East Lancashire Hospitals
NHS Trust

# EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

Personal

Effective

East Lancashire Hospitals NHS Trust

# TRUST BOARD MEETING (OPEN SESSION)

## 10 JULY 2019, 13.00

## SEMINAR ROOM 6, ROYAL BLACKBURN HOSPITAL

## AGENDA

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

| | | | | |
|---|---|---|---|---|
| **OPENING MATTERS** | | | | |
| **TB/2019/080** | **Chairman's Welcome** | Chairman | v | |
| **TB/2019/081** | **Open Forum**<br>To consider questions from the public | Chairman | v | |
| **TB/2019/082** | **Apologies**<br>To note apologies. | Chairman | v | |
| **TB/2019/083** | **Declaration of Interest**<br>To note the directors register of interests and note any new declarations from Directors. | Chairman | d✓ | |
| **TB/2019/084** | **Minutes of the Previous Meeting**<br>To approve or amend the minutes of the previous meeting held on 8 May 2019. | Chairman | d✓ | Approval |
| **TB/2019/085** | **Matters Arising**<br>To discuss any matters arising from the minutes that are not on this agenda. | Chairman | v | |
| **TB/2019/086** | **Action Matrix**<br>To consider progress against outstanding items requested at previous meetings. | Chairman | d✓ | Information |
| **TB/2019/087** | **Chairman's Report**<br>To receive an update on the Chairman's activities and work streams. | Chairman | v | Information |
| **TB/2019/088** | **Chief Executive's Report**<br>To receive an update on national, regional and local developments of note. | Chief Executive and Acting Chief Executive | d✓ | Information |
| **QUALITY AND SAFETY** | | | | |
| **TB/2019/089** | **Patient Story**<br>To receive and consider the learning from a patient story. | Executive Director of Nursing | p | Information/ Assurance |
| **TB/2019/090** | **Corporate Risk Register**<br>To receive an update on the Corporate Risk Register and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives. | Acting Executive Medical Director | d✓ | Assurance/ Approval |
| **TB/2019/091** | **Board Assurance Framework**<br>To receive an update on the Board Assurance Framework and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives. | Acting Executive Medical Director | d✓ | Assurance/ Approval |

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| **TB/2019/092** | **Serious Incidents Requiring Investigation Report**<br>To receive information in relation to incidents in month or that may come to public attention in month and be assured about the associated learning. | Acting Executive Medical Director | d✓ | Information/ Assurance |
| **ACCOUNTABILITY AND PERFORMANCE** | | | | |
| **TB/2019/093** | **Integrated Performance Report**<br>To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed, with items being raised by exception:<br>• Introduction (Acting Chief Executive)<br>• Safe (Acting Executive Medical Director and Executive Director of Nursing)<br>• Caring (Executive Director of Nursing)<br>• Effective (Acting Executive Medical Director)<br>• Responsive (Director of Operations)<br>• Well-Led (Executive Director of HR and OD and Executive Director of Finance) | Executive Directors | d✓ | Information/ Assurance |
| **TB/2019/094** | **Raising Concerns Annual Report** | Executive Director of HR and OD | d✓ | Information |
| **TB/2019/095** | **Seven Day Services Update** | Executive Medical Director | d | Information |
| **STRATEGY** | | | | |
| **TB/2019/096** | **People Strategy/ Creating Supportive Staff Culture** | Executive Director of HR and OD | d✓ | Information |
| **GOVERNANCE** | | | | |
| **TB/2019/097** | **Annual Audit Letter** | Executive Director of Finance | d✓ | Information |
| **TB/2019/098** | **Audit Committee Update Report**<br>To note the matters considered by the Committee in discharging its duties | Committee Chair | d✓ | Information/ Assurance |
| **TB/2019/099** | **Finance and Performance Committee Update Report**<br>To note the matters considered by the Committee in discharging its duties. | Committee Chair | d✓ | Information/ Assurance/ Approval |
| **TB/2019/100** | **Quality Committee Update Report**<br>To note the matters considered by the Committee in discharging its duties. | Committee Chair | d✓ | Information/ Assurance/ Approval |

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| **TB/2019/101** | **Remuneration Committee Information Report**<br>To note the matters considered by the Committee in discharging its duties | Chairman | d✓ | Information |
| **TB/2019/102** | **Trust Board Part Two Information Report**<br>To note the matters considered by the Committee in discharging its duties | Chairman | d✓ | Information |
| **FOR INFORMATION** | | | | |
| **TB/2019/103** | **Any Other Business**<br>To discuss any urgent items of business. | Chairman | v | |
| **TB/2019/104** | **Open Forum**<br>To consider questions from the public. | Chairman | v | |
| **TB/2019/105** | **Board Performance and Reflection**<br>To consider the performance of the Trust Board, including asking:<br>• Has the Board focussed on the appropriate agenda items? Any item(s) missing or not given enough attention?<br>• Is the Board shaping a healthy culture for the Board and the organisation and holding to account?<br>• Are the Trust's strategies informed by the soft intelligence from local people's needs, trends and comparative information?<br>• Does the Board give enough priority to engagement with stakeholders and opinion formers within and beyond the organisation? | Chairman | v | |
| **TB/2019/106** | **Date and Time of Next Meeting**<br>Wednesday 11 September 2019, 1.00pm, Seminar Room 6, Learning Centre, Royal Blackburn Teaching Hospital. | Chairman | v | |

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**10 July 2019**

**Item** 83

**Purpose** Information
Approval

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

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

**Recommendation:** The Board is asked to note the presented Register of Directors' Interests and Board Members are invited to notify the Company Secretary of any changes to their interests within 28 days of the change occurring.

## Report linkages

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

regulatory requirements

**Impact**

| | | | |
|---|---|---|---|
| Legal | Yes | Financial | No |
| Equality | No | Confidentiality | No |

**Directors Register of Interests**

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

| Name and Title | Interest Declared | Date last updated |
|---|---|---|
| **Professor Eileen Fairhurst**<br>Chairman | • Professor at Salford University (until 21.12.2017).<br>• Trustee, Beth Johnson Foundation (until 31.03.2017).<br>• Chairman of Bury Hospice (from 23.01.2017 until 19.06.2018)<br>• Member of the Learning, Training & Education (LTE) Group and Higher Education Board (until 12.3.2017).<br>• Chairman of the NHS England Performers Lists Decision making Panel (PDLP) (until November 2018)<br>Honorary Doctorate UCLan awarded 2018 | 09.05.2019 |
| **Kevin McGee**<br>Chief Executive (Accountable Officer) | • Spouse is the Director of Finance and Commercial Development at Warrington and Halton Hospitals NHS Foundation Trust<br>• Honorary Fellow at University of Central Lancashire | 09.01.2019 |
| **Patricia Anderson**<br>Non-Executive Director (until 10 May 2019) | • Accountable Officer at Wigan Borough CCG (until 31.05.2018).<br>• Public Sector Director on One Partnership (LIFTCO) (January 2015 until 31.05.2018)<br>• Spouse is a recently retired Consultant Psychiatrist formerly employed at Mersey Care NHS Trust | 09.01.2019 |

| Name and Title | Interest Declared | Date last updated |
|---|---|---|
| **John Bannister**<br>Executive Director of Operations<br>(until 24 May 2019) | Positive Nil Declaration. | 09.01.2019 |
| **Stephen Barnes**<br>Non-Executive Director | • Chair of Nelson and Colne College.<br>• Member of the National Board of the Association of Colleges (from 02.03.2017).<br>• Vice Chair of the National Council of Governors of the Association of Colleges (from 02.03.2017). | 09.01.2019 |
| **Martin Hodgson**<br>Executive Director of Service Development | Partner is the Chief Operating Officer at Aintree University Hospital NHS Foundation Trust. | 02.07.2019 |
| **Christine Hughes**<br>Executive Director of Communications and Engagement | Positive Nil Declaration. | 09.01.2019 |
| **Naseem Malik**<br>Non-Executive Director | • Independent Assessor- Student Loans Company- Department for Education - Public Appointment.<br>• Fitness to Practice, Panel Chair: Health & Care Professions Tribunal Service (HCPTS) - Independent Contractor. | 08.05.2019 |

| Name and Title | Interest Declared | Date last updated |
|---|---|---|
| | • Investigations Committee Panel Chair at Nursing & Midwifery Council (NMC) - Independent Contractor.<br>• NED and SID at Lancashire Care NHS Foundation Trust (until 29.07.2016).<br>• Worked for Blackburn Borough Council (now Blackburn with Darwen Borough Council) in 1995/6.<br>• NED at Blackburn with Darwen Primary Care Trust (from 2004 until 2010).<br>• Relative (first cousin) is a GP in the NHS (GP Practice).<br>• Relative (brother-in-law) is a registered nurse (replaces online declaration 726). | |
| **Kevin Moynes**<br>Executive Director of Human Resources & Organisational Development | • Spouse is a very senior manager at Health Education England (from 02.10.2017)<br>• Governor of Nelson and Colne College (until 01.02.2018). | 09.01.2019 |
| **Christine Pearson**<br>Executive Director of Nursing | • Spouse is the Head of Medicines Optimisation, at Heywood, Middleton & Rochdale Clinical Commissioning Group | 20.05.2019 |
| **Damian Riley**<br>Acting Chief Executive | • Spouse may undertake work in PWE practices, and ELHT has a financial commitment to PWE Consortium. | 26.06.2019 |

| Name and Title | Interest Declared | Date last updated |
|---|---|---|
| **Richard Smyth**<br>Non-Executive Director | • Consultant Solicitor with DLA Piper UK LLP Law Firm. DLA Piper undertakes work for the NHS.<br>• Spouse is a Lay Member of Calderdale CCG (until 31 January 2019).<br>• Spouse is a Patient & Public Involvement and Engagement Lay Leader for the Yorkshire and Humber Patient Safety Translational Research Centre, based at Bradford Institute for Health Research, Bradford Royal Infirmary.<br>• Sister is an advanced clinical nurse practitioner with Pennine Acute Hospitals Trust based at the Royal Oldham hospital.<br>• Member of the Law Society.<br>• Spouse is a Non-Executive Director at Lancashire Teachings Hospitals Foundation Trust as from 4 February 2019. | 21.03.2019 |
| **Ian Stanley**<br>Acting Executive Medical Director | • Working for Facing Africa (Charity) in Ethiopia (two weeks oer year) | 02.07.2019 |
| **Professor Michael Thomas**<br>Associate Non-Executive Director | • Vice-Chancellor of UCLAN (to 30.11.2018).<br>• Brother-in-Law is senior manager within Lancashire Care NHS Trust.<br>• Sister-in-Law works within Lancashire Education and Social Services. | 08.05.2019 |

| Name and Title | Interest Declared | Date last updated |
|---|---|---|
| | • Self Employed (Thomas and Drake Consultancy) from 01.04.19 | |
| **Michael Wedgeworth**<br>Associate Non-Executive Director | • Honorary Canon of Blackburn Cathedral in 2003<br>• Assistant Priest at Blackburn Cathedral since 1995.<br>• Member of the Lancashire Health and Well-Being Board (from 2011 to 2017).<br>• Elected Public Governor at Lancashire Care Foundation Trust and Chair of the Patient Experience Group (until April 2017).<br>• Chair of Healthwatch Lancashire (until December 2017).<br>• Healthwatch Representative on NHS governing bodies and Trusts (since 2015).<br>• Member of the Lancashire and South Cumbria Sustainability and Transformation Programme Board and its workstream on Acute and Specialised Services (since 2015).<br>• NED Representative for the Pennine Lancashire system on the Lancashire and South Cumbria Sustainability and Transformation Partnership Board (now the Integrated Care Organisation Board). | 09.01.2019 |
| **David Wharfe**<br>Non-Executive Director | • Trustee of Pendleside Hospice (from June 2018) | 09.01.2019 |
| **Jonathan Wood**<br>Executive Director of Finance | • Spouse is the Director of Finance at the Oldham Care Group Hospital, part of Pennine Acute Hospitals NHS Trust. Pennine Acute Hospitals currently form part of the 'hospital chain' with Salford Royal Hospitals Foundation Trust (replaced by declaration below number 1133) – | 01.04.2019 |

| Name and Title | Interest Declared | Date last updated |
|---|---|---|
| | removed from register on 26.04.2019)<br>• Chair of Blackburn Cathedral Finance Committee<br>• Married to Director of Finance North West Ambulance Service<br>• Non-Executive of the East Lancashire Financial Service (hosted by Salford Royal Foundation Trust). | |

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**Item** 84

**13 July 2019**

**Purpose** Action

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

**Summary:** The minutes of the previous Trust Board meeting held on 8 May 2019 are presented for approval or amendment as appropriate.

## Report linkages

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

## Impact

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

Previously considered by: NA

# EAST LANCASHIRE HOSPITALS NHS TRUST
# TRUST BOARD MEETING, 1.00PM, 8 MAY 2019
# MINUTES

## PRESENT

| | | |
|---|---|---|
| Professor E Fairhurst | Chairman | Chairman |
| Mr K McGee | Chief Executive | |
| Mrs P Anderson | Non-Executive Director | |
| Mr J Bannister | Director of Operations | Non-voting |
| Mr S Barnes | Non-Executive Director | |
| Mr M Hodgson | Director of Service Development | |
| Mrs C Hughes | Director of Communications and Engagement | Non-voting |
| Miss N Malik | Non-Executive Director/ Vice Chair | |
| Mrs C Pearson | Director of Nursing | |
| Dr D Riley | Medical Director | |
| Mr R Smyth | Non-Executive Director | |
| Professor M Thomas | Associate Non-Executive Director | Non-voting |
| Mr M Wedgeworth | Associate Non-Executive Director | Non-voting |
| Mr J Wood | Director of Finance | |

## IN ATTENDANCE

| | | |
|---|---|---|
| Mrs A Bosnjak-Szekeres | Associate Director of Corporate Governance/ Company Secretary | |
| Mrs G Cairns | Acting Assistant Director Of Education | Observer |
| Mrs EL Cooke | Senior Communications Manager | Observer |
| Miss K Ingham | Corporate Governance Manager/Assistant Company Secretary | Minutes |
| Mr J Walton Pollard | Divisional Director of Nursing, Surgical and Anaesthetic Services | Observer |
| Mr D Simpson | Advanced Clinical Matron, Diabetes and Endocrinology | |

## APOLOGIES

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

**TB/2019/055 CHAIRMAN'S WELCOME**

Professor Fairhurst welcomed the Directors and members of the public to the meeting. She reported that there had been a number of changes to the Executive Team at the Trust since the last meeting. Mr McGee had been approached by NHS Improvement (NHSI) to take on the temporary role of Chief Executive at Blackpool Teaching Hospitals NHS Foundation Trust, whilst remaining in post at the Trust. The joint appointment commenced on 1 May 2019 and will run for a period of six months, with a review at three months. As a result, Dr Riley has been appointed as the Acting Chief Executive, with Dr Stanley taking up the Acting Medical Director post. Directors noted that Mr McGee will be at Blackpool for three days per week with the remaining two days per week being dedicated to ICS/ICP work on behalf of ELHT.

Professor Fairhurst welcomed Mrs Feroza Patel to the Trust Board in her role as Associate Non-Executive Director.

**TB/2019/056 OPEN FORUM**

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

**TB/2019/057 APOLOGIES**

Apologies were received as recorded above.

**TB/2019/058 DECLARATIONS OF INTEREST**

There were no declarations of interest made.

**TB/2019/059 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 13 March 2019 were approved as a true and accurate record.**

**TB/2019/060 MATTERS ARISING**

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

**TB/2019/061 ACTION MATRIX**

All items on the action matrix were reported as complete or were to be presented as agenda

items at this meeting or subsequent meetings. The following updates were provided:

**TB/2019/038: Patient Story** – Mrs Hughes confirmed that Mrs Edmonson's patient story will be shared widely through the Trust generated publications.

**TB/2019/038: Patient Story** – Mr Bannister confirmed that a review of medication to take out (TTOs) had been carried out and confirmed that the experiences shared by Mr Edmonson had predated the full implementation of the ward based pharmacists roles. He went on to confirm that since the roles had been rolled out across all ward areas, the completion of TTOs and discharge letters had improved.

**TB/2019/039: Corporate Risk Register (CRR)** – Mr Bannister reported that he had met with Mr Smyth regarding the mitigation of risks and the recording of actions to reduce and manage risks and the outcome of the discussion were reflected in the CRR presented to the Board.

**TB/2019/041: Serious Incidents Requiring Investigation Report** – Dr Stanley confirmed that since the last meeting of the Board it has been agreed that entering duty of candour letters into patient files will be included as a formal step in the 'duty of candour' process.

**TB/2019/045: Seven Day Services Report** – Dr Stanley confirmed that the Trust continues to work with the Divisions to ensure that evidence can be provided to show that no harm has come to patients. In addition, the Trust continues to closely monitor mortality rates and ratios, particularly comparing weekday and out of hour's mortality.

**TB/2019/053: Board Performance and Reflection** – Mrs Hughes confirmed that she had not had the opportunity to meet with Professor Thomas since the last meeting, but she and the Communications and Engagement Team were working to develop a programme to raise Board visibility across the Trust.

**RESOLVED:** **The position of the action matrix was noted.**
**Mrs Hughes will provide an update on the work being undertaken to develop a Board visibility programme at the next meeting.**

**TB/2019/062** **CHAIRMAN'S REPORT**

Professor Fairhurst reported that she had opened the refurbished children's play area at the Royal Blackburn Teaching Hospital site and commented that the area is now a really stimulating and fun play area for the children who are being treated in the hospital. She went on to confirm that the work and equipment was funded by Euro Garages and a small number of other local businesses who either offered time or resources to complete the renovation. Directors noted that the area was a great way to showcase the good work that

the Trust is doing with its charity, ELHT&Me.

Professor Fairhurst reported that she and Mr McGee had met with Peter Mileham, Chairman of the Rosemere Cancer Foundation to discuss cancer care across the ICS. She went on to confirm that the foundation had contributed a significant sum towards the development of the Trust's cancer centre at the Burnley General Teaching Hospital site.

Directors noted that Professor Fairhurst and Mr McGee had attended the retirement event for Mr Harry Catherall who had retired from his post as Chief Executive of Blackburn with Darwen Borough Council at the end of April 2019. The Board recognised the work that Mr Catherall had done with the Trust and the planned continuation of this work by his colleagues.

Professor Fairhurst reported that she had met with Professor's Jackson and Crean from UCLan Medical School to discuss the expansion of work between the Trust and the University.

Professor Fairhurst went on to highlight the Trust's first 'Inclusion Week' and confirmed that she had been privileged to open the event. She thanked Mrs Quinn and Mr Makda for their efforts in arranging such a complex and interesting event.

Directors noted that the Trust had held its STAR awards on 3 May 2019, where a number of awards were awarded to individual members of staff and teams for their efforts over the course of the year. Professor Fairhurst commented that the event was a marvellous celebration of the hard work and commitment of the staff working in the Trust.

Finally, Professor Fairhurst confirmed that the Trust had held the first of the three shadow Board meetings planned earlier in the week. The intention of the Shadow Board is to offer the opportunity to aspirant directors to get a feel for, and experience of how Board meetings are conducted. She went on to report that one of the features of the Shadow Board was that comments made there will be fed into the Board meeting where relevant.

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

**TB/2019/063 CHIEF EXECUTIVE'S REPORT**

Mr McGee referred Directors to the previously circulated report and provided an overview of the national headlines from his report, particularly his attendance at the National Guardian's Panel. He also highlighted the number of cancer checks and screening campaigns that were being undertaken and the associated increase in the number of people accessing screening. Directors noted that the Trust was working with the ICS to disseminate the message to the population about the importance of cancer screening.

Mr McGee reported that the number of physical attacks on staff in hospital settings across the Lancashire area had increased. He confirmed that the numbers of staff suffering an assault whilst working for the Trust were comparable to those of Blackpool Teaching Hospitals NHS Foundation Trust and University Hospitals Morecambe Bay Foundation Trust. From a Pennine Lancashire perspective the work to develop neighbourhood teams was continuing and the Trust is leading significant parts of the work, particularly through its Community Services.

In relation to Trust specific matters, Mr McGee thanked members of staff who had attended the Trust's STAR awards and thanked Mrs Butcher and the Staff Engagement team for their efforts to ensure that the ceremony was a great celebration of the work of the Trust in the last year.

He went on to confirm that the Trust had been identified as the best Trust to receive paediatric medical training in the country. Similarly, the Trust's Obstetrics department had been identified as providing the best obstetric training in the country. Both of these accolades were as a result of feedback from the medical trainees.

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

**TB/2019/064 PATIENT STORY**

Mrs Emma Davies, Deputy Director of HR and OD attended the meeting to share her experience of care and treatment at the Trust whilst being treated for bowel cancer. She reported that in 2018, at the age of 36, she was diagnosed with bowel cancer after displaying transient symptoms. She confirmed that she had initially been referred to another hospital in the Lancashire area and had been subject to a significant period of waiting for initial diagnostic assessments. As a result, she requested that her care be transferred to ELHT. Upon transfer of her care and the conclusion of the diagnostic testing she was diagnosed with bowel cancer. She underwent a lengthy operation to remove the tumour and received high quality patient centred care from the Trust's cancer service.

Mrs Davies confirmed that post-surgery she was treated under the enhanced recovery programme and was able to go home after four days. She commented that one downside to the treatment she received was that the nurse had really struggled to insert the cannula in preparation for a diagnostic scan. Eventually the nurse sought assistance and the cannula was inserted correctly, but this did nothing to alleviate the stress of the overall situation.

Mrs Davies confirmed that following discharge and completion of follow up treatment she had sought support for her mental health due to the psychological impact of being diagnosed

with cancer at a relatively young age and with a young family. She reported that she sought input in November 2018 and waited for five months for her first appointment. This was an area where she raised concerns about the capacity of such services to manage demand within a reasonable timeframe.

She went on to say that the overall experience had highlighted a number of areas where the Trust's HR policies and ways of managing staff who are on long term sick leave could be improved. As a result, the Trust is working to revise policies and support offered to managers and staff who are either managing a member of staff on long term sickness or being managed whilst on long term sick leave.

Professor Fairhurst thanked Mrs Davies for her candidness and bravery in sharing her experience with the Board.

In response to Professor Thomas's question, Mrs Pearson confirmed that contact with the department where the cannula issue had occurred had already been made and staff were being supported with additional training where required.

Directors acknowledged that the biggest issue for patients was the waiting for either diagnostic testing or results of testing, which undoubtedly had a significant impact on the levels of anxiety experienced by patients.

The Directors also noted the involvement that Mrs Davies had in relation to patient involvement/experience through Bowel Cancer UK and the Cancer Alliance. In addition Mrs Davies confirmed that she was keen to become more involved in the Trust's work relating to patient experience in order to improve it further for future patients.

*Ms Malik left the meeting at this point (2.00pm)*

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

**TB/2019/065** **CORPORATE RISK REGISTER (CRR)**

Dr Stanley presented the report to the Directors and confirmed that one risk has been de-escalated following the Risk Assurance Meeting (RAM) in April 2019. He confirmed that the Information Technology (IT) related risk has been combined into one overarching risk. The Board was asked to approve the revisions to the document and confirm that adequate assurance had been gained that the risks are being robustly managed.

Mr Barnes asked whether Directors were suitably assured in relation to the rating of the risk pertaining to medical recruitment. He commented that he felt as though the issue was becoming increasingly problematic as there seemed to have been an increasing number of gaps and he was concerned about the impact of this on morale and performance measures.

In response, Dr Stanley said that there was evidence being seen through the Trust's education directorate to suggest that the gaps in recruitment were reducing and recruitment was getting better. In some medical specialties consultant recruitment is difficult and has been for a sustained period of time, but in other areas it is much easier to recruit to posts.

In response to Mrs Anderson's question, Dr Stanley reported that, like many other Trusts, ELHT operates a holding list for patients requiring follow up appointments. Patients can be held on the list for a number of reasons, but there was a current issue within the Trust's ophthalmology service which meant that the holding list for this area had grown significantly. The matter relates to staffing capacity issues due to sickness within the specialty group. The Quality Committee received a report on this matter at its last meeting and was sufficiently assured that matters were under control and patients had been risk assessed and were seen in order of clinical priority.

Directors approved the CRR based on the information presented to the Board.

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

**TB/2019/066 BOARD ASSURANCE FRAMEWORK**

Dr Stanley provided an overview of the process for reviewing the Board Assurance Framework. He highlighted the changes to the document, particularly the updates to BAF Risk 1 (transformation, efficiency savings and Vital Signs), updates to the mitigating factors section of BAF Risk 2 (workforce) and the increase in score of BAF Risk 5 (performance against constitutional standards) to 16. Directors noted that the proposed increase in the score was reflective of the ongoing difficulties in achieving the 4 hour standard, RTT performance and holding list.

Mrs Quinn commented that the issues relating to pensions that had been discussed in the earlier part of the meeting are being worked on internally and across the ICS to mitigate the risks across the wider Lancashire and South Cumbria patch.

Directors accepted and approved the revised Board Assurance Framework.

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

**TB/2019/067 SERIOUS INCIDENTS REQUIRING INVESTIGATION REPORT**

Dr Stanley referred the Directors to the previously circulated report and confirmed that it covered the period from February 2019 to March 2019. He highlighted that the section of

the report which usually focused on a specific theme had been replaced in this month's report and instead provided an overview of the Trust's serious untoward incident (SUI) process.

Directors noted the increase in the number of incidents which had been reported through the Strategic Executive Information System (StEIS) and that whist it initially looked alarming, there would be a number of the incidents reported that would be de-escalated following investigation.

Dr Stanley confirmed that the theme of 'issues with diagnosis and initial treatment commencement' had been introduced as a result of the SIRI and Structured Judgement Review (SJR) process and it was intended that a deep dive be undertaken on this matter with the results being reported to a future Board meeting through this report.

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

**TB/2019/068 INTEGRATED PERFORMANCE REPORT**

Dr Riley introduced the report to the Directors and confirmed that the report related to the period to the end of March 2019. He confirmed that presentation of the report would be on an exception basis. Directors noted that there had been no never events identified in the month, which was pleasing to note.

In response to Mr Barnes's question regarding recruitment of staff and vacancy rates, Dr Riley agreed that recruitment to clinical and nursing posts was challenging and confirmed that the risk was included on the Trust's Corporate Risk Register. He went on to suggest that there were a number of specialty areas, one being emergency medicine, where the issues in recruitment were reflective of the national position and confirmed that the Trust was taking all possible steps to recruit staff to vacant posts.

**a) Performance**

Mr Bannister confirmed that the executive summary section of the report had been revised following the comments received at the last Board meeting and now it included positive performance, areas of concern and areas where no change had been identified. Directors noted that due to the need to reschedule the April Finance and Performance Committee meeting, the document had not yet been presented to the Committee for detailed discussion.

Mr Bannister reported that the Trust had failed to achieve the Referral to Treatment (RTT) target for the third reporting month in a row and confirmed that plans were in place to manage the workforce issues that were contributing to the reduction in performance.

In relation to the 4 hour standard, the Trust achieved a performance rate of 81% of patients being seen within the required timeframe. Although this was an improvement on the position at the end of March 2019, there was a way to go to achieve the required 95%. Directors noted that NHSI had set a challenge for the Trust to achieve a compliance rate in excess of that achieved in May 2018 (85%) for May 2019.

Mr Bannister reported that the Trust had met all cancer standards for the reporting month of February 2019 (cancer standards report one month behind other indicators) and were on track to meet the standards for the reporting month of March 2019.

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

**b) Quality**

Dr Stanley reported that the backlog of Structured Judgement Reviews (SJR's) had been cleared with a further 24 reviews in the process of being completed. He went on to report that there had been a significant issue in relation to the national antibiotic usage CQUIN which was outside the control of the Trust. This issue was caused because the factory that makes Tazocin burned down; leaving the only alternative for such antibiotic prescribing to be a group of medications known as carbapenems and therefore affecting the ability to achieve the CQUIN target. Dr Stanley confirmed that the CQUIN indicator was not revised to reflect this issue and as a result the majority of NHS Trusts in the country had failed this particular CQUIN measure.

Dr Stanley reported that the Trust had a total of 26 cases of Clostridium Difficile in 2018/19 which was one case fewer than the target total number of cases set by NHSI.

Mr McGee commented that it was pleasing to note that both mortality indicators were better than the national average. In response to his question regarding crude mortality over the winter period, Dr Stanley confirmed that there had been very little variation over the preceding three month period.

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

**c) Workforce**

Mrs Quinn reported that sickness absence rates had reduced since the previous reporting month, but remained above the threshold. Work is being undertaken to implement a new way of managing staff sickness and support for staff and managers. Mrs Quinn provided a

brief overview of the early intervention work that was taking place to manage staff sickness, including improved access to MSK and mental health services. In addition, the Trust policies relating to absence management will be revised to be reflective of compassionate leadership.

Directors noted that the number of vacancies across the Trust had increased and work was being undertaken to understand whether the increase was an anomaly or part of an ongoing trend. Temporary staffing remains a challenge for the Trust and it is reflective of the NHS in general. The Trust had implemented a number of pieces of work to reduce the impact of this challenge, particularly in relation to medical staffing; one such piece of work is to establish a medical staff bank. It was agreed that an update on this work would be provided at the next meeting.

**RESOLVED:** **Directors noted the information provided under the Human Resources section of the Integrated Performance Report.**
**An update on the work being undertaken to reduce the impact of temporary staffing issues will be provided at the next meeting.**

**d) Safer Staffing**

Mrs Pearson confirmed that staffing across the Trust remained a challenge as documented in the main report. She went on to report that responses to the emergency department Friends and Family Test have improved with higher numbers of respondents recommending the department as a place to receive treatment.

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

**e) Finance**

Mr Wood reported that the Trust had met the required year-end financial control total set by NHSI. In doing so, the Trust had attracted some additional bonus monies which had improved the final year end position further. Mr Wood confirmed that in order to meet the required financial position the Trust had needed to achieve £18,000,000 in efficiency savings, of which only 50% were recurrent savings.

Mr McGee commented that the year-end position for the Trust was reflective of the work that had taken place over the year and thanked Mr Wood and the finance team for their efforts.

Professor Fairhurst stated that in the context of the pressures faced by the NHS, the scorecard for the Trust was positive and down to the hard work of staff across the Trust.

Professor Fairhurst went on to ask Mrs Bosnjak-Szekeres whether there was any feedback from the Shadow Board on the document as it had been discussed at length at the meeting. Mrs Bosnjak-Szekeres confirmed that the themes discussed at today's meeting were reflective of the discussions that had taken place at the Shadow Board.

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

**TB/2019/069 EVOLVING THE ACUTE OFFERING**

Dr Riley gave a presentation to the Board on the evolution of the acute offering in the context of developing integrated care. The presentation covered the following items: the current model, proposed future model, the potential configuration of acute services across the ICS, the benefits of having strong acute service providers, what the ask is for each constituent organisation type within the ICS, the connections that are needed to ensure effective joint working and the potential benefits for the Trust.

Mr Barnes stated that the Trust needed to be clear about its ambitions and aspirations for the future and how partners across the ICP and ICS would be brought along. Dr Riley confirmed that this was the case and confirmed that he and his Executive colleagues were already laying the foundations for the Pennine Lancashire ICP to work cohesively and share a single vision of the future for the benefit of the population of East Lancashire and Blackburn with Darwen.

Mr McGee emphasised the need to work collaboratively for the benefit of patients and move away from the idea of competition. He also stressed the need to progress at pace and that there was a real chance for the two local CCGs to have a combined commissioning budget in the coming year.

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

**TB/2019/070 NHSI SELF-CERTIFICATION DECLARATION**

Mrs Bosnjak-Szekeres referred Directors to the previously circulated documents and confirmed that NHS providers are required to self-certify after the end of the financial year as to whether they have the following in place:

- Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have a regard to the NHS Constitution (condition G6);
- Complied with governance arrangements (condition FT4).

She went on to recommend that the Trust Board approved the self-certification and to confirm compliance with both conditions. The narrative setting out the factors for confirming compliance was provided in the attached templates issued by NHS Improvement.

Directors reviewed the proposed responses and agreed for it to be signed by the Chairman and the Chief Executive before its publication on the Trust website.

**RESOLVED: Directors received the self-certification documents and approved them for signature and publication on the Trust's website.**

**TB/2019/071 FINANCE AND PERFORMANCE COMMITTEE UPDATE REPORT**

Mr Wood presented the report on behalf of Mr Wharfe and highlighted that the main issue for the Committee at its last meeting was the approval of the Operational and Financial plans for 2019/20 on behalf of the Board, which had been completed as discussed at the earlier part of today's meetings.

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

**TB/2019/072 AUDIT COMMITTEE UPDATE REPORT**

Mr Wood presented the report to the Board on behalf of Mr Smyth and confirmed that the Committee had reviewed a range of reports from internal auditors and management responses/updates to previous audit reports. Directors noted that a small number of actions remained open in relation to the work being undertaken to strengthen cyber security within the Trust.

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

**TB/2019/073 QUALITY COMMITTEE UPDATE REPORT**

Mrs Anderson presented the report and highlighted a range of reports received by the Committee, including the report on Doctors and Dentists in Training. She confirmed that the Committee had spent time discussing the results of the Maternity Services and Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme and the professional judgement report; both reports featured requests for additional resources for additional staffing. The Committee was unable to act on the requests, as it is not within the remit of the Committee to make such decisions. Instead, it was recommended that the proposals were considered as part of the wider Trust strategy. The Committee also considered the proposed changes to patient safety walkrounds.

Mrs Pearson confirmed that whilst the Quality Committee had the responsibility to receive

the professional judgement reports the requests for additional funds for staffing needed to be taken into consideration by the Finance and Performance Committee, who had received the request as part of the budget setting paper that had been discussed at their previous meeting.

**RESOLVED:** **Directors received the report and noted its contents.**
**The requests for additional resources for staffing noted in the Maternity Services CNST report and professional judgement report will be considered as part of the Trust's wider strategy.**

**TB/2019/074 REMUNERATION COMMITTEE INFORMATION REPORT**

The report was presented to the Board for information.

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

**TB/2019/075 TRUST BOARD PART TWO INFORMATION REPORT**

The report was presented to the Board for information.

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

**TB/2019/076 ANY OTHER BUSINESS**

**Thanks to Mr Bannister**

Professor Fairhurst stated that Mr Bannister would be leaving the Trust at the end of the month and as such this was his last Trust Board meeting. She thanked him on behalf of the Trust Board for the work he has undertaken whilst with the Trust and the legacy that he will leave. She wished him well for his future.

**Multi-Faith and Community Event**

Mr Wedgeworth reported that there would be a multi-faith and community event held at Blackburn Cathedral on 27 May and encouraged attendance. He confirmed that there would be a range of presenters at the event, including Professor Dominic Harrison and Mrs Catriona Logan. Professor Fairhurst asked that any feedback from the event be provided to the Trust as it was a good source of soft intelligence.

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

**TB/2019/077 OPEN FORUM**

Mrs Cairns commented that the Shadow Board meeting that she had attended the previous

day had been both interesting and informative. She went on to thank Professor Fairhurst, Dr Riley and Mrs Bosnjak-Szekeres for their time and expertise at the meeting.

**TB/2019/078 BOARD PERFORMANCE AND REFLECTION**

Professor Fairhurst invited comments and observations about the meeting from the Directors. Mrs Anderson commented that receiving a patient story from a member of staff had given the story an added dimension as she was able to see things from the point of view of a patient and also a senior member of the Trust staff.

Mr McGee commented that the majority of the Board meeting had been positive, which was not always the case, as the Board tended to concentrate on matters that were somewhat negative in nature. He went on to comment that the discussion resulting from the strategy item was beneficial and balanced.

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

**TB/2019/079 DATE AND TIME OF NEXT MEETING**

The next Trust Board meeting will take place on Wednesday 10 July 2019, 13:00, Seminar Room 6, Learning Centre, Royal Blackburn Teaching Hospital.

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**Item** 86

**10 July 2019**

**Purpose** Information

| | |
|---|---|
| **Title** | Action Matrix |
| **Author** | Miss K Ingham, Corporate Governance Manager/Assistant Company Secretary |
| **Executive sponsor** | Professor E Fairhurst, Chairman |

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

## Report linkages

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

## Impact

| | | | |
|---|---|---|---|
| Legal | No | Financial | No |
| Equality | No | Confidentiality | No |

# ACTION MATRIX

| Item Number | Action | Assigned To | Deadline | Status |
|---|---|---|---|---|
| TB/2019/042: National NHS Staff Survey | An update on the actions stemming from the national Staff Survey report to be provided to the Board in July 2019. | Director of HR and OD | July 2019 | Agenda Item July 2019 Item TB/2019/096 |
| TB/2019/061: Action Matrix | *TB/2019/053: Board Performance and Reflection* Mrs Hughes will provide an update on the work being undertaken to develop a Board visibility programme. | Director of Communications and Engagement | July 2019 | Verbal Report |
| TB/2019/068: Integrated Performance Report | *Workforce:* An update on the work being undertaken to reduce the impact of temporary staffing issues will be provided at the next meeting. | Director of HR and OD | July 2019 | Verbal Report |
| TB/2019/070: NHSI Self-Certification Declaration | Directors received the self-certification documents and approved them for signature and publication on the Trust's website. | Associate Director of Corporate Governance | July 2019 | Verbal Report **Complete** |
| TB/2019/073: Quality Committee Update Report | The requests for additional resources for staffing noted in the Maternity Services CNST report and professional judgement report will be considered as part of the Trust's wider strategy. | Executive Directors | July 2019 | Verbal Report |

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**Item** 88

**10 July 2019**

**Purpose** Information

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

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

## Impact

| | | | |
|---|---|---|---|
| Legal | Yes | Financial | Yes |
| Equality | No | Confidentiality | No |

Previously considered by: N/A

# CEO Report

July 2019

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

## One - National Headlines

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

### New appointment to the Chief Operating Officer and Chief Executive of NHS Improvement position

Amanda Pritchard has been appointed as the NHS' Chief Operating Officer (COO). Currently Chief Executive of Guy's and St Thomas' NHS FT, Amanda was appointed following an open competitive selection process. Amanda will take up post full time on 31 July.

The new post is directly accountable to the NHS Chief Executive, and serves as a member of the combined NHS England/NHS Improvement National Leadership Team. The COO oversees NHS operational performance and delivery, as well as implementation of the service transformation and patient care improvements set out in the NHS Long Term Plan. The COO is also accountable to the NHSI Board as NHS Improvement's designated accountable officer with regulatory responsibility for Monitor.

