+K+M)/S)
RXR60	ACCRINGTON VICTORIA HOSPITAL - RXR60	Ward 2	314 - REHABILITATION	1,350	923	960	1,350	630	630	315	651	68.3%	140.6%	100.0%	206.7%	524	2.96	3.82	6.78
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Acute Stroke Unit (ASU)	300 - GENERAL MEDICINE	2,250	1,770	1,125	1,470	945	977	630	1,008	78.7%	130.7%	103.3%	160.0%	639	4.30	3.88	8.18
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B18	320 - CARDIOLOGY	2,025	1,725	900	945	645	645	645	688	85.2%	105.0%	100.0%	106.7%	717	3.31	2.28	5.58
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B20	145 - ORAL & MAXILLO FA	1,560	1,157	780	1,021	660	671	330	616	74.2%	130.8%	101.7%	186.7%	518	3.53	3.16	6.69
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B22	110 - TRAUMA & ORTHOP	1,560	1,300	1,560	2,139	660	649	990	1,584	83.3%	137.1%	98.3%	160.0%	622	3.13	5.98	9.12
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B24	110 - TRAUMA & ORTHOP	1,560	1,385	1,170	1,261	660	660	660	704	88.8%	107.8%	100.0%	106.7%	618	3.31	3.18	6.49
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B4	430 - GERIATRIC MEDICINE	1,800	1,373	1,575	2,355	630	641	630	1,239	76.3%	149.5%	101.7%	196.7%	710	2.84	5.06	7.90
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Blackburn Birth Centre	501 - OBSTETRICS	1,350	1,162	450	398	968	892	323	323	86.1%	88.3%	92.2%	100.0%	58	35.42	12.41	47.83
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C1	300 - GENERAL MEDICINE	1,575	1,215	1,350	1,620	645	645	645	785	77.1%	120.0%	100.0%	121.7%	549	3.39	4.38	7.77
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C10	300 - GENERAL MEDICINE	1,800	1,455	1,575	1,583	630	651	630	830	80.8%	100.5%	103.3%	131.7%	634	3.32	3.80	7.13
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C11	300 - GENERAL MEDICINE	1,800	1,380	1,125	1,425	645	645	645	871	76.7%	126.7%	100.0%	135.0%	621	3.26	3.70	6.96
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14	100 - GENERAL SURGERY	2,340	1,781	1,560	2,028	990	1,012	990	1,540	76.1%	130.0%	102.2%	155.6%	973	2.87	3.67	6.54
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18	100 - GENERAL SURGERY	2,340	1,931	1,560	1,560	990	979	990	1,034	82.5%	100.0%	98.9%	104.4%	1007	2.89	2.58	5.47
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C2	300 - GENERAL MEDICINE	1,800	1,380	1,125	1,515	645	645	645	806	76.7%	134.7%	100.0%	125.0%	713	2.84	3.26	6.10
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C22	101 - UROLOGY	2,418	2,119	1,612	1,723	1,023	1,001	1,023	1,023	87.6%	106.9%	97.8%	100.0%	901	3.46	3.05	6.51
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C3	300 - GENERAL MEDICINE	1,125	983	900	1,118	645	677	645	699	87.3%	124.2%	105.0%	108.3%	417	3.98	4.36	8.34
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C4	300 - GENERAL MEDICINE	1,800	1,335	1,125	1,950	645	645	645	1,215	74.2%	173.3%	100.0%	188.3%	703	2.82	4.50	7.32
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C5	430 - GERIATRIC MEDICINE	1,080	744	1,452	1,344	630	630	630	1,061	68.9%	92.6%	100.0%	168.3%	414	3.32	5.81	9.13
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C6	MEDICINE	1,800	1,508	1,125	1,223	645	645	645	860	83.8%	108.7%	100.0%	133.3%	727	2.96	2.86	5.83
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C7	340 - RESPIRATORY MEDICINE	1,800	1,425	1,125	1,320	645	645	645	753	79.2%	117.3%	100.0%	116.7%	602	3.44	3.44	6.88
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C8	340 - RESPIRATORY MEDICINE	2,250	1,778	1,125	1,215	968	968	645	720	79.0%	108.0%	100.0%	111.7%	562	4.88	3.44	8.33
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C9	300 - GENERAL MEDICINE	1,800	1,403	1,350	1,673	645	656	645	871	77.9%	123.9%	101.7%	135.0%	615	3.35	4.14	7.48