### Launch of national patient safety strategy

The first ever NHS Patient Safety Strategy has been published to support NHS care being delivered, from GP practices to hospitals and in the community, in the safest possible way.

The strategy sets a vision of continuous safety improvement, underpinned by a safety culture and effective safety systems. Its strategic aims commit to a series of actions to support the NHS to save more lives and the costs associated with patient safety incidents.

### NHS to launch young people's gambling addiction service

The first NHS gambling clinic for children will open this year as part of a new network of services for addicts being rolled out as part of the NHS Long Term Plan.

The ground-breaking move comes amid growing concern that the problem of children gambling is being fuelled by online gaming sites and targeted adverts. The number of children classed as having a gambling problem is 55,000, according to the Gambling Commission. The Commission also found that 450,000 are gambling regularly, more than those who have taken drugs, drunk alcohol or smoked.

Specialist face-to-face NHS treatment for gambling addiction has only been available in London but is now being made available across the country. Up to 14 new NHS clinics are being opened – starting with the NHS Northern Gambling Service in Leeds this summer, followed by Manchester and Sunderland.

## Caring for the young carers

A series of practical plans and actions have been outlined to help young carers who may be 'hidden', unpaid and under the age of sixteen. Family doctors across the country can now offer a new package of services for children and young adults who perform an informal caring role for a family member. This includes priority appointments for carers, home visits, additional mental health checks, and 'double appointments' for the carer and those they provide care for.

## Integrated care systems to serve more than 20 million

One in three people in England, 21 million, are set to further benefit from improved health and care, as three new areas were recently announced as 'integrated care systems' (ICS).

The North East and North Cumbria will become the country's largest ICS, serving more than three million people alone. South East London becomes the first ICS in the capital while Buckinghamshire, Oxfordshire and Berkshire West makes up the third new area.

They follow in the footsteps of the 12 earliest integrated care systems announced in 2018, plus two devolved health systems in Greater Manchester and Surrey. ICSs are already helping people to stay healthy and independent for longer, giving more care closer to where they live and work, and improving response times and performance in areas such as cancer and A&E.

## Thousands more GP staff recruited across England

NHS England has recruited 300 more family doctors and thousands more nurses, pharmacists and other staff to work alongside GPs delivering better care in the community. Figures released show there are now 7,302 more full time equivalent (FTE) health professionals working in

primary care than three years ago. That exceeds NHS England's target of an additional 5,000 by 2020 set out in the General Practice Forward View.

## 'Game changing' cancer drugs to be fast-tracked

New cancer drugs that target tumours according to their genetic make-up, rather than where they originate in the body, are set to be fast-tracked

The revolutionary treatments – known as 'tumour agnostic' drugs – can be used against a wide range of cancers and could offer hope to patients with rare forms of the disease that may previously have been untreatable. Extensive preparation has meant that patients in England were among the first in the world to benefit from genetically modified CAR-T cancer therapy.

## Personal heath budgets provide control to 50,000 people

More than 50,000 people have taken charge of their own care after being handed control of how their NHS funding is spent. Personal Health Budgets can be used to purchase personalised wheelchairs, assistance dogs and respite care to manage complex health problems, as well as tech devices that can control curtains, lighting, heating and door intercoms to help people live independent lives. The rollout of the Budgets across the country is two years ahead of scheme and being ramped up further as part of the NHS Long Term Plan.

## NHS 111 prevents more than 12 million unnecessary A&E visits

Recently released figures revealed 80 million calls were made to 111 between its foundation in April 2011 and September 2018. Analysis shows that more than one in four people (28%) would otherwise have attended A&E. One in six (16%) would have phoned for an ambulance, meaning 111 prevented three million 999 calls that could have resulted in unnecessary ambulance call outs.

Increasing numbers of people are receiving the health care help they need by phone or online without having to spend time in A&E or call an ambulance. The NHS 111 service dealt with almost 75,000 extra calls over this winter, with the proportion of calls receiving input from a clinician increasing to 53.7% in March 2019, compared to 48.8% in March 2018.

# Two - Pennine Lancashire Headlines

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

## Together a Healthier Future update

### Delivering The Pennine Plan

Chief Officers across health and local authorities have continued to work together to agree delivery objectives and arrangements for 2019/20, ensuring an enhanced focus on a smaller number of priority areas. It is anticipated that the ICP delivery plan objectives will be finalised by the end of July. These will go on to form part of a single operational plan for Pennine Lancashire, aligning organisational delivery responsibilities alongside those of the Partnership. The delivery objectives will be published as part of an annual report for the ICP, summarising the work and achievements of the Partnership in 2018/19.

In finalising delivery objectives for the next year, it has been important to ensure appropriate, robust, delivery structures are in place with the ICP, to provide clear responsibilities and accountability for achieving the agreed objectives. As such, the Partnership Leaders' Forum have agreed in principle, a new structure for governing the delivery. This will see the establishment of Programme Boards will take responsibility for achieving the agreed objectives in the following areas:

- Prevention
- Integrated Community Care
- Mental Health and Wellbeing
- Scheduled Care
- Accident and Emergency (A&E Delivery Board will continue to provide this role)

The Partnership Leaders' Forum received a detailed update on Accident and Emergency performance and considered some of the activities proposed to improve performance.

The Forum were made aware of the decisions made by Lancashire County Council's Cabinet in relation to a number of budget proposals and service reductions. The decisions had been made following public consultation and engagement and a number of mitigating actions were being put in place to minimise the impact of any service reductions.

**Our journey to integration**

As the ICP Chief Officers, Dr Julie Higgins and I met with the Chairs from ELHT, Blackburn with Darwen CCG and East Lancashire CCG, to consider how our organisations can progress towards integration.

The Chairs identified that there was an absolute need for openness and transparency. They concluded the most important thing was to focus on delivery changes on the ground for people, patients and staff, rather than focus on organisational form and structure.

Taking forward the journey to integration will be a key topic of discussion for the tripartite Board meeting to be held on 31 July 2019.

## SEND Improvement Plan published

Lancashire Special Educational Needs and Disability Services (SEND) Partnership has published its new improvement plan which identifies the key priorities, actions, measures and targets for 2019 to 2020.

The Partnership brings together all the agencies in Lancashire which provide the SEND services for children, young people, their parents and carers. It ensures everybody can work together to provide the best outcomes for children, young people and their families, with representatives who use the service.

## Suicide bereavement service expanded

Thanks to national funding a service which provides support to those bereaved by a suspected suicide has been expanded to across Lancashire, offering vital support to local people.

The support provided by AMPARO which already helps people in Blackburn with Darwen, Hyndburn and Burnley, has now been extended to cover Blackpool, Fylde and Wyre. AMPARO can support anyone affected by a suspected suicide, this can be family members, friends or colleagues. The service provides support in a range of ways including one to one individual support, help with media enquiries, support and guidance up to and including the inquest and signposting to further services.

## UNICEF UK Baby Friendly accreditation renewed

Following an inspection by independent UNICEF UK assessors in March, the hard work and dedication of staff and supporters at Blackburn with Darwen Children's Centres and Lancashire Care Foundation NHS Trust's (LCFT) Health Visiting service have been rewarded by having their UNICEF UK Baby Friendly Initiative status renewed.

Mums giving birth in Pennine Lancashire can be assured that the best start in life is being provided for their babies. This is down to the continued partnership working Lancashire Care, East Lancashire Hospitals and Blackburn with Darwen Council to achieve and maintain the UNICEF UK Baby Friendly standard.

## Maternity transformation programme

The recent Lancashire and South Cumbria Better Births Maternity Transformation Programme six-monthly Maternity Assembly was a huge success. Hosted by Rineke Schram, Lead Obstetrician for the programme and Nicola Parry, Lead Midwife for the programme, the event introduced a number of key speakers and included workshops on themes of communications, innovative workforce solutions and Personalised Care Plans. The theme for the next Assembly, in November will have an overarching theme of Prevention.

## CAMHS redesign update

More than 70 individuals from 27 NHS, Local Authorities, education, police, voluntary and community organisations across Lancashire and South Cumbria have been working together with parents, carers and young people, to redesign and improve emotional health and wellbeing services for children and adolescents aged 0-19, in a programme known as THRIVE.

Since the beginning of April, five full week workshops have taken place to develop a THRIVE-based model of care which will ensure that services in the future are integrated and person-centred. These have been supported by Northumberland, Tyne and Wear NHS Foundation Trust and have involved partners from NHS, Local Authorities, education, police, voluntary and community organisations along with valuable contributions from young people, parents and carers.

The Care Partnership will continue the work, with partners from across the system, to develop sustainable and standardised care and support for young people and their families.

## Success for local bid to tackle childhood obesity

Pennine Lancashire has been selected to receive a further £100k funding as part of a nation initiative tackling childhood obesity - The Childhood Obesity Trailblazer Programme. The area, along with four others, were chosen to take their local plans forward over three years, receiving £100k per year to do so.

This trailblazer programme is about supporting innovation, harnessing the full potential of local levers and sharing learning. It is about tackling obstacles head on and finding solutions

together, including actions government can take to enable ambitious local action. It also includes working with planning authorities to drive a consistent policy for effective control of fast food outlets, advertising of junk food and the availability of affordable nutritious food; working directly with elected members and residents in communities as well as supporting existing and developing social movements that back the drive for healthier food.

# Three - ELHT Headlines

Sponsored by Dr Damian Riley, Acting Chief Executive. Important news and information from around the Trust which supports our vision, values and objects.

## Use of the Trust Seal

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

- On the 4 June 2019 and it was applied to the Deed of Grant of Easement relating to the Burnley Ambulance Station, Briercliffe Road, Burnley. The parties to the contract were ELHT, East Lancashire Capital Projects LTD, ESP Electricity Limited and North West Ambulance Service NHS Trust. The Director of Service Development/Deputy Chief Executive and the Director of Nursing.

## New Burnley Mayor pledges a year of support

Councillor Anne Kelly pledged her support to ELHT&Me, the Trust's charity, as she was sworn in as Mayor of Burnley. It is a huge honour to be selected as the Mayor's chosen charity and to receive her support. Councillor Kelly aims to raise a minimum of £25,000 for ELHT&Me, for diagnostic equipment solely for Burnley General Hospital.

## Trust Anaesthetists rewarded for high quality patient care

The prestigious Anaesthesia Clinical Services Accreditation (ACSA) from the Royal College of Anaesthetists (RCoA) was presented to Dr Tim Clarke, Consultant Anaesthetist at the annual ceremony. The evidence process involved almost every member of the anaesthetic department and many members of support services.

The peer-reviewed scheme promotes quality improvement and the highest standards of anaesthetic service. To receive accreditation, ELHT's anaesthetic service demonstrated high standards in areas such as patient experience, patient safety and clinical leadership. They were also able to highlight areas of good practice, develop new policies, increase staffing numbers and purchase new equipment.

## A&E welcomes Bereavement Champions

Four Emergency Department nursing staff received the title 'Bereavement Champions' in recognition of the work they've achieved to improve bereavement and end of life care.

Together the team worked to create an environment for patients' relatives which is more conducive to having difficult and distressing conversations. Bereavement care workshops have been arranged and a *'care after death'* box has been created so all the equipment needed to deliver care after death is readily available.

## New toys for children's clinic

The children's clinic on the Blackburn site were overjoyed to receive a generous donation of toys to brighten up their outdoor play area. The Issa family visited the clinic to make the donation, to mark the end of the Islamic holy month of Ramadan and to celebrate the festival of Eid.

The donation is an extension of the charitable giving from EuroGarages (EG) Group, the Issa family's company. EG Group have already altruistically committed their UK charitable expenditure to ELHT&Me.

## ELHT in top 10 for VTE risk assessments

Latest statistics released by NHS Improvement reveal that staff at ELHT are consistently achieving the national standard for patients who receive a venous thromboembolism (VTE) risk assessment on admission to hospital. In the 12 months between April 2018 and March 2019, records show that the number of VTE risk assessments carried out by staff at ELHT was reliably above 99 per cent throughout the entire year.

## 'Walking the walk' for ELHT&Me

It was a perfect day for the very first Big NHS Walk. Over two hundred members of staff and public donned their walking boots to cover the beautiful 12 mile course. Participants where waved off from the Blackburn and Burnley hospital sites by the respective Mayors, and the first to welcome the finishers was ELHT&Me mascot, ELMORE. Each finisher was presented with a specially designed Big NHS Walk medal. When all registration fees and sponsorship monies are counted, the Big NHS Walk will have raised in excess of £10,000 of vital funds which will help to improve NHS hospital and community services in across East Lancashire.

## Construction starts on Emergency Care Village

The vision for an Emergency Care Village is becoming a reality with the start of construction on the £9.95 million project this month. Adding to the hospital's Accident and Emergency and Urgent

Care facilities, the new development will see existing Acute Medical Units merge into a single facility, in addition to an enhanced, short stay Ambulatory Emergency Care Unit.

On completion, in winter 2020, the Phase 6 development will provide 31 patient beds plus a number of further improvements. These include a high support bedded area, staff teaching facilities and a dedicated inpatient pharmacy service. Medical staff will benefit from faster, improved access to emergency patients.

## ELHT obstetrics training 'best in the UK'

The Trust's Obstetrics and Gynaecology team has been recognised as the top training unit in the country for the obstetrics training it provides trainee doctors.

The accolade was awarded by the Royal College of Gynaecology's national training survey which saw the East Lancashire service, based at the Burnley Lancashire Women and Newborn Centre, score top marks for general training in obstetrics. Out of 166 NHS Trusts surveyed, ELHT is also rated very highly for professional development (5th nationally), general gynaecology training (15th) and overall recommendation (7th).

East Lancashire Hospitals
NHS Trust

# Four – Communications and Engagement

A summary of the external communications and engagement activity.

May 2019

## Communications and Engagement

# Monthly Media Update

### Top Stories...

- Celebrating 'International Day of the Midwife' and 'International Nurse's day
- East Lancashire couple grateful for research opportunity after giving birth to second child
- Trust anaesthetists rewarded for high quality patient care
- Trust staff take part in "I'm not a Muslim but I will fast for one day"

Trust celebrates 'STAR' staff at annual awards

### Press and Media Relations...

| 36 | 11 | 10 | 92% | +19 |
|---|---|---|---|---|
| Mentions in all media ↑ | Media enquiries handled → | Media releases issued this month | of stories were positive or neutral ↑ | The monthly media net score (positive minus negative |

### Projects the Communications Department has supported...

- STAR awards
- International Nurses and Midwives Days
- New online expenses system
- PLACE
- Sustainability
- TOGETHER a healthier future
- Staff survey videos
- Procurement Cluster promotion
- Legs matters awareness week

### Website...

Our website got **102,906** page views by **34,309** people .

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

## Social media and digital...

| Followers on social media: | 24,100 | 77% |
|---|---|---|
| 9,768 | Avg Weekly Facebook Reach | Facebook page responsiveness |
| 5,987 | 251,000 | 651 |
| 1,371 | Twitter Impressions | Twitter mentions |

## The most talked about issues on our social networks..

- STAR Awards
- International Nurses day
- Recruitment posts
- Dementia Awareness

## Posts of the month...


**Top Tweet** earned 266 impressions

** Nominations have opened for The Our Health Heroes Awards 2019! **
If you know any porters, painters, cleaners or more that could be Operational Services Support Worker of the Year, nominate them today! ow.ly/eHob50usKG5
pic.twitter.com/FPUBDz26Qu

## Facebook review rating:

# 4.5 out of 5

## Routine activity:

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

Safe | Personal | Effective

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

East Lancashire Hospitals
NHS Trust

June 2019

## Communications and Engagement

# Monthly Media Update

## Top Stories...

- Big NHS Walk
- Work starting on new emergency care village
- New bereavement champions for the emergency department
- Cancer patients in East Lancashire being seen quicker
- Employee of the Month Sean Greenwood

New bereavement champions for the ED

## Press and Media Relations...

| | | | | |
|---|---|---|---|---|
| **37** Mentions in all media ↑ | **7** Media enquiries handled ↓ | **15** Media releases issued this month ↑ | **100%** of stories were positive or neutral ↑ | **+37** The monthly media net score (positive minus negative |

## Projects the Communications Department has supported...

- TOGETHER a healthier future
- Well Service events
- Big NHS Walk
- NHS Big Tea Parties
- Therapy Dog
- Ophthalmology profile raising
- Endoscopy video planning
- Mentor video planning
- GRASP study celebrations
- Phase 6

## Website...

Our website got **97,740** page views by **33,276** people .

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

## Social media and digital...

Followers on social media:

10,335

6,065

1,385

72,391

Avg Weekly Facebook Reach

234,000

Twitter Impressions

69%

Facebook page responsiveness

600

Twitter mentions

## The most talked about issues on our social networks..

- Jasper the Therapy Dog
- Emergency Care Village
- Dragon's Den
- Maternity Support Worker Keelie Barret

## Posts of the month...


**Top Tweet** earned 17 impressions

Calling all RCM members: Maternity Support Worker Keelie Barrett needs your support if she is to create history and become the first MSW ever to be elected to the Board of the Royal College of Midwives
ow.ly/JUWM50uJPiS
pic.twitter.com/c55hfDMgNO

## Facebook review rating:

# 4.5 out of 5

## Routine activity:

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

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

Safe | Personal | Effective

Safe | Personal | Effective

# Five - Chief Executive's Meetings

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

### June 2019 Meetings

| Date | Meeting |
|---|---|
| 3 June | Meet the 'Quit Smoking Team' |
| 4 June | Clinical Strategic Executive/Operational Executive |
| 5 June | L&SC Integrated Care System Board |
| 5 June | Mental Health System Improvement Board |
| 5 June | Team Brief |
| 5 June | Employee of the Month |
| 6 June | Board Development Session |
| 11 June | Clinical Strategic Executive/Operational Executive |
| 17 June | Financial Resources Group |
| 17 June | Financial Sustainability Meeting |
| 18 June | Clinical Strategic Executive/Operational Executive |
| 18 June | ELHT/Blackburn College/UCLan meeting |
| 19 June | Partnership Leaders Forum |
| 19 June | GP/ELHT Educations Event |
| 20 June | ELHT/UCLan Education Day |
| 21 June | Report Out Session |
| 21 June | Meeting with David Fillingham |
| 24 June | North West CEO/AO event, Manchester |
| 25 June | Clinical Strategic Executive/Operational Executive |
| 25 June | Operational Delivery Board |
| 26 June | Quality Committee |
| 26 June | Team Brief Filming |

| | |
|---|---|
| 27 June | Employee of the Month |
| 27 June | Visit to Pathology Department |
| 27 June | Visit to the Therapies Department |
| 27 June | Live interview with BBC Radio Lancashire on Phase 6 |
| 27 June | Meet the Team – Share to Care meeting Radiology |
| 27 June | Julie Cooper MP catch-up and visit to OPRA |

**July 2018 Meetings**

| Date | Meeting |
|---|---|
| 1 July | Meet the Coders |
| 1 July | Cancer Target and Diagnostics Programme |
| 2 July | Clinical Strategic Executive/Operational Executive |
| 2 July | Visit to Estates and Facilities |
| 2 July | Chairman/CEO meeting |
| 3 July | A&E Delivery Board Workshop |
| 3 July | Team Brief (Blackburn, Burnley and Pendle) |
| 4 July | Theatre Efficiency Delivery Group |
| 4 July | Team Brief (Accrington and Clitheroe) |
| 5 July | Provider Workshop with Sir David Dalton |
| 9 July | Clinical Strategic Executive/Operational Executive |
| 10 July | Trust Board |
| 15 July | Financial Sustainability Meeting |
| 16 July | Clinical Strategic Executive/Operational Executive |
| 16 July | Kerala Government Visit |
| 16 July | Chairman/CEO meeting |
| 17 July | AOs/CEOs and ICS meeting |
| 17 July | Team Brief Filming |
| 17 July | Improvement Guiding Board |
| 17 July | PL Resources Group |
| 18 July | Visit to Breast Screening Team – BGTH |
| 18 July | Visit to Estates and Facilities – BGTH |
| 18 July | Partnership Delivery Group |
| 19 July | Report Out Session |
| 22 July | Present Corporate Induction |

| | |
|---|---|
| 22 July | Systems Leaders Development across Cancer |
| 23 July | Clinical Strategic Executive/Operational Executive |
| 23 July | Chairman/CEO meeting |
| 24 July | Partnership Leaders Meeting |
| 25 July | Visit to Estates and Facilities |
| 26 July | Cancer Alliance Meeting |
| 26 July | Sponsor Group |
| 29 July | Finance and Performance |
| 30 July | Clinical Strategic Executive/Operational Executive |
| 30 July | Operational Delivery Board |
| 30 July | Board Session |
| 31 July | Invitation to join CQC Style Inspection |
| 31 July | Tripartite Board |

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**Item** 90

**10 July 2019**

**Purpose** Assurance
Approval

| | |
|---|---|
| **Title** | Corporate Risk Register Report |
| **Author** | Mr D Tita, Risk Manager |
| **Executive sponsor** | Dr I Stanley, Acting Executive Medical Director |

**Summary:** This report presents an overview of the Corporate Risk Register (CRR) for May – June 2019 and some risks which were presented at the Risk Assurance Meeting (RAM) by the Divisions and Corporate services for review, scrutiny, assurance and recommendation for inclusion onto the CRR. The Corporate Risk Register is presented for approval with changes in month highlighted in the body of this report. This report also provides a synopsis of the MIAA re-audit of the Trust`s risk management performance in 2019/20 which demonstrates that there is substantial and robust assurance in place in underpinning its risk management systems, processes and governance arrangements.

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

## Report linkages

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

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

**Impact**

| | | | |
|---|---|---|---|
| Legal | No | Financial | Yes |
| Equality | No | Confidentiality | No |

Previously considered by:

**Table 1: The Corporate Risk Register (CRR) as of June 2019 RAM meeting:**

There are currently 10 `live` risks on the CRR which were discussed, reviewed, scrutinised and recommended at the RAM meeting which held on 14th June, 2019.

| Risk | Title | Current Score |
|---|---|---|
| 7010 | Aggregated Risk - Failure to meet internal & external financial targets in year will adversely impact the continuity of service Risk Rating | 20 |
| 8061 | Aggregated Risk - Management of Holding List | 16 |
| 7067 | Aggregated Risk - Failure to obtain timely MH treatment impacts adversely on patient care, safety and quality | 15 |
| 1810 | Aggregated Risk - Failure to adequately manage the Emergency Capacity *and* Flow system. | 15 |
| 5791 | Aggregated Risk - Failure to adequately recruit to substantive nursing & midwifery posts may adversely impact on patient care and finance. | 15 |
| 5790 | Aggregated risk – Failure to adequately recruit to substantive medical posts may adversely impact on patient care and finance. | 15 |
| 7008 | Failure to comply with the 62 day cancer waiting time. | 15 |
| 7552 | Risk that PACS downtime occurs and brings delay to patient pathways or delays in operating theatre activity. | 15 |
| 8060 | Potential to compromise patient care/deliver sub-optimal care on the elective centre & infusion suite | 15 |
| 8126 | Aggregated Risk - Potential to compromise patient care due to lack of Trust-wide advanced Electronic Patient Record (EPR) System. | 15 |

Table 1: The CRR as of June 2019.

1. **Risks recommended for inclusion onto the CRR at the May/June RAM meetings:**

   The following risks which were presented at the RAM meetings that held in May/June were reviewed, scrutinised and recommended for inclusion onto the CRR:-

| Risk | Title | Current Score |
|---|---|---|
| 8060 | Potential to compromise patient care/deliver sub-optimal care on the elective centre & infusion suite | 15 |
| 6190 | Insufficient capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescales **(Added as a linked risk to Risk ID 8061 - Management of Holding List).** | 16 |

Table 2: Risk discussed, scrutinised and recommended for inclusion onto the CRR.

2. **Summary of risk presented, discussed, scrutinised and recommended for inclusion onto the CRR:**

- **Risk ID 8060: Potential to compromise patient care/deliver sub-optimal care on the elective centre & infusion suite.** This risk which was presented at the RAM meetings in March/April was discussed as the RAM had invited ICG/SAS Divisions to attend to provide assurance on the cross-divisional work they are doing in mitigating it. This risk underscores the importance and challenge around the provision of high quality, patient-centred safe care at the Elective Centre with the plan being to mitigate it through the development and expansion of the acute care team to provide enhanced and advanced clinical care. It thus relates to medical patients who access care at the Elective Centre as they are sometimes unable to get timely medical assessments since this unit sits in Surgery. After some discussion, members expressed satisfaction with the plan in place and ongoing cross-divisional collaborative work in mitigating this risk and recommended it for inclusion onto the CRR as the potential to compromise the provision of safe, high quality patient-centred care was deemed likely.
- **Risk ID 6190: Insufficient Capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescale.** This risk highlights the potential to compromise patient safety as a result of insufficient clinic capacity for review of patients to be seen in outpatient clinics. This has resulted in a holding list being created for patients who need to be allocated a clinic appointment once capacity becomes available. Despite the efforts being made by the Directorate in mitigating this risk, members recognised the fact that delays in patients being seen in the outpatient clinics in Ophthalmology could lead to the potential loss/deterioration in patient sight. This risk was thus recommended for inclusion onto the CRR as a linked risk to risk ID **8061 - Management of Holding List.**

- **Risk ID 8126 - Aggregated Risk - Potential to compromise patient care due to lack of Trust-wide advanced Electronic Patient Record (EPR) System:** This IT-related risk highlights and demonstrates how the potential delay in the implementation of a Trust-wide advanced EPR system could lead to reliance on paper-based casenotes and assessments with the possibility of negatively impacting on e-prescribing and the overall safety of patient care and enhanced experience. It was approved for inclusion onto the CRR through Chair`s action.

3. **Risks de-escalated from the CRR:** The following two risks which were presented at the RAM were recommended for de-escalation from the CRR in confirmation of the great work that has been undertaken by the Divisions/Corporate Services in mitigating them.

| Risk | Title | Current Score |
|---|---|---|
| 7583 | Loss of facility for Level 3 Containment in pathology | 10 |
| 7330 | Aggregated Risk - Inability to identify, track & monitor the cohorts of women and new borns who require and have screening due to lack of an end-to-end IT System for Maternity. | 10 |

Table 3: Risk recommended for de-escalation from the CRR:

4. **Summary of the MIAA Re-audit of the Trust`s Risk Management Performance for 2019/20:**

Following their audit of the Trust`s risk management culture in 2018/19 which highlighted limited assurance, the MIAA have published its 2019/20 re-audit of the Trust`s risk management performance. The report acknowledges the significant progress the Trust has made in raising the profile of risk management, clarifying, strengthening and embedding its risk management systems, processes and governance arrangements amongst other tangible improvements. Although the report confirms that there is substantial and robust assurance, underpinned by strong staff engagement it however requests for Divisional risk management performance reports to be shared with the Patient Safety and Risk Assurance Committee for assurance.

**5. Corporate Risk Register (Appendix 1):**

Details of the current Corporate Risk Register can be found in appendix 1 while appendix 2 articulates risks that were recommended by the RAM for de-escalation from the CRR and appendix 3 provides a one page representation of all risks on the CRR by current score.

**6. Conclusion**

Members of the Board are hereby requested to:

- Review, scrutinise and approve the Corporate Risk Register (appendix 1).
- Gain assurance that risks on the CRR are being robustly managed in line with best practice and the Trust Risk Management Strategy.

David Tita, Trust Risk Manager, June 2019

| | | | | | |
|---|---|---|---|---|---|
| | **Appendix 1: The Corporate Risk Register – Current Risks** | | | | |
| **Title** | **Aggregated Risk – Failure to meet internal and external financial targets in year will adversely impact the Continuity of Service Risk Rating** | | | | |
| **Risk ID** | 7010 | Date opened | 25/08/2016 | | |
| **Risk Handler** | Allen Graves | Exec Director/Risk Lead | Jonathan Wood | | |
| **Identified in BAF Risk ID** | BAF/04: The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework. | | | | |
| **Linked to Risks:** | 1487 - Failure to deliver the SRCP- (15)<br>1489 - Failure to meet the activity and income targets - (12)<br>6692 - Risk to safe, personal and effective service delivery due to lack of quality information from Community IT systems (EMIS) - (10) | | | | |
| **Initial Rating** | **Likelihood: 3**<br>**Consequence: 5**<br>**Total: 15** | Current Rating: | **Likelihood: 5**<br>**Consequence: 4**<br>**Total: 20** | Target Rating: | **Likelihood: 4**<br>**Consequence: 3**<br>**Total: 12** |
| **What is the Hazard** | • Failure to meet the targets will result in the Trust having an unsustainable financial position going forward and the likely imposition of special measures | | What are the risks associated with the hazard | | • If Divisions deliver their SRCP and meet their Divisional financial plans the Trust will achieve its agreed control total.<br>• Breach of control totals will likely result in special measures for the Trust, adverse impact on reputation and loss of autonomy for the Trust.<br>• Sustainability and Transformational funding would not be available to the Trust.<br>• Cash position would be severely compromised. |
| **What controls are in place** | • Standing Orders.<br>• Standing Financial Instructions.<br>• Procurement standard operating practice and | | What are the gaps in controls | | • Individual acting outside control environment in place. |

| | | | |
|---|---|---|---|
| | procedures.<br>• Delegated authority limits at appropriate levels<br>• Training for budget holders.<br>• Availability of guidance and policies on Trust intranet.<br>• Monthly reconciliation.<br>• Daily review of cash balances.<br>• Finance department standard operating procedures and segregation of duties. | | |
| **What assurances are in place** | • Variety of financial monitoring reports produced to support planning and performance.<br>• Monthly budget variance undertaken and reported widely.<br>• External audit reports on financial systems and their operation.<br>• Monthly budget variance undertaken by Directorate and reported at Divisional Meeting.<br>• Monthly budget variance report produced and considered by corporate and Trust Board meetings.<br>• Internal audit reports on financial system and their operation. | What are the gaps in assurance | • None identified. |

Actions to be carried out in mitigating this risk

| No | Action | Action Lead | Due date | Expected Completion date | Progress on implementation of action | RAG Rating |
|---|---|---|---|---|---|---|
| 1 | Per individual linked risks | Allen Graves | 27/09/2018 | 27/09/2018 | completed | |
| 2 | Risk mitigation action plans are appended to each of the linked risks and are reviewed by the Divisions on an on-going basis with assurances being provided to Divisional meetings. | Allen Graves | 27/09/2019 | 27/09/2019 | On track | |

| | | | | | |
|---|---|---|---|---|---|
| **Title** | **Aggregated Risk - Management of Holding List** | | | | |
| **Risk ID** | 8061 | | Date opened | 05/02/2019 | |
| **Risk Handler** | Victoria Bateman | | Exec Director/Risk Lead | Natalie Hudson | |
| **Identified in BAF Risk ID** | **BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations. (Poor patient experience and risk to patient safety). | | | | |
| **Linked to Risks:** | 6190 - Insufficient Capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescale (16). | | | | |
| **Initial Rating** | **Likelihood: 4 Consequence: 4 Total: 16** | Current Rating: | **Likelihood: 4 Consequence: 4 Total: 16** | Target Rating: | **Likelihood: 2 Consequence: 4 Total: 8** |
| **What is the Hazard** | • Patients waiting past their intended date for review appointment and subsequently coming to harm due to a deteriorating condition or suffering complications due to delayed decision making or clinical intervention. | | What are the risks associated with the hazard | • At ELHT Directorates utilise holding lists to manage patients who require a future follow appointment but due to capacity constraints, there are not the available slots to book into. Patients are also added to a holding list when clinics are cancelled due to annual or study leave and there is no available capacity to rebook.<br>• Reports are readily available which identify patients waiting on a holding list and how long they have been waiting. They can be seen prospectively and retrospectively. Some of these patients may have comments in their PAS record which identify their urgency but many do not.<br>• In some Directorates due to capacity constraints patients are waiting past their intended date for review. The risk to patients is that they may come to harm due to a | | |

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

| | | | |
|---|---|---|---|
| | (7) A process has been agreed to ensure all follow up patients in the future are assigned a RAG rating at time of putting them on the holding list. Rolling out new process from 6th February across the Trust.<br>(8) An automated reporting system is in development to ensure oversight of the risk stratified lists by speciality.<br>(9) Underlying demand and capacity gaps must be quantified and plans put in place to support these specialities in improving the current position and reduce the reliance on holding lists in the future.<br>(10) Report being provided weekly to the Executive Team. | | |
| **What assurances are in place** | • All coding sheets being monitored in outpatient clinic to ensure RAG rating completed at time of appointment.<br>• All patients to have RAG rating recorded on Outpatient Waiting List.<br>• Automated report produced to show RAG status of patients on holding list and identify any who have not been given a RAG rating.<br>• Failsafe officer appointed in Ophthalmology to track holding list and manage clinical urgency of patients waiting in conjunctions with responsible consultants. | What are the gaps in assurance | • Demand and Capacity gaps within specialities which may result in delayed appointments outside of RAG rating recommendation.<br>• If clinicians do not comply with RAG rating process in clinic this will be captured on the automated report but will need administrative process to be followed to complete retrospective RAG rating following clinic appointment. |

| Actions to be carried out in mitigating this risk | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **No** | **Action** | **Action Lead** | **Due date** | **Expected Completion date** | **Progress on implementation of action** | **RAG Rating** |
| | 1 | Weekly review of the Holding List by identified fail safe officer | Natalie Hudson | 07/03/2019 | 08/04/2019 (Original completion date changed from 07/03/2019 due to recruitment to the failsafe officer post for Ophthalmology which has now been filled and start date agreed. | Completed - Failsafe Officer for Ophthalmology in post from 29th April. | |
| | 2 | Standardised DCO1 referral form for Trust Wide use | Susan Elliston | 07/03/2019 | 07/03/2019 | Completed on 06/03/2019 | |
| | 3 | Detailed capacity and demand comparison | Leigh Hudson | 07/05/2019 | 07/05/2019 | 02/04/2019 | |
| | 4 | Progress Report and Harm assessment to be provided to Trust Quality Committee | Natalie Hudson | 30/04/2019 | 31/12/2019 Original completion date changed from 30/04/2019 as regular updates are being sent to the Executive Team and bi-monthly to the Quality Committee. | Ongoing | |
| | 5 | Automated holding list report to be integrated in Trust's weekly ops meeting | Natalie Hudson | 30/04/2019 | 31/12/2019 Original completion date changed from 30/04/2019 as new report has been designed and is being circulated weekly to the Directorates. | Ongoing | |

| | | | | | |
|---|---|---|---|---|---|
| **Title** | **Aggregated Risk - Failure to obtain timely Mental Health treatment impacts adversely on patient care, safety and quality.** | | | | |
| **Risk ID** | 7067 | Date opened | 06/10/2016 | | |
| **Risk Handler** | Jonathan Smith | Exec Director/Risk Lead | Sharon Gilligan | | |
| **Identified in BAF Risk ID** | **BAF/03:** Lack of effective engagement within partnership organisations (ICS and ICP) results in failure to work together causing detrimental effect on the health and wellbeing of our communities.<br><br>BAF/05: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety). | | | | |
| **Linked to Risks:** | 2161 - Failure to provide sufficient skilled staffing for the needs of Tier 4 patients on the Paediatrics Ward will adversely continue - (12).<br><br>7582 -Inability to meet the needs of high risk mental health patients on in patient wards within ICG - (8) (5083 – Linked to 7582 - Failure to have a robust system to assess and manage patients with mental health needs - 8). | | | | |
| **Initial Rating** | **Likelihood: 5**<br>**Consequence: 3**<br>**Total: 15** | Current Rating: | **Likelihood: 5**<br>**Consequence: 3**<br>**Total: 15** | Target Rating: | **Likelihood: 2**<br>**Consequence: 3**<br>**Total: 6** |
| **What is the Hazard** | • ELHT is not a specialist provider or equipped to provide inpatient mental health services. However, patients with mental health need do present to the Trust and they may require both physical and mental health assessments, treatment and referral to specialist services.<br>• Due to lack of specialist knowledge, this may cause deterioration of the patient.<br>• Staff generally do not have training in physical interventions and restraint. | | What are the risks associated with the hazard | • Breach of statutory targets<br>• Impact on other patient care due to resource use and patients and/or carers perceptions.<br>• Risk of harm to other patients<br>• Impact on staffing (medical and nursing) to monitor/ manage patients with MH needs.<br>• Patient deterioration or failure to Safeguard.<br>• Risk of patient harm to themselves. | |

| | | | |
|---|---|---|---|
| **What controls are in place** | • Frequent meetings to minimise risk between senior LCFT managers, specialist and urgent care commissioners and Senior ELHT managers to discuss issues and develop pathways to mitigate risk including; Mental Health Shared Care policy, OOH Escalation pathway for Mental health patients, Instigation of 24hrs a day Band 3 MH Observation staff. Ring fenced assessment beds within LCFT bed base (x1Male, x1Female). In Family Care ongoing liaison with ELCAS and Commissioners.<br>• Monthly performance monitoring.<br>• Monitoring through Pennine Lancashire Improvement pathway.<br>• Monitoring by Lancashire and Cumbria Mental Health Group.<br>• Twice weekly review of performance at Executive Team teleconference.<br>• Discussion and review at four times daily clinical flow meeting.<br>• Introduction of mental health triage service within ED. | What are the gaps in controls | • Unplanned demand.<br>• ELCAS only commissioned to provide weekday service.<br>• Limited appropriately trained agency staff available. |
| **What assurances are in place** | • Appropriate management structures in place to monitor and manage performance.<br>• Appropriate monitoring and escalation processes in place to highlight and mitigate risks.<br>• Ongoing monitoring of patient feedback through a variety of sources.<br>• Escalation of adverse incidents through internal and external governance processes.<br>• Review of performance by Executive Team members on a weekly basis.<br>• Monthly Performance Report to Trust Board.<br>• Appropriate escalation and management policies and procedures are in place and regularly reviewed.<br>• Joint working with external partners on pathways and | What are the gaps in assurance | • The daily system teleconference between health and social partners was stood down from daily to twice weekly w/c 2-7-18. |

| | | | |
|---|---|---|---|
| | design improvements.<br>• 12 hour breach monitoring.<br>• Cluster reviews of 12 hour breaches undertaken. Presented at A and E Delivery board and SIRI (if required).<br>• Every 12 hour breach is incident reported and has a timeline undertaken to identify themes for shared learning.<br>• Themes from timelines/cluster reviews are discussed weekly with commissioners, NHS England and LCFT<br>• SOP in place for management of high risk patients (recently reviewed and up-dated). | | |