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Children's Unit	420 - PAEDIATRICS	4,080	3,576	1,080	1,116	3,150	3,014	315	336	87.6%	103.3%	95.7%	106.7%	858	7.68	1.69	9.37
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Coronary Care Unit (CCU)	320 - CARDIOLOGY	1,800	1,613	450	540	968	968	-	-	89.6%	120.0%	100.0%	0.0%	246	10.49	2.20	12.68
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Critical Care Unit	192 - CRITICAL CARE MED	6,825	6,812	1,014	858	5,247	5,247	-	22	99.8%	84.6%	100.0%	2200.0%	540	22.33	1.63	23.96
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D1	300 - GENERAL MEDICINE	1,800	1,440	1,350	1,538	645	645	645	1,011	80.0%	113.9%	100.0%	156.7%	548	3.80	4.65	8.45
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D3	300 - GENERAL MEDICINE	1,800	1,478	1,125	1,388	645	677	645	925	82.1%	123.3%	105.0%	143.3%	581	3.71	3.98	7.69
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUA)	300 - GENERAL MEDICINE	3,375	3,176	1,688	2,149	3,038	2,711	1,013	1,271	94.1%	127.3%	89.3%	125.6%	1149	5.12	2.98	8.10
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUB)	300 - GENERAL MEDICINE	3,600	3,593	2,700	2,700	2,205	2,058	1,260	1,260	99.8%	100.0%	93.3%	100.0%	1174	4.81	3.37	8.19
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Neonatal Intensive Care Unit	420 - PAEDIATRICS	4,932	4,626	360	222	4,320	4,212	360	264	93.8%	61.7%	97.5%	73.3%	854	10.35	0.57	10.92
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Surgical Triage Unit	100 - GENERAL SURGERY	1,560	1,573	780	917	990	979	330	638	100.8%	117.5%	98.9%	193.3%	474	5.38	3.28	8.66
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Antenatal Ward	501 - OBSTETRICS	1,440	1,460	720	738	1,080	1,080	720	720	101.4%	102.5%	100.0%	100.0%	151	16.82	9.66	26.47
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Burnley Birth Centre	501 - OBSTETRICS	1,362	1,308	357	345	1,104	1,080	360	360	96.0%	96.6%	97.8%	100.0%	50	47.75	14.10	61.85
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Central Birth Suite	501 - OBSTETRICS	3,600	3,522	720	708	3,600	3,336	720	705	97.8%	98.3%	92.7%	97.9%	226	30.35	6.25	36.60
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Gynaecology and Breast Care Ward	502 - GYNAECOLOGY	1,322	1,306	498	482	819	819	348	348	98.8%	96.7%	100.0%	100.0%	353	6.02	2.35	8.37
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Postnatal Ward	501 - OBSTETRICS	2,160	2,180	1,080	1,104	2,160	1,920	1,080	1,320	100.9%	102.2%	88.9%	122.2%	816	5.02	2.97	8.00
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Rakehead	314 - REHABILITATION	1,350	1,268	1,800	1,703	570	570	570	827	93.9%	94.6%	100.0%	145.0%	409	4.49	6.18	10.68
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 15	110 - TRAUMA & ORTHOP	1,456	1,469	975	975	660	693	572	660	100.9%	100.0%	105.0%	115.4%	536	4.03	3.05	7.08
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 16	300 - GENERAL MEDICINE	2,250	1,733	1,575	2,168	630	641	945	1,323	77.0%	137.6%	101.7%	140.0%	868	2.73	4.02	6.76
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 28	300 - GENERAL MEDICINE	1,455	1,388	465	473	183	183	183	183	95.4%	101.6%	100.0%	100.0%	76	20.66	8.62	29.28
RXR70	CLITHEROE COMMUNITY HOSPITAL - RXR70	Ribblesdale	314 - REHABILITATION	2,250	1,853	1,800	2,220	945	966	945	1,334	82.3%	123.3%	102.2%	141.1%	917	3.07	3.88	6.95
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Hartley	314 - REHABILITATION	1,800	1,395	1,125	1,575	645	645	645	667	77.5%	140.0%	100.0%	103.3%	727	2.81	3.08	5.89
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Marsden	314 - REHABILITATION	1,800	1,403	1,800	1,770	645	645	645	645	77.9%	98.3%	100.0%	100.0%	715	2.86	3.38	6.24
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Reedyford	314 - REHABILITATION	1,800	1,410	1,125	1,388	645	645	645	817	78.3%	123.3%	100.0%	126.7%	703	2.92	3.14	6.06