Actions to be carried out in mitigating this risk

| No | Action | Action Lead | Due date | Expected completion date | Progress on implementation of action | RAG Rating |
|---|---|---|---|---|---|---|
| 1 | Emergency Care Improvement Programme mental health "Deep dive" – audit. | Jillian Wild | 29/06/2018 | 29/06/2018 | Completed | |
| 2 | Daily teleconference with LCFT commenced 9-7-18 due to LCFT being at OPEL level 4. | Jillian Wild | 27/09/2018 | 27/09/2018 | Completed | |
| 3 | New procedures to be introduced for creating a safe environment to cohort high risk mental health patients. | Jillian Wild | 27/09/2018 | 27/09/2018 | Completed | |
| 4 | Per linked risks. Risk mitigation action plans are appended to each of the linked risks and are reviewed by the Divisions on an on-going basis with assurances being provided to Divisional meetings. | Jillian Wild | 27/09/2018 | 27/09/2018 | On track | |
| 5 | Outcomes of VSA to be incorporated into work streams for improvement of mental health provision in ED (including partnership working with LCFT). | Jonathan Smith / Jillian Wild | 28/06/2019 | 28/06/2019 | On track | |

| | | | | | |
|---|---|---|---|---|---|
| **Title** | **Aggregated Risk - Failure to adequately manage the Emergency Capacity *and* Flow system.** | | | | |
| **Risk ID** | 1810 | Date opened | 05/07/2013 | | |
| **Risk Handler** | Donna Worrall | Exec Director/Risk Lead | Sharon Gilligan | | |
| **Identified in BAF Risk ID** | **BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety). | | | | |
| **Linked to Risks:** | 908 - The inability to provide performance and patient care due to low medical staffing levels within the ED department – (12).<br><br>7587 - There is a risk that patient's in ED at RBH are not always receiving optimal care due to a lack of embedded clinical systems- (12).<br><br>7108 - Extreme escalation areas open in response to capacity issues in ICG - (8). | | | | |
| **Initial Rating** | **Likelihood: 5<br>Consequence: 3<br>Total: 15** | Current Rating: | **Likelihood: 5<br>Consequence: 3<br>Total: 15** | Target Rating: | **Likelihood: 3<br>Consequence: 3<br>Total: 9** |
| **What is the Hazard** | • Lack of bed capacity across the Trust can lead to extreme pressure resulting in a delayed delivery of the optimal standard of care across departments.<br>• At times of extreme pressure this increase in the numbers of patients within the emergency pathway makes medical/nursing care difficult and impacts on clinical flow. | | What are the risks associated with the hazard | | • Patients being managed on trolleys in the corridor areas of the emergency /urgent care departments impacting on privacy and dignity.<br>• Delay in administration of non-critical medication.<br>• Delays in time critical patient targets (four hour standard, stroke target, sepsis six, and access to early senior review for trauma patients).<br>• Delay in patient assessment.<br>• Potential complaints and litigation.<br>• Potential for increase in staff sickness and turnover.<br>• Increase in use of bank and agency staff to backfill.<br>• Lack of capacity to meet unexpected |

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| | | | demands.<br>• Delays in safe and timely transfer of patients. |
| **What controls are in place** | • Daily staff capacity assessment.<br>• Daily Consultant ward rounds.<br>• Opening of Ambulatory Emergency Care Unit for Acute Medicine including frailty patients and rapid chest pain assessment.<br>• Review of the use of the old Ambulatory Emergency Care for Surgery in progress.<br>• Pennine Lancashire and ELHT Winter Plans approved by Pennine Lancashire A&E Delivery Board and ELHT Operational Delivery Board to support safety and timely care and movement of patients.<br>• Introduction of ED & UCC Trigger Tools and Escalation arrangements including actions cards for relevant roles and services linked to Trust Resilience and Escalation Policy and Procedures.<br>• Establishment of specialised flow team.<br>• Bed management teams.<br>• Delayed discharge teams.<br>• Ongoing recruitment.<br>• Ongoing discussion with commissioners for health economy solutions.<br>• ED/UCC/AMU will take stable assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley.<br>• Introduction of Full Capacity Protocol.<br>• Refined 2 hourly patient flow meetings. | What are the gaps in controls | • Trust has no control over the number of attendees accessing ED/UCC services. |
| **What assurances are in place** | • Regular reports to a variety of specialist and Trust wide committees.<br>• Consultant recruitment action plan.<br>• Escalation policy and process. | What are the gaps in assurance | • None identified |

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| | • Monthly reporting as part of Integrated Performance Report.<br>• Weekly reporting at Exec Team.<br>• System Oversight by Pennine Lancashire A+E Delivery Board. | | |

Actions to be carried out in mitigating this risk

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

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| **Title** | **Aggregated risk –Failure to adequately recruit to substantive nursing posts may adversely impact on patient care and Finance.** | | | | |
| **Risk ID** | 5791 | Date opened | 11/09/15 | | |
| **Risk Handler** | Julie Molyneaux | Exec Director/Risk Lead | Christine Pearson | | |
| **Identified in BAF Risk ID** | **BAF/02:** Recruitment and workforce planning fail to deliver the Trust objectives.<br><br>**BAF/04:** The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework.<br><br>**BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations. | | | | |
| **Linked to Risks:** | 3804 - Failure to recruit and retain nursing staff across inpatient wards and departments may result in inadequate nurse staffing - (12)<br>7496 - There is a risk of failing to deliver financial balance against the ICG nursing budget - (15) | | | | |
| **Initial Rating** | **Likelihood: 3**<br>**Consequence: 5**<br>**Total: 15** | Current Rating: | **Likelihood: 3**<br>**Consequence: 5**<br>**Total: 15** | Target Rating: | **Likelihood: 2**<br>**Consequence: 2**<br>**Total: 4** |
| **What is the Hazard** | • Use of agency staff is costly in terms of finance and levels of care provided to patients | | What are the risks associated with the hazard | • Breach of agency cap<br>• Agency costs jeopardising budget management | |
| **What controls are in place** | • Daily staff teleconference<br>• Reallocation of staff to address deficits in skills/numbers<br>• Ongoing reviews of ward staffing levels and numbers at a corporate level<br>• Daily review of acuity and dependency to staffing levels<br>• Recording and reporting of planned to actual staffing levels and Care Hours per Patient Day (CHPPD)<br>• E-rostering KPI's<br>• Ongoing recruitment campaigns<br>• Overseas recruitment as appropriate | | What are the gaps in controls | • Unplanned short notice leave and sickness.<br>• Non elective activity impacting on associated staffing<br>• Break downs in discharge planning<br>• Individuals acting outside control environment | |

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| | • Establishment of internal staff bank arrangements<br>• Senior nursing staff authorisation of agency usage<br>• Monthly financial reporting | | |
| **What assurances are in place** | • Daily staffing teleconference with Divisional Director of Nursing<br>• 6 monthly formal audit of staffing needs to acuity of patients<br>• Formal review of nursing and midwifery establishments annually more often if required<br>• Exercise of professional judgment on a daily basis to allocate staff appropriately, alongside Safe Care acuity data<br>• Monthly integrated performance report contains staffing data containing planned to actual nurse staffing levels and CHPPD<br>• Active progression of recruitment programmes in identified areas. | What are the gaps in assurance | • None identified. |

Actions to be carried out in mitigating this risk

| No | Action | Action Lead | Due date | Expected completion date | Progress on implementation of action | RAG Rating |
|---|---|---|---|---|---|---|
| 1 | All current planned actions completed as shown in “what controls are in place” | Julie Molyneaux | 03/09/2018 | 03/09/2018 | Completed | |
| 2 | Non-Medical Bank and Agency Group | Julie Molyneaux | 31/12/2019 | 31/12/2019 | On track | |
| 3 | Risk mitigation action plans are appended to each of the linked risks and are reviewed by the Divisions on an ongoing basis with assurances being provided to Divisional meetings | Julie Molyneaux | 31/12/2019 | 31/12/2019 | On track | |

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| **Title** | **Aggregated risk – Failure to adequately recruit to substantive medical posts may adversely impact on patient care and Finance.** | | | | |
| **Risk ID** | 5790 | Date opened | 11/09/15 | | |
| **Risk Handler** | Simon Hill | Exec Director/Risk Lead | Ian Stanley | | |
| **Identified in BAF Risk ID** | **BAF/02:** Recruitment and workforce planning fail to deliver the Trust objectives.<br><br>**BAF/04:** The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework.<br><br>**BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations. | | | | |
| **Linked to Risks:** | 7268 - Clinical, financial and organisational risks of (SOS) and T&O short and long term rota gaps – (9).<br><br>3835 - Failure to appoint to vacant oncologist posts is impacting on service delivery and provision of safe, personal, effective care - (9).<br><br>7401- There is a risk that patients may not receive timely clinical care due to a lack of junior doctor cover on medical wards in ICG - (8).<br><br>7816 - Medical (psychiatric) waiting list (15). | | | | |
| **Initial Rating** | **Likelihood: 5**<br>**Consequence: 3**<br>**Total: 15** | Current Rating: | **Likelihood: 5**<br>**Consequence: 3**<br>**Total: 15** | Target Rating: | **Likelihood: 3**<br>**Consequence: 3**<br>**Total: 9** |
| **What is the Hazard** | • Gaps in medical rotas require the use of locums to meet service needs at a premium cost to the Trust. | | What are the risks associated with the hazard | • Escalating costs for locums.<br>• Breach of agency cap.<br>• Unplanned expenditure.<br>• Need to find savings from elsewhere in budgets.<br>• Impact on staff stress and wellbeing. | |
| **What controls are** | • Divisional Director signs off for locum usage.<br>• Ongoing advertisement of medical vacancies. | | What are the gaps in controls | • Reduction in agency staffing costs form previous year has already been | |

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| **in place** | • Consultant crosses cover at times of need.<br>• Development of alternate roles.<br>• Offer of OH support if felt needed. | | demonstrated, however, the availability of medical staff to fill permanent posts continues in some areas, linked to regional or national shortages in some specialties. |
| **What assurances are in place** | • Directorate action plans to recruit to vacancies.<br>• Reviews of action plans and staffing requirements at Divisional meetings.<br>• Reviews of action plans and staffing requirements at trust Board meetings and Board subcommittees.<br>• Reviews of plans and staffing requirements at performance meetings.<br>• Analysis of detailed monthly report through AMG (Agency Monitoring Group). Areas for targeted action understood. | What are the gaps in assurance | • Unexpected operational pressures could further stress an already stressed system. |

Actions to be carried out in mitigating this risk

| No | Action | Action Lead | Due date | Expected completion date | Progress on implementation of action | RAG Rating |
|---|---|---|---|---|---|---|
| 1 | Per individual linked risks. | Simon Hill | 10/07/2017 | 10/07/2017 | Completed | |
| 2 | Ongoing recruitment and innovative packages offered. | Simon Hill | 31/12/2019 | 31/12/2019 | On track | |
| 3 | Workforce transformation and new models of skill mix. | Simon Hill | 31/12/2019 | 31/12/2019 | On track | |
| 4 | On-going pressure to reduce locum rates. | Simon Hill | 31/12/2019 | 31/12/2019 | On track | |
| 5 | All requests to exceed capped rates to be approved by medical directorate on a case by case basis. | Simon Hill | 31/12/2019 | 31/12/2019 | On track | |

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| **Title** | **Failure to comply with the 62 day cancer waiting time.** | | | | |
| **Risk ID** | 7008 | Date opened | 01/08/2018 | | |
| **Risk Handler** | William Wood | Exec Director/Risk Lead | Natalie Hudson | | |
| **Identified in BAF Risk ID** | **BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety). | | | | |
| **Linked to Risks:** | N/A | | | | |
| **Initial Rating** | **Likelihood: 3<br>Consequence: 3<br>Total: 9** | Current Rating: | **Likelihood: 5<br>Consequence: 3<br>Total: 15** | Target Rating: | **Likelihood: 3<br>Consequence: 2<br>Total: 6** |
| **What is the Hazard** | • Cancer treatment delayed.<br>• Potential to cause clinical harm to a patient if the treatment is delayed.<br>• Damage to Organisational reputation. | | What are the risks associated with the hazard | • Trust fails to achieve compliance with the 85% national standard for the cancer 62 day waiting time target.<br>• The Trust is performance managed for failure to comply with cancer waiting time targets - the cancer waiting times are key performance indicators for all NHS providers.<br>• Potential to cause clinical harm to a patient if the treatment is delayed.<br>• There is also a risk to the patient experience and risk of adverse publicity/reputation to the Trust. | |
| **What controls are in place** | Immediate ongoing actions to improve performance:-<br>a) CNS engagement with virtual PTL.<br>b) Cancer escalation process modified and re-issued.<br>c) Cancer Hot List issued twice weekly.<br>d) Additional theatre capacity.<br>e) Daily prioritisation of elective and cancer activity by clinical and pathway urgency. | | What are the gaps in controls | • Multiple Actions require recruitment of 'difficult to recruit' personnel.<br>• Patient choice and compliance is a factor which cannot easily by influence. | |

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| | f) Additional Alliance funding provided to Radiology for in-house Cancer Reporting in March.<br>g) Re-validate previous months (review all treatments capture, all breaches and re-allocations).<br>h) Continued micro-management of all patients at risk on hot list.<br>i) Senior Directorate Managers to attend all PTLs in coming weeks to gain assurance of efficient and appropriate process.<br>j) Weekly performance forecast issued to Cancer Management Team and DGMs.<br>k) Ongoing Breach analysis. | | |
| **What assurances are in place** | • None identified | What are the gaps in assurance | • None identified |

Actions to be carried out in mitigating this risk

| No | Action | Action Lead | Due date | Expected completion date | Progress on implementation of action | RAG Rating |
|---|---|---|---|---|---|---|
| 1 | Patient education. | William Wood | 14/05/2019 | 14/05/2019 | Action has now become business as usual. | |
| 2 | Collaborative working with Primary Care. | William Wood | 14/05/2019 | 14/05/2019 | Action has now become business as usual. | |
| 3 | Recruitment to vacancies within Clinical service. | William Wood | 14/05/2019 | 14/05/2019 | Action has now become business as usual. | |
| 4 | Capacity review. | William Wood | 31/07/2019 | 31/07/2019 | On track | |

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| | 5 | Pathway review – New alliance pathway for Prostate, Upper GI, Colorectal and Lung. | William Wood | 30/04/2019 | 31/03/2020<br><br>Original completion date changed from 30/04/2019 to 31/03/2020 as the new Upper GI has only just been published and will take some time and cross organisational work to complete. | On track | |
| | 6 | Investment of Alliance Funding in pathways to improve processes. | William Wood | 31/03/2020 | 31/03/2020 | On track | |
| | 7 | Establishment of Template Biopsy Service at ELHT for Urology. | William Wood | 31/03/2019 | 14/05/2019 | Completed | |
| | 8 | To implement a new Breach Analysis Process | William Wood | 30/08/2019 | 30/08/2019 | On track | |
| | 9 | Creation of a comprehensive Cancer PTL and automated Hot List | William Wood | 30/06/2019 | 30/06/2019 | On track | |
| | 10 | To recruit to Oncology Vacancies | William Wood | 31/07/2019 | 31/07/2019 | On track | |
| | 11 | Implementation of Urology One Stop | William Wood | 30/06/2019 | 30/06/2019 | On track | |

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| **Title** | Risk that PACS downtime occurs and brings delay to patient pathways or delays in operating theatre activity. | | | | |
| **Risk ID** | 7552 | | Date opened | 25/10/2017 | |
| **Risk Handler** | Mark Johnson | | Exec Director/Risk Lead | Jonathan Wood | |
| **Identified in BAF Risk ID** | **BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk of safety & poor patient experience). | | | | |
| **Linked to Risks:** | N/A | | | | |
| **Initial Rating** | **Likelihood: 5**<br>**Consequence: 3**<br>**Total: 15** | Current Rating: | **Likelihood: 5**<br>**Consequence: 3**<br>**Total: 15** | Target Rating: | **Likelihood: 3**<br>**Consequence: 3**<br>**Total: 9** |
| **What is the Hazard** | • Lack of data available while treating patient could cause harm.<br>• The system is periodically failing / turning over so that images are not available as required. This may be due to PACs or networking issues.<br>• The impact of this for the Orthopaedic team is that clinics are delayed/ overrunning and patients are waiting longer than required.<br>• On occasion patients have left having not been able to get the necessary information to talk through their appropriate care.<br>• The impact for theatres is also real and in the past cases have had to be cancelled due to delays and unavailability of appropriate images. | | What are the risks associated with the hazard | The risks are:<br>• Trust targets<br>• Delays in patient pathway.<br>• Downtime in clinics and theatres due to periodic system failure.<br>• Poor patient experience having to wait around while backup systems are used.<br>• Some occasions backup systems have failed<br>• Increased complaints.<br>• Concerns re patient in theatre and system going down meaning may have to stop / delay operating. This may cause patient harm.<br>• The impact on the consultants is then the clinic over runs into the afternoon session. | |
| **What controls are in place** | • Backup systems involving getting physical or disk copies of images.<br>• MDT computers have been upgraded to | | What are the gaps in controls | • Physical copies of images via backup are not instantaneous.<br>• Time gap whilst waiting for new equipment and | |

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| | reduce PACs access speed. All wards in process of having at least 1 PACS enhanced machine.<br>• Images available at both the modality and via the Radiology department.<br>• VNA viewer via Web Browser enabled to allow access to images without requirement to view via PACS. – May 2019<br>• Sectra PACs go live on track for Sept 2019<br>• Rebuild of new high speed IT network, completed, with links to BGH.<br>• 24/7 IT support in place with senior manager backup to escalate PACS issues.<br>• New PACS infrastructure in place and being commissioned.<br>• New configuration of PACS allows for significantly more resilience and stability.<br>• New PACS operational board being set up to monitor wider PACs delivery. | | system to come on line – relaying on physical intervention. |
| **What assurances are in place** | • Current controls can only reduce the potential impact patients. | What are the gaps in assurance | • Controls are being manually implemented and can`t stop the system from going down. |

| Actions to be carried out in mitigating this risk | | | | | | | |
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| | **No** | **Action** | **Action Lead** | **Due date** | **Expected completion date** | **Progress on implementation of action** | **RAG Rating** |
| | 1 | Commission new Sectra PACS system | Tom Newton | 31/03/2019 | 19/09/2019<br><br>(Original completion date was 29.03.2019 but was moved to 31.08.2019 and then to 19/09/2019 as project has commenced). | Delays due to contractual processes from supplier. All new PACS hardware in place, testing of new software ongoing. VNA commissioned and image / data migration underway. | |
| | 2 | VNA Viewer | Tom Newton | 31/05/2019 | 31/05/2019 | Date scheduled for viewer release to coincide with VNA software upgrade. | |
| | 3 | View station upgrades | Mark Johnson | 01/06/2019 | 28/06/2019 | All MDT stations upgraded. List provided of all wards requiring hardware update. IT team working through list. PC base units and SSD's ordered. | |
| | 4 | PACs operational board | Tom Newton | 02/05/2019 | 02/05/2019 | ToR developed. Aligning diaries for first meeting. Informal operational and formal project groups are already in place. PACs is a standing agenda item on eHealth Board | |

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| **Title** | **Potential to compromise patient care/deliver sub-optimal care on the elective centre & infusion suite** | | | | |
| **Risk ID** | 8060 | | Date opened | 04/02/2019 | |
| **Risk handler** | Jarrod Walton-Pollard | | Exec Director/Risk Lead | Natalie Hudson | |
| **Identified in BAF Risk ID** | BAF 5: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety). | | | | |
| **Linked to Risks:** | N/A | | | | |
| **Initial Rating** | **Likelihood: 5 Consequence: 3 Total: 15** | Current Rating: | **Likelihood: 5 Consequence: 3 Total: 15** | Target Rating: | **Likelihood: 2 Consequence: 3 Total: 6** |
| **What is the Hazard** | • Nurse-led Elective Centre dealing with patients who are on defined pathways. Occasionally patient's condition deteriorates and therefore, may require specialist medical support. The appropriate support may not be available (particularly out of hours) on the BGH site resulting in a transfer to the RBH site.<br>• There is a lack of appropriate policies that support a nurse led unit.<br>• Although all patients have a designated consultant. There is not always a member of their team available to review patients on the BGH site.<br>• There is a trust wide initiative to transfer as much activity as | What are the risks associated with the hazard | • Potential serious injury to patients as the team will be unable to care properly for the patients due to lack of skill mix, medications or skills.<br>• Potential loss of income for the Trust as surgery will be cancelled as it would be unsafe to continue on the BGH site.<br>• Potential loss of reputation to the Trust should the patient complain or media sources become aware and report any negative events.<br>• Creation of a 28 day rule if procedure cancelled on the day increasing operational pressures to directorates to meet targets.<br>• Lack of policies, procedures, clinical guidelines and protocols for medical patients<br>• Lack of clinical cover for the routine care of all patients such as prescribing, reviewing if none emergency issues as the RMO service is only contracted to deal with emergency situations.<br>• At times current clinical cover is substandard for centre's needs | | |

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| | possible onto the BHG site; this at times results in insufficient/inappropriate equipment especially in the case of extra lists.<br>• Staff maybe unable to appropriately administer medication - in the infusion suite due to lack of policies and other specialist medication which staff aren't familiar with.<br>• Cancellation of surgery due to inappropriate site suitability.<br>• Patient safety and care maybe compromised due to delayed/incorrect treatment<br>• Potential loss of income if procedures are cancelled. | | • Poor site suitability criteria and/or site suitability criteria not being following or interpreted differently.<br>• Extra lists being moved to BGH due to bed pressures on RBH site.<br>• Elective centre deemed a place of safety despite being nurse led resulting in delays in transfer by the ambulance service resulting in patients not been transferred in a timely manner. |
| **What controls are in place** | • RMO service in place for emergency situation out of hours.<br>• Site Suitability Policy is in place<br>• There is an onsite anaesthetist during evenings who can review patients at the request of the nursing staff on the unit.<br>• 24 hour senior nursing cover on the BGH site.<br>• Out of hours duty sister to offer support and advice<br>• Can contract ambulatory care for any medical advice between 08:00 - 20:00 Mon-Fri.<br>• Can contact surgical on call for telephone advice. | What are the gaps in controls | • Out-of hours service is due to change from April 2019. Uncertainty surrounding how this is going to change going forward.<br>• Lack of compliance to Policy.<br>• This is a Nurse-led unit without senior clinical cover. |

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| **What assurances are in place** | • Incidents are now being mapped to this risk.<br>• Risk is now being regularly monitored, reviewed and scrutinised at appropriate governance meeting. | What are the gaps in assurance | • Lack senior clinical supervision/support for this Elective Centre. |

Actions to be carried out in mitigating this risk

| No | Action | Action Lead | Due date | Expected completion date | Progress on implementation of action | RAG Rating |
|---|---|---|---|---|---|---|
| 1 | Review of the service provision at the Elective centre and infusion suite. | Michelle Turner | 06/05/2019 | 06/05/2019 | Completed on 03/04/2019 | |
| 2 | To create templates for each treatment/medication administered at infusion suite. | Michelle Turner | 30/08/2019 | 30/08/2019 | On track | |
| 3 | To identify suitable clinical cover including specialist medical cover. | Charles Thomson | 08/07/2019 | 08/07/2019 | On track | |

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| **Title** | **Aggregated Risk - Potential to compromise patient care due to lack of Trust-wide advanced Electronic Patient Record (EPR) System.** | | | | |
| **Risk ID** | 8126 | | Date opened | 02/05/2019 | |
| **Risk handler** | Mark Johnson | | Exec Director/Risk Lead | Jonathan Wood | |
| **Identified in BAF Risk ID** | BAF 5: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety). | | | | |
| **Linked to Risks:** | 7330 - Aggregated Risk - Inability to identify, track & monitor the cohorts of women and newborns who require and have screening due to lack of an end-to-end IT System for Maternity.<br><br>7123 - Inadequate Safeguarding Information Recorded in Maternity Notes (12). | | | | |
| **Initial Rating** | **Likelihood: 5<br>Consequence: 3<br>Total: 15** | Current Rating: | **Likelihood: 5<br>Consequence: 3<br>Total: 15** | Target Rating: | **Likelihood: 2<br>Consequence: 3<br>Total: 6** |
| **What is the Hazard** | • The delay in implementing a Trust-wide Electronic Patient System.<br>• Continued reliance on paper-based casenotes, assessments and prescriptions as well as the multiple minimally interconnected electronic systems in the Trust. | | What are the risks associated with the hazard | • Inability to effectively share a persons medical record with the treatment and support teams.<br>• Potential increase in prescribing errors due to the absence of a ePMA system.<br>• Inability to effectively monitor patient flow and patient care.<br>• Inability to capture required patient and statutory data sets with contingent solutions causing disruptions to patient care.<br>• Loss of income due to poor capture of patient activity.<br>• Inability for patients to contribute and be informed of their care.<br>• Increased risk of harm due to manual transcription of results and observations.<br>• Reduced clinical decision making and excessive tests due to lack of effective decision support | |

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| | | | systems.<br>• Significant costs to the organisation due to the storage and retrieval of paper case notes.<br>• Increased costs to the organisation due to the inability to comply with regulatory and dataset requirements (eg CNST).<br>• Increased costs to the organisation due to ineffective monitoring of key clinical conditions and treatments (eg sepsis, pressure ulcers, VTE, infection).<br>• Excessive variation in clinical practice leading to sub optimal outcomes for patients due to the inability to monitor practice and effectively implement care pathways.<br>• Potential for limited coordination of care across specialties, primary and secondary care and other outside agencies.<br>• Potential of delivering of sub-optimal patient experience/outcomes due to ineffective referrals and discharge systems due to paper based systems.<br>• Potential to compromise the quality of data due to transcription errors between clinical systems both internally and externally.<br>• Inability to undertake detailed review of patient care due to paper based data collection systems.<br>• Increased patient risk due to inability to capture certain data sets (such as MSDS).<br>• Inability to integrate with Trusts within and outside of the organisation.<br>• Inability to attract senior clinical and operational leaders due to the Trust using ineffective and aged systems.<br>• Poor practice may not be picked up due to inability to measure outcomes consistently. |

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| | | | • Patient may become 'lost in the system' due to inability to track them through the stages of care effectively.<br>• Significant reputational damage due to clinical, operational and financial limitations.<br>• |
| **What controls are in place** | • Stable PAS system (albeit 25+ years old).<br>• Extramed patient flow system, including capture of nursing docs.<br>• ICE system.<br>• EMIS system.<br>• Winscribe digital dictation system<br>• Windip scanning solution<br>• Orion Portal.<br>• 24/7 system support services.<br>• Large medical record department.<br>• Paper contingencies for data capture.<br>• Additional administrative staff as required.<br>• All critical systems managed by informatics or services with direct links to Informatics.<br>• Register of non-core systems capturing patient information (feral systems) in place.<br>• Improved infrastructure (including storage) to maintain and manage existing systems. | What are the gaps in controls | • Windip scanning solution not across all specialties and casenote groups.<br>• EMIS system only supports community activity, no significant system in acute setting.<br>• Not all 'feral' systems are registered (or known about).<br>• Contracts for current systems being 'rolled over' annually, cannot identify specific 'switch over' dates.<br>• Inability to rapidly flex the current system to emerging demands from NHSI / D for additional information.<br>• Limited capital budget to invest in additional hardware / software as clinical requirements develop. |
| **What assurances are in place** | • Consistent monitoring of current clinical systems and support via helpdesks and informatics | What are the gaps in assurance | • Whilst many reports may be produced the Trust does not always have enough admin or clinical resource to action. |

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| | services.<br>• Significant amount of Business Intelligence system data quality and usage reports.<br>• Support from Executive ,Board and clinical leaders relating to the OBC / FBC | | • Unable to plan infrastructure as new technologies and clinical techniques develop in isolation from the main ePR.<br>• The lack of full commitment from ICS to support ELHT Cerner ePR. |

Actions to be carried out in mitigating this risk

| No | Action | Action Lead | Due date | Expected completion date | Progress on implementation of action | RAG Rating |
|---|---|---|---|---|---|---|
| 1 | Presentation and approval of business cases for investment | Mark Johnson | 24/05/2019 | 24/05/2019 | Completed | |
| 2 | Mobilisation of clinical staff to support ELHT epR plans | Mark Johnson | 30/05/2019 | 30/05/2019 | Completed | |
| 3 | Submission of FBC for approval | Charlotte Henson | 31/07/2019 | 31/07/2019<br><br>Completion date moved from 06/06/2019 to 31/07/2019 as OBC has been completed and to enable submission of FBC for approval. | On track | |
| 4 | ICS support and approval for ELHT ePR route | Mark Johnson | 27/06/2019 | 27/06/2019 | On track | |

| Title | Loss of facility for Containment Level 3 in pathology | | | | |
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| **Risk ID** | 7583 | Date opened | 26/11/2017 | | |
| **Risk handler** | Pamela Henderson | Exec Director/Risk Lead | Jonathan Wood | | |
| **Identified in BAF Risk ID** | **BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety). | | | | |
| **Linked to Risks:** | N/A | | | | |
| **Initial Rating** | **Likelihood: 3<br>Consequence: 5<br>Total: 15** | Current Rating: | **Likelihood: 2<br>Consequence: 5<br>Total: 10** | Target Rating: | **Likelihood: 1<br>Consequence: 5<br>Total: 5** |
| **What is the Hazard** | • Changes to air pressure to resolve the air pressure fault (risk 7342) have caused rips and bubbling of the vinyl wall covering from the wall. If the wall covering integrity is damaged beyond immediate repair the CL3 facility will be put out of use.<br>• Limitation in operational capacity leading to delays in diagnosis.<br>• Loss of service and income.<br>• Patient safety concerns. | | What are the risks associated with the hazard | • If the vinyl wall covering is damaged, the containment properties of the facility are compromised and therefore it cannot be used.<br>• Potential delays in diagnosis which may trigger patient safety concerns.<br>• Limitation in operational capacity may lead to loss of service and income. | |
| **What controls are in place** | • Emergency remedial work has been assessed for sealability by Crowthorne Ltd in order to continue to provide an emergency fumigation service (requirement for CL3 facility).<br>• Visual inspection of vinyl wall covering recorded daily by Laboratory staff and repairs conducted before any processing can begin. If tears are found, Engie is informed immediately and work does not start in the facility until they have filled the breach with silicon sealant.<br>• Current safety procedures for working in CL3 to be adhered to as per policy.<br>• Contractor has been appointed and is working to an agreed | | What are the gaps in controls | • Unexpected breach could occur between the daily (and weekly) checks. | |

| | | | |
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| | program with Pathology, Estates and Consort. | | |
| **What assurances are in place** | • Completed worksheets available demonstrating checks are conducted daily.<br>• Risk assessment and actions reviewed at departmental quality meetings and CLM governance meetings.<br>• Refurbishment work due to be completed by September 2019.<br>• Risk will be regularly monitored at the Capital Board. | What are the gaps in assurance | • Unexpected breach could occur between the daily (and weekly) checks.<br>• Project meetings may be stood down in times of high activity within the Trust. |

Actions to be carried out in mitigating this risk

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

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| **Title** | **Aggregated risk – Inability to identify, track & monitor the cohorts of women and newborns who require and have screening due to lack of an end-to-end IT System for Maternity.** | | | | |
| **Risk ID** | 7330 | | Date opened | 29/01/2018 | |
| **Risk Handler** | Mark Johnson | | Exec Director/Risk Lead | Jonathan Wood | |
| **Identified in BAF Risk ID** | BAF/05: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety & poor patient experience). | | | | |
| **Linked to Risks:** | 7123 - Inadequate Safeguarding Information Recorded in Maternity Notes (12). | | | | |
| **Initial Rating** | **Likelihood: 3<br>Consequence: 5<br>Total: 15** | Current Rating: | **Likelihood: 2<br>Consequence: 5<br>Total: 10** | Target Rating: | **Likelihood: 2<br>Consequence: 5<br>Total: 10** |
| **What is the Hazard** | • Inability to identify the cohort of women, fetus' and babies who require screening in the antenatal and postnatal period.<br>• Potential for abnormal screening tests not to be followed up/acted upon as midwives working in community do not have access to the ICE system.<br>• Impacts on resources and staff time managing these gaps, collect data and track this cohorts of women.<br>• Potential for litigation.<br>• Potential for adverse media coverage and negative reputation to the Trust.<br>• An emerging hazard relating to the Newborn Physical Infant Examination whereby assurance is not being provided to PHE and QA that neonates are being referred and followed up within a timely manner. | | What are the risks associated with the hazard | • Inability to achieve the national mandated screening target for the Antenatal and Newborn Screening Programme and provide assurance to Public Heath England and Quality Assurance.<br>• Abnormal screening results not identified and acted upon within the required timescales.<br>• Significant avoidable harm to a mother and baby.<br>• The current system is not robust, designed or organized to reduce the likelihood of errors occurring and the impact of errors when they occur.<br>• The current paper based system does not support staff to deliver reliable safe systems of care.<br>• Poor patient experience.<br>• Potential fines for not meeting national targets / KPI's.<br>• Potential to be identified as outliers nationally in national reports for example the National | | |

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| | | | Maternal Perinatal Audit / National Neonatal Audit.<br>• Potential for staff to be stressed and fatigued when involved in clinical incidents due lacking of equipment for them to provide safe, personal, effective care.<br>• Potential for the Trust to be identified as having a poor safety culture due to lack of resources.<br>• Midwives and Maternity Support Workers manually input data in a variety of ways. |
| **What controls are in place** | • Dedicated clinic for quadruple screening.<br>• Limited locally designed databases to track and monitor the cohort. | What are the gaps in controls | • The local databases that have been developed have no staffing resources dedicated to checking this daily and is reliant on staff ad hoc checking the databases.<br>• The quad clinic is still reliant on staff booking women into this clinic and there is error still for women to be missed as this is not done electronically.<br>• The CERNER EPR IT system procured by the trust is forecasted to implement in 2020.<br>• There is no interoperability between Athena, BadgerNet and NIPESMART thereby limited assurance is provided to PHE and QA that neonates are being screened appropriately and ongoing referrals being undertaken within the required timescales. |
| **What assurances are in place** | • Risk assessment to be reviewed every 3 months at Divisional Management Board and progress against the actions overall risk discussed and escalated through the Risk Assurance Meeting.<br>• Risk assessment to be monitored via the Risk Assurance Meeting once accepted on to the Trust Risk Register. | What are the gaps in assurance | • The current paper-based system for identifying and tracking cohorts of women for screening isn`t effective, reliable and robust. |

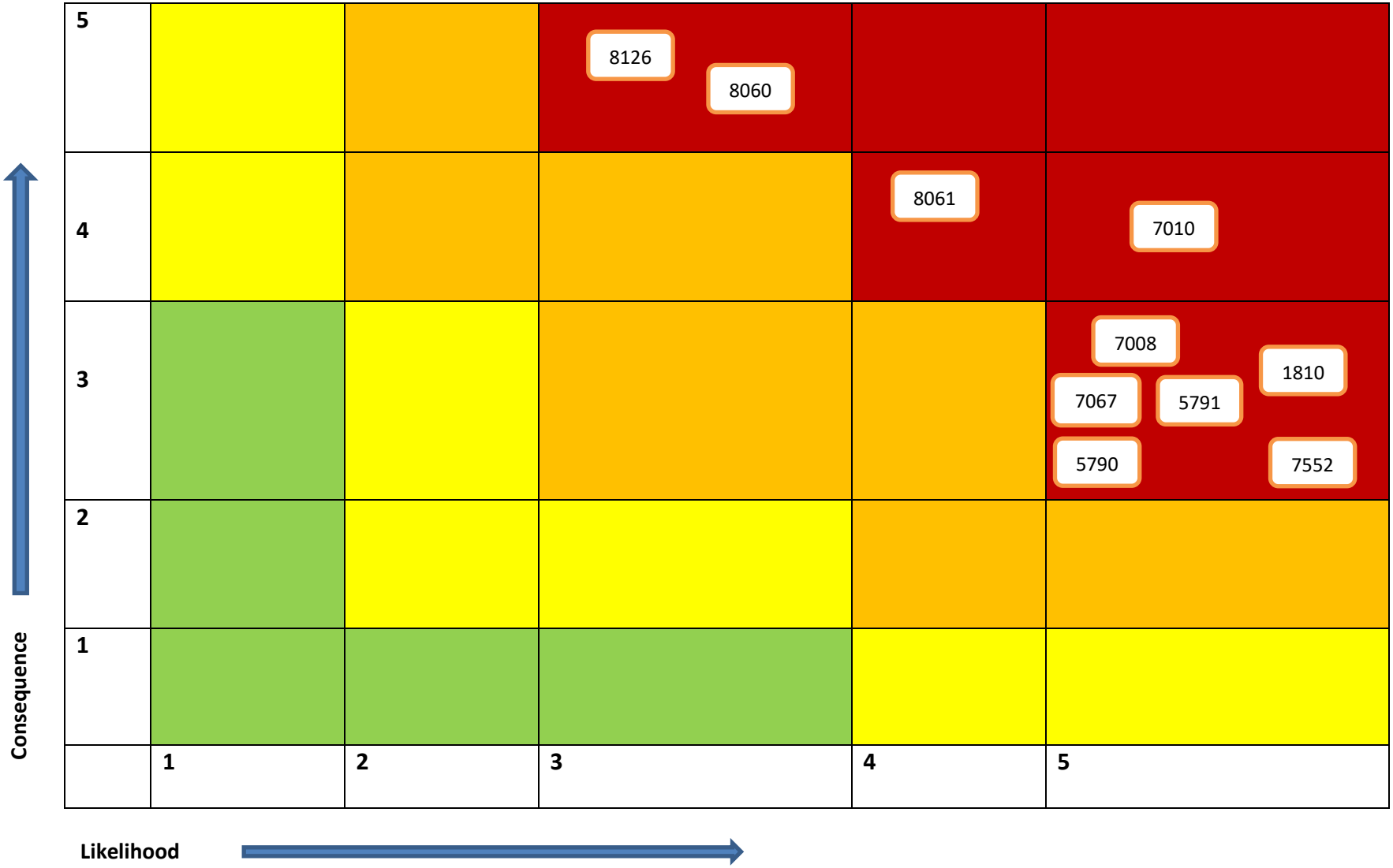
| Actions to be carried out in mitigating this risk | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **No** | **Action** | **Action Lead** | **Due date** | **Expected completion date** | **Progress on implementation of action** | **RAG Rating** |
| | 1 | To review and identify gaps in data submission.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

**RAG Key:**

| | | | | | |
|---|---|---|---|---|---|
| | Outstanding/Overdue | | In progress & on track | | Completed |

**Appendix 3: One page representation of the Corporate Risk Register as at 20th June, 2109 mapping all risks onto the 5X5 Matrix based on current score (10 Risks in total)**

East Lancashire Hospitals NHS Trust




Safe | Personal | Effective

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**10 July 2019**

**Item** 91

**Purpose** Discussion / Approval

| | |
|---|---|
| **Title** | Board Assurance Framework (BAF) |
| **Author** | Mrs A Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary<br>Miss K Ingham, Corporate Governance Manager/ Assistant Company Secretary |
| **Executive sponsor** | Dr I Stanley, Acting Executive Medical Director |

**Summary:** The Executive Directors have revised the BAF and examined the controls and assurances, together with any gaps, to establish whether they have changed since the May 2019 Board meeting.