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RXR East Lancashire Hospitals NHS Trust

Period: June_2016-17

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

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

Comments

Validation alerts (see control panel)	Only complete sites your organisation is accountable for	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
							Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff									
		Site code *The Site code is automatically populated when a Site name is selected	Hospital Site 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 - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
		RXR60	ACCRINGTON VICTORIA HOSPITAL	Ward 2	314 - REHABILITATION		1350	922.5	960	1350	630	630	315	651	68.3%	140.6%	100.0%	206.7%	524	3.0	3.8	6.8
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Acute Stroke Unit (ASU)	300 - GENERAL MEDICINE		2250	1770	1125	1470	945	976.5	630	1008	78.7%	130.7%	103.3%	160.0%	639	4.3	3.9	8.2
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B18	320 - CARDIOLOGY		2025	1725	900	945	645	645	645	688	85.2%	105.0%	100.0%	106.7%	717	3.3	2.3	5.6
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B20	145 - ORAL & MAXILLO FACIAL SURGERY		1560	1157	780	1020.5	660	671	330	616	74.2%	130.8%	101.7%	186.7%	518	3.5	3.2	6.7
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B22	110 - TRAUMA & ORTHOPAEDICS		1560	1300	1560	2138.5	660	649	990	1584	83.3%	137.1%	98.3%	160.0%	622	3.1	6.0	9.1
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B24	110 - TRAUMA & ORTHOPAEDICS		1560	1384.5	1170	1261	660	660	660	704	88.8%	107.8%	100.0%	106.7%	618	3.3	3.2	6.5
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B4	430 - GERIATRIC MEDICINE		1800	1372.5	1575	2355	630	640.5	630	1239	76.3%	149.5%	101.7%	196.7%	710	2.8	5.1	7.9
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Blackburn Birth Centre	501 - OBSTETRICS		1350	1162	450	397.5	967.5	892.25	322.5	322.5	86.1%	88.3%	92.2%	100.0%	58	35.4	12.4	47.8
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C1	300 - GENERAL MEDICINE		1575	1215	1350	1620	645	645	645	784.75	77.1%	120.0%	100.0%	121.7%	549	3.4	4.4	7.8
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C10	300 - GENERAL MEDICINE		1800	1455	1575	1582.5	630	651	630	829.5	80.8%	100.5%	103.3%	131.7%	634	3.3	3.8	7.1
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C11	300 - GENERAL MEDICINE		1800	1380	1125	1425	645	645	645	870.75	76.7%	126.7%	100.0%	135.0%	621	3.3	3.7	7.0
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14	100 - GENERAL SURGERY		2340	1781	1560	2028	990	1012	990	1540	76.1%	130.0%	102.2%	155.6%	973	2.9	3.7	6.5
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18	100 - GENERAL SURGERY		2340	1930.5	1560	1560	990	979	990	1034	82.5%	100.0%	98.9%	104.4%	1007	2.9	2.6	5.5
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C2	300 - GENERAL MEDICINE		1800	1380	1125	1515	645	645	645	806.25	76.7%	134.7%	100.0%	125.0%	713	2.8	3.3	6.1
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C22	101 - UROLOGY		2418	2119	1612	1722.5	1023	1001	1023	1023	87.6%	106.9%	97.8%	100.0%	901	3.5	3.0	6.5
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C3	300 - GENERAL MEDICINE		1125	982.5	900	1117.5	645	677.25	645	698.75	87.3%	124.2%	105.0%	108.3%	417	4.0	4.4	8.3
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C4	300 - GENERAL MEDICINE		1800	1335	1125	1950	645	645	645	1214.75	74.2%	173.3%	100.0%	188.3%	703	2.8	4.5	7.3
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C5	430 - GERIATRIC MEDICINE		1080	744	1452	1344	630	630	630	1060.5	68.9%	92.6%	100.0%	168.3%	414	3.3	5.8	9.1
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C6	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	1800	1507.5	1125	1222.5	645	645	645	860	83.8%	108.7%	100.0%	133.3%	727	3.0	2.9	5.8
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C7	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	1800	1425	1125	1320	645	645	645	752.5	79.2%	117.3%	100.0%	116.7%	602	3.4	3.4	6.9
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C8	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	2250	1777.5	1125	1215	967.5	967.5	645	720.25	79.0%	108.0%	100.0%	111.7%	562	4.9	3.4	8.3
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C9	300 - GENERAL MEDICINE		1800	1402.5	1350	1672.5	645	655.75	645	870.75	77.9%	123.9%	101.7%	135.0%	615	3.3	4.1	7.5
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Children's Unit	420 - PAEDIATRICS		4080	3576	1080	1116	3150	3013.5	315	336	87.6%	103.3%	95.7%	106.7%	858	7.7	1.7	9.4
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Coronary Care Unit (CCU)	320 - CARDIOLOGY		1800	1612.5	450	540	967.5	967.5	0	0	89.6%	120.0%	100.0%	-	246	10.5	2.2	12.7
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Critical Care Unit	192 - CRITICAL CARE MEDICINE		6825	6812	1014	858	5247	5247	0	22	99.8%	84.6%	100.0%	-	540	22.3	1.6	24.0
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D1	300 - GENERAL MEDICINE		1800	1440	1350	1537.5	645	645	645	1010.5	80.0%	113.9%	100.0%	156.7%	548	3.8	4.6	8.5
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D3	300 - GENERAL MEDICINE		1800	1477.5	1125	1387.5	645	677.25	645	924.5	82.1%	123.3%	105.0%	143.3%	581	3.7	4.0	7.7
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUA)	300 - GENERAL MEDICINE		3375	3176.25	1687.5	2148.75	3037.5	2711.25	1012.5	1271.25	94.1%	127.3%	89.3%	125.6%	1149	5.1	3.0	8.1
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUB)	300 - GENERAL MEDICINE		3600	3592.5	2700	2700	2205	2058	1260	1260	99.8%	100.0%	93.3%	100.0%	1174	4.8	3.4	8.2
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Neonatal Intensive Care Unit	420 - PAEDIATRICS		4932	4626	360	222	4320	4212	360	264	93.8%	61.7%	97.5%	73.3%	854	10.3	0.6	10.9
		RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Surgical Triage Unit	100 - GENERAL SURGERY		1560	1573	780	916.5	990	979	330	638	100.8%	117.5%	98.9%	193.3%	474	5.4	3.3	8.7
		RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Antenatal Ward	501 - OBSTETRICS		1440	1459.5	720	738	1080	1080	720	720	101.4%	102.5%	100.0%	100.0%	151	16.8	9.7	26.5
		RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Burnley Birth Centre	501 - OBSTETRICS		1362	1307.5	357	345	1104	1080	360	360	96.0%	96.6%	97.8%	100.0%	50	47.8	14.1	61.9
		RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Central Birth Suite	501 - OBSTETRICS		3600	3522	720	708	3600	3336	720	705	97.8%	98.3%	92.7%	97.9%	226	30.3	6.3	36.6
		RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Gynaecology and Breast Care Ward	502 - GYNAECOLOGY		1322	1306	498	481.5	819	819	348	348	98.8%	96.7%	100.0%	100.0%	353	6.0	2.3	8.4
		RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Postnatal Ward	501 - OBSTETRICS		2160	2180	1080	1104	2160	1920	1080	1320	100.9%	102.2%	88.9%	122.2%	816	5.0	3.0	8.0
		RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Rakehead	314 - REHABILITATION		1350	1267.5	1800	1702.5	570	570	570	826.5	93.9%	94.6%	100.0%	145.0%	409	4.5	6.2	10.7
		RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 15	110 - TRAUMA & ORTHOPAEDICS		1456	1469	975	975	660	693	572	660	100.9%	100.0%	105.0%	115.4%	536	4.0	3.1	7.1
		RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 16	300 - GENERAL MEDICINE		2250	1732.5	1575	2167.5	630	640.5	945	1323	77.0%	137.6%	101.7%	140.0%	868	2.7	4.0	6.8
		RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 28	300 - GENERAL MEDICINE		1455	1387.5	465	472.5	182.75	182.75	182.75	182.75	95.4%	101.6%	100.0%	100.0%	76	20.7	8.6	29.3
		RXR70	CLITHEROE COMMUNITY HOSPITAL	Ribblesdale	314 - REHABILITATION		2250	1852.5	1800	2220	945	966	945	1333.5	82.3%	123.3%	102.2%	141.1%	917	3.1	3.9	6.9
		RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Hartley	314 - REHABILITATION		1800	1395	1125	1575	645	645	645	666.5	77.5%	140.0%	100.0%	103.3%	727	2.8	3.1	5.9