The Finance and Performance Committee and Quality Committee reviewed the BAF and requested a further review by the Executive Directors in relation to a proposal to increase the scoring of the BAF risk 2 to 25 considering both the likelihood and the consequence scores as the two committees have considered various aspects within their remit relating to this risk. The Quality Committee had a detailed discussion whether the workforce risk is having an impact on the patient safety and the delivery of Safe, Personal and Effective care.

The Executive Directors have reviewed the consequence and the likelihood of the risk materialising and agreed that although the likelihood of the risk materialising is increasing and warrants a score of 5 (with the changes to the pension rules and taxation resulting in a reduction in clinical capacity), the mitigating actions undertaken to manage the risk at Trust level have supported a reduction in the consequence score from 5 to 4 at the current time. The Committees have also considered the close correlation between the workforce risk and the performance and finance risks (BAF risks 5 and 4).

The workforce risk, together with the rest of the BAF risks, is closely monitored at operational level. Any changes are mapped through the Datix system and risk assurance processes and will be fed into future BAF reports to the Board.

The score for the remaining BAF risks remain the same and BAF risk 1 has been entirely reviewed and the title changed as set out in the report and BAF matrix.

**Recommendation:** The Board is asked to discuss and approve the recommended changes to the BAF.

**Report linkages**

| | |
|---|---|
| Related strategic aim and corporate objective | Put safety and quality at the heart of everything we do<br>Invest in and develop our workforce<br>Work with key stakeholders to develop effective |

Safe | Personal | Effective

| | |
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| | partnerships |
| | Encourage innovation and pathway reform, and deliver best practice |

**Impact**

| | | | |
|---|---|---|---|
| Legal | No | Financial | No |
| Equality | No | Confidentiality | No |

Previously considered by:

Executive Directors

Finance and Performance Committee (24 June 2019)

Operational Delivery Board (25 June 2019)

Quality Committee (26 June 2019)

Operational Executive Briefing (2 July 2019)

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

**Risk 1: Transformation schemes fail to deliver the anticipated benefits, thereby impeding the Trust's ability to deliver safe, personal and effective care.**

**4.** There is a proposal to slightly revise the wording of the strategic risk to the following: **Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care.**

5. The risk score remains 20 (likelihood 5 x consequence 4). The risk was entirely reviewed, including the controls, assurances, the gaps and the updates and the Board is asked to note these changes on the BAF matrix and approve the revised risk title.

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

6. It is proposed that the **risk score remains at 20 (likelihood 5 x consequence 4),** however the Board is asked to note the increase in the likelihood score from 4 to 5 and the reduction in the consequence score from 5 to 4. The rationale for this has been set out in the summary section of the report.
7. The potential sources of assurance have been updated to include:

a) People Strategy aligned to deliver National ICB, ICP and Trust workforce objectives. NHS launched interim People Plan

8. The external sources of assurance have been updated to include:

a) ICS collaboration on Careers, International Recruitment and Workforce mobility.

b) Pensions link to Finance and Performance 'Gaps in Assurance'.

9. Gaps in control have been updated to include the following:

c) The impact of the changes to the pension rules and taxation has resulted in a significant reduction in capacity and additional work being undertaken by senior medical staff. This has resulted in a reduction in clinical capacity.

10. Actions and updates have been updated as to include the following:

a) Currently there are a further 113 external nurses in the recruitment pipeline due to start with the Trust between now and May 2019. 16 nurses have been sourced and started via the Global Learners Programme with a further 33 in the registration process for the programme.

b) E&D Action Plan to be updated by the end of July 2019.

c) Culture and Leadership Programme is now entering phase 2 (Design) and an update was presented to the Quality Committee in June.

d) The Vital Signs programme is underway to improve the employee experience from recruitment through to them leaving the organisation.

e) HEE funding secured to develop clinical leadership for workforce transformation through the WRAPT process. The training commenced in May 2019.

f) Launch of the volunteer learning passport in January 2019 enabled the mobility of volunteers between organisations. There was an evaluation period at the end of February 2019 and a wider rollout is now being considered nationally and across the ICS. A further update will be provided to the Board in quarter 3.

g) An apprenticeship strategy is now in place, as well as additional further proposals, to support a passport levy between partner organisations. A paper was presented to the ODB on exploring expansion in May 2019. The Board will be updated on developments in quarter 3.

h) The Trust is working with partners across the ICS to develop a co-ordinated response to the aforementioned pension's issues.

i) The Trust has undertaken a survey of all staff that may be impacted by the pension rules and taxation changes to gauge their awareness and identify any actions they may take. This will equip the Trust to make appropriate plans to

ensure service delivery. The results of the survey found that the majority of staff are aware of the Annual and Lifetime Allowance taxation rules (82%) but many staff are still unclear as to how they will be impacted individually (42%). The Trust has arranged a number of additional awareness sessions for staff in June 2019.

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

11. The **risk score remains 12** (likelihood 3 x consequence 4).
12. Actions and updates have now been updated to include the following:
    d) Agreement reached to focus on all aspects of improving the emergency pathway, including ED, Assessment Same Day Emergency Care, Discharge and out of hospital services and the acute adult mental health pathway. Aiming to develop a clear and succinct integrated action plan with associated metrics over the next six weeks.

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

13. The **risk score remains at 20** (likelihood 5 x consequence 4).
14. The potential sources of assurance section has been updated and now includes the following sources of internal assurance:
    e) The introduction of the Improvement Board will strengthen governance and oversight. Rates relating to agency medical and nursing rates.
    f) GIRFT programme
15. The gaps in control section has been updated with the following:
    g) Significant external pressures which may intensify internal financial pressure.

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

16. The **risk score** remains at **16** (likelihood **4** x consequences **4**).
17. Key controls have been updated to include the weekly ED / urgent care performance improvement meeting.

18. Potential sources of assurance have been updated to include the following under internal sources of assurance:

    h) Performance monitoring provided through the weekly operational meeting, Scheduled Care Board (joint Board with CCG).

    i) Silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments continues. There are currently 13 Silver Accreditation of a ward approved by the Trust Board with further two awaiting approval.

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

19. The 'gaps in control' section has been updated and the issues relating to the heating system failure at Accrington Victoria Community Hospital have been removed as this has now been resolved.

20. In addition the following has been included in the gaps in control section:

    k) The impact of the changes to the pension rules and taxation has resulted in a significant reduction in capacity and additional work being undertaken by senior medical staff. This has resulted in a reduction in clinical capacity which is affecting the Trust's ability to deliver against 18 week RTT and cancer targets.

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

    a) Trust's lifecycle upgrade programme (estates and facilities) developed and signed off by the end of April 2019. The programme has now commenced. Review in quarter 3.

    b) CQC action plan monitored by the CQC and through the Quality Committee, the next report to the Quality Committee in September.

    c) RTT and Holding Lists - streamlined directorate level trajectories and action plans being developed. These have been completed in June and are monitored through weekly Executive meetings and monthly through ODB. Next report is due in September.

    d) Clinical model review and development of Medicine and Emergency Care division improvement for future for Phase 6 - 13 June was carried out.

    e) Due to national timeline changes the PLACE assessments have not yet been completed and are expected in September 2019.

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance, 03 July 2019.

| | |
|---|---|
| **Reference Number:** BAF/01 | |
| **Responsible Director(s):** Director of Finance and Medical Director | |
| **Aligned to Strategic Objectives:** 1, 2, 3 and 4. | |
| **Strategic** Risk: Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. | |
| **Consequences of the Risk Materialising:**<br>1. Ability to deliver against the constitutional standards and organisational delivery would be adversely affected<br>2. Inability to provide financial assurance to the Board<br>3. Reduced ability to integrate primary and secondary care<br>4. Reduced ability to have the right workforce planning<br>5. Reduced ability to achieve access and operational standards<br>6. Reduced ability to improve quality standards | |
| **Key Controls**<br>*What controls/ systems, we have in place to assist in securing delivery of our objective.* | **Potential Sources of Assurance**<br>*Where we can gain evidence that our controls/systems on which we are place reliance, are effective* |
| We have developed the 2019 plan for the Trust in conjunction with the Pennine Lancashire ICP partners to achieve a single plan for the ICP. This focusses on delivering our quadruple aim of balancing quality with delivery/performance, finances and impact of change on people (patients, staff or the public).<br><br>The Trust has invested in an Improvement Practice team who will work with transformation and quality improvement teams across Pennine Lancashire and the Trust to lead, facilitate and deliver improvement in line with the agreed priorities from the planning round. The programme also aligns the improvement methodologies utilised across the Trust and wider-ICP to ensure consistency of approach.<br><br>The programme is monitored through the Improvement Practice Office who report to the Operational Delivery Board, Finance and Performance Committee and Quality Committee as well as the Executives through the leadership wall.<br><br>Established Corporate Quality Improvement (QI) team within Quality and Safety Unit<br><br>**QI Governance (both report to Clinical Effectiveness Committees (CEC)**<br>Divisional CEC (ICG, Family Care, SAS)<br><br>Quality Improvement Project (QIP) Triage Group<br><br>**QI Register**<br>Improvement projects by Division and harm (if applicable) and/or Trust wide<br><br>**Harm Free Care Programme**<br>Including Falls, Deteriorating Patient, Medication errors, Pressure Ulcers, Infection Prevention etc. | **Internal Assurances**<br>The Trust planning process has been designed to enable the identification of a single set of transformation priorities for the Trust in conjunction with ICP Partners. The priorities identified are aligned to the Trust's Clinical Strategy, the ICP priorities as outlined in the Pennine Plan, to key ICS priorities and to the NHS Long-Term Plan.<br><br>The Trust has adopted and is implementing (and building capacity to undertake) improvement (incorporating quality improvement, transformation/service development and improvement) utilising a consistent improvement approach based on Lean.<br><br>The Trust has invested in dedicated improvement capacity through the development of the Improvement Practice Team/Office and has sought, through the planning round, to align capacity across the organisation to the delivery of a single plan. The Trust has invested in external expert advice and support via the NHS Improvement Vital Signs Programme to ensure improvement is delivered to a high standard.<br><br>Through alignment of priorities to the Improvement Practice Office there will be oversight of all improvement work.<br><br>Operational and Executive oversight will be provided via:<br>• Executive Visibility Wall – bi-weekly<br>• Guiding Board (Improvement Board) - monthly<br><br>Board assurance will be provided via reporting to:<br>• Finance and Performance<br>• Quality Committee<br>• Trust Board (information papers and minutes)<br><br>A revised clinical divisional structure has been implemented with a newly formed community services and intermediate care division to strengthen our leadership and provide capacity to support the transformation and partnership working with the wider system.<br><br>The Acting Chief Executive of the Trust appointed as the Professional Lead for the Pennine Lancashire ICP influencing the collaborative work on transformation.<br><br>Director of Operations responsible for community and intermediate care services is one of the portfolio delivery leads for the Pennine Lancs ICP.<br><br>**External Assurances**<br>System-wide reporting is currently being developed through the Pennine Lancs Business Intelligence group and the Pennine Lancs Way programme.<br><br>ICP system level aiming to prioritise health improvements that can deliver beneficial outcomes more quickly.<br><br>Care Professional Board workshop with a wider audience held in August 2018 resulted in the creation of Pennine Lancashire Professional Leadership Committee, bringing together relevant professionals to support the Pennine Lancashire transformation. Several senior ELHT clinicians attending and actively participating in the Professional Leadership Committee and associated workshops.<br><br>System wide reviews completed including a discharge community and intermediate care diagnostic assessment by Newton Europe and a Lancashire intermediate care review completed by Carnall Farah. The progressions of these reviews and their associated recommendations are being overseen by the Pennine Lancashire intermediate care programme board which reports into the Pennine Lancashire Together a Healthier Future programme.<br><br>To support a whole system multi agency approach to the development of community services, Integrated Neighbourhood Local Community partnerships (LCP's) have been established for Blackburn with Darwen and East Lancashire and these report into the Pennine Lancs Together Healthier Future programme.<br><br>There is commitment to the alignment of the improvement approach across the ICP. Work is on-going to align approaches and deliver associated training to upskill across the ICP<br><br>There has been good participation by system partners in several system-agreed improvement events.<br><br>There is ongoing alignment of improvement resources across the ICP including commissioning portfolios.<br><br>System-wide Programme Boards are currently being developed which will focus on delivery of system priorities and will dovetail to the Improvement Practice Office<br><br>System-wide reporting is currently being developed through a review of current ICP governance structures.<br><br>**Internal / External Assurances**<br>A revised clinical divisional structure has been implemented with a newly formed community services and intermediate care division to strengthen our leadership and provide capacity to support the transformation and partnership working with the wider system. In addition a community services transformation board meets monthly and this includes a commissioner representative as part of its membership. A community systems board has also been established which meets monthly, reporting to the community services transformation board.<br><br>- Harmfree Care Assurance report to Patient Safety Risk Assurance Committee (PSARC)<br>- QI Register report to monthly QIP Triage group (reporting through to CEC)<br>- Divisional CEC established in ICG, SAS and Family Care<br>- Centralised and automated 'Ward Audit Database' went live in May 2019 |

| Initial Risk Score | Risk Tolerance Score | Current Risk Score | Likelihood x Consequence | Annual Risk Score | | | | Gaps in Control<br>*Where we are failing to put controls/ systems in place. Where we are failing in making them effective.* | Gaps in Assurance<br>*Where we are failing to gain evidence that our controls/ systems, on which we place reliance, are effective.* | Actions Planned / Update<br>*Dates, notes on slippage or controls/assurance failing.* |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 2018/19 | | | 2019/20 | | | |
| | | | | Q2 | Q3 | Q4 | Q1 | | | |
| 16 | 10 | 20 | 5x4 | 20 | 20 | 20 | 20 | Capacity and resilience building in relation to improvement is in early phase<br><br>Short term regulatory targets detracting from the delivery of short to medium term objectives of the transformation programme resulting in competing priorities in delivery of business as usual and improvement work<br><br>Dependency on stakeholders to deliver key pieces of transformation<br><br>Financial constraints<br><br>Transformation priorities not yet fully aligned to appraisal and objective setting<br><br>Capacity and time to release staff to attend training<br><br>Linking between clinical effectiveness/quality improvement and the Improvement Office needs to be further developed<br><br>System wide working is still developing, and priorities are not yet completely aligned<br><br>Risk to external support via NHSI Vital Signs programme due to unavailability of NHSI consultant | Assurance in place about the Trust planning process and plans for implementation of the Improvement Approach, but assurance about the delivery and benefits is still work in progress at this stage.<br><br>Further assurance needed on alignment of plans and planning processes across the ICP<br><br>There is an ongoing dependency on external stakeholders to deliver key pieces of transformation.<br><br>Exploring the opportunities in a changing leadership at collaborative level and linking into the new system executive roles.<br><br>Whilst there is one agreed set of priorities there may still be insufficient capacity to deliver the required level of change/improvement<br><br>Not delivering the percentage increase regarding the Productivity and Efficiency transformation that we aspire to. Internal changes are needed, external efficiencies require Pennine Lancashire whole system working.<br><br>Interlinkage between QI and transformation IPO is in the early stages and requires more development. | There will be a re-focus on delivery and impact via the Guiding Board and Executive Visibility Board which will improve assurance to Trust Board sub-committees<br><br>Improve the robustness of reporting of impact through adoption of A3<br><br>Improvement Practice Team now fully established. Staff undertaking practice coach training and have an agreed portfolio of work aligned to agreed priorities.<br><br>Continued alignment of improvement approach for the Trust – The Pennine Lancashire Way<br><br>Establishment of system-wide Programme Boards e.g. Scheduled Care Board to ensure alignment of priorities across the ICP<br><br>Consider options for continuation of external support<br><br>**Harmfree Care**<br>Falls: Monthly falls steering group<br><br>Medication Errors: Diagnostic and Scoping event planned for June 2019<br><br>Pressure Ulcers: Continued monitoring through performance reports<br><br>Deteriorating Patients: Monthly Steering Group |

**Reference Number:** BAF/02

**Responsible Director(s):** Director of HR and OD

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

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

**Consequences of the Risk Materialising:**

1. Gaps on rotas impacting adversely on ability to deliver safe, personal and effective care
2. Negative impact on financial position through high use of agency staff
3. Inability to staff escalation areas
4. Inability to create an integrated workforce
5. Unable to recruit a representative workforce
6. Inability to release staff for training and appraisal

| **Key Controls**<br>*What controls/systems, we have in place to assist in securing delivery of our objective.* | **Potential Sources of Assurance**<br>*Where we can gain evidence that our controls/systems on which we are place reliance, are effective* | **Initial Risk Score** | **Risk Tolerance Score** | **Current Risk Score** | **Likelihood x Consequence** | **Annual Risk Score 2018/19** | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | **Q2** | **Q3** | **Q4** | **Q1 2019/20** |
| Workforce Transformation strategy in place and associated Divisional and Trust-wide plans monitored through the Workforce Transformation Board.<br><br>Divisional Workforce Plans aligned to Business & Financial Plans.<br><br>Divisional Performance Meetings.<br><br>Reports to Finance & Performance Committee Recruitment strategy and plans linked to Workforce Plans.<br><br>Trust Workforce Controls group in place to review all vacancies and support the Workforce Transformation strategy.<br><br>One Workforce Planning Methodology across Pennine Lancashire<br>Workforce planning at STP level, e.g. Apprenticeships, recruitment and retention initiatives, collaborative medical banks and talent management.<br>Pennine Lancashire Workforce Transformation Group.<br><br>People Strategy aligned to deliver National ICB, ICP and Trust workforce objectives.<br><br>NHS launched interim People Plan<br><br>Divisional Finance and Performance meetings. | **Internal Assurances**<br>On-going monitoring of vacancies and bank/agency usage at Trust Operational Delivery Board via Trust performance report. Performance measures, time limited focus groups with action plans, board and committee reports, regulatory and inspection agencies, stakeholders, internal audit.<br><br>WRES action plan with timelines in place. Regular reporting to the Board on progress. Work with the Fanshawe Report. Ongoing monitoring of workforce diversity through the re-establishment of the Diversity and Inclusion Steering Group and Trust Operational Delivery Board.<br><br>Workforce Control Group regularly reports to the Executive on workforce control measures and indicators. Dashboard developed. Annual report to the Quality Committee.<br><br>Joint Medical and Non-Medical Agency Group in place. Dashboard giving overview of bank/agency usage presented to the Executive team meeting monthly. Additional scrutiny from a nursing perspective.<br><br>The Performance Assurance Framework<br><br>Lean Programme (Vital Signs) overall linking into workforce transformation.<br><br>Agency staffing group monitoring the use of agency spend.<br><br>Implementation of Allocate rostering/ publication dates for rosters.<br><br>Uptake of flu vaccine across the workforce.<br><br>Completion rates of the annual staff survey and low rates of turnover.<br><br>Integrated performance report.<br><br>Implementation of new absence management process to support staff attendance and to mitigate need for use of bank and agency.<br><br>Workforce Dashboard reporting key performance indicators within division on a monthly basis, Details of these reported on a quarterly basis to the Finance & Performance committee.<br><br>A Senior Medical Staffing Performance Review Group established - responsibility for reviewing all consultant job plans, consultant vacancies etc. adding further rigor on our appropriate use of resource.<br><br>Workforce Solutions Board now aligned to deliver Trust Business Plan & Clinical Strategy.<br><br>**External Assurances**<br>Friends and family test (further detail in BAF risk 5)<br><br>Benchmarking of agency spend is available through the Model Hospital data.<br><br>Collaboration across the ICS on agency usage.<br><br>Joint work taking place across the ICS to consider implications and options to mitigate the impact on pensions.<br><br>Broader quality and diversity group and a better understanding of workforce demographics in relation to the over 55 workforce.<br><br>ICS collaboration on Careers, International Recruitment and Workforce mobility.<br><br>Pensions link to Finance and Performance 'Gaps in Assurance'. | 16 | 10 | 20 | 5 x 4 | 12 | 12 | 20 | 20 |

| **Gaps in Control**<br>*Where we are failing to put controls/systems in place. Where we are failing in making them effective.* | **Gaps in Assurance**<br>*Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.* | **Actions Planned / Update**<br>*Dates, notes on slippage or controls/assurance failing.* |
|---|---|---|
| National recruitment shortages, capacity for delivery of transformation programmes, financial restrictions. Reduction of CPD monies from HEE (could be off-set by the apprenticeship levy). Varying incentive schemes/packages across provider sector.<br><br>Implications of Brexit on the workforce - uncertainty/ workforce are yet to be determined.<br><br>Integrated workforce assurance group<br><br>The impact of the changes to the pension rules and taxation has resulted in a significant reduction in capacity and additional work being undertaken by senior medical staff. This has resulted in a reduction in clinical capacity. | Inability to control external factors (Brexit, visas etc).<br><br>National approach to pension issue.<br><br>Regulators stance on safe staffing and substitution of roles in place of registered workforce.<br><br>Lack of data/intelligence regarding the number of nurses and clinical staff in the 55+ age category and the related risk of 'brain drain' in the coming years. Work has been done by ICS across the system but it does not contain the level of detail needed for each Trust. Efforts need to be made to understand and refine the workforce data in order to address the issues in the Trust. | Currently there are a further 113 external nurses in the recruitment pipeline due to start with the Trust between now and May 2019. 16 nurses have been sourced and started via the Global Learners Programme with a further 33 in the registration process for the programme. 3rd cohort has been interviewed from recruit to arrival in post there is an approximate lead time of 6 months.<br><br>HCA recruitment continues, contributing to the reduction in HCA bank shift requests adding further stability and flexibility to our support workforce.<br><br>E&D Action Plan to be updated by July 2019.<br><br>Festival of Diversity was held in April 2019, now planned as an annual event.<br><br>Culture and Leadership Programme is now entering phase 2 (Design) and an update is to be presented to the Quality Committee in June.<br><br>Significant progress made with WRES action plan. The NHS National Workforce Race Equality Standard (WRES) 2017 data analysis report December 2017 demonstrated continued improvement and ELHT are highlighted as better than average in Indicator 6: a decrease in the overall percentage of staff experiencing harassment, bullying or abuse from other colleagues. Review of internal data in January demonstrates further improvements in WRES indicators 1, 2 and 3. The national WRES lead attended the Trust in October 2018 and following this, a refreshed WRES action plan will be produced. A broader Workforce Inclusion Group was established from February 2019 to consider the wider diversity agenda.<br><br>Shadow Board commenced in April 2019, with its first meeting in May 2019.<br><br>Vital Signs improvement programme is underway to improve employee experience from recruitment through to them leaving the organisation. The Hire to Retire VSA has now delivered improvements over 90 days and is now working on improvements for the next 90 days reporting in June.<br><br>The Workforce Transformation Strategy addresses the future workforce supply pipeline, opportunities to up skill current staff, introducing new competencies, e.g. Physicians Associates and Associate Nurses and establishing new ways of working. The 2018-19 Business Planning approach has included a Workforce Planning and Transformation return from each Division which will inform the Trusts and Pennine Lancashire Transformation and Workforce priorities.<br>We are now working with ICP partners to undertake systematic and integrated workforce transformation linked to the NHSI LEAN improvement programme. We are working across the ICS to develop a mobility agreement to assist with the movement of staff across the region. A Recruitment and Retention Strategy is being developed to underpin a system wide approach to recruitment.<br><br>2 Workforce Repository and Planning Tool (WRAPT) planning projects are underway across the organisation.<br><br>HEE funding secured to develop clear clinical leadership for workforce transformation through the WRAPT process. Training commenced in May 2019.<br><br>Establishment of a Care Academy for Pennine Lancashire to secure a talent pipeline locally, due to launch in July 2019<br><br>Development of a Recruitment and Retention strategy to reflect emerging labour market and to sell ELHT and Pennine Lancashire as employer of choice.<br><br>Launch of volunteer learning passport in January 2019 enabling mobility of volunteers between organisations. There was an evaluation period at the end of February 2019 and now considering a wider rollout across the ICS and nationally.<br><br>An apprenticeship strategy is now in place, as well as additional further proposals, to support a passport levy between partner organisations. A paper will come to the Operational Executive in June to explore expansion.<br><br>Scoping of potential opportunities to manage medical agency staffing differently commenced in April 2019. Proposed restructure of Trust Medical Staffing team to amalgamate the existing locum booking team with the Temporary Staffing team, to ensure greater consistency of service provided to the whole workforce<br><br>The Trust is working with partners across the ICS to develop a co-ordinated response to the aforementioned pensions issues.<br><br>The Trust has undertaken a survey of all staff who may be impacted by the pension rules and taxation changes to gauge their awareness and identify any actions they may take. This will equip the Trust to make appropriate plans to ensure service delivery. The results of the survey found that the majority of staff are aware of the Annual and Lifetime Allowance taxation rules (82%) but many staff are still unclear as to how they will be impacted individually (42%). The Trust is arranging a number of additional awareness sessions for staff in June 2019. |

**Reference Number:** BAF/03

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

**Aligned to Strategic Objectives:** 3 and 4

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

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

| **Key Controls**<br>*What controls/systems, we have in place to assist in securing delivery of our objective.* | **Potential Sources of Assurance**<br>*Where we can gain evidence that our controls/systems on which we are place reliance, are effective* | **Initial Risk Score** | **Risk Tolerance Score** | **Current Risk Score** | **Likelihood x Consequence** | **Annual Risk Score 2018/19** | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | **Q2** | **Q3** | **Q4** | **Q1 2019/20** |
| Pennine Lancashire System Leaders' Forum meets to discuss strategy. Engagement by senior leaders in wider transformation programmes. Regular Board updates and decisions on key actions.<br><br>At Pennine Lancashire level health improvement priorities agreed (HIMPs). HIMPs reporting to the Professional Leadership Committee (PLC)<br>Number of senior clinicians involved with ICS work groups.<br>Professional Leadership Committee (PLC) has ELHT representation.<br><br>ICS Finance Group and ICP Finance and Investment Group with ELHT senior representation .<br><br>The ELHT Accountable Officer is the senior responsible officer (SRO) for the Pennine Lancashire Transformation Programme, sits on the System Leaders Forum and on the Integrated Care System for Lancashire and South Cumbria (ICS) Programme Board.<br><br>The Trust's Acting Chief Executive is the professional lead for the Pennine Lancashire ICP.<br><br>Vital Signs Programme ensures the ICP as a system is having a significant participation as part of the transformation programme.<br><br>ICS level Planning Group has been formed and met for the first time on 3 December 2018. The Director of Service Development attends to represent the ICP. The role of the group is centred around the 5 year plan which is due to be developed by Summer 2019. | **Internal Assurances**<br>Verbal and written updates, where appropriate Board approvals will be established and permissions will be provided by the Board to let Executives progress the generation of ideas and options with external stakeholders.<br><br>Potential gains in strengthened reputation with regulators and across the ICS footprint with regular reporting to the Board via the Finance and Performance Committee on progress, milestones and risks linked to the gateway process.<br><br>Mitigation in place for creating single teams across the system, e.g, 'one workforce' with timelines for implementation. Progress covered under BAF risk 2.<br><br>**Internal / External Assurances**<br>The Pennine Lancashire and ICS Cases for Change have been published.<br><br>Pennine Lancashire resource in post working on developing models of care against specific improvement priorities (paediatrics, respiratory and frailty).<br><br>Health and Wellbeing Improvement Partnerships (HIMPs) at Pennine Lancashire level reviewed around the health improvement priorities and the majority are relatively well established with minor changes needed to link into the new structures.<br><br>ICS governance oversight forms part of the Audit Committee standing agenda for 2018/19.<br><br>Fostering good relationships with GP practices and Federations e.g. service pilots and as a result of tenders and general dialogue.<br><br>Pennine Lancashire ICP Memorandum of Understanding agreed by stakeholders.<br><br>ELHT Chief Executive chairing the ICS Providers' Forum. ELHT hosting the Providers Programme Director for the ICS Provider Board who reports to the Chief Executive of ELHT. Director of Service Development leading on the construction of the work programme with the Directors of Strategy from all the providers.<br><br>Component business cases at Pennine Lancashire level forming a draft overarching ICP plan. Plan on a page for the ICP, connecting to the Plan on a page for ELHT completed and shared with the Commissioners.<br><br>CEO of ELHT and Accountable Officer of East Lancashire CCG jointly chairing the Pennine Lancashire ICP Programme. Posts for Portfolio Holders at ICP level are in development. Cultural development programme for system level leadership established with involvement of all senior leaders across the ICP.<br><br>ICS architecture on clinical services is developing (eg pathology, stroke and frailty).<br>Positive feedback from service reviews (stroke and endoscopy). Structures in place for the Out of Hospital stream with the Trust significantly contributing to the workstream.<br><br>Clinical leadership through the Professional Leadership Committee (PLC) at Pennine Lancashire ICP level giving consistent message about the importance of working as a system. Strengthening the relationship with primary care networks' leadership. Associate Medical Director for Service Improvement appointed, increasing our capacity for clinical leadership in relation to service improvements.<br><br>Pennine Lancashire Delivery Group has ELHT representation and is chaired by the Trust's Chief Executive. A&E Delivery Board meets monthly, chaired by the ELHT Chief Executive. Progress on collaborative efforts in relation to the emergency pathway is covered under BAF risk 5.<br><br>Vital Signs is a system wide transformation programme across the Pennine Lancashire ICP. Patient experience strategy envisages good patient and public involvement to support the collaborative transformation. Progress with work covered under BAF risk 1.<br><br>Producing ELHT demand and capacity plan to be signed off by the Executive Team. The wider system demand and capacity plan will be signed off by the Partnership Delivery Group.<br><br>Pennine Lancashire Partnership Delivery Group is the engine/delivery room for the ICP. The group has been given delegated authority from the Pennine Lancashire Leaders' Forum and the planning process is driven through this group. The Pennine Lancashire system planning reports into the Partnership Delivery Group.<br><br>Joint accountable officer for CCG's is now in post.<br><br>A system financial and investment group for the ICP looking into the priorities and aligning them with the financial envelope for the local system.<br><br>Creation of single teams to deliver the transformation agenda at ICP system level. (MOVED FROM GAPS IN ASSURANCE)<br><br>Priorities of the individual organisations and those of the system aligned/agreed. (MOVED FROM GAPS IN ASSURANCE) | 16 | 12 | 12 | 3x4 | 12 | 12 | 12 | 12 |

| **Gaps in Control**<br>*Where we are failing to put controls/systems in place. Where we are failing in making them effective.* | **Gaps in Assurance**<br>*Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.* | **Actions Planned / Update**<br>*Dates, notes on slippage or controls/assurance failing.* |
|---|---|---|
| System leaders agreed a process to develop the governance system across Pennine Lancashire; however this is still in development<br><br>ICS System Management model is in early stages of development.<br><br>Decision making process for Pennine Lancashire system will need agreement.<br><br>There is a need for consistent leadership across the system. in order to ensure that we continue prioritising in line with system affordability.<br><br>Building trust and confidence and agreeing collaborative approaches to service provision | Timeline for consultation with public - uncertainty about the detail of the consultation for the component business case at ICP level.<br><br>Lack of unified approach in relation to procurement by Commissioners.<br><br>Priorities of CCGs starting to be aligned with priorities for pathway redesign (e.g. stroke) but this work is still in the early phases.<br><br>Future role of NHSE/NHSI merged teams to be determined.<br><br>Ensuring consistent capacity to work externally as well as internally by building system collaboration into the leadership roles and having good joined leadership programmes.<br><br>Adequate assurance mechanism that the service integration plans are on track together with the rigour of governance arrangements/lack of delegation from the sovereign bodies to the system.<br><br>It is unclear what the impact of the changes in senior leadership in partner organisations will be.<br><br>Understanding what is happening to providers with regard to financial milestones in the ICS. | Regular updates provided to Board and the Audit Committee.<br><br>Standing agenda item at Execs and Trust Board.<br><br>Across the ICS footprint the Medical Directors of the four Trusts agreed to focus on urology, vascular services, stroke, emergency department, interventional radiology and gastrointestinal bleed, and neonatology.<br><br>At ICS level all providers met to formulate work programme - 3 categories of services agreed<br>a) services that are fragile now<br>b) services where there is no immediate risk but possible in the not too distant future<br>c) services that need to be managed across the whole footprint. Agreement on the way of taking this forward to be agreed. Prioritisation of diagnostics, pathology and cancer work streams agreed.<br>Developed work programme discussed by the Provider Board at ICS level. and work on developing future configuration continues, no timelines for completion set at this stage.<br><br>Meetings are ongoing regarding the acute Programme and more focused work is taking place in Stroke, Vascular, Urological Cancer and Diagnostics. A range of services are being developed for Head & Neck.<br><br>Pennine Lancashire ICP component business case. Focus on LDP level wider deliverables.<br><br>East Lancashire CCG extended the Community Services contract by 12 months allowing for the principles of the new clinical model at ICP level to be developed. Ongoing progress is being made with more focus on the future model of care (not the current model of care). An update was provided at the Trust Board in March 2019. Neighbourhood system event held at end of January 2019. Subsequent 'big ticket' events were held and Value Stream Analysis (VSA) planned under the Vital Signs Programme.<br><br>Good co-production on developing clinical model across the ICS for CAMHS services was presented to the Commissioners. Clinical model accepted,. A neighbourhood system event held at end of January 2019. supporting, ongoing discussions about affordability with help from the Northumberland, Tyne and Wear Trust.The model (stage 1) had been signed and providers are working on the detail (stage 2). A timetable has been produced, presented to local commissioners and approved by them (1 year plan). Milestones have been developed and a financial exercise has been undertaken to determine the resources required to implement the new model.<br><br>The Director of Service Development has led discussions with other providers of CAMHS services about potential future configurations and alliance, the model was universally supported.<br><br>Agreement reached to focus on all aspects of improving the emergency pathway - ED, Assessment Same Day Emergency Care, Discharge and out of hospital services and the acute adult mental health pathway. The Trust is aiming to develop a clear and succinct integrated action plan with associated metrics over the next six weeks. |

**Reference Number:** BAF/04

**Responsible Director(s):** Director of Finance

**Aligned to Strategic Objectives:** 3 and 4.

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

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

| **Key Controls**<br>*What controls/systems, we have in place to assist in securing delivery of our objective.* | **Potential Sources of Assurance**<br>*Where we can gain evidence that our controls/systems on which we are place reliance, are effective* | **Initial Risk Score** | **Risk Tolerance Score** | **Current Risk Score** | **Likelihood x Consequence** | **Annual Risk Score 2018/19** | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | **Q2** | **Q3** | **Q4** | **Q1 2019/20** |
| Budgetary controls (income & expenditure) in place including virement authorisation, workforce control, monthly performance meetings and variance analysis.<br><br>Measures to mitigate financial risk overseen by Finance and Performance Committee. | **Internal Assurances**<br>Monthly reporting to Finance and Performance reports and the Board to reflect financial position. Separate reporting available to support assurances on the transformation programme.<br><br>Regular Performance Review meetings between Executives and Divisions. Using the Performance Accountability Framework (PAF) to provide assurance that action is taken to help ensure the delivery of objectives.<br><br>Financial objective included in individual appraisals.<br>Setting of financial objectives in senior management appraisals.<br>Budget setting<br>Financial Forecasts<br>Briefings on risk<br>Pipeline of schemes to reduce cost.<br><br>Use of data sources (e.g. Model hospital data.) to drive improvement and mitigate deterioration. Evidencing the routine use of benchmarking data to drive positive change.<br><br>Revised Performance Accountability Framework presented to the Finance and Performance Committee on 29 October 2018 and to the Operational Delivery Board on the 31 October 2018, with final approval by the Finance and Performance Committee at the end of November.<br><br>The introduction of the Improvement Board will strengthen governance and oversight.<br><br>Rates relating to agency medical and nursing rates.<br><br>Off framework agency usage.<br><br>Extra contractual payments to staff (capacity lists etc.)<br><br>Agreed control total for 2019/20.<br><br>**External Assurances**<br>External audit view on value for money.<br><br>Model Hospital benchmarking (including cost per Weighted Activity Unit).<br><br>ICS Led Theatre Productivity analysis.<br><br>GIRFT Programme | 16 | 12 | 20 | 5x4 | 20 | 20 | 20 | 20 |

| **Gaps in Control**<br>*Where we are failing to put controls/systems in place. Where we are failing in making them effective.* | **Gaps in Assurance**<br>*Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.* | **Actions Planned / Update**<br>*Dates, notes on slippage or controls/assurance failing.* |
|---|---|---|
| Additional workforce controls to remain in place. Policies and procedures may require amendments where they are no longer fit for purpose.<br><br>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.<br><br>Gaps in control regarding funding for A&E and PSF funding - recovery plan underway.<br><br>Lack of standardisation in applying rostering controls.<br><br>Weaknesses in discretionary non-pay spend.<br><br>Deterioration in the underlying financial position requiring additional transformation schemes in 2018/19. SRCP being delivered non-recurrently.<br><br>Officers operating outside the scheme of delegation.<br><br>Inadequate funding assumptions applied by external bodies (pay awards).<br><br>Hidden costs of additional regulatory requirements - highlighted with NHSI.<br><br>Cost shunting of public sector partners increasingly managed through ICS and ICP.<br><br>Failure to meet Provider Sustainability Fund requirements.<br><br>Agency and locum sign off with escalation of cost.<br><br>Significant external pressures which may intensify internal financial pressure. | Utilise the internal audit programme to test for assurance on core controls, SRCP and transformation plans.<br><br>Lack of consistency in divisional governance processes.<br><br>Understanding the changes in income services (NHS and private).<br><br>Weaknesses in appraisals and accountability framework.<br><br>Improve oversight of agency spend, capacity list spend and variations to national contracts.<br><br>Understanding financial milestones and financial delivery of partner organisations - ICS. | Regular updates to Board and Finance and Performance Committee.<br><br>Actions and risk relating to the achievement of 'incentivised funding' (e.g. Provider Sustainability Funding) will be routinely reviewed.<br><br>Risks in relation to the impact of the changes to CQUIN and Provider Sustainability Funding arrangements to the end of 2018/19 are being managed and reporting to the Quality Committee and Finance and Performance Committee.<br><br>Agency and locum sign off with escalation of cost, total hours booked and average per hour will be reported to the Finance and Performance Committee from September 2018 as part of the Financial Performance Report.<br><br>Cash borrowings have increased above plan as a consequence of not delivering A&E PSF and non cash backed SRCP.<br><br>Detailed plan for 2019-20 to be developed in light of additional financial focus.<br><br>Merge medical + non-medical temporary staffing groups for improved oversight chaired by DOF.<br><br>Shared Cost Improvement Programme (CIP) and Quality, Innovation, Productivity and Prevention (QIPP) group established with the CCGs.<br><br>Quality Improvement (QI) established Resources Committee to improve the business case process with CCG's - planned for Q1. |