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RXR East Lancashire Hospitals NHS Trust

Period: June_2016-17

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

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

Comments

Validation alerts (see control panel)	Only complete sites your organisation is accountable for					Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site 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								
	RXR60	ACCRINGTON VICTORIA HOSPITAL	Ward 2	314 - REHABILITATION		1350	922.5	960	1350	630	630	315	651	68.3%	140.6%	100.0%	206.7%	524	3.0	3.8	6.8
	RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Marsden	314 - REHABILITATION		1800	1402.5	1800	1770	645	645	645	645	77.9%	98.3%	100.0%	100.0%	715	2.9	3.4	6.2
	RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Reedyford	314 - REHABILITATION		1800	1410	1125	1387.5	645	645	645	817	78.3%	123.3%	100.0%	126.7%	703	2.9	3.1	6.1

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 219

27 July 2016

Purpose Information

Title	Quality Committee Update Report (May and July 2016)
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Mr P Rowe, Non-Executive Director

Summary: The report sets out the matters discussed and decisions made at the Quality Committee meetings held on 11 May and 13 July 2016.

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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust

The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Quality Committee Update: May 2016

1. At the meeting of the Quality Committee held on Wednesday 11 May 2016 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.
2. The Committee received the Quality Dashboard and discussed the performance against the Venus Thromboembolism (VTE) indicators. The he Committee requested further assurance on this issue and further work would be undertaken in this matter. The Committee noted that there were several campaigns undertaken to promote hand hygiene throughout the Trust.
3. The Committee received an overview of the 1:1 specialing pilot and received an update on the proposed roll-out schedule. Non-Executive members noted that a number of Trusts and the CQC were keen to understand more about the work the Trust has carried out in this area and have requested site visits.
4. The Committee received an overview of the evaluation of the Winter Resilience Plan and noted the key issues that had had an effect on performance over the winter months. Members noted the next steps, including the need to review commissioning of mental health services with commissioners.
5. It was agreed that all Non-Executive Directors would be sent the Winter Resilience Plan Evaluation Report presented to the Committee.
6. Members of the Committee received a summary report from the Health and Safety Committee and requested assurance regarding the compliance with fire safety training and local fire assessments.
7. The Committee received the End of Life Care Annual Report. The key issues were noted, including the lack of meaningful information to assist with the investigation of complaints, provision of the seven day palliative care service and effective commissioning of the service. Members agreed that more assurance is needed in this area and requested a follow up report in six months' time.
8. The Committee received the draft Quality Account for 2015/16 for comments and noting prior to approval by the Audit Committee.
9. The Committee also received the Corporate Risk Register, the Falls Prevention Update Report, the Mortality Report, the Trust Education Board minutes and summary reports from the following meetings:
    a. Infection Prevention and Control Committee
    b. Patient Experience Committee
    c. Internal Safeguarding Board

d. Patient Safety and Risk Assurance Committee
e. Clinical Effectiveness Committee