**Reference Number:** BAF/05

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

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

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

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

| **Key Controls**<br>*What controls/systems, we have in place to assist in securing delivery of our objective.* | **Potential Sources of Assurance**<br>*Where we can gain evidence that our controls/systems on which we are place reliance, are effective* | **Initial Risk Score** | **Risk Tolerance Score** | **Current Risk Score** | **Likelihood x Consequence** | **Annual Risk Score 2018/19** | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | **Q2** | **Q3** | **Q4** | **Q1 2019/20** |
| Weekly operational performance meeting covering RTT, cancer, 4 hour performance and holding list management monitoring delivery against the divisional business plans and the operational delivery standard.<br><br>Engagement meetings with CQC in place monitoring performance against the CQC standards.<br><br>Quality and safety compliance assessed by each division and assurance through the Divisional Quality and Safety Boards (DQSB) reporting into the Quality Committee Sub-Committees.<br><br>Divisional assurance boards feeding into the operational sub-committees and the Quality Committee.<br><br>Nursing Assessment Performance Framework reporting through to the Quality Committee and involvement of NEDs on the SPEC Panels and Board approval for the award of SPEC awards.<br><br>A&E Delivery Board with Emergency Care Pathway assurance feeding into it.<br><br>System-wide Scheduled Care Board with elective pathway assurance feeding into it.<br><br>Daily nurse staffing review using safe care/allocate Nursing and Midwifery.<br><br>Weekly Medical Staffing Review - Nursing and Midwifery staffing review feeding into the annual professional judgement review for all wards.<br><br>Operational flow meetings at 08.30, 12.30, 15.30, 18.00 and 19.30<br>=<br>Weekly ED / urgent care performance and improvement meeting. | **Internal Assurances**<br>IPR reporting to the ODB and at Board/Committee level.<br><br>Regular deep dive into the IPR through Finance and Performance Committee including RTT, all cancer standards and the emergency care standards.<br><br>ED performance and four hour improvement action plan aligned with the NHSI Rapid Improvement Collaborative and agreed by NHS England.<br><br>Performance monitoring provided through the weekly operational meeting, Scheduled Care Board (joint Board with CCG)<br><br>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.<br><br>Silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments continues. There are currently 13 Silver Accreditation of a ward approved by the Trust Board with further two awaiting approval.<br><br>Increased number of assessments under the framework planned all inpatient wards completed in ICG and SAS. Work started on Family Care and Community Services and a plan is in place for 2019/20.<br><br>Significant reduction in the number of complaints upheld by the Ombudsman. Comprehensive system for addressing complaints. Reduction on overall number of complaints, 50+ and 40+ days continues with regular reporting at operational and Board level.<br><br>Quality Committee will oversee the CQC action plan.<br><br>Mini mock-CQC visits regularly carried out and focussing on all areas with regular reporting back to the Quality Committee.<br><br>Reduction in use of nursing agency staff continues.<br><br>Staffing escalation process for nursing including forecast gaps in staffing and senior decision making. Standard Operating Procedure (SOP) developed and monitoring through Nursing and Midwifery Leaders' Forum.<br><br>Quality Walkrounds in all clinical areas.<br><br>The Performance Assurance Framework.<br><br>Recovery plans in relation to the risks around some of the national trajectories addressed through the Emergency Care Pathway Transformation programme, Scheduled Care Programme, Cancer Improvement Action Plan and Outpatients Improvement Group. Regular monitoring by Executive Team and ODB.<br><br>Weekly monitoring of complaints and reporting to the Patient Experience Committee and End of Life Care Group, focusing on reducing any 50+ day complaints (non currently in the system).<br><br>Staffing (nursing/midwifery) report to Quality Committee.<br><br>NAPF - operational monitoring through the Nursing and Midwifery Leaders' Forum monthly, receiving assurance from the Assistant Director of Nursing and NAPF team and monitoring by matrons at ward level where they carry out mini-NAPFs on a weekly basis to keep up the improvement work and report to Quality Committee (every other meeting).<br><br>Escalation area in the Victoria Wing at BGTH is now in place.<br><br>**External Assurances**<br>Trust rated 'Good' by CQC in 2018 with improvements in various areas and some outstanding services.<br><br>Nurse staffing review as part of the IPR. Staff Care Allocate and daily monitoring of allocation for staff and three times daily matrons meetings to monitor. Audit carried out by MIAA for nurse staffing received significant assurance.<br><br>MIAA have carried out an emergency care risk assessment audit which gained an assurance rating of 'Significant Assurance'.<br><br>**Internal / External Assurances**<br>System wide approach to Emergency Care Pathway, as part of monthly A&E Delivery Board supported operationally by the A&E Delivery Group.<br><br>PLACE assessments - percentage improved in all areas and monitoring continues. Annual PLACE report presented to the Quality Committee for assurance. Nursing and Midwifery Leaders' Forum also monitor. Patient Experience Committee receive minutes of the PLACE Steering Group. NAPF Team also monitors environmental issues linking to PLACE Assessments.<br><br>Positive responses to Friends and Family Test and patient surveys with improvement areas identified. Monitoring at ward level, local divisions prepare monthly patient experience action plans that feed into the Patient Experience Committee that reports to the Quality Committee. Monthly monitoring is provided by the Nursing and Midwifery Leaders' Forum.<br><br>Positive response and results from the 2018 National Staff Survey.<br><br>Inpatient survey 2018/19 results were presented to the Executive team by Quality Health. | 15 | 9 | 16 | 4x4 | 16 | 16 | 12 | 16 |

| **Gaps in Control**<br>*Where we are failing to put controls/systems in place. Where we are failing in making them effective.* | **Gaps in Assurance**<br>*Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.* | **Actions Planned / Update**<br>*Dates, notes on slippage or controls/assurance failing.* |
|---|---|---|
| Restrictions in the supply of medical, nursing, midwifery and other staff groups to meet demand. Reference in BAF risk 2.<br><br>Risk of mental health providers not being able to ensure sufficient assessment and treatment capacity.<br><br>Restrictions in the primary care system to ensure sufficient capacity.<br><br>Insufficient capacity to deliver comprehensive seven day services across all areas.<br><br>Insufficient bed capacity to ensure there are no delays from decision to point of admission.<br><br>The impact of the changes to the pension rules and taxation has resulted in a significant reduction in capacity and additional work being undertaken by senior medical staff. This has resulted in a reduction in clinical capacity which is affecting the Trust's ability to deliver against 18 week RTT and cancer targets. | Staffing gaps on rotas. Gaps in assurance from the medical staffing perspective. E-Rostering inability to fill all vacant shifts/short term sickness or non-attendance.<br><br>Challenges to the delivery of the four hour standard and the delivery of the 62 day cancer standard<br><br>Extended waiting times for mental health patients.<br><br>Continued non-elective activity is placing pressure on the elective care and the RTT standard.<br><br>Wards and departments overdue for refurbishment due to the lack of decant facilities.<br><br>Temporary funding secured for an additional member of staff enabling the Nursing Assessment Performance Framework (NAPF) team to carry out further assessments.<br><br>Increase in Delayed Transfers of Care and increasing number of longer stay patients.<br><br>Demand and capacity issues relating to senior medical vacancies are affecting the 18 weeks RTT and holding list position. | Review of the complaints element of the Patient Experience Strategy has been launched and a user friendly version developed and presented to the Patient Experience Committee in October 2018 and launched in November. Now taken place with ongoing implementation.<br><br>The Patient Participation Panel held an open day on 17 January 2019. The panel was launched on 27th February 2019 and it is made up of 15-20 people. Two meetings held and panel members receiving training.<br><br>The Trust is developing a full clinical model regarding the emergency care pathway and ithis s anticipated to be ready for presentation and sign off in 2019. External support sourced for patient flow modelling.<br><br>Plans for staffing and estates challenges have progressed as follows:<br>1. Emergency care pathway action plan in place and is monitored monthly through the ECP Programme Board.<br>2. Ambulatory Care Emergency Unit opened as planned on 14 September 2018. Fortnightly service reviews carried out to ensure service delivery as expected.<br>3. Business case approved by the Trust Board and submitted to NHSI in July 2018 for the extended acute medical facility.<br>4. Frailty Assessment Unit opened on 7th January 2019.<br>Surgical & Ambulatory Emergency Care unit moved to the old ambulatory care on 7th of Jan 2019 and additional beds opened on B14.<br><br>Board receives regular SRCP and transformation updates.<br><br>Nursing Assessment and Performance Framework (NAPF) assessments are continuing. 13 Silver Accreditation of wards approved by the Trust Board. with a further two to be presented to the Trust Board for approval.<br>Further inspections planned for a number of wards awaiting third assessment following two green assessments.<br>Work is planned within the NAPF team to develop the process to incorporate non-nursing areas, such as pharmacy and IHSS. Objective is for a 50% reduction in all red wards was achieved by the end of March 2020. Objectives for 19/20 being set as part of the objective setting process.<br><br>Core 24 (Lancashire Care Foundation Trust mental health programme) implementation commenced in April 2018 and ran until March 2019. Development of mental health decision unit planned by July 2018 had been delayed by external partners. Unit has opened in August 2018. The Trust continues to work with external partners. The system wide action plan for mental health services has been agreed by the ICS in November.<br><br>Trust's lifecycle upgrade programme (Estates and Facilities) was developed and signed off by the end of April 2019. Programme now commenced.<br><br>CQC report published on 12 February 2019, improvements in some areas and outstanding services. Action plan monitored by the CQC and through the Quality Committee. Returned action plan in relation to notices regarding fridges, document storage and fluid thickening.<br><br>Refocused efforts across clinical teams and system partners to reduce longLength of Stay (LoS) patients and Delayed Transfers of Care (DTOC).<br><br>Report to the Quality Committee on the holding list and 18 week RTT action plans to be refreshed and finalised to ensure that coherent action plans are in place to improve performance. Reporting to the Finance & Performance Committee by the end of May/June.<br><br>Clinical model review and development of Medicine and Emergency Care division - improvement for future for Phase 6 - 13 June was carried out.<br><br>RTT and Holding Lists - streamlined directorate level trajectories and action plans being developed. These will be completed in June and monitored on a weekly basis via Execs meetings and monthly through the ODB.<br><br>Due to national timeline changes the PLACE assessments have not yet been completed and are expected in September 2019. |

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**Item** 92

**10 July 2019**

**Purpose** Information
Assurance

| | |
|---|---|
| **Title** | Serious Incidents Requiring Investigation Report |
| **Author** | Mrs R Jones , Patient Safety Manager |
| **Executive sponsor** | Dr I Stanley, Acting Executive Medical Director |

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

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

## Report linkages

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

## Impact

| | | | |
|---|---|---|---|
| Legal | Yes | Financial | Yes |

| | | | |
|---|---|---|---|
| Equality | No | Confidentiality | Yes |

Previously considered by: Quality Committee (June 2019)

**Contents** **Page No**

**Executive Summary**

In April and May 2019 the Trust reported 34 serious incidents:

- 19 to the Strategic Executive Information System (StEIS)
- 15 to Divisional Serious Incident Review Group (DSIRG).

For the 12 month reporting period June 2018 to May 2019 the Trust reported 184 serious incidents:

- 113 StEIS reported incidents
- 70 DSIRG reported incidents.

The top 3 incident categories for this reporting period were

- Falls
- Pressure Ulcers
- Diagnosis Failure / Problem

These are the same categories as the previous SIRI report April 2019 and have already been escalated to SIRI Panel and Patient Safety and Risk Committee. Both Falls Steering Group and Pressure Ulcers Steering Group have been notified and are working on improvements projects. A thematic review is being completed on incidents under the category of Diagnosis Failure / Problem and the results will be reported in the August 2019 SIRI report.

There have been 3 breaches of duty of candour for the months April and May 2019.

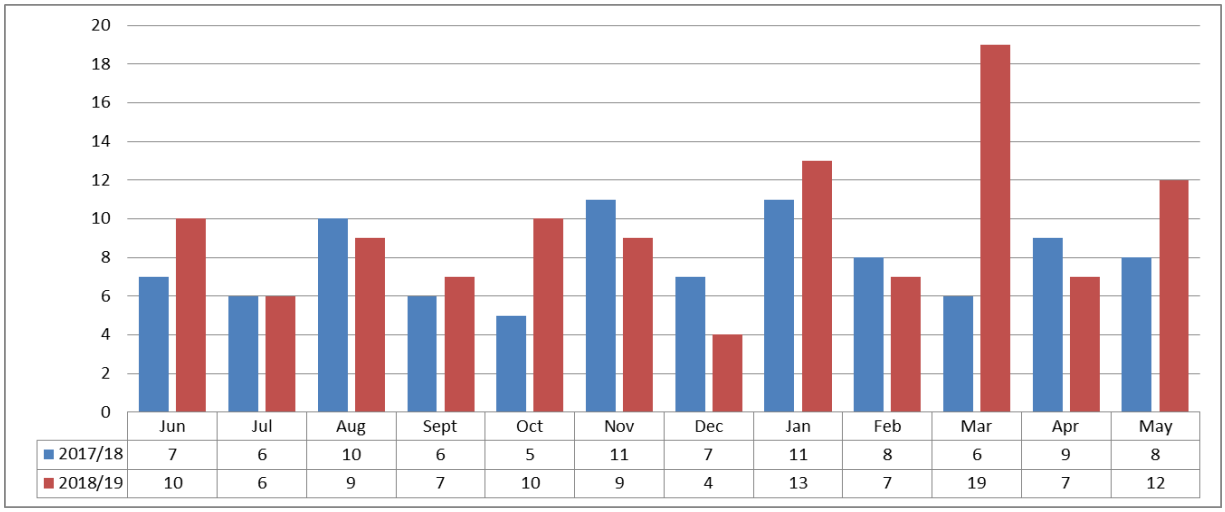
The Clinical Commissioner Group (CCG) dashboard provides assurance on improvements of investigations. There are no backlogs of incidents reported to StEIS on previous financial years; these have all been approved for closure. Currently the Trust have:

- 43 incidents open on StEIS - 24 for 2018/2019 and 19 for 2019/20
    - 8 awaiting closure by the CCG
    - 5 awaiting additional information by divisions before sending back to the CCG for closure
    - 29 undergoing investigation and due at SIRI panel in the coming months.

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

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

**Graph 1: StEIS reportable incidents year on year**




| | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 7 | 6 | 10 | 6 | 5 | 11 | 7 | 11 | 8 | 6 | 9 | 8 |
| 2018/19 | 10 | 6 | 9 | 7 | 10 | 9 | 4 | 13 | 7 | 19 | 7 | 12 |

When comparing the figures year on year there has been an increase in the number of Serious Incident reported from 94 in 2017/18 to 113 in 2018/19.

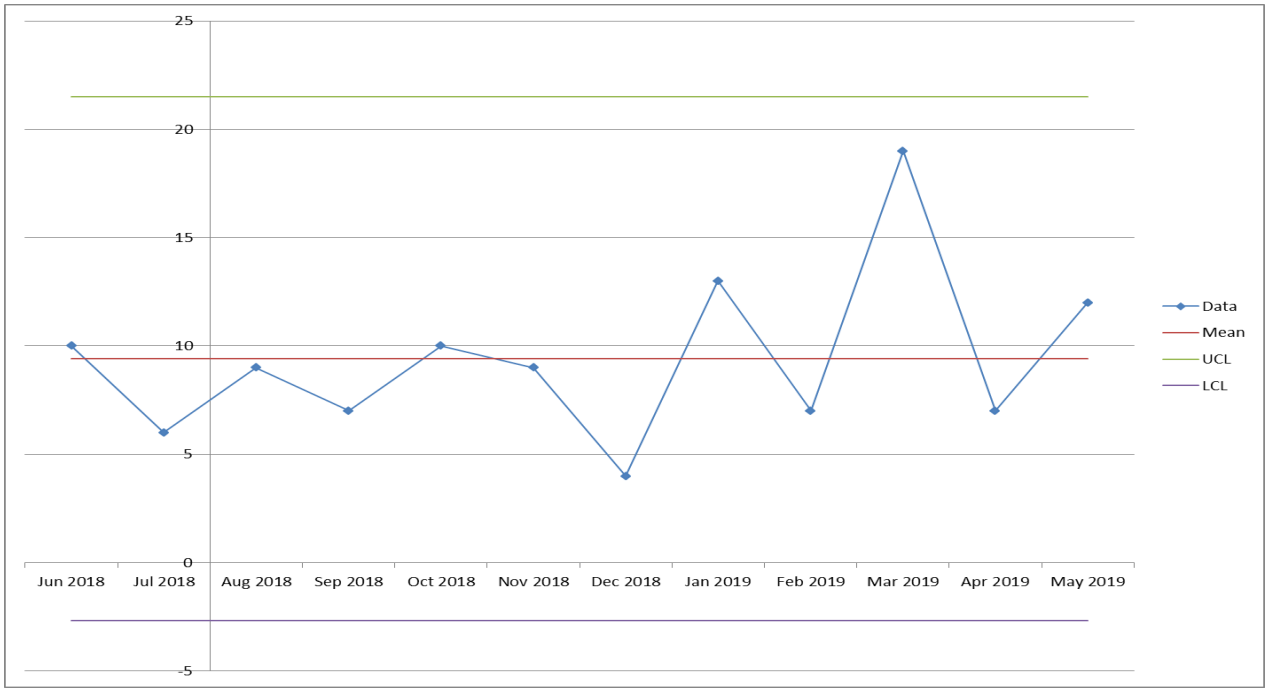
- A yearly increase of 20% on reported serious incidents.

It is important to state that a number of StEIS incidents under investigation are de-escalated on completion of the investigation as they are deemed unavoidable. Meaning the reported figure for 2018/19 of 113 may decrease if incidents are de-escalated.

Of the 94 incidents reported in 2017/18, the Trust reported 6 incidents that met the criteria of the NHS Never Event Framework and in 2018/19 the Trust reported 2 never event incidents.

- All actions plans for the Never Event Incidents in 2017/18 and 2018/19 have been completed and signed off by the CCG
- The Trust has not reported any Never Events for 11 months; the last reported Never Event was 3rd July 2018.

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




The above graph shows that the incidents are within the reportable control limits. The peak in March 2019 was reported in the last April 2019 SIRI paper and an action from this was to monitor over the next 2-4 months.

Pressure Ulcer incidents are currently the highest incident type reported in the last 12 months and this is in line with the spike reported in March 2019. This may be an indicator of the new pressure ulcer guidance being implemented. This current figure for March 2019 may see a decrease in the number reported on completion of the investigations if the pressure ulcers investigation deemed no service or care delivery problems have been identified.

**The table 1 below shows StEIS incidents by categories and lead division from June 2018 to May 2019**

| | ICG | Community | SAS | FC | DCS | Corp | Total |
|---|---|---|---|---|---|---|---|
| Antenatal and Newborn Screening | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| Communication problems | 1 | 0 | 0 | 0 | 1 | 1 | 3 |
| Diabetes related | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| Diagnosis failure / problem | 7 | 0 | 9 | 0 | 2 | 0 | 18 |
| Discharge or transfer problem | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Infection Control Incident | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Maternity/Obstetrics | 1 | 0 | 0 | 4 | 0 | 0 | 5 |
| Medication | 0 | 0 | 2 | 0 | 0 | 0 | 2 |
| Moisture Associated Skin Damage (MASD) | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Neonatal / NICU | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| Personal Injury/Accident | 0 | 2 | 0 | 0 | 0 | 0 | 2 |
| Pressure Ulcers - NEW CODES | 0 | 6 | 1 | 0 | 0 | 0 | 7 |
| Problems with appointments/admissions | 0 | 0 | 2 | 0 | 0 | 0 | 2 |
| Return to theatre | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| Safeguarding - Adult | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Safeguarding - Child | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Self harm | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Slips, trips and falls | 17 | 0 | 4 | 0 | 0 | 0 | 21 |
| Staffing Issue | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| Treatment problem/issue | 10 | 0 | 4 | 1 | 0 | 0 | 15 |
| Venous thromboembolism | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Violence/abuse/harassment | 2 | 0 | 1 | 0 | 0 | 0 | 3 |
| Pressure ulcer - OLD CODES pre Apr 2019 | 2 | 15 | 3 | 1 | 0 | 0 | 21 |
| Total | 45 | 24 | 29 | 11 | 3 | 1 | 113 |

*Nb: Lead division is determined by the location of the incident, but the incident may involve cross divisional learning. The Division ICG has been split (table above) into ICG and Community, this is in line with the new divisional structure within the Trust.*

The top three categories for incidents reported over the last 12 months account for 59% of all incidents reported:

1. Pressure Ulcers x 31 (x2 reported under personal injury x1 reported under diabetes related) (27%) – of these 12 have been de-escalated, 5 have been requested for de-escalation and 2 for closure and awaiting confirmation, 1 upheld as lessons learnt and 11 are still undergoing investigation completion.
2. Falls x 21 (18%) – of these 9 have been de-escalated, 1 requested for de-escalation and 2 requested for closure to the CCG and awaiting confirmation, 4 still awaiting investigation completion and 5 upheld as lessons learnt
3. Diagnosis failure / problem x 18 (16%) – of these 5 have been de-escalated, 7 upheld as lessons learnt, 2 awaiting closure from CCG awaiting confirmation and 4 are still undergoing investigation completion.

Out of the 67 (59%) serious incidents within the top 3 categories:

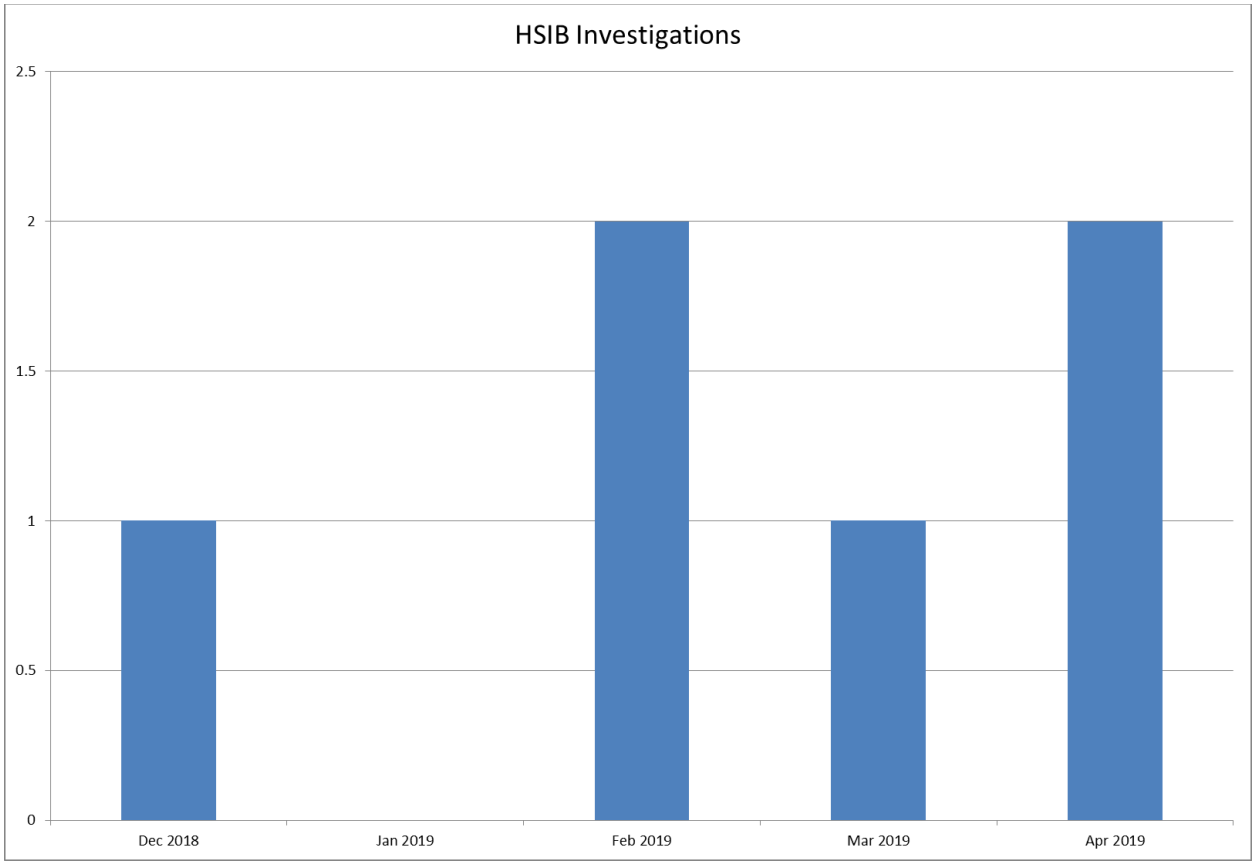
- 26 (23%) have been de-escalated
- 6 (5%) awaiting confirmation of de-escalation
- 13 (11%) lessons learnt identified
- 19 (17%) still awaiting outcome of investigation

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

The top 3 incidents were raised in April 2019 SIRI report. A thematic review is underway for diagnosis failure/problem and the results will be published within August 2019 SIRI paper. Falls Steering Group and Pressure Ulcer Steering Group have been notified and both groups are working on improvement projects.

**Healthcare and Safety Investigation Branch (HSIB)**

There are currently 6 investigations underway. 1 incident has been StEIS reported and 5 incidents will be presented to DSIRG. Below is a graph outlining when the incidents were reported to HSIB:



The Trust are not provided with any clear timescales from the HSIB on completion of these incidents but are monitor their progress.

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

There have been 19 serious incidents requiring investigation which have been reported through Strategic Executive Information System (StEIS). This is an increase of 10% on the same time period last year when 17 incidents were reported. The main reasons for the increase in the number of incidents reported are:

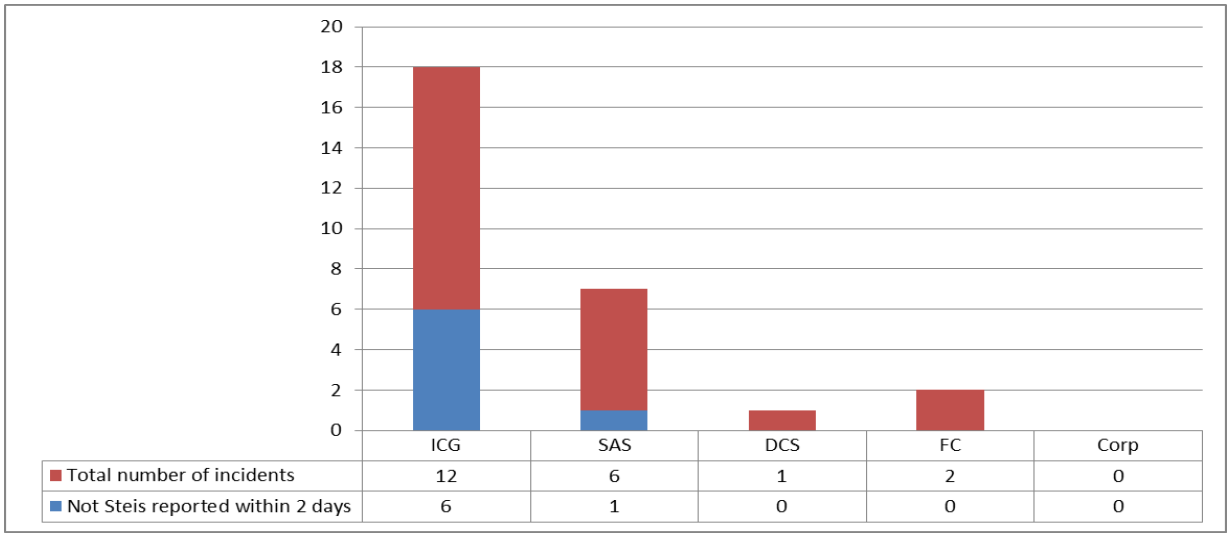
- increase in reporting of pressure ulcers (8) – only 2 reported in the same time period last year

As previously stated on page 6 the current figures may see a decrease in number reported once the investigation have been completed and any pressure ulcers where no service or care delivery problems have been identified.

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

- 2 incidents have breached the duty of candour requirements and reasons for these are outlined on page 14
- 6 serious incidents were not reported within the required 2 days which is a reduction on the 11 reported in the previous paper.

**Graph 3: Overview by division**




| | ICG | SAS | DCS | FC | Corp |
|---|---|---|---|---|---|
| Total number of incidents | 12 | 6 | 1 | 2 | 0 |
| Not Steis reported within 2 days | 6 | 1 | 0 | 0 | 0 |

Incidents where there has been a delay in reporting to StEIS are due to the rapid reviews not being completed in a timely manner to enable the level of harm of the incident and/or pressures ulcers awaiting verification, leading to late notification to central team. A daily rapid review report is sent out to Divisional Quality and Safety Teams for assurance and to monitor compliance.

**Action:**

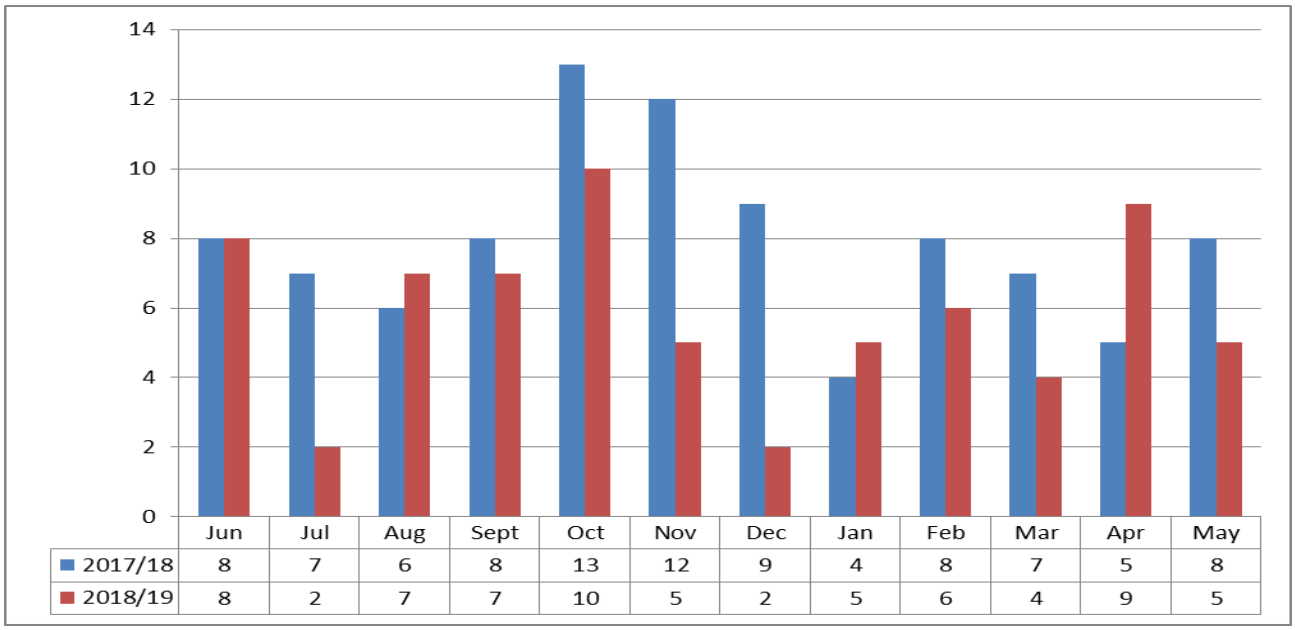
1. Divisions to provide assurance on timely completion of rapid reviews
2. TVNs to provide timely notification of verification of unstageable and category 3 or above pressure ulcers

For further information for each of the 19 incidents requiring a SIRI level investigation see Appendix B for breakdown.

**Part 2a: Overview of Divisional Serious Incident review group (DSIRG) from June 2018 to May 2019**

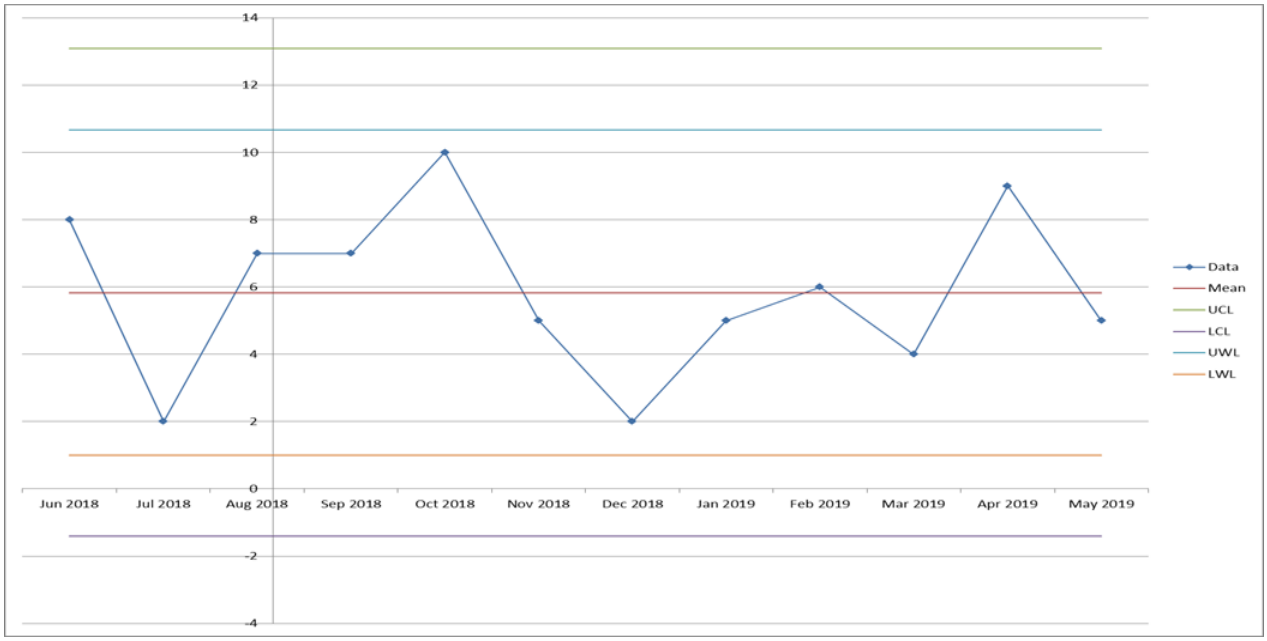
*Definition of DSIRG reportable incident*: These incidents do not meet the criteria of harm under the NHS Serious Incident Framework which would be reportable on StEIS, but have been identified as incidents that raise a level of internal concern and warrant an investigation to ensure lessons are learned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

**Graph 4: Reportable incidents to DSIRG year on year**




| | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 8 | 7 | 6 | 8 | 13 | 12 | 9 | 4 | 8 | 7 | 5 | 8 |
| 2018/19 | 8 | 2 | 7 | 7 | 10 | 5 | 2 | 5 | 6 | 4 | 9 | 5 |

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




When comparing the figures year on year graph 4 and 5 show there has been a decrease in the number of Divisional Serious Incidents reported from 95 in 2017/18 to 70 in 2018/19.

- A yearly decrease of 27% on reported serious incidents. The decrease is due to a number of reasons:
  - daily triage of serious incidents more robust process
  - improvement in rapid reviews completion time
  - SJR process being introduced

**The table 2 below shows DSIRG incidents by categories and lead division from June 2018 to May 2019**

| | ICG | Community | SAS | FC | DCS | Total |
|---|---|---|---|---|---|---|
| Anaesthetics | 0 | 0 | 1 | 0 | 0 | 1 |
| Communication problems | 1 | 1 | 2 | 1 | 0 | 5 |
| Consent | 0 | 0 | 2 | 0 | 0 | 2 |
| Diabetes related | 0 | 0 | 1 | 0 | 0 | 1 |
| Diagnosis failure / problem | 10 | 0 | 7 | 0 | 7 | 24 |
| Discharge or transfer problem | 3 | 0 | 2 | 0 | 0 | 5 |
| Enteral Nutrition | 1 | 0 | 0 | 0 | 0 | 1 |
| High Risk Sepsis | 2 | 0 | 0 | 0 | 0 | 2 |
| Ill health | 2 | 0 | 1 | 2 | 0 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Infection Control Incident | 15 | 0 | 1 | 1 | 0 | 17 |
| Laboratory | 0 | 0 | 1 | 0 | 0 | 1 |
| Maternity/Obstetrics | 0 | 0 | 0 | 10 | 0 | 10 |
| Medical devices & equipment | 0 | 0 | 1 | 0 | 0 | 1 |
| Medication | 7 | 0 | 2 | 0 | 2 | 11 |
| Neonatal / NICU | 0 | 0 | 0 | 3 | 0 | 3 |
| Oral Nutrition & Hydration | 1 | 0 | 0 | 0 | 0 | 1 |
| Personal Injury/Accident | 1 | 0 | 2 | 0 | 1 | 4 |
| Pressure Ulcers - NEW CODES | 0 | 0 | 4 | 0 | 0 | 4 |
| Problem with patient records/information | 2 | 0 | 1 | 2 | 0 | 5 |
| Problems with appointments/admissions | 1 | 0 | 2 | 0 | 0 | 3 |
| Return to hospital | 1 | 0 | 0 | 1 | 0 | 2 |
| Return to theatre | 0 | 0 | 4 | 0 | 0 | 4 |
| Safeguarding - Adult | 1 | 0 | 0 | 0 | 0 | 1 |
| Self harm | 1 | 0 | 0 | 0 | 0 | 1 |
| Slips, trips and falls | 19 | 0 | 0 | 1 | 0 | 20 |
| Theatres | 0 | 0 | 2 | 1 | 0 | 3 |
| Treatment problem/issue | 12 | 0 | 9 | 0 | 0 | 21 |
| Venous thromboembolism | 0 | 0 | 1 | 2 | 0 | 3 |
| Pressure ulcer - OLD CODES pre Apr 2019 | 2 | 1 | 1 | 0 | 0 | 4 |
| Total | 82 | 2 | 47 | 24 | 10 | 165 |

The top three categories for incidents reported over the last 12 months account for 39% of all incidents reported:

1. Diagnosis failure/problem (24) 14%
2. Treatment problem/issue (21)13%
3. Slips, trips and falls (20)12%

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

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

There were 15 incidents that did not meet the reporting requirements for strategic executive information system incidents (StEIS) but deemed to be serious enough to require a Trust Level investigation.