Quality Committee Update: July 2016

10. At the last meeting of the Quality Committee held on Wednesday 13 July 2016 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.
11. The Committee received an update concerning the Nursing Assessment and Performance Framework. Committee members agreed that it provided assurance about the programme to improve quality of care within the Trust and looked forward to receiving future reports on this matter.
12. The Committee received a presentation regarding the quality and risk assurance process around the safely releasing costs programme. Committee members discussed the process at length and noted that transformational schemes would be quality and risk assessed as part of the business case process.
13. The Committee received the Annual Report from the Health and Safety Committee and noted that whilst adequate assurance was provided in the majority of areas, assurance could not be provided at this time regarding the Control of Substances Hazardous to Health (COSHH), but a system was being procured which would enable the Trust to implement the necessary improvements in this area.
14. The Committee also noted the progress being made in relation to Fire Safety training and the identification and training of Fire Wardens within the Trust. Non-Executive members were keen to ensure that this issue is progressed at pace and requested an update for the next meeting.
15. The Committee were presented with the Raising Concerns Annual Report and noted the work done to date in in the Trust in setting up the framework to enable staff to report concerns; the Raising Concerns at Work Policy required further work and it will be presented to the next meeting for ratification. The Company Secretary was tasked with ensuring that the policy is taken through the correct governance processes before its presentation to the Committee.
16. The Committee received the Medicines Management Annual Report. The Committee members discussed the commissioning of the Outpatient Antibiotic Therapy (OPAT) service and were keen for the Trust to develop further discussions with Commissioners on this matter. Members noted that a Medicines Strategy would be developed and presented to the Committee in September.

17. The Committee received the Internal Safeguarding Board Summary Report and received an update from the recent CQC Looked After Children's Review that was carried out across the Lancashire County Council area.
18. The Committee received and approved the revised Risk Strategy.
19. The Committee also received the Serious Incidents Requiring Investigation (SIRI) Report, Quality Dashboard and summary reports from the following meetings:
    a. Patient Safety and Risk Assurance Committee
    b. Health and Safety Committee
    c. Infection Prevention and Control Committee
    d. Patient Experience Committee

Kea Ingham, Company Secretarial Assistant, 17 July 2016

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 220

27 July 2016

Purpose Information

Title	Finance and Performance Committee Update Report (May and June 2016)
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Mr David Wharfe, Non-Executive Director

Summary: The report sets out the matters discussed and decisions made at the Finance and Performance Committee meeting held on the 25 April 2016.

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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust

The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Finance and Performance Committee Update: May 2016

1. At the Finance and Performance Committee held on Monday 23 May 2016 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.
2. The Committee received the draft annual accounts and noted the achievement of the control total set by the regulator. The Committee noted the capital to revenue transfer that took place at year end and the impact that this had on the financial position.
3. The Committee received and update on temporary staffing, including the divisional spend on overtime and the developments in increasing the number of staff signing up to cover bank shifts. The Committee members also received and update on the development of the new staff attendance policy and the work being undertaken to ensure that the Trust becomes 'employer of choice'.
4. The Committee received the Sustaining Safe, Personal and Effective Care 2016/17 report and noted that the schemes had been grouped into nine overarching transformational programmes, each with a Senior Responsible Officer and Project Manager. The programmes will be presented for in depth discussion at future Trust Board part 2 meetings.
5. The Committee noted that the Transformation Board will now include external partners which will help them to develop a better understanding of the transformation work being carried out across the Trust.
6. The Committee also received the Integrated Performance Report, Finance Report, Medicine Prescription Delay and Discharge Letters and E-Health Board minutes.

Finance and Performance Committee Update: June 2016

7. At the last meeting of the Finance and Performance Committee held on Monday 27 June 2016 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.
8. The Committee received the Sustaining Safe, Personal and Effective Care 2016/17 report and noted that the recommendations and actions from the Carter Review will be included in the work of the Programme Management Office/Transformation Programmes. The Committee requested that the work relating to the Carter Review be presented to future Committee meetings.
9. The Committee discussed the result of the EU referendum and the potential implications that this may have for Trusts.

10. The Committee also received the Integrated Performance Report, Finance Report, Contract and Data Quality minutes and E-Health Board minutes.

Kea Ingham, Company Secretarial Assistant, 18 July 2016

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 221

27 July 2016

Purpose Information

Title	Audit Committee Update Report (June and July 2016)
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Mrs E Sedgley, Non-Executive Director

Summary: The report sets out the matters discussed and decisions made at the Quality Committee meetings held on 1 June and 6 July 2016.