- There has been a 13% decrease on the same time period last year when 13 incidents were reported.

For further information for each of the 15 incidents requiring a DSIRG level investigation see Appendix B for breakdown

**Table 3: Incidents Requiring Completion of Duty of candour (as of 10th June 2019)**

For the figures below the breach figures for the month the incident was reported has been used and not the month they breached.

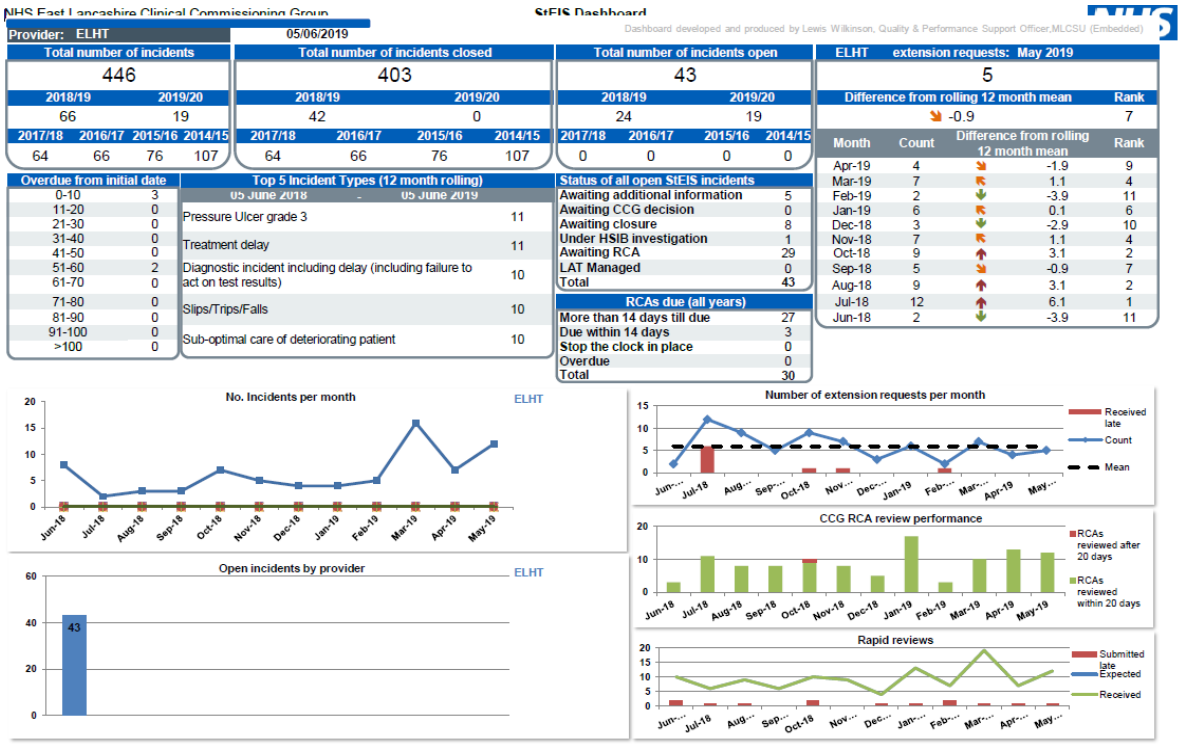
| | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 |
|---|---|---|---|---|---|
| Reported in month | 11 | 11 | 17 | 12 | 15 |
| Completed in 10 days | 11 | 9 | 13 | 11 | 10 |
| Breached | 0 | 1 | 2 | 1 | 2 |
| Structured Judgement Reviews | 0 | 1 | 2 | 0 | 1 |
| Still within Timescale | 0 | 0 | 0 | 0 | 2 |

Reasons for delay for April and May 2019 breaches:-

1. Eir1162942 – this incident was cross divisional and there was a delay in the decision as to who was completing. Apology now given and letter sent to patient. Divisions to discuss DOC if cross divisional in daily triage and agree responsibility.
2. Eir1164627 – Originally put down as not a patient safety incident, this has now been changed and duty of candour is being completed, awaiting confirmation of apology and letter.

3. Eir1165084: Incident reported 11th May and received 13th May when duty of candour started, A training need has been identified with staff at Rakehead around the timeframes and requirements of DOC i.e. Verbal apology given in 10 working days and written in patients case notes and then if not given at the time of apology followed up by a letter. Training is being but in place for staff by the Matron.

## Part 3: Overview of the CCG StEIS Dashboard




There are currently 43 incidents open on StEIS:

- 24 for 2018/2019 and 19 for 2019/20,
  - 8 of which are awaiting closure by the CCG
  - 5 awaiting additional information by divisions before sending back to the CCG for closure
  - 29 are currently under investigation
  - There have been 9 extension requests in April and May
- There are no outstanding incidents from previous financial years.

There are 2 late submissions of rapid reviews:

- April: A concise report which identified the need for StEIS reporting
- May: Author of the rapid review unable to complete in time due to other commitments

The CCG has identified treatment delay/issues as the second highest category reported by the Trust on StEIS in the last twelve months. This is slightly different to the Trust who rank this category as fourth, this may be down to slight coding differences within system.

**Appendix A:**

| Number | eIR | Division | Incident reported | Reported to STEIS within 2 working days | Category/Allegation | Relevant to Duty of candour | Rapid Review | Any immediate changes initiated | Level of harm | Next steps |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1164627 | SAS | 03/05/19 | Y | Treatment delay | Y | Y | No immediate changes made at initial judgement | Death / Catastrophic | RCA to SIRI |
| 2 | 1165133 | ICG | 13/05/19 | Y | Disruptive, Aggressive, Violent behaviour | Y | Y | Security put in place to prevent further violence and aggression | Moderate | RCA to SIRI |
| 3 | 1164783 | SAS | 06/05/19 | Y | Delay in treatment | Y | Y | No immediate changes made at initial judgement | Moderate | RCA to SIRI |
| 4 | 1165372 | ICG | 16/05/19 | Y | Pressure Ulcer | Y | Y | Pressure ulcer steering group notified of increase and to monitor/take forward | Moderate | RCA to SIRI |
| 5 | 1161083 | ICG | 01/03/19 | N | Slips Trips Falls | Y | Y | No immediate changes made at initial judgement | Moderate | RCA to SIRI |
| 6 | 1163588 | ICG | 14/04/19 | N | Pressure Ulcer | Y | Y | Pressure ulcer steering group notified of increase and to monitor/take forward | Moderate | RCA to SIRI |
| 7 | 1164511 | ICG | 01/05/19 | N | Pressure Ulcer | Y | Y | Pressure ulcer steering group notified of increase and to monitor/take forward | Moderate | RCA to SIRI |
| 8 | 1166069 | SAS | 28/05/19 | Y | Diagnostic | Y | Y | No immediate changes made at initial judgement | Moderate | RCA to SIRI |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 9 | 1162466 | SAS | 25/03/19 | N | Pressure Ulcer Category 3 | Y | Y | Pressure ulcer steering group notified of increase and to monitor/take forward | No harm - Impact not prevented - Unavoidable | RCA to SIRI |
| 10 | 1163493 | ICG | 12/04/19 | N | Treatment Delay | Y | Y | No immediate changes made at initial judgement | Moderate | RCA to SIRI |
| 11 | 1165722 | SAS | 22/05/19 | Y | Pressure Ulcer | Y | Y | Pressure ulcer steering group notified of increase and to monitor/take forward | Moderate | RCA to SIRI |
| 12 | 1164965 | DCS | 09/05/19 | Y | Diagnostic | Y | Y | Complaint received and investigation initiated | Severe / Major | RCA to SIRI |
| 13 | 1163642 | ICG | 15/04/19 | Y | VTE | Y | Y | No immediate changes made at initial judgement | Death / Catastrophic | RCA to SIRI |
| 14 | 1163396 | ICG | 10/04/19 | Y | Pressure Ulcer | Y | Y | Pressure ulcer steering group notified of increase and to monitor/take forward | Moderate | RCA to SIRI |
| 15 | 1162942 | ICG | 03/04/19 | Y | Diagnostic | Y | Y | Soft intel received - incident raised and investigation initiated | Moderate | RCA to SIRI |
| 16 | 1163643 | ICG | 15/04/19 | N | Pressure Ulcer | Y | Y | Pressure ulcer steering group notified of increase and to monitor/take forward | Moderate | RCA to SIRI |
| 17 | 1164921 | ICG | 08/05/19 | Y | Pressure ulcer | Y | Y | Pressure ulcer steering group notified of increase and to monitor/take forward | Moderate | RCA to SIRI |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 18 | 1163880 | ICG | 19/04/19 | N | Pressure Ulcer | Y | Y | Pressure ulcer steering group notified of increase and to monitor/take forward | Moderate | RCA to SIRI |
| 19 | 1165393 | SAS | 16/05/19 | Y | Treatment Delay | Y | Y | Structured judgement review initiated investigation | Severe / Major | RCA to SIRI |

**Appendix B**

| | eIR1 | Division | Incident reported | Category/Allegation | Relevant to Duty of candour | Rapid Review done? | Any immediate changes initiated | Level of Harm | Next steps |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 1162291 | ICG | 22/03/19 | Slips, trips and falls | Y | N | No immediate changes made at initial judgement | Moderate | RCA to DSIRG |
| 2 | 1163061 | ICG | 04/04/19 | Treatment problem/issue | N | N | No immediate changes made at initial judgement | Low / Minor | RCA to DSIRG |
| 3 | 1164137 | FC | 25/04/19 | Communication problems | N | Y | No immediate changes made at initial judgement | No harm - Impact prevented | RCA to DSIRG |
| 4 | 1163102 | SAS | 05/04/19 | Pressure Ulcers – GRADE 2 | N | N | No immediate changes made at initial judgement | Low / Minor | RCA to DSIRG |
| 5 | 1165080 | ICG | 11/05/19 | Safeguarding - Adult | N | Y | No immediate changes made at initial judgement | No harm - Impact prevented | RCA to DSIRG |
| 6 | 1163966 | FC | 21/04/19 | Venous thromboembolism | N | Y | VTE process in place | No harm - Impact prevented | RCA to DSIRG |
| 7 | 1165895 | ICG | 24/05/19 | Pressure Ulcers – GRADE 2 | N | N | No immediate changes made at initial judgement | Low / Minor | RCA to DSIRG |
| 8 | 1164697 | SAS | 04/05/19 | Pressure Ulcers – GRADE 2 | N | N | No immediate changes made at initial judgement | No harm - Impact not prevented | RCA to DSIRG |
| 9 | 1161993 | ICG | 16/03/19 | Communication problems | N | N | No immediate changes made at initial judgement | No harm - Impact prevented | RCA to DSIRG |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 10 | 1162208 | ICG | 21/03/19 | Slips, trips and falls | Y | Y | No immediate changes made at initial judgement | Moderate | RCA to DSIRG |
| 11 | 1161904 | ICG | 15/03/19 | Slips, trips and falls | Y | Y | No immediate changes made at initial judgement | Moderate | RCA to DSIRG |
| 12 | 1162751 | SAS | 30/03/19 | Pressure ulcer – GRADE 2 | N | N | No immediate changes made at initial judgement | Low / Minor | RCA to DSIRG |
| 13 | 1159304 | DCS | 28/01/19 | Radiation incident | Y | Y | Pregnancy tests to be completed on females aged 14+ prior to tests/treatment | Moderate | RCA to DSIRG |
| 14 | 1164043 | SAS | 23/04/19 | Pressure Ulcers – GRADE 2 | N | N | No immediate changes made at initial judgement | Low / Minor | RCA to DSIRG |
| 15 | 1164911 | ICG | 08/05/19 | Medication error | Y | N | No immediate changes made at initial judgement | No harm - Impact not prevented | RCA to DSIRG |

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**Item** 93

**10 July 2019**

**Purpose** Information Assurance

| | |
|---|---|
| **Title** | Integrated Performance Report (May 2019) |
| **Author** | Mr M Johnson, Associate Director of Performance and Informatics |
| **Executive sponsor** | Mrs N Hudson, Director of Operations |

**Summary:** This paper presents the corporate performance data at May 2019.

**Recommendation:** Members are requested to note the attached report for assurance.

## Report linkages

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

(93) Integrated Performance Report

**Impact**

| | | | |
|---|---|---|---|
| Financial | Yes | Legal | No |
| Confidentiality | No | Equality | No |

Previously considered by: Not applicable

# Board of Directors, Update

## Corporate Report

### Executive Overview Summary

### Positive News

- There were no never events.
- There were three clostridium difficile infections detected during April ('Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)', which is on trajectory for the month. The cumulative position is 9 against trust target of 51 for the year.
- No hospital acquired MRSA infections were detected during May 2019.
- SHMI has improved and is 'as expected'.
- The cancer 62 day standard was met in April.
- The number of ambulance handovers over 30 minutes is improving.
- For 2019-20, the Trust has agreed an underlying control total of a £7.0 million deficit. At month 2, the Trust is reporting a £0.8 million underlying deficit, in line with its financial plans.

### Areas of Challenge

- E-coli and klebsiella bacteraemia were above trajectory in May.
- Nursing and midwifery staffing in May 2019 continued to be a challenge, with 4 areas falling below an 80% average fill rate for registered nurses on day shifts.
- The 'Emergency Care 4 hour standard' (Pennine A&E Delivery Board) is showing deterioration and is consistently below standard at 79.7%
- There were 13 breaches of the 12 hour trolley wait standard in May. Eleven were as a result of waits for mental health beds within LCFT.
- The Referral to Treatment (RTT) target was not achieved at 90.6% and the total of ongoing pathways has increased to 32,878.
- RTT over 40wks has increased to 50.
- The 6wk diagnostic target was not met at 1.8% in May
- There were six breaches of the 28 day standard for operations cancelled on the day.
- Cancer 14 day and breast symptomatic were not achieved in April.
- Cancer 62 day consultant upgrade was not achieved in April
- There were 3.5 breaches of the 104 day cancer wait standard.
- Delayed discharges was above the 3.5% standard at 3.6% in May.
- Sickness rates remain above threshold at 5.0%
- The vacancy rate remains above threshold at 6.5%.
- Compliance against the Information Governance Toolkit and Appraisal (AFC staff) remains below threshold.
- Temporary costs as % of total pay bill remains above threshold at 8%

- VTE risk assessment rate has fallen in May, although still above threshold
- A&E Friends & Family is consistently below threshold

**No Change**

- The HAS compliance remained above the threshold.
- There were no breaches of the 52wk standard at the end of May.
- All areas of core skills training except IG and Appraisal compliance are above threshold
- HSMR remains 'better than expected'.
- Trust turnover rate is below threshold at 7.5%

## Introduction

This report presents an update on the performance for May 2019 and follows the NHS Improvement Single Oversight Framework. The narrative provides details on specific indicators under the five areas; Safe, Caring, Effective, Responsive, Well Led.

| | Indicator | Target | Actual | Variation | Assurance |
|---|---|---|---|---|---|
| Safe | | | | | |
| M64 | CDIFF - HOHA | 2 | 1 | | |
| M64.3 | CDIFF - COHA | 2 | 2 | | |
| M64.4 | Cdiff Cumulative from April (HOHA& COHA) | 10 | 9 | | |
| M65 | MRSA | 0 | 0 | | |
| M124 | E-Coli (post 2 days) | 3 | 6 | | |
| M155 | P. aeruginosa bacteraemia (total post 2 days) | 1 | 1 | | |
| M157 | Klebsiella species bacteraemia (total post 2 days) | 0 | 1 | | |
| M66 | Never Event Incidence | 0 | 0 | | |
| M67 | Medication errors causing serious harm (Steis reported date) | 0 | 0 | | |
| M68 | Maternal deaths | 1 | 0 | | |
| M64.2 | C Diff per 100,000 Occupied Bed Days (HOHA) | | 3.7 |  | |
| M69 | Serious Incidents (Steis) | | 12 |  | |
| M70 | CAS Alerts - non compliance | 0 | 0 | | |
| C28 | Percentage of Harm Free Care | 92% | 99% |  | |
| C29 | Proportion of patients risk assessed for Venous Thromboembolism | 95% | 96% |  |  |
| M146 | Safer Staffing -Day-Average fill rate - registered nurses/midwives (%) | 80.0% | 91.7% |  |  |
| M147 | Safer Staffing -Day-Average fill rate - care staff (%) | 80.0% | 106.3% |  |  |
| M148 | Safer Staffing -Night-Average fill rate - registered nurses/midwives (%) | 80.0% | 98.5% |  |  |
| M149 | Safer Staffing -Night-Average fill rate - care staff (%) | 80.0% | 116.6% |  |  |
| M150 | Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80% | 0 | 4 | | |
| M151 | Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80% | 0 | 1 | | |
| M152 | Safer Staffing - Day -Average fill rate - care staff- number of wards <80% | 0 | 0 | | |
| M153 | Safer Staffing - Night -Average fill rate - care staff- number of wards <80% | 0 | 1 | | |

| | Indicator | Target | Actual | Variation | Assurance |
|---|---|---|---|---|---|
| **Caring** | | | | | |
| C38 | Inpatient Friends and Family - % who would recommend | 90% | 99% |  |  |
| C31 | NHS England Inpatients response rate from Friends and Family Test | | 53% |  | |
| C40 | Maternity Friends and Family - % who would recommend | 90% | 96% |  |  |
| C42 | A&E Friends and Family - % who would recommend | 90% | 81% |  |  |
| C32 | NHS England A&E response rate from Friends and Family Test | | 16% |  | |
| C44 | Community Friends and Family - % who would recommend | 90% | 97% |  |  |
| C15 | Complaints – rate per 1000 contacts | 0.40 | 0.25 |  |  |
| M52 | Mixed Sex Breaches | 0 | 0 | | |
| **Effective** | | | | | |
| M53 | Summary Hospital Mortality Indicator (HSCIC Published data) | Within Expected Levels | 1.05 | | |
| M54 | Hospital Standardised Mortality Ratio (DFI Indicative) (as at Feb-19) | Within Expected Levels | 93.5 |  | |
| M74 | Hospital Standardised Mortality Ratio - Weekday (as at Feb-19) | Within Expected Levels | 93.5 |  | |
| M75 | Hospital Standardised Mortality Ratio - Weekend (as at Feb-19) | Within Expected Levels | 93.6 |  | |
| M73 | Deaths in Low Risk Conditions (as at Feb-19) | Within Expected Levels | 97.6 |  | |
| M159 | Stillbirths | <5 | | | |
| M160 | Stillbirths - Improvements in care that impacted on the outcome | | | | |
| M89 | CQUIN schemes at risk | | | | |

| | Indicator | Target | Actual | Variation | Assurance |
|---|---|---|---|---|---|
| **Responsive** | | | | | |
| C2 | Proportion of patients spending less than 4 hours in A&E (Trust) | 95.0% | 78.4% |  |  |
| C2ii | Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board) | 95.0% | 79.7% |  |  |
| M62 | 12 hour trolley waits in A&E | 0 | 13 |  |  |
| M81 | HAS Compliance | 90.0% | 93.7% |  |  |
| M82 | Handovers > 30 mins ALL | 0 | 424 |  |  |
| M82.6P | Handovers > 30 mins ALL (NWAS Confirmed Penalty) | 0 | 176 |  |  |
| C1 | RTT admitted: percentage within 18 weeks | | 65.4% |  | |
| C3 | RTT non- admitted pathways: percentage within 18 weeks | | 92.4% |  | |
| C4 | RTT waiting times Incomplete pathways % | 92.0% | 90.6% |  |  |
| C4.1 | RTT waiting times Incomplete pathways Total | <29,619 | 32,878 |  |  |
| C4.2 | RTT waiting times Incomplete pathways -over 40 wks | | 50 |  | |
| C37.1 | RTT 52 Weeks (Ongoing) | 0 | 0 | | |
| C17 | Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test | 1.0% | 1.8% |  |  |
| C18 | Cancer - Treatment within 62 days of referral from GP | 85.0% | 86.3% |  |  |
| C19 | Cancer - Treatment within 62 days of referral from screening | 90.0% | 96.6% |  |  |
| C20 | Cancer - Treatment within 31 days of decision to treat | 96.0% | 99.0% |  |  |
| C24 | Cancer - seen within 14 days of urgent GP referral | 93.0% | 91.4% |  |  |
| C25 | Cancer - breast symptoms seen within 14 days of GP referral | 93.0% | 72.7% |  |  |
| C21 | Cancer - Subsequent treatment within 31 days (Drug) | 98.0% | 100.0% |  |  |
| C22 | Cancer - Subsequent treatment within 31 days (Surgery) | 94.0% | 88.0% |  |  |
| C36 | Cancer 62 Day Consultant Upgrade | 85.0% | 98.0% |  |  |
| C25.1 | Cancer - Patients treated > day 104 | 0 | 3.5 |  |  |
| M9 | Urgent operations cancelled for 2nd time | 0 | 0 | | |
| C27a | Not treated within 28 days of last minute cancellation due to non clinical reasons - actual | 0 | 6 | | |
| M138 | No.Cancelled operations on day | | 101 |  | |

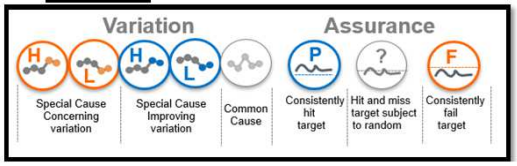
| | Indicator | Target | Actual | Variation | Assurance |
|---|---|---|---|---|---|
| M55 | Proportion of delayed discharges attributable to the NHS | 3.5% | 3.6% | | |
| C16 | Emergency re-admissions within 30 days | | 13.2% | | |
| M90 | Average LOS elective (excl daycase) | | 3.1 | | |
| M91 | Average LOS non-elective | | 5.2 | | |
| **Well Led** | | | | | |
| M77 | Trust turnover rate | 12.0% | 7.5% | | |
| M78 | Trust level total sickness rate (Reported 1 Month in arrears) | 4.5% | 5.0% | | |
| M79 | Total Trust vacancy rate | 5.0% | 6.5% | | |
| M80.3 | Appraisal (AFC) | 90.0% | 86.0% | | |
| M80.35 | Appraisal (Consultant) | 90.0% | 100.0% | | |
| M80.4 | Appraisal (Other Medical) | 90.0% | 84.0% | | |
| M80.2 | Safeguarding Children | 90.0% | 95.0% | | |
| M80.21 | Information Governance Toolkit Compliance | 95.0% | 93.0% | | |
| F8 | Temporary costs as % of total paybill | 4.0% | 8.0% | | |
| F9 | Overtime as % of total paybill | 0.0% | 0.0% | | |
| F1 | Adjusted financial performance (deficit) including PSF (£M) | 6.7 | 0.9 | | |
| F1.1 | Adjusted financial performance (deficit) excluding PSF (£M) | (7.0) | (0.8) | | |
| F2 | SRCP Achieved % (green schemes only) | 100.0% | 34.0% | | |
| F3 | Liquidity days | >(14.0) | (5.6) | | |
| F4 | Capital spend v plan | 85.0% | 121.0% | | |
| F16 | Finance & Use of Resources (UoR) metric - overall | 3 | 2 | | |
| F18 | Finance and UoR metric - capital service capacity | 3 | 2 | | |
| F17 | Finance and UoR metric - liquidity | 3 | 2 | | |
| F19 | Finance and UoR metric - I&E margin | 1 | 1 | | |
| F20 | Finance and UoR metric - distance from financial plan | 1 | 1 | | |
| F21 | Finance and UoR metric - agency spend | 3 | 3 | | |
| F12 | BPPC Non NHS No of Invoices | 95.0% | 98.1% | | |
| F13 | BPPC Non NHS Value of Invoices | 95.0% | 98.9% | | |
| F14 | BPPC NHS No of Invoices | 95.0% | 99.0% | | |
| F15 | BPPC NHS Value of Invoices | 95.0% | 99.5% | | |

**NB: Finance Metrics are reported year to date.**

**SPC Control Limits**

**The data period used to calculate the SPC control limits is Apr 17 - Mar 19.**

KEY



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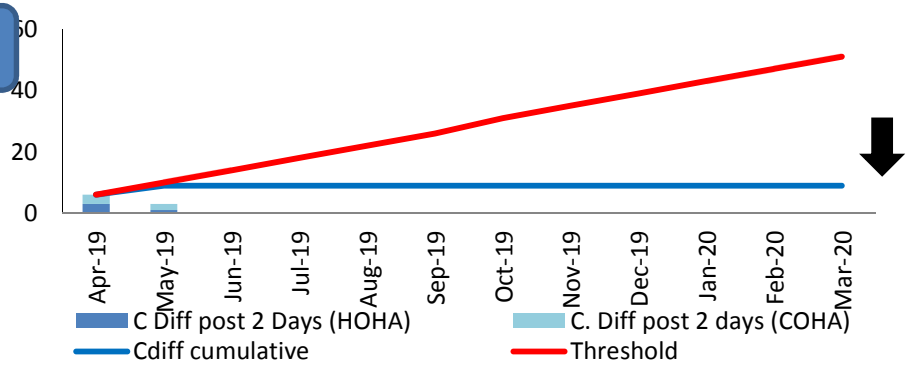
## C Difficile

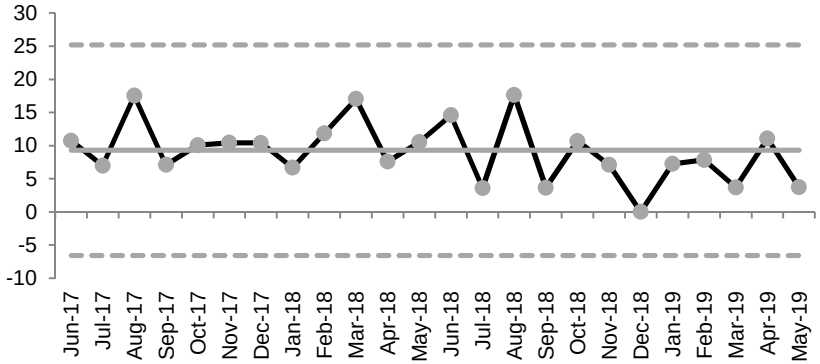



There were no post 2 day MRSA infections reported in May.

The objective for 2019/20 is no more than 51 cases of 'Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)' . In 2019/20 there will be changes to the reporting algorithm. The number of days to identify hospital onset healthcare associated cases from ≥3 to ≥2 days following admission and adding a prior healthcare exposure element for community onset cases including day cases.

There were 3 Clostridium difficile toxin positive isolates identified in the laboratory in May, post 2 days of admission, of which 1 was 'Hospital onset healthcare associated (HOHA)' and 2 were 'Community onset healthcare associated (COHA)'.

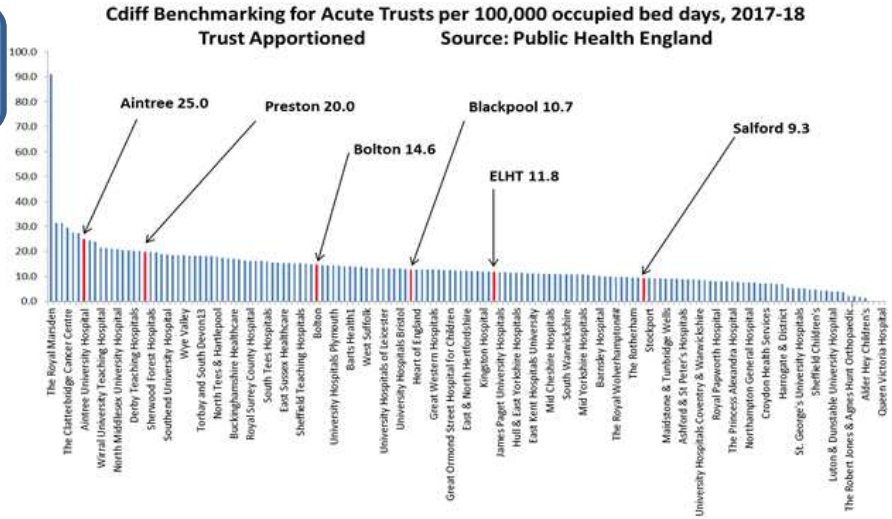
## C Diff per 100,000 Occupied Bed Days (HOHA)




The year to date cumulative figure is 9 against the trust target of 51. The detailed infection control report will be reviewed through the Quality Committee.

The rate of HOHA infection per 100,000 bed days is showing normal variation.

## C Difficile benchmarking




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

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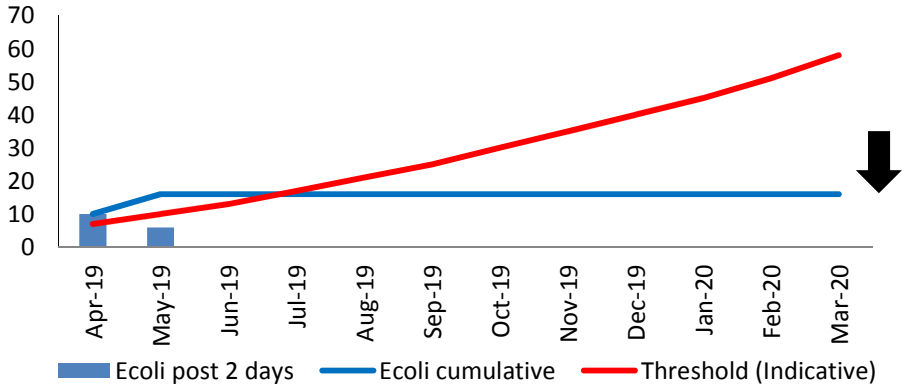
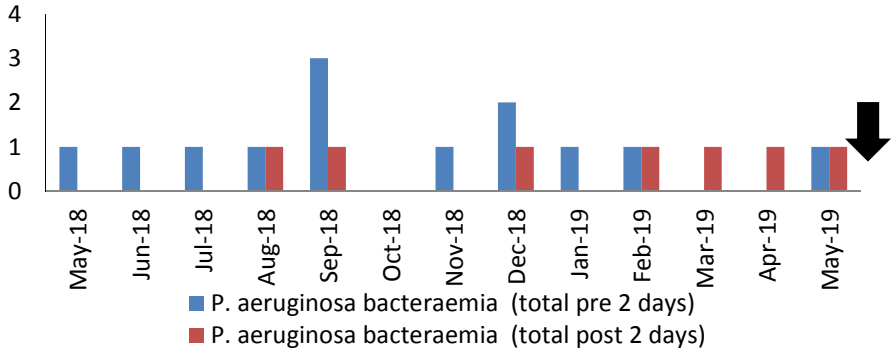
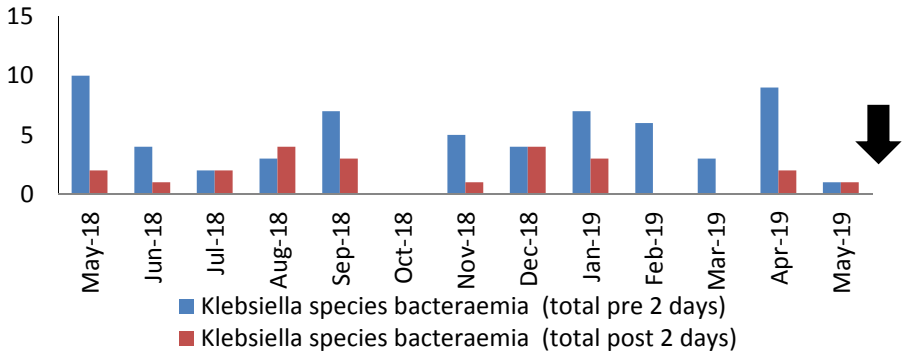
## E. Coli




## P.aeruginosa




## Klebsiella




The Government initiative to reduce Gram-negative bloodstream infections by 50% by 2021 has been revised and now is to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

The year end figure for 2018/19 was 66 cases, above the trajectory of 48.

This year's trajectory for reduction of E.coli has not yet been published, so an indicative trajectory has been included for information.

There were 6 E.coli bacteraemia detected in May, which is above the indicative monthly threshold.

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

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

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

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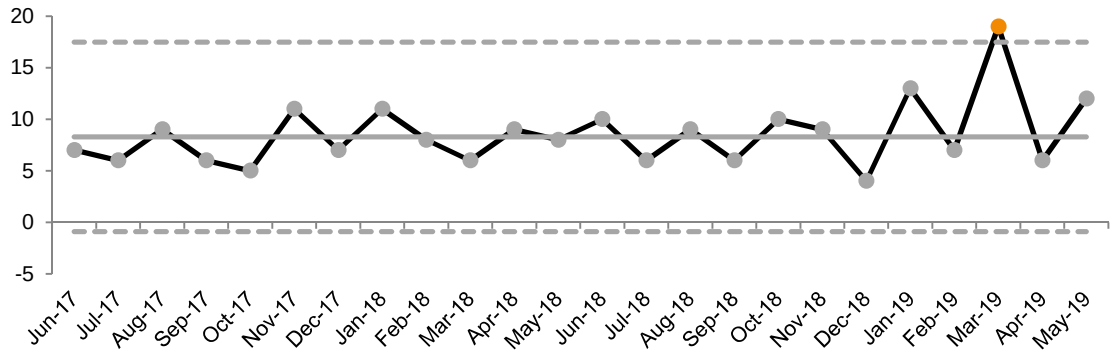
## Serious Incidents




There were no never events reported in May.

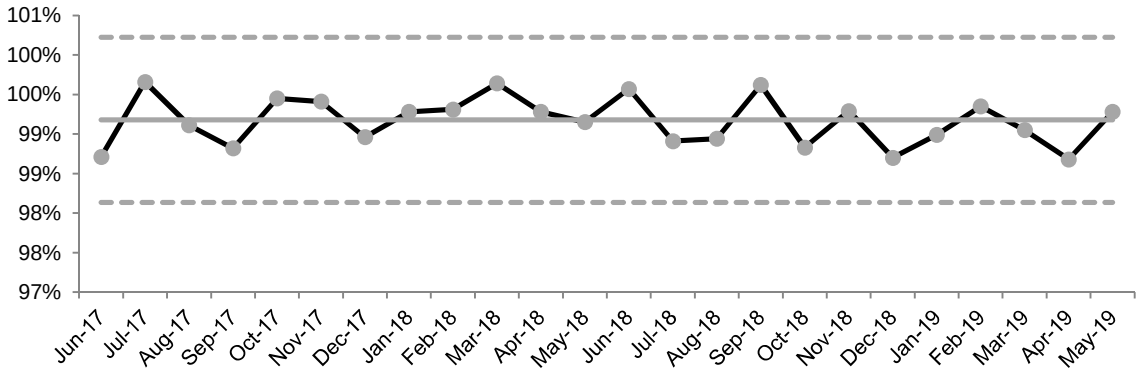
The Trust unverified position for incidents reported to the Strategic Executive Information System (StEIS) in May was twelve incidents.

The trend is not showing any significant change.

| StEIS Category | No. Incidents |
|---|---|
| Pressure Ulcer | 5 |
| Treatment Delay | 4 |
| Diagnostic | 2 |
| Disruptive, Aggressive, Violent behaviour | 1 |

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

## % Harm Free Care from safety




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

The trend is showing no significant change.

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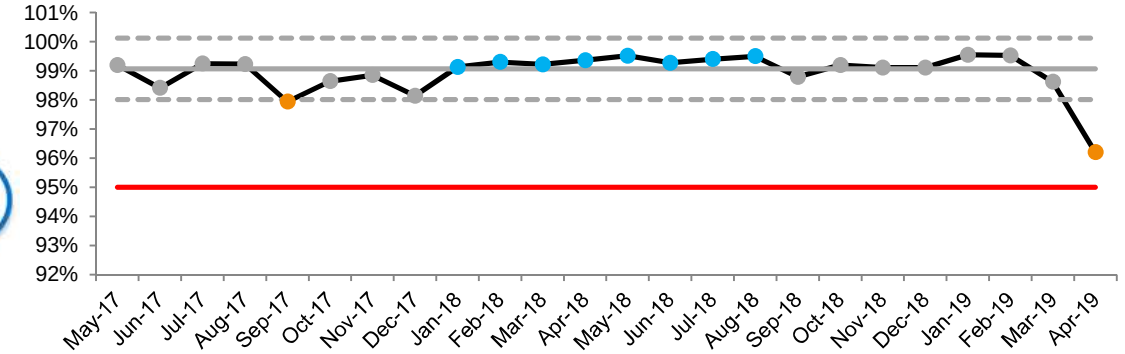
## VTE assessment




The VTE assessment trend is showing April performance to be significantly lower than previous months, although still above threshold.