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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust

The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Audit Committee Update: June 2016

1. At the meeting of the Audit Committee held on Wednesday 1 June 2016 members considered the following matters:
2. The Committee reviewed the Annual Report of the Trust for 2015/16. The Committee noted that the Trust does not currently have a Remuneration Policy; however one would be developed by the end of September 2016 and a statement to this effect be included in the Annual Report The Annual Report was approved for submission as per the mandated deadline.
3. The Committee received the Annual Accounts for 2015/16 for review and approval, following a presentation by Mrs Brown. .The Committee approved the Annual Accounts for submission as per the prescribed deadline.
4. The Committee reviewed the Going Concern statement. The Committee felt that the report provided the required level of assurance in relation to adherence to appropriate accounting policies and practices.
5. The Committee received a report about the management responses in relation to risk and fraud within the organisation. The Committee noted the proactive approach that the Trust takes with regards to the identification of risks relating to fraud. The Committee members requested a more in depth reporting of counter fraud activity, particularly relating to any investigations that were currently underway. The Committee noted that a Code of Conduct would be developed for approval in the near future.
6. Committee members requested that the increased number of limited assurance reports received from the Trust's Internal Auditors be raised with the Trust Board members.
7. Mr Rowe, Chair of the Quality Committee presented the Quality Account of the Trust for 2015/16 for information and recommendation to the Trust Board. The Committee discussed some of the feedback from the external stakeholders, particularly those relating to accessing and providing information. Committee members sought additional assurance on this issue, which will be provided by the Quality and Safety Team. The Committee sought additional information regarding the Venous Thromboembolism (VTE) audits, which was provided by Mr Tansley.
8. The Committee received and approved the Annual Governance Statement for 2015/16 for submission to the regulators.

The Trust's External Auditors presented their review of the Audited Annual Accounts and Financial Statements to the Committee. The Committee received the auditors Letter of Representation which was approved for signing at the meeting.

9. The Committee also received a revised Terms of Reference, which included the role of the Audit Committee members on the Auditor Panel.

10. The Committee approved the revised document and recommended it for presentation to the Trust Board for formal ratification.

Audit Committee Update: July 2016

11. At the last meeting of the Audit Committee held on Wednesday 6 July 2016 members considered the following matters

12. The Committee received the management responses in relation to the Information Governance Toolkit internal audit. The Internal Auditors were satisfied with the progress made to date. The Committee members agreed to receive a further update report in six months' time.

13. The following internal audit reports were presented to the Committee:

    a. Consultant Job Plans (limited assurance received)
    b. Emergency Department Staffing Follow Up Report (limited assurance received)
    c. Cyber Security (limited assurance received)
    d. Combined Financial Systems (significant assurance received)
    e. Nurse Staffing Levels (significant assurance received)
    f. Duty of Candour (significant assurance received)
    g. Serious Incidents Requiring Investigation (significant assurance received)
    h. Agency Staffing (significant assurance received)
    i. Asset Management Follow Up Report (significant assurance received)
    j. Quality Account Testing (information report)

14. The Committee agreed that management responses for the three limited assurance reports would be requested for presentation at the next meeting.

15. The Committee received the Counter Fraud Service progress report and noted the progress being made in relation to the referrals made since April 2016 and investigations that were currently underway.

16. The Committee discussed the level at which the Fit and Proper Persons Test is carried out and it was agreed that the test could also be carried out at sub-Board/senior management level in the future.

17. The Committee also received the External Audit Progress Plan, Losses and Special Payments Report and a report on Declarations of Interest, Gifts and Hospitality.

Kea Ingham, Company Secretarial Assistant, 15 July 2016

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 223

27 July 2016

Purpose Action

Title	Audit Committee Terms of Reference
Author	Mrs A Bosnjak-Szekeres, Company Secretary

Summary:
The Audit Committee terms of reference have been reviewed and agreed by the Committee at its meeting on 1 June 2016. The revised terms include a section about the Auditor Panel. The revised terms of reference are presented to the Board for ratification.

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

Recommendation:

The Audit Committee is recommending to the Board to ratify its revised terms of reference.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust

The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: NA

Audit Committee Terms of Reference

Constitution

The Board has resolved to establish a Committee of the Board to be known as the Audit Committee. The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. The Audit Committee is the high level risk committee operating on behalf of the Board and concerns itself with the function and effectiveness of all committees. It is the committee that brings all aspects of governance and risk management together.

Purpose of the Committee

The Audit Committee is charged with ensuring that the Board and Accounting Officer of the organisation gain the assurance they need on governance, risk management, the control environment and on the integrity of the financial statements, as well as other elements of the Annual Report and Accounts

The role of the Audit Committee is a challenging one and needs strong, independent members with an appropriate range of skills and experience. The committee acts as the "conscience" of the organisation and demonstrates strong constructive challenge where required, for example, regarding risks arising from increasing fiscal and resource constraints, new service delivery models, information flows on risk and control, and the agility of the organisation to respond to emerging risks.

The Audit Committee fulfils a major part in providing independent and objective assurance through the work of internal and external auditors and counter fraud, and reviewing reports and intelligence from external bodies including regulators.

It is essential that the Audit Committee understands how the governance arrangements support the achievement of the Trust's strategies and objectives, especially:

- The Trust's vision and purpose;
- The mechanisms in place to ensure effective organisational accountability, performance and risk management;
- The roles and responsibilities of individuals and committees and other groups to support the effective discharge of the Trust's responsibilities, decision making and reporting;

The committee must also understand the organisation's business strategy, operating environment and the associated risks. It must take into account the role and activities of the

Board and other committees in relation to managing risk and should ensure the Board discusses its policies, attitude to and appetite for risk to ensure these are appropriately defined and communicated so management operates within these parameters.