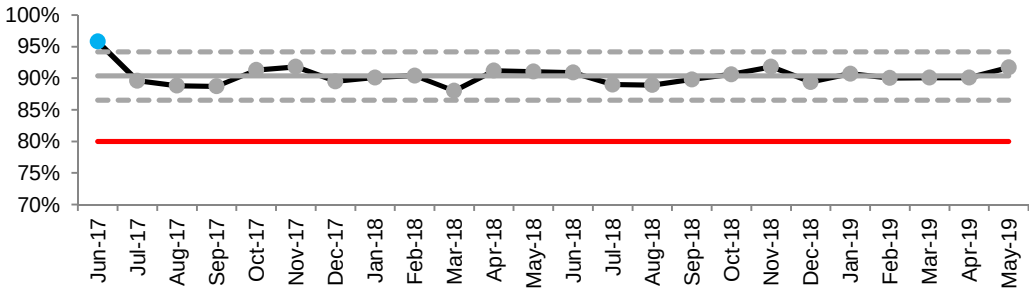
## Pressure Ulcers

| | |
|---|---|
| Pressure Ulcer - Cat 2 - Device related - developed/ deteriorated during ELHT care | 1 |
| Pressure Ulcer - Cat 2 - Developed / Deteriorated during care of ELHT | 5 |
| Pressure Ulcer - Cat 3 - Device related - developed / deteriorated during care of ELHT | 0 |
| Pressure Ulcer - Cat 3 - Developed / deteriorated during care of ELHT | 2 |
| Pressure Ulcer - Cat 4 - Device related - developed / deteriorated during the care of ELHT | 0 |
| Pressure Ulcer - Cat 4 - Developed / deteriorated during the care of ELHT | 0 |
| Pressure Ulcer - Deep tissue injury - Device related - developed / deteriorated during the care of ELHT | 0 |
| Pressure Ulcer - Deep tissue inury - developed / deteriorated during the care of ELHT | 2 |
| Pressure Ulcer - Unstageable - device related - developed / deteriorated under the care of ELHT | 0 |
| Pressure Ulcer - Unstageable - developed / deteriorated under the care of ELHT | 1 |

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

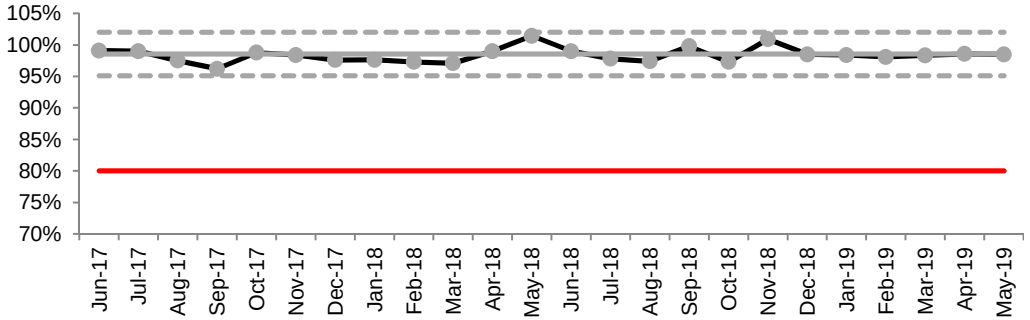
SAFE

## Registered Nurses/ Midwives - Day



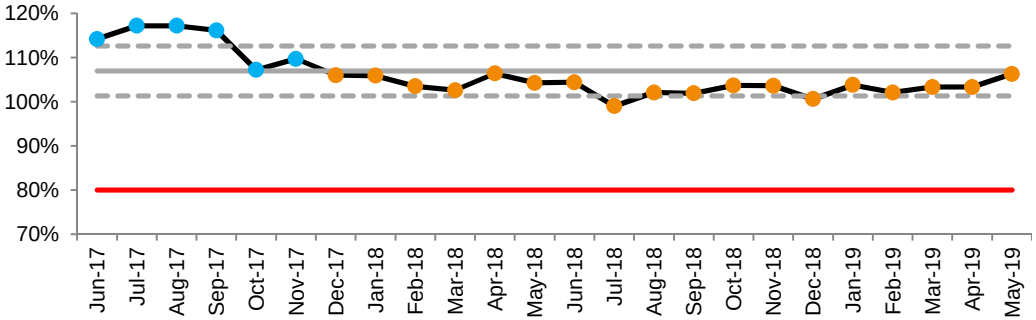

The average fill rate for registered nurses/ midwives during the day is showing no significant change and based on current variation will consistently be above threshold.

## Registered Nurses/ Midwives - Night



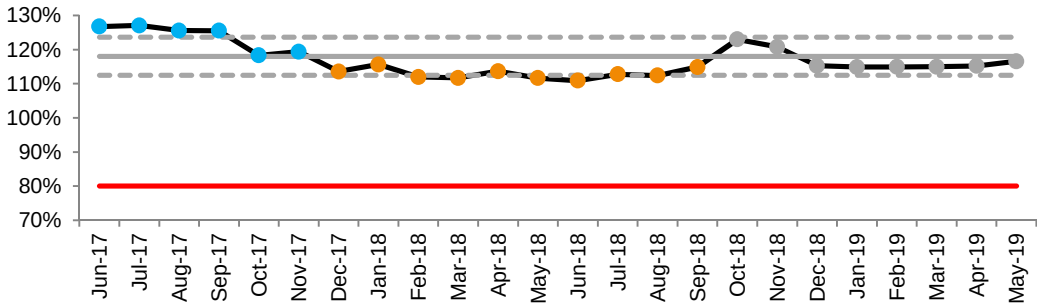

The average fill rate for registered nurses/ midwives at night is showing no significant change and based on current variation will consistently be above threshold.

## Care Staff - Day




The average fill rate for care staff during the day is showing a significant reduction, however the indicator remains above the threshold and based on current variation will consistently be above the threshold.

## Care Staff - Night




The average fill rate for care staff at night is showing no significant change and based on current variation will consistently be above threshold.

Nursing and midwifery staffing in May 2019 continued to be a challenge. The causative factors remain as in previous months, compounded by escalation areas being open, pressures within the emergency department, vacancies, sickness and the ability to fill all requests through ELHT internal bank or via framework agency. Safe care (acuity data) is utilised when considering safe staffing and the redeployment of staff and safe staffing is monitored throughout the day.

There were 4 areas below the 80% for registered nurses on day shifts, which was a slight improvement from April, all were due to lack of co-ordinator presence which is in addition to safe staffing levels.

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

**Average Fill Rate**

| | Average Fill Rate | | | | CHPPD | | Number of wards < 80 % | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Day | | Night | | | | Day | | Night | |
| Month | Average fill rate - registered nurses /midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses /midwives (%) | Average fill rate - care staff (%) | Midnight Counts of Patients | Care Hours Per Patient Day (CHPPD) | registered nurses/ midwives | care staff | registered nurses/ midwives | care staff |
| May-19 | 91.7% | 106.3% | 98.5% | 116.6% | 26,952 | 8.95 | 4 | 1 | 0 | 1 |

**Red Flag Incidents**

There was 1 red flag incident reported in the red flag category of DATIX in May 2019: This relates to Urgent Care, no harm has been identified as a consequence.

In ICG 10 incidents were submitted in relation to staffing, all were reported as no harm. Themes were poor skill mix, delays in transfer to mortuary and challenges in bay tagging and individual patient supervision

**Actions taken to mitigate risk:**

- Safe staffing conference at 10 am followed up with meetings through out the day where required to ensure safe staffing, with contingencies agreed for weekends and out of hours, utilising acuity and dependency (Safe Care)
- Extra health care assistant shifts are utilised to support registered nurse gaps if required
- On going recruitment.
- The Trust has engaged with Health Education England (HEE) to work collaboratively with the Global Learners Programme. 15 nurses have arrived so far, 10 have their NMC registration and 1 is awaiting the outcome of their OSCE. 3 further nurses are due to take their OSCE in June. Between the end of April and the end of September a further 12 nurses are expected. This leaves 27 nurses in various stages of the process to still arrive
- A further cohort of trainee nurse associates has been recruited to.

**Family Care May 2019**

**Maternity**

Maternity have a high number of midwife vacancies out to recruitment some of these staff are still in post and some of these vacancies are to fill the professional judgement uplifts.

Maternity are proactive in ensuring that as soon as a termination of employment is received the VR process is initiated to cause minimal vacancy pressures.

There has been a high level of sicknesses within the unregistered team; the majority of this is due to long term sickness which is being managed within the policy guidance.

There has been a couple of occasions this month when birth activity at the Blackburn Birth centre has had to be suspended for the night so that staff can be redeployed to other areas of the service to maintain patient safety.

The midwife to birth ratio has not been affected this month as these gaps have been covered by using bank staff and redeploying staff from areas of lower acuity/activity to the areas of higher acuity/activity.

Where the midwife staffing levels are not at the maximum levels, staff are rotated dependent on acuity and services diverted to other areas of maternity to maintain safety at all times. This is completed formally as part of safety huddles within a 24 hour period with interim or point prevalent huddles if required.

Acuity and activity are assessed four times daily with a multi professional team being part of the safety huddles on Central Birth Suite, the huddles assess the whole picture across maternity services at ELHT and staff with relevant skills and competencies are moved accordingly to ensure safe staffing throughout the services.

SAFE

**Maternity Midwife to Birth Ratio**

| Month | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staffed to full Establishment | 01:28.7 | 01:29.2 | 01:29 | 01:27 | 01:26 | 01:28 | 01:27 | 01:27 | 01:27 | 01:27 | 01:28 | 01:27 |
| Excluding mat leave and vacancies | 01:29.9 | 01:30.8 | 01:30 | 01:28.4 | 01:27.5 | 01:29 | 01:28 | 01:28 | 01:28 | 01:28 | 01:29 | 01:28 |
| With gaps filled through ELHT Midwife staff bank | 01:28.8 | 01:29.4 | 01:29 | 01:27 | 01:26 | 01:28 | 01:27 | 01:27 | 01:27 | 01:27 | 01:28 | 01:27 |
| | Bank Usage 7.9 WTE | Bank Usage 9.5 WTE | Bank Usage 9.28 WTE | Bank Usage 9.5 WTE | Bank Usage 6.5WTE | Bank Usage 5.74WTE | Bank Usage 5.8WTE | Bank Usage 7.0WTE | Bank Usage 4.8WTE | Bank Usage 6.3WTE | Bank Usage 5.17 WTE | Bank Usage 7.27 WTE |

The staffing figures do not reflect how many women were in labour or acuity of areas.
The midwife to birth ratio should be 1:28 for the period 01/10/18 - 31/03/19

**Family Care Staffing Red Flag Events**

On reviewing Datix, 12 incidents were reported overall as Red Flag events in Family Care Division in May 2019
Of the 12 incidents reported, 8 have been excluded as they related to outpatient services.
Of the remaining 4 incidents reported, all of them occurred within Maternity Services. All 4 were reported under the category Maternity / Obstetrics with sub-categories of missed or delayed care X 3 and staff moved to another site ward X1.
The incidents were reported under the following category and sub-categories:

**Maternity Services -**
1 Maternity / Obstetrics - missed or delayed care. *Low / Minor*
1 Maternity / Obstetrics – missed or delayed care. *Impact not prevented.*
1 Maternity / Obstetrics – missed or delayed care. *Impact prevented.*
1 Maternity / Obstetrics – staff moved to another site ward. *Impact prevented.*

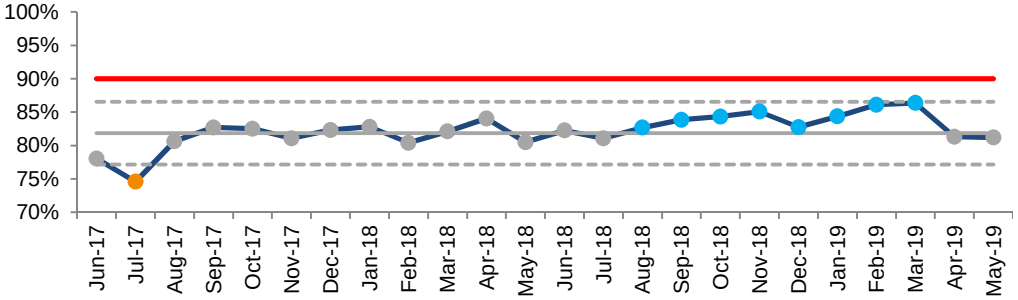
**No harm** was caused.
There was appropriate escalation and implementation of the escalation policy when acuity and activity was high. Workload was prioritised and staff moved to the areas with the highest workload. All area leads, shift co-ordinators, Matron on Call, and Night Manager were informed of plans and communication with all disciplines involved in care and service delivery was excellent throughout.
The notes were requested and reviewed for the incident relating to missed or delayed treatment and no gaps in care were identified

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

CARING

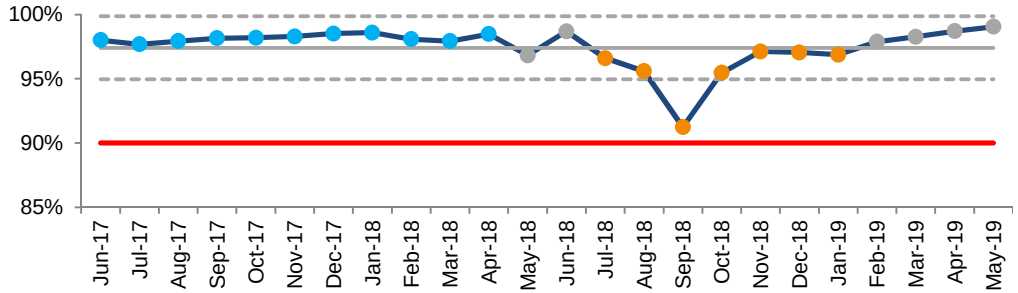
These metrics reflect national measurement methodology, which measures the proportion of patients that would recommend the Trust to friends and family. The threshold has been set at 90% since April 2018.

## Friends & Family A&E



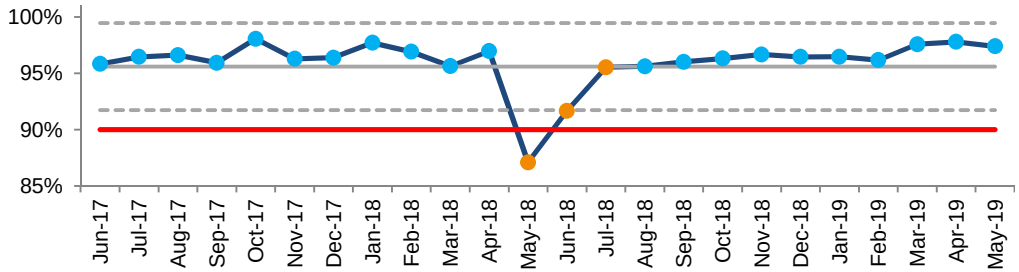

A&E scores show normal variation following a period of significant improvement since August 2018. Based on current variation this indicator is not capable of hitting the target.

## Friends & Family Inpatient



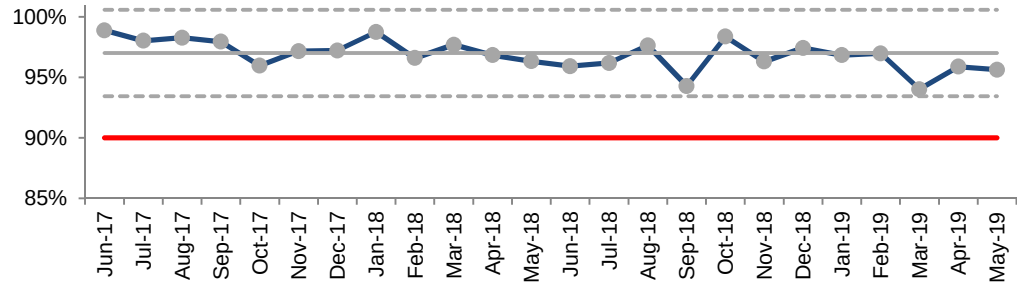

Inpatient scores show no significant change after a period of significant low scores ending in February 19 . Based on current variation this indicator should consistently hit the target.

## Friends & Family Community




Community scores show significant improvement for the past 10 months. Based on current variation this indicator should consistently hit the target.

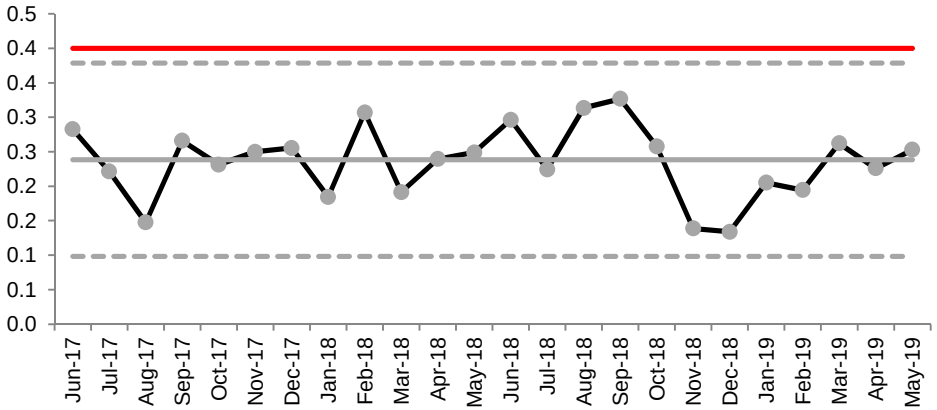
## Friends & Family Maternity




Maternity scores show no recent significant change and based on current variation this indicator should consistently hit the target.

CARING

## Complaints per 1000 contacts




The Trust opened 33 new formal complaints in May. The number of complaints closed was 31.

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

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

The trend is showing no significant change and based on current variation will consistently achieve the target.

## Patient Experience

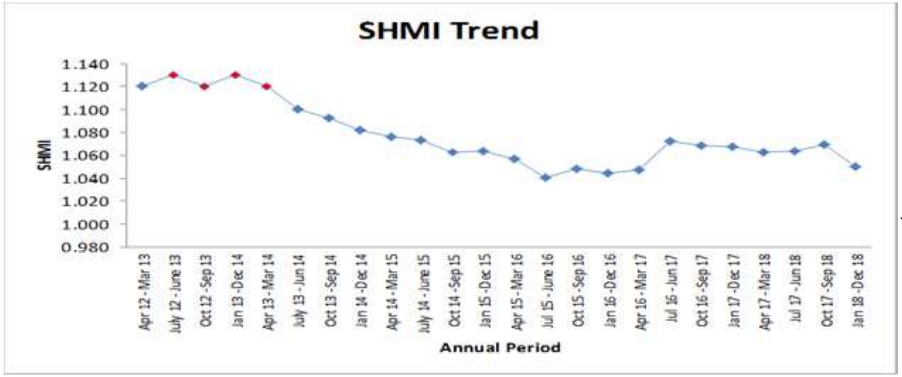
| May 2019 Totals | Dignity | Information | Involvement | Quality | Overall |
|---|---|---|---|---|---|
| | Average Score % | Average Score % | Average Score % | Average Score % | Average Score % |
| Trust | 96 | 90 | 93 | 95 | 93 |
| Integrated Care Group – Acute | 95 | 90 | 93 | 95 | 93 |
| Integrated Care Group – Community | 96 | 94 | 94 | 95 | 95 |
| Surgery | 92 | 87 | 88 | 91 | 89 |
| Family care | 99 | 93 | 98 | 97 | 97 |
| Diagnostic and Clinical | 96 | 93 | 94 | 96 | 95 |

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

Three divisional areas fell below threshold in May in the Surgical Division.

EFFECTIVE

SHMI Published Trend




The latest Trust SHMI value as reported by the Health and Social Care Information Centre and Care Quality Commission for the period January 18 to December 18 has improved to 1.05 and is still within expected levels, as published in May 19.

Dr Foster HSMR rolling 12 month

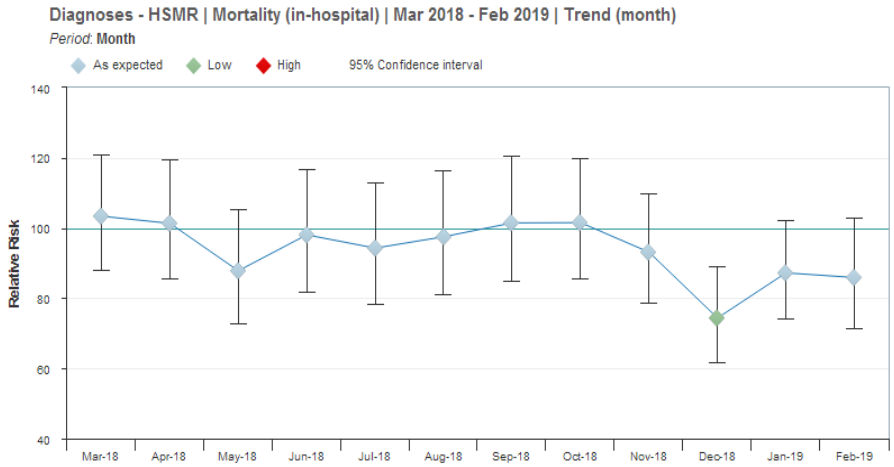
| | HSMR Rebased on latest month Mar 18 – Feb 19 (Risk model Nov 18) |
|---|---|
| **TOTAL** | 93.5 (CI 89.0 – 98.2) |
| **Weekday** | 93.5 (CI 88.2 – 98.9) |
| **Weekend** | 93.6 (CI 84.7 – 103.2) |
| **Deaths in Low Risk Diagnosis Groups** | 97.6 (CI 60.0 – 149.0) |

The latest indicative 12 month rolling HSMR (March 18 – February 19) remains 'significantly better than expected' at 93.5 against the monthly rebased risk model.

The weekday HSMR is also 'significantly better than expected'

Septicaemia continues to alert on the HSMR and the SHMI.

Dr. Foster HSMR monthly Trend




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

No further learning disability deaths were reviewed through the Learning Disability Mortality Review Panel. All cases have been reported to the LeDeR National Programme. The LDMR Panel continue to meet on a monthly basis as required to review cases.

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

EFFECTIVE

## Structured Judgement Review Summary

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

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

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

| | Month of Death | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Stage 1 | pre Oct 17 | Oct 17 - Mar 18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | TOTAL |
| Deaths requiring SJR (Stage 1) | 47 | 212 | 41 | 26 | 21 | 26 | 19 | 27 | 21 | 15 | 14 | 21 | 3 | 7 | 22 | 5 | 527 |
| Allocated for review | 47 | 212 | 41 | 26 | 21 | 26 | 19 | 27 | 21 | 15 | 14 | 21 | 3 | 7 | 22 | 5 | 527 |
| SJR Complete | 46 | 212 | 41 | 24 | 20 | 25 | 19 | 27 | 20 | 12 | 12 | 17 | 1 | 5 | 5 | 0 | 486 |
| 1 - Very Poor Care | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| 2 - Poor Care | 8 | 19 | 2 | 2 | 3 | 2 | 0 | 1 | 3 | 1 | 2 | 2 | 0 | 1 | 1 | 0 | 47 |
| 3 - Adequate Care | 14 | 68 | 10 | 9 | 1 | 9 | 7 | 10 | 4 | 4 | 3 | 3 | 0 | 2 | 0 | 0 | 144 |
| 4 - Good Care | 20 | 106 | 26 | 9 | 13 | 11 | 9 | 14 | 12 | 6 | 5 | 11 | 1 | 2 | 4 | 0 | 249 |
| 5 - Excellent Care | 3 | 18 | 3 | 4 | 3 | 3 | 3 | 2 | 1 | 1 | 2 | 1 | 0 | 0 | 0 | 0 | 44 |
| Stage 2 | | | | | | | | | | | | | | | | | |
| Deaths requiring SJR (Stage 2) | 9 | 20 | 2 | 2 | 3 | 2 | 0 | 1 | 3 | 1 | 2 | 2 | 0 | 1 | 1 | 0 | 49 |
| Deaths not requiring Stage 2 due to undergoing SIRI or similar | 3 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 |
| Allocated for review | 6 | 18 | 2 | 2 | 2 | 2 | 0 | 1 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 36 |
| SJR-2 Complete | 6 | 18 | 2 | 2 | 2 | 2 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 35 |
| 1 - Very Poor Care | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| 2 - Poor Care | 3 | 6 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 |
| 3 - Adequate Care | 2 | 10 | 1 | 1 | 2 | 2 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 20 |
| 4 - Good Care | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| 5 - Excellent Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | pre Oct 17 | t 17 - Mar | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| stage 1 requiring allocation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| stage 1 requiring completion | 1 | 0 | 0 | 2 | 1 | 1 | 0 | 0 | 1 | 3 | 2 | 4 | 2 | 2 | 17 | 5 | 41 |
| Backlog | 1 | 0 | 0 | 2 | 1 | 1 | 0 | 0 | 1 | 3 | 2 | 4 | 2 | 2 | 17 | 5 | 41 |
| stage 2 requiring allocation | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 2 | 2 | 0 | 1 | 1 | 0 | 8 |
| stage 2 requiring completion | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Backlog | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 2 | 2 | 0 | 1 | 1 | 0 | 9 |

## EFFECTIVE

Commissioning for Quality and Innovation (CQUIN)

in 2019/20 the Trust is participating in the following 5 national CQUIN schemes as agreed with the CSU.

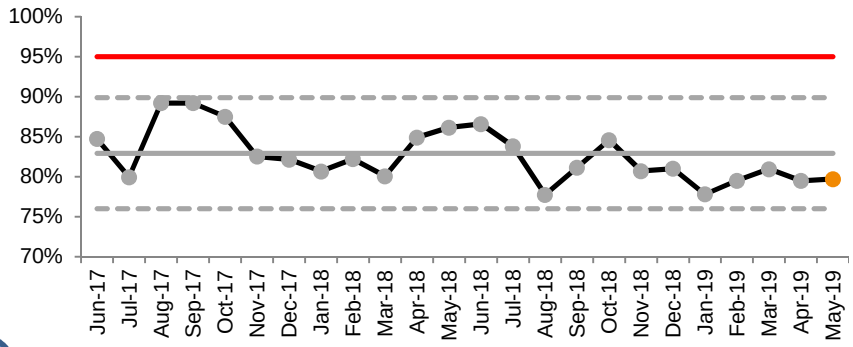
1. NHS Staff Health and Wellbeing - Staff Flu Vaccinations
2. Alcohol and Tobacco Brief advice
3. Three High Impact interventions to prevent Hospital Falls
4. Antimicrobial Resistance –Urinary Tract Infections and Antibiotic Prophylaxis for Elective Colorectal Surgery
5. Same Day Emergency Care –Pulmonary Embolus/ Tachycardia with Atrial Fibrillation/ Pneumonia

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

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

RESPONSIVE

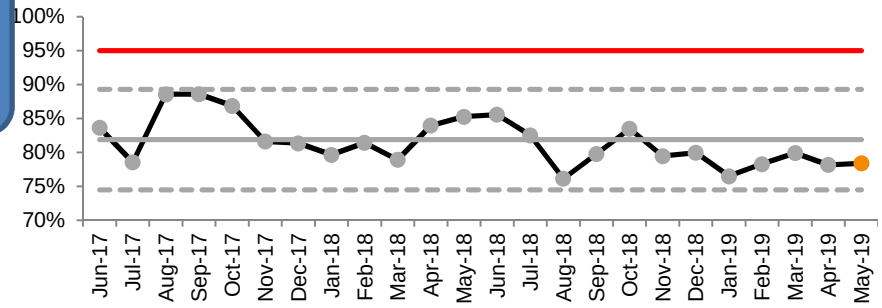
A&E 4 hour standard % performance -




Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 79.7% in May, which remains below the 95% threshold.

The trend is showing significant deterioration and based on current variation is not capable of hitting the target.

A&E 4 hour standard % performance - Trust

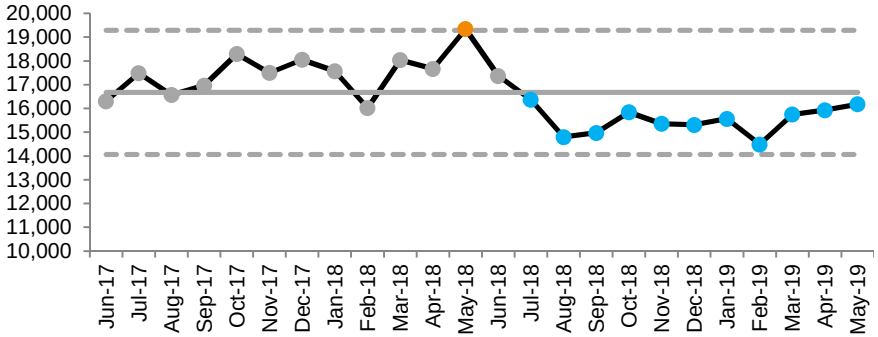



Performance against the ELHT four hour standard was 78.4% in May.

The trend is showing significant deterioration and based on current variation is not capable of hitting the target.

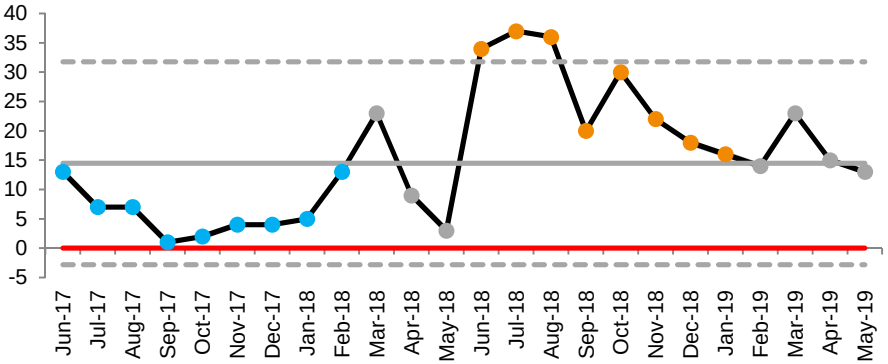
The national performance improved to 86.6% in May (All types) with 7 out of 119 reporting trusts with type 1 departments achieving the 95% standard. (Field testing sites excluded)

A&E Attendances - Trust




The number of attendances during May was 16,180 and the trend is showing a significant reduction in attendances since June 18, when the HAC closed.

12 Hr Trolley Waits

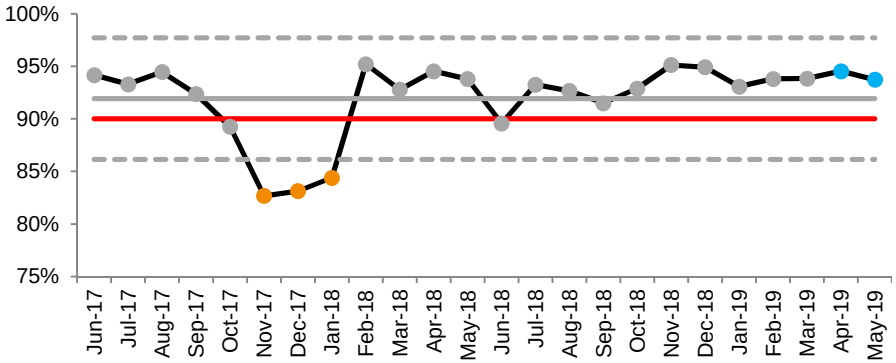



There were 13 reported breaches of the 12 hour trolley wait standard from decision to admit during May. 11 were mental health breaches and 2 were physical health breaches. Rapid review timelines are completed in accordance with the NHS England Framework and a root cause analysis will be undertaken.

The trend is showing normal variation following a period of significantly higher numbers.

RESPONSIVE

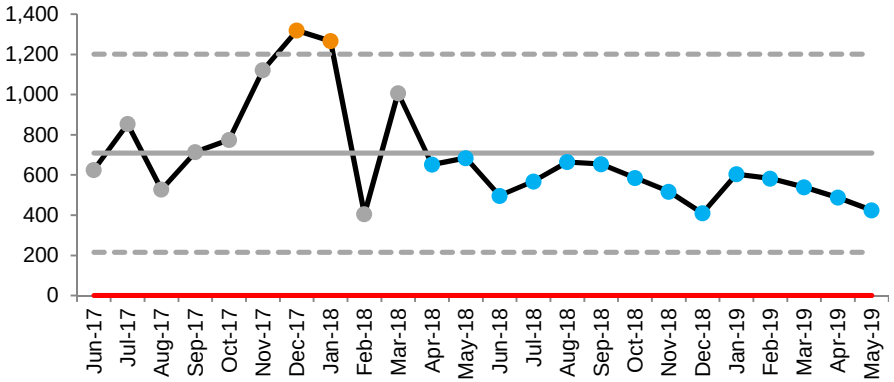
## HAS Compliance




The ambulance handover compliance indicator measures the compliance with PIN entry on completion of patient handover. This was achieved at 93.7% in May, which is above the 90% threshold.

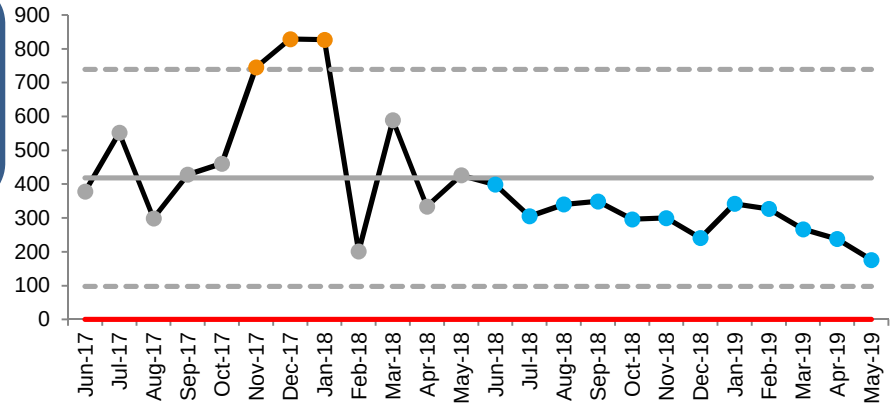
The trend is showing significant improvement, however based on current variation, the target is still at risk of failure.

## Ambulance Handovers - >30Minutes




The number of handovers over 30 minutes is showing significant improvement, with 424 reported for May.

## Ambulance Handovers - HAS Confirmed Penalty >30Minutes



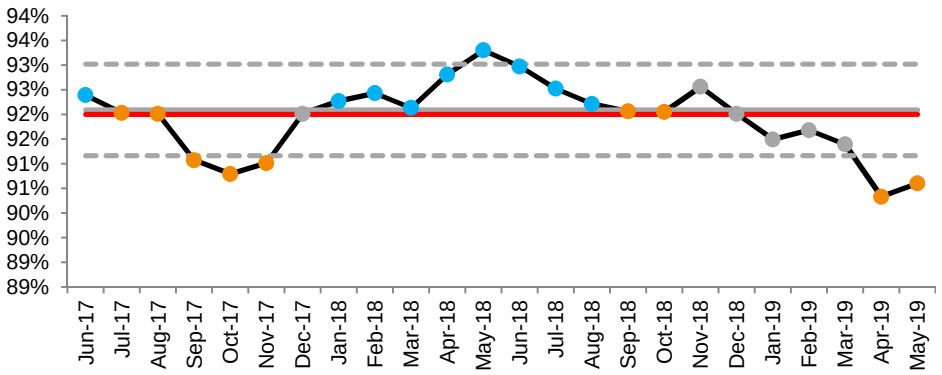

The validated NWAS penalty figures are reported as at May as;- 134 missing timestamps, 153 handover breaches (30-60 mins) and 23 handover breaches (>60 mins).

The trend is showing significant improvement, however based on current variation, the indicator is not capable of hitting the target.

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

RESPONSIVE

## RTT Ongoing %

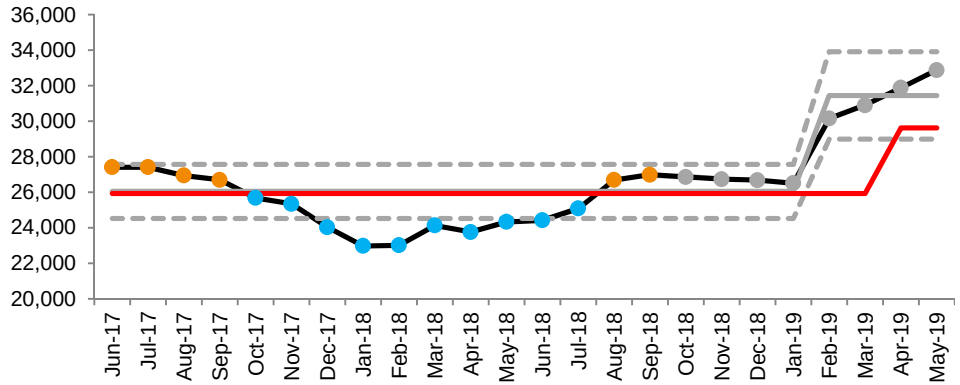



The 18 week referral to treatment (RTT) % ongoing position was not achieved in May with 90.6% patients, waiting less than 18 weeks to start treatment at month end.

The trend is showing significant deterioration in the last 2 months and based on current variation this indicator is at risk of failing the target.

The latest published figures from NHS England show continued failure of the ongoing standard nationally (reported 1 month behind), with 86.5% of patients waiting less than 18 weeks to start treatment in April.

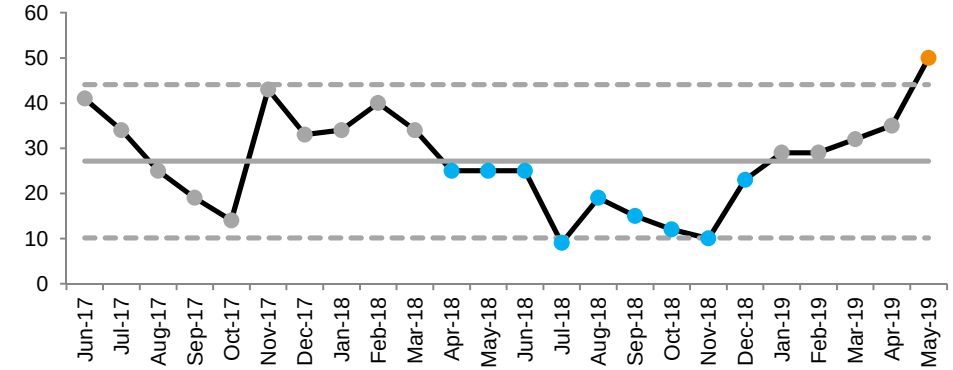
## RTT Total Ongoing




The total ongoing RTT pathways is showing a significant increase in total numbers ongoing at the end of the month. This is mostly due to the inclusion of additional patients from the MSK service, from February 2019.
The target has been revised for 2019/20 to reduce the total to less than 29,619 by end of March 2020.

The rebased trend shows the indicator is at risk of not achieving this reduction.