Membership

The Committee members are appointed by the Board from amongst the non–executive directors of the Trust and consist of not less than three members.

One of the members of the committee will have the required qualifications to be an Audit Committee Chair and will be appointed Chairman of the Audit Committee by the Board.

The Audit Committee should corporately possess knowledge/skills/experience / understanding of:

- accounting;
- risk management;
- internal / external audit; and
- technical or specialist issues pertinent to the organisation's business.
- experience of managing similar sized organisations;
- the wider relevant environments in which the organisation operates
- the accountability structures

The Chairman of the Trust shall not be a member of the Committee.

Quorum

The committee shall be deemed quorate if there are two members of the committee present.

Delegated Deputies

Members are expected to attend at least 75% of the meetings but in the unusual event that a member of the committee cannot attend the following are the delegated deputies.

- Chair of the Committee – A member of the Committee
- Member of the Committee – A Non-Executive Director
- Executive Directors who would normally be in attendance or in attendance because of the nature of the agenda items may be deputised by a senior manager within their corporate structure.

Attendance

The Director of Finance, ~~Medicine, and Chief Nurse,~~ Associate Director of Quality and Safety and appropriate internal and external audit representatives shall normally attend meetings. At least once a year the Committee members will meet privately with the external and internal Auditors.

The Chief Executive will be invited to attend and will discuss at least annually with the Committee the process for assurance that supports the Annual Governance Statement. He/she will also attend when the Committee considers the draft internal audit plan and the annual accounts. All other Executive Directors will be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

The Company Secretary, or whoever covers these duties, shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members. His/her duties will include:

- Agreement of the agenda with Chair and attendees and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent issues/areas

Frequency

A minimum of four meetings per annum will be held in accordance with the timetable agreed by the Trust Board. Members or their nominated representative are expected to attend at each meeting.

The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

It is good practice for the Chair of the Audit Committee to meet with the Accounting Officer, the Finance Director, the Head of Internal Audit and the external auditor's senior representative outside of the formal committee structure.

Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee or agent and all employees are directed to co-operate with any request made by the Committee.

As well as having the permanent members of the committee the committee is empowered to co-opt non-executive members for a period of time (not exceeding a year, and with the approval of the Board) to provide specialist skills, knowledge and experience which the

Committee needs at a particular time and procure specialist advice at the expense of the organisation on an ad- hoc basis to support them in relation to particular pieces of committee business.

Duties

The duties of the Committee are categorised as follows:

Governance, Risk Management and Internal Control

- The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In particular the Committee will review the adequacy and effectiveness of:
  - All risk and control related disclosure statements (in particular the Annual Governance Statement, formally known as Statement on Internal Control) together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to their endorsement by the Board.
  - The underlying assurance processes that indicate the degree of achievement of the corporate objectives, the effectiveness of the management of the principal risks and the appropriateness of the above disclosure statements
  - The policies for ensuring compliance with the relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
  - The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.
- In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of the effectiveness.
- This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

- The role of the Audit Committee in relation to internal audit should include advising the Accounting Officer and Board on the:
  - Internal Audit Charter and periodic internal audit plans, forming a view on how well they reflect the organisation's risk exposure and support the Head of Internal Audit's responsibility to provide an annual opinion;
  - adequacy of the resources available to internal audit;
  - internal audit charter, or terms of reference, for internal audit;
  - results of internal audit work, including reports on the effectiveness of systems for governance, risk management and control, and management responses to issues raised;
  - annual internal audit opinion and annual report; and
- The Committee shall ensure that there is an effective internal audit function that meets mandatory *NHS Internal Audit Standards* and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:
  - Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
  - Review and approval of the Internal Audit Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
  - Considering the major findings of internal audit work (and management's response) and ensuring coordination between the internal and external auditors to optimise audit resources
  - Ensuring that the internal audit function is adequately resources and has appropriate standing within the organisation
  - The Annual review of the effectiveness of internal audit

External Audit

- The Committee shall review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved by:
  - Consideration of the appointment and performance of the external auditors,

as far as the rules governing the appointment permit

- Discussion and agreement with the external auditors, before the audit commences, of the scope and nature of the audit as set out in the annual plan, and ensuring coordination, as appropriate, with other external auditors in the local health economy
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions

- The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications for the governance of the organisation.
- These will include, but will not be limited to, any reviews by Department of Health arms- length bodies or regulators/ inspectors and professional bodies with responsibility for the performance of staff or functions.
- To seek assurance on the implementation of guidance and recommendations from external inspection and accreditation visits from the Patient Safety and Governance Committee.
- In addition, the Committee will review the work of all other committees within the organisation whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the work and functionality of the Patient Safety and Governance Committee which reports to the Board on all aspects of clinical governance and risk management and the Executive Management Board that reports to the Board on all aspects of corporate governance and performance. This function will be undertaken through the review of the Annual Reports of the Board's formal subcommittees.
- The Audit Committee will receive an annual report on the review of the effectiveness of the Trust's arrangements for staff to raise concerns and whistleblowing
- The Audit Committee will review the Quality Account prior to publication.

Counter Fraud

- The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Management

- The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- The Committee may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.

Financial Reporting

- The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.
- The Audit Committee will review the annual report and financial statements before submission to the Board, focussing particularly on:
  - The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
  - Changes in and compliance with accounting policies, practices and estimation techniques
  - Unadjusted mis-statements in the financial statements
  - Significant judgements in preparation of the financial statements
  - Significant adjustments resulting from the audit
  - Letter of Representation
  - Qualitative aspects of financial reporting
- In reaching a view on the accounts, the Committee will consider:
  - key accounting policies and disclosures;
  - assurances about the financial systems which provide the figures for the accounts;

- the quality of the control arrangements over the preparation of the accounts;
- key judgements made in preparing the accounts;
- any disputes arising between those preparing the accounts and the auditors; and
- reports, advice and findings from external audit (especially the Audit Completion Report – ISA 260 Report)

Acting as the Auditor Panel

- The Auditor Panel will be made up of the Non-Executive Directors serving on the Audit Committee and the Director of Finance. The role of the Auditor Panel is to advise on the selection, appointment and removal of the external auditors as well as on the maintenance of an independent relationship with that auditor, including dealing with possible conflicts of interest.
- The Auditor Panel will have a role in establishing and monitoring the Trust's policy on the awarding of non-audit services.
- The Trust must consult and take account of the Auditor Panel's advice on the selection and appointment of the external auditor. The advice given by the Panel must be published and should the Trust not follow that advice, the reasons for not doing so must also be published.
- The Auditor Panel must have at least three members, including a Chair who is an independent non-executive member of the Trust Board. The majority of the Panel's members must also be independent and non-executive members of the Trust Board.
- In order to take a decision, the Auditor Panel must be quorate, which means that the independent members (NEDs) must be in the majority and there must be at least 2 independent members present or 50% of the Auditor Panel's total membership, whichever is the highest.
- The Auditor Panel is an advisory body only. Responsibility to the actual procurement and appointment of the auditors remains with the Trust Board. The Chair of the Auditor Panel will be required to provide a report to the Governing Board about the activities and decisions of the Panel.

Other Matters

- The minutes of the Audit Committee meetings shall be formally recorded by the Company Secretary and a report submitted into the Board. From each meeting the

Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

- For monitoring compliance purposes the Committee will report to the Board at least once each calendar year on its work in support of the Annual Governance Statement for the previous financial year. Its report will specifically cover the a statement about the fitness for purpose of the Assurance Framework, and assurance that the risk management system is complete and embedded in the organisation and the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts.

Committee Support

Company Secretary

Director of Finance

Review

The committee will review its own effectiveness at least once a year taking into account the views of internal and external audit as well as other external bodies including regulators

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 224

27 July 2016

Purpose Information

Title	Remuneration Committee Information Report – (May and June 2016)
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The list of matters discussed at the last Remuneration Committee is presented for Board members' information.

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.

Recommendation: This paper is brought to the Committee 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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the

delivery of sustainable services by the Trust

The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

Remuneration Committee Information Report: May 2016

1. At the last meeting of the Remuneration Committee held on Wednesday 29 May 2016 members considered the following matters:
   a) Harmonising Terms and Conditions of Employment
   b) 1% Cost of Living Pay Award for Directors
   c) Appointment of the Director of Communications and Engagement

Remuneration Committee Information Report: June 2016

2. At the last meeting of the Remuneration Committee held on Wednesday 29 June 2016 members considered the following matters:
   a) Acting Director of Finance Arrangements
   b) Deputy Chief Executive Arrangements
   c) Director of Sustainability

Kea Ingham, Company Secretarial Assistant, 11 July 2016

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 225

27 July 2016

Purpose Information

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

Summary: The report details the agenda items discussed in Part 2 of the Board meetings held in May and June 2016.

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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk

rating.

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: n/a

Trust Board Part Two Information Report: 25 May 2016

1. At the meeting of the Trust Board on 25 May 2016, the following matters were discussed in private:
   a) Care Quality Commission Report
   b) Royal Blackburn Hospital Primary Care Assessment Centre
   c) Pennine Lancashire and Healthier Lancashire Updates
   d) Accountable Care System
   e) Fracture Clinic Additional Information
   f) Finance Report
   g) Sustaining Safe, Personal and Effective Care 2016/17
   h) Proposal for a Smoke Free Site
   i) Draft Annual Report
   j) Draft Annual Accounts
   k) Draft Quality Committee
   l) Serious Untoward Incident Report
   m) Doctors with Restrictions

Trust Board Part Two Information Report: 29 June 2016

2. At the meeting of the Trust Board on 29 June 2016, the following matters were discussed in private:
   a) Care Quality Commission Update
   b) Healthier Lancashire and Pennine Lancashire Updates
   c) Integrated Performance Report Development Discussion
   d) Finance Report
   e) Sustaining Safe, Personal and Effective Care 2016/17
   f) Sustaining Safe, Personal and Effective Care 2016/17 Themed Programme Discussion: Stroke Services
   g) Quality Account
   h) Serious Untoward Incident Report
   i) Doctors with Restrictions

3. 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 reported to Part 1 of Board Meetings at the appropriate time.