## RTT Total Over 40 wks



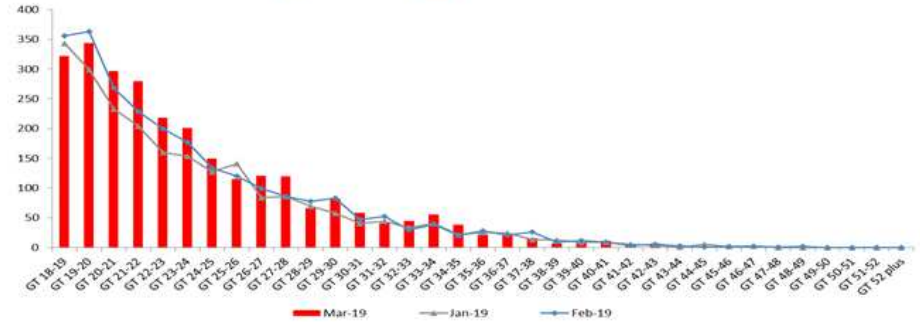

The number of pathways over 40wks has increased significantly in May with 50 patients waiting over 40 wks at month end.

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

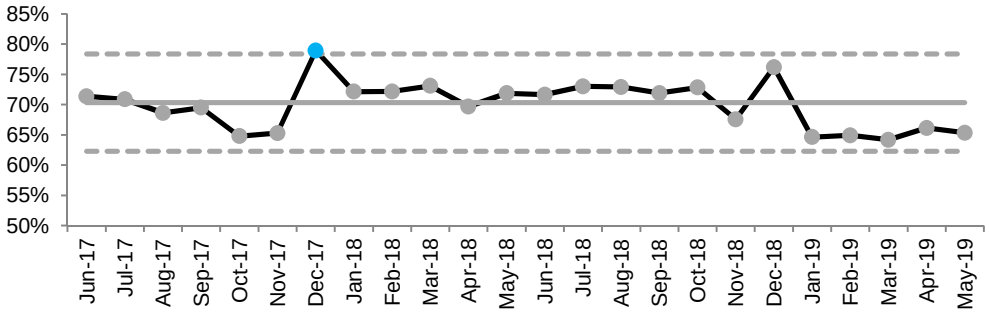
RESPONSIVE

RTT Ongoing 0-18 Weeks

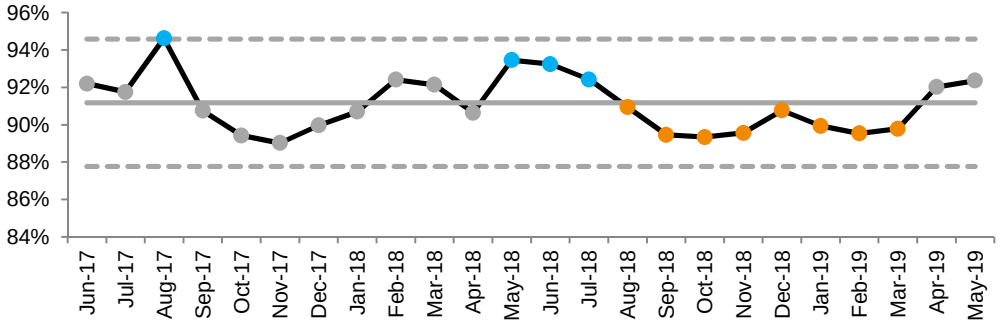

RTT Over 18 weeks




RTT Admitted




RTT Non-Admitted



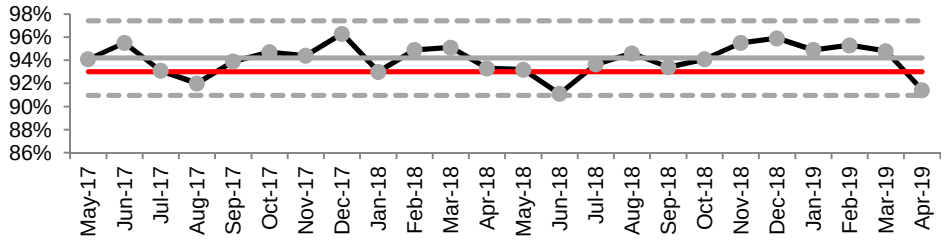

The bar charts show the numbers of RTT ongoing pathways by weekband, compared with previous 2 months.

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

The trend for RTT admitted and non-admitted is showing normal variation.

RESPONSIVE

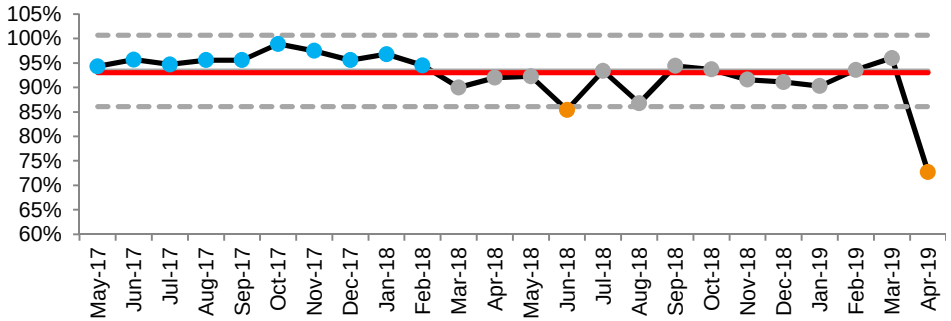
## Cancer 2 Week




The cancer 2 week wait for GP referrals standard was not achieved in April at 91.4%, below the 93% threshold.

The trend is showing normal variation and based on current variation, the indicator is at risk of failing the standard.

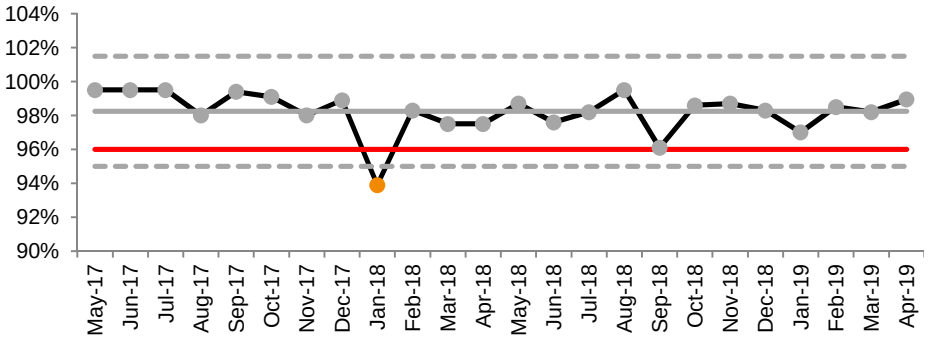
## Cancer 2 Week - breast




The 2 week breast symptomatic standard was not achieved in April at 72.7%, below the 93% threshold.

The trend shows a significant decline in performance for April and based on current variation this indicator is at risk of failing the standard.

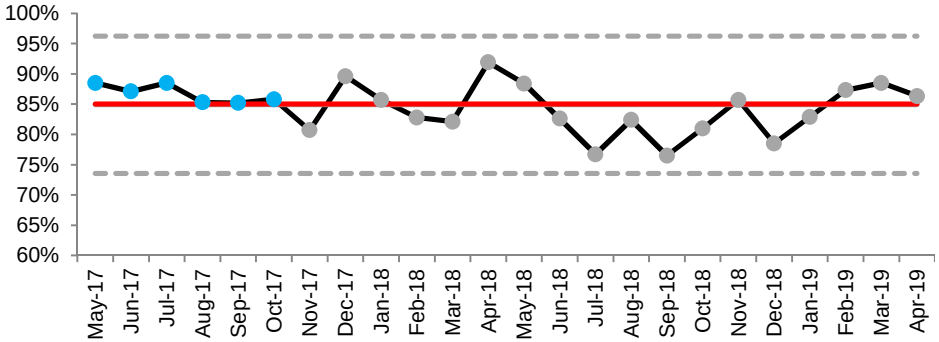
## Cancer 31 day




The 31 day standard was achieved in April at 99.0%, above the 96% threshold.

The trend is showing no significant change and based on current variation may occasionally fall below the standard.

## 62 Day Cancer

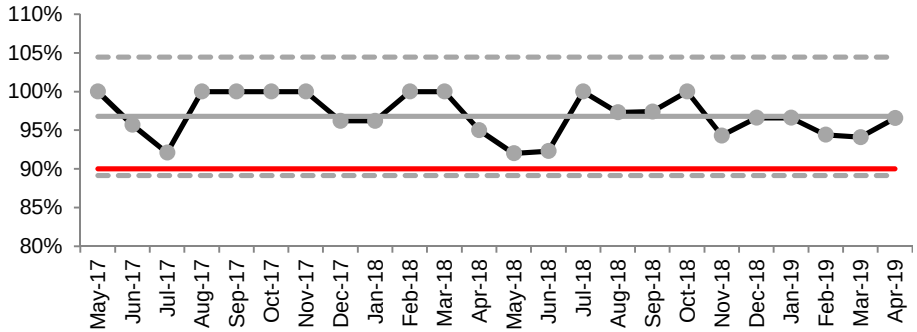



The 62 day cancer standard was achieved in April at 86.3% above the 85% threshold.

The trend is showing normal variation and based on the current variation, the indicator is at risk of not meeting the standard.

RESPONSIVE

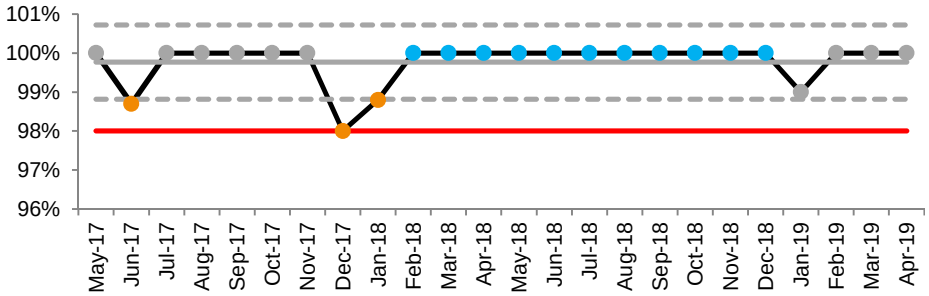
## 62 Day Screening




62 day screening performance was achieved in April at 96.6%, above the 90% threshold.

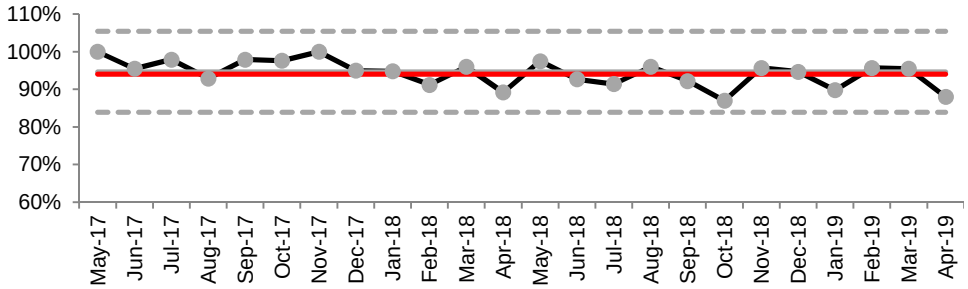
The trend is showing no significant change and based on current variation may occasionally fall below standard.

## Cancer - Subsequent treatment within



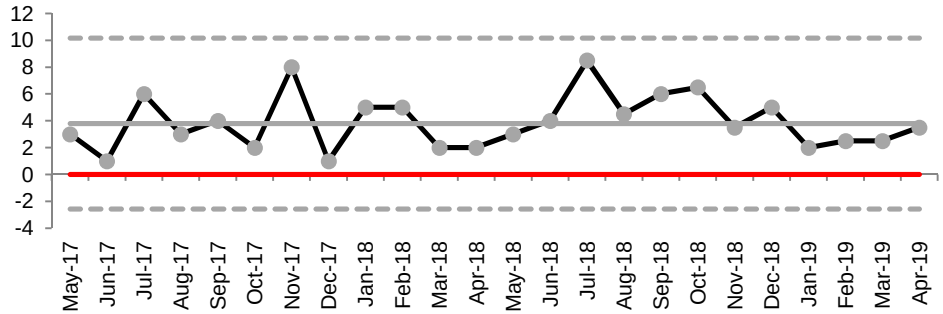

The subsequent treatment - drug standard was met in April at 100%. The trend shows no significant change and based on the current variation, the indicator will consistently achieve the standard.

## Cancer - Subsequent treatment within 31 days (Surgery)




The subsequent treatment - surgery standard was not met in April at 88%, below the 94% standard. The trend shows no significant change and based on the current variation, the indicator is at risk of falling below threshold.

## Cancer Patients Treated > Day 104

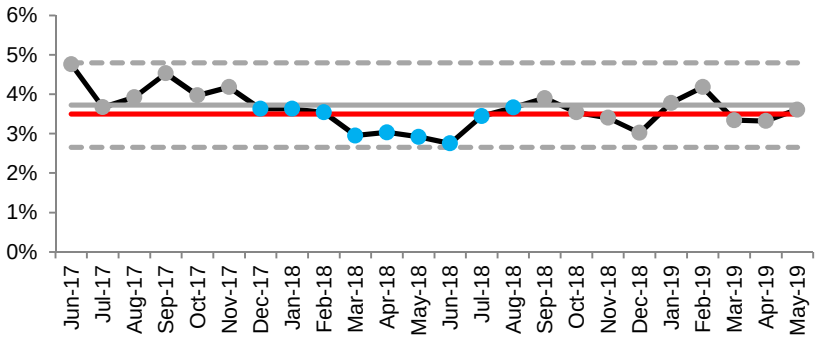



There were 3.5 breaches allocated to the Trust, treated after day 104 in April and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the Consultants involved in the pathway as required.

The trend is showing no significant change.

RESPONSIVE

## Delayed Discharges per 1000 bed days

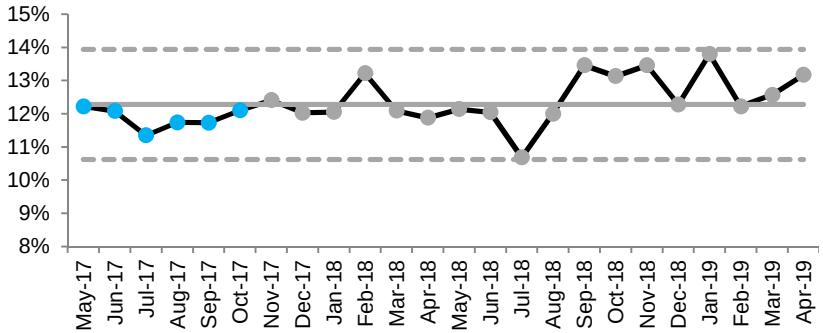



The proportion of delays reported against the delayed transfers of care standard was 3.6% for May.

The trend is showing no significant change and based on current variation this indicator may or may not achieve the target.

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

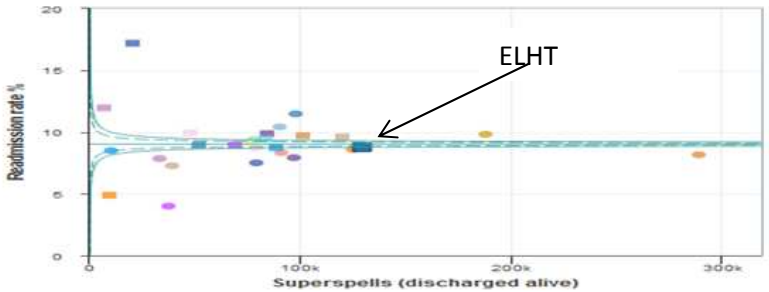
## Emergency Readmissions



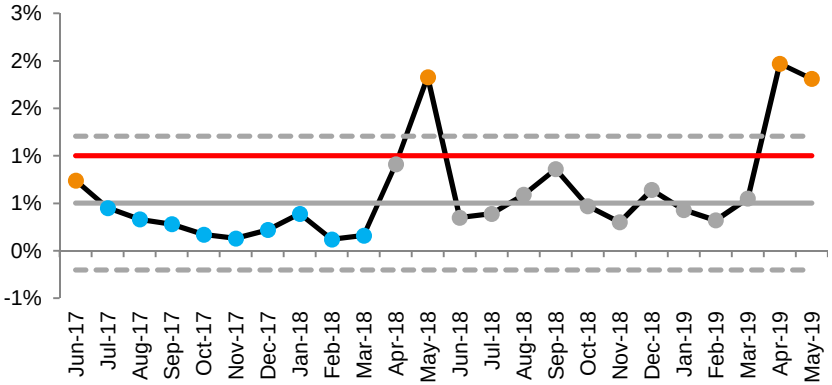

The emergency readmission rate trend is showing no significant change.

Dr Foster benchmarking shows the ELHT readmission rate is

**Readmissions within 30 days vs North West - Dr Foster**




## Diagnostic Waits




In May 1.8% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is above the 1% threshold.

The trend is showing the last 2 months are significantly high and based on current variation this indicator is at risk of failing the target.

Nationally, the performance is still failing the 1% target at 3.6% in April (reported 1 month behind).

RESPONSIVE

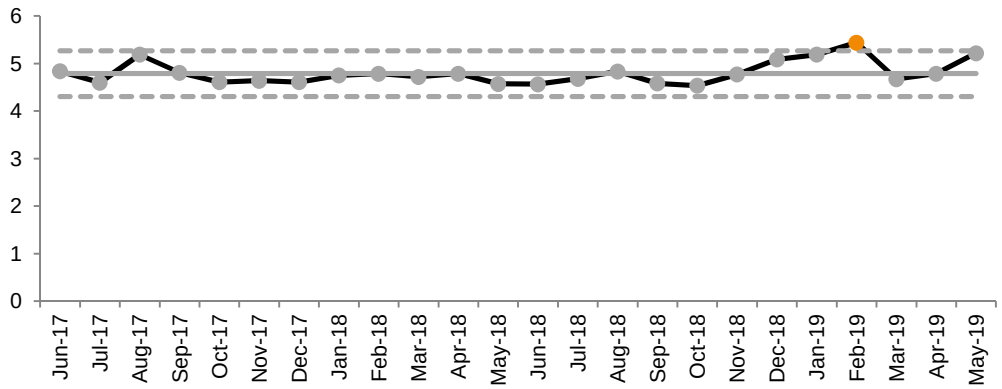
## Average length of stay benchmarking

Dr Foster Benchmarking March 18 - February 19

| | Spells | Inpatients | Day Cases | Expected LOS | LOS | Difference |
|---|---|---|---|---|---|---|
| Elective | 62,007 | 9,390 | 52,617 | 3.4 | 2.6 | -0.8 |
| Emergency | 56,829 | 56,829 | 0 | 4.6 | 4.6 | 0.1 |
| Maternity/ Birth | 13,359 | 13,359 | 0 | 2.1 | 2.4 | 0.2 |
| Transfer | 209 | 209 | 0 | 11.6 | 27.5 | 15.9 |

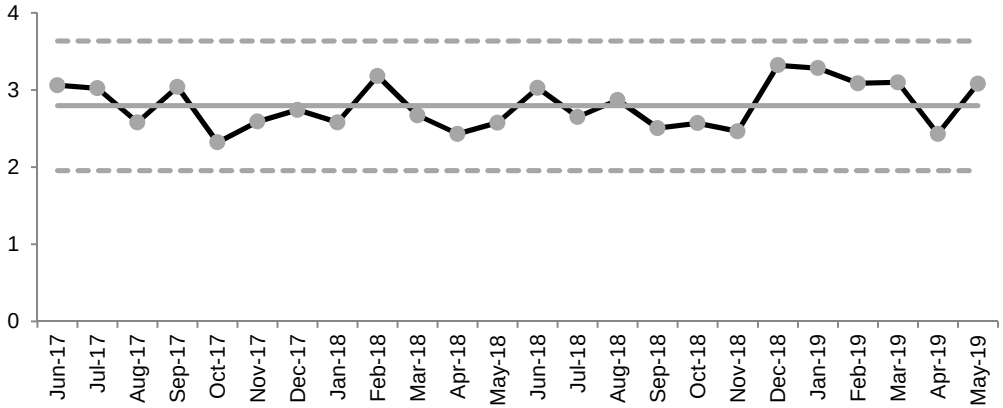
Dr Foster benchmarking shows the Trust length of stay to be as expected for non-elective and below expected for elective when compared to national case mix adjusted.

## Average length of stay - non elective




The Trust non elective average length of stay is showing no significant change

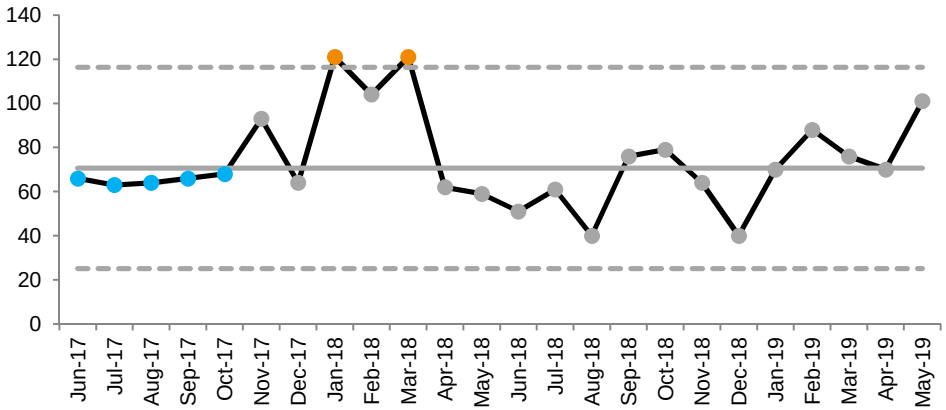
## Average length of stay - elective




The Trust elective average length of stay is showing no significant change

RESPONSIVE

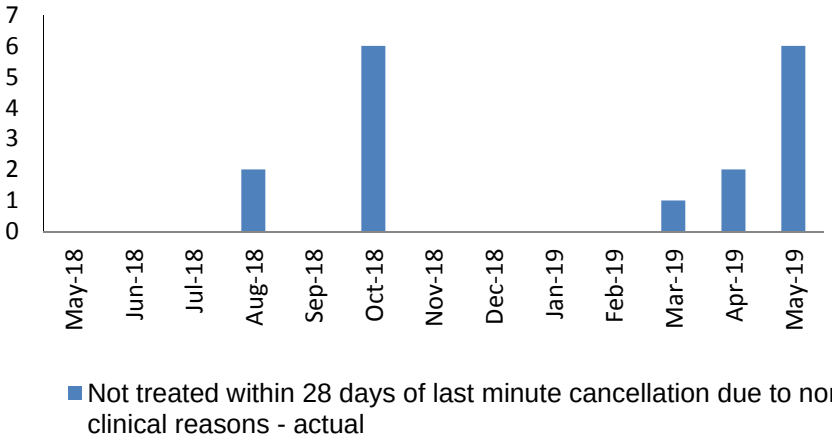
## Operations cancelled on day




There were 101 operations cancelled on the day of operation - non clinical reasons, in May.

The trend is showing normal variation.

## Operations cancelled on day - breaches of 28 day standard




There were six 'on the day' cancelled operation not rebooked within 28 days in May.

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

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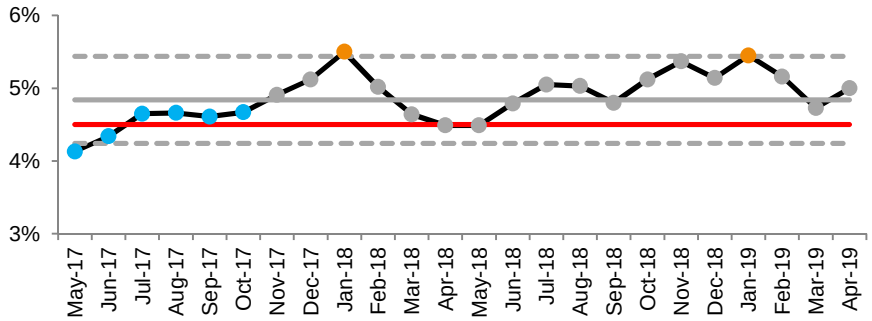
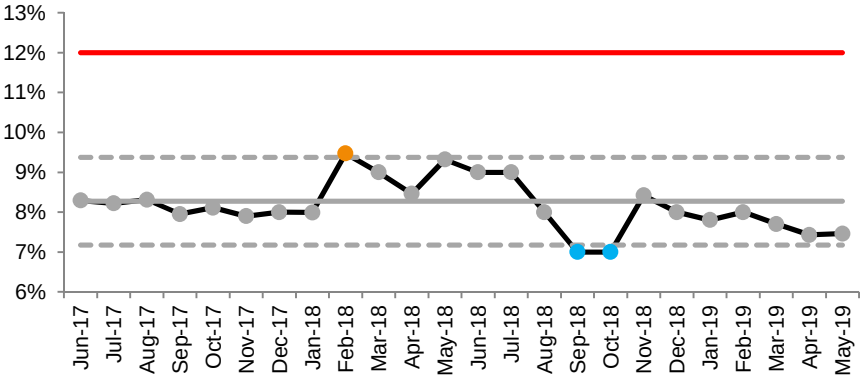
## Sickness



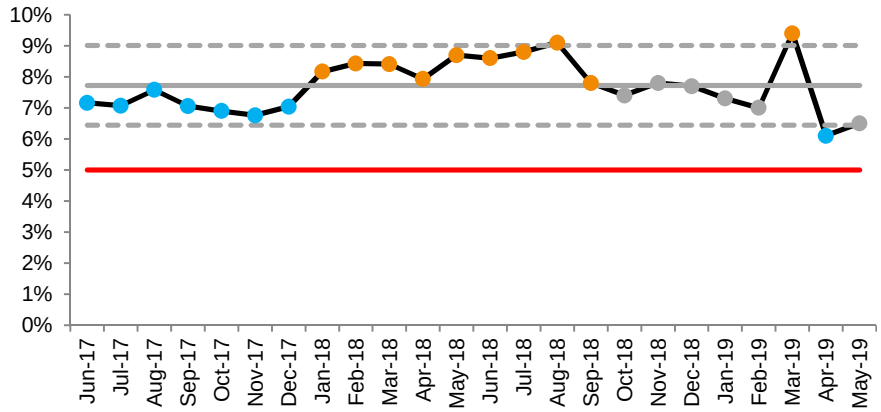

The sickness absence rate is 5% for April which is above threshold. The trend is showing normal variation and based on the current level of variaton, may occasionally acheive the target.

## Turnover Rate




The trust turnover rate is 7.5% in May which is below threshold. Based on current variation, the indicator will consistently achieve target.

## Vacancy Rate




The vacancy rate is 6.5% for May which is above the 5% threshold.

The trend is showing normal variation and based on current variation, will consistently be above threshold.

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

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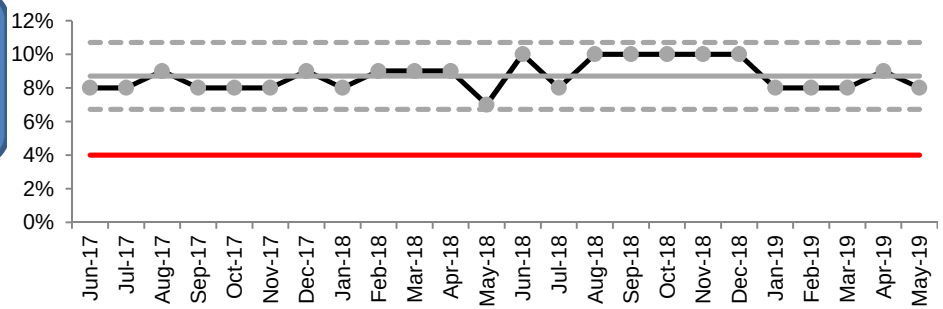
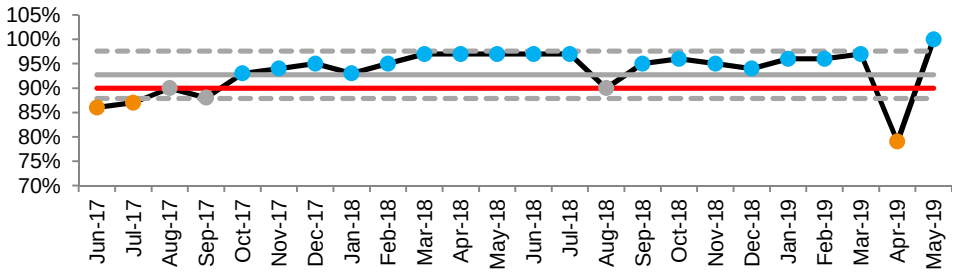
## Temporary costs and overtime as % total pay bill




In May 2019 £2.6 million was spent on temporary staff. £1 million expenditure on agency staff and £1.6 million expenditure on bank staff.
Wte staff worked (8,268 wte) was 92 wte less than is funded substantively (8,360 wte).
Pay costs are £784k less than budgeted establishment in May.

At the end of May 19 there were 529 vacancies

## Appraisals, Consultant

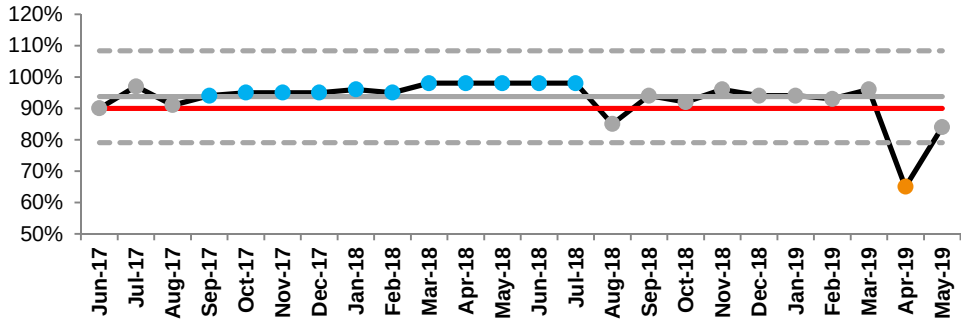



The temporary staffing cost trend shows no significant change and is not capable of hitting the target.

The appraisal rates for consultants and career grade doctors are reported cumulative year to date and reflect the number of reviews completed that were due in this period.

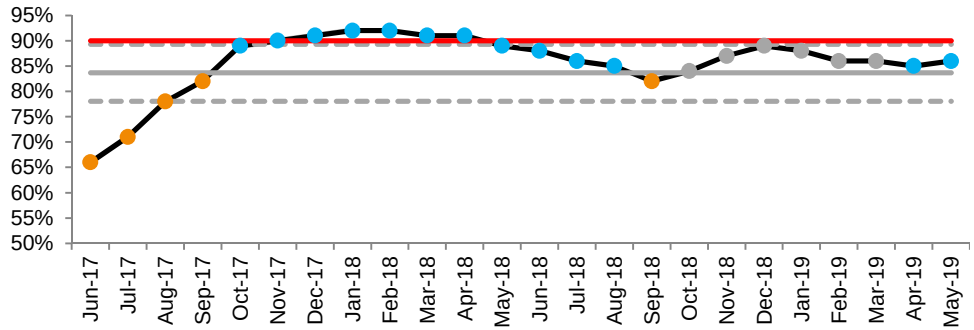
The trend for consultant appraisals shows improvement following a drop in April however based on current variation is still at risk of not achieving the target.

## Appraisals, Other Medical




The trend for medical staff appraisal rates is showing normal variation, following a drop in April and based on current variation is at risk of non achievement.

## Appraisals AFC




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

The trend is showing improvement, however based on current variation the indicator is not capable of achieving the target

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

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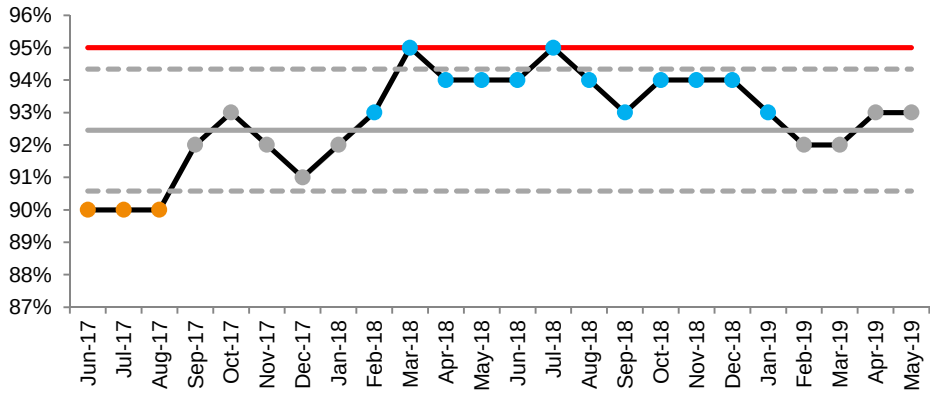
## Job Plans

| Stage | Consultant | SAS Doctor |
|---|---|---|
| Draft | 0 | |
| In discussion with 1st stage manager | 214 | 27 |
| 1st stage sign off by consultant | 21 | |
| 1st stage sign off by manager | 29 | 1 |
| 2nd stage sign off | 14 | |
| Signed Off | 20 | |

There are 298 Consultants and 28 SAS doctors registered with a job plan on Allocate.

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

## Information Governance Toolkit Compliance




Information governance toolkit compliance has remained at 93% in May below the 95% threshold. The trend is showing normal variation, however based on current variation, the indicator is not capable of achieving the target.

## Core Skills Training %

| | Target | Compliance at end May |
|---|---|---|
| Basic Life Support | 90% | 92% |
| Conflict Resolution Training Level 1 | 90% | 97% |
| Equality, Diversity and Human Rights | 90% | 97% |
| Fire Safety | 90% | 97% |
| Health, Safety and Welfare Level 1 | 90% | 98% |
| Infection Prevention | 90% | 97% |
| Information Governance | 95% | 93% |
| Prevent Healthwrap | 90% | 96% |
| Safeguarding Adults | 90% | 97% |
| Safeguarding Children | 90% | 95% |
| Safer Handling Theory | 90% | 97% |

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

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

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

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## Finance & Use of Resource metrics

| Area | Metric | Actual YTD Performance | Actual YTD Score | Forecast outturn Performance | Forecast outturn Score |
|---|---|---|---|---|---|
| Financial sustainability | Capital service capacity | 1.8 | 2 | 1.8 | 2 |
| | Liquidity (days) | (5.6) | 2 | (5.3) | 2 |
| Financial efficiency | I&E margin | 1.0% | 1 | 1.3% | 1 |
| Financial control | Variance from control total rating | 0.0% | 1 | 0.0% | 1 |
| | Agency spend | 48.7% | 3 | 34.9% | 3 |
| Total | | | 2 | | 2 |

For 2019-20, the Trust has agreed an underlying control total of a £7.0 million deficit, which gives the Trust access to up to £13.6 million of Provider Sustainability Fund (PSF) and Marginal Rate Emergency Rule (MRET) funding.

Access to the £9.2 million PSF allocation is conditional on achieving the 4 hour target (30%) and the underlying control total (70%).

At month 2 the Trust is reporting an underlying £0.8 million deficit, in line with its financial plans.

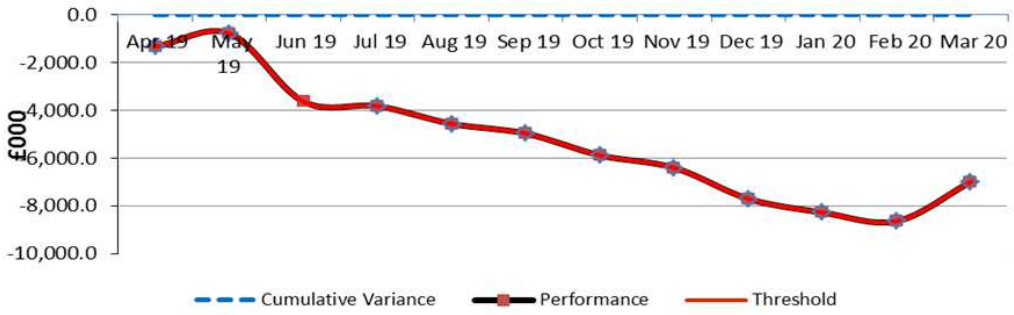
The Safely Releasing Cost Programme (SRCP) is £16.4 million for 2019-20. £5.6 million has been actioned to month 2, of which £3.2 million is recurrent.

The Better Payment Practice Code (BPPC) targets have been achieved across all four areas both in month 2 and for the financial year to date.

The 'Finance and use of resources metrics score' of 2 for the financial year is consistent with the planned position.

The cash balance as at 30 April 2019 was £9.1 million.

## Adjusted financial performance




* - excludes PSF allocation

## Efficiency Savings

| Division | Target | Green | Amber | Red | Total | Non Rec | Rec | Identified |
|---|---|---|---|---|---|---|---|---|
| | | £000's | £000's | £000's | £000's | £000's | £000's | £000's |
| Medicne & Emergency Care | 2,093 | 470 | 1,952 | 20 | 2,442 | 0 | 470 | 470 |
| Community & Intermediate Care | 882 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SAS | 4,844 | 393 | 465 | 2,120 | 2,978 | 37 | 356 | 393 |
| Family Care | 3,040 | 703 | 190 | 1,349 | 2,242 | 639 | 64 | 703 |
| DCS | 1,113 | 1,113 | 0 | 0 | 1,113 | 0 | 1,113 | 1,113 |
| Estates & Facilities | 1,356 | 56 | 790 | 300 | 1,146 | 0 | 56 | 56 |
| Corporate Services | 672 | 235 | 154 | 90 | 479 | 0 | 235 | 235 |
| Cross divisional | 0 | 0 | 2,612 | 0 | 2,612 | 0 | 0 | 0 |
| Targetted Transformation | 2,433 | 2,597 | 625 | 200 | 3,422 | 1,634 | 963 | 2,597 |
| **Total** | **16,433** | **5,567** | **6,788** | **4,079** | **16,434** | 2,310 | 3,257 | 5,567 |

# Safe Staffing (Rota Fill Rates and CHPPD ) Collection

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

Trust Website where staffing information is available

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

| Hospital Site Details | | Ward name | Main 2 Specialties on each ward | | Day | | | | Night | | | | Day | | Night | | Care Hours Per Patient Day (CHPPD) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | midwives/nurses | | Care Staff | | midwives/nurses | | Care Staff | | | | | | | | | |
| Site code | Hospital Site name | Ward Name | Specialty 1 | Specialty 2 | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Average fill rate - nurses/midwives (%) | Average fill rate - care staff (%) | Average fill rate - nurses/midwives (%) | Average fill rate - care staff (%) | Cumulative count over the month of patients at 23:59 each day | Nurses & Midwives | Care staff | Overall |
| RXR60 | ACCRINGTON VICTORIA HOSPITAL - RXR60 | Ward 2 | 314 - REHABILITATION | | - | - | - | - | - | - | - | - | 0.0% | 0.0% | 0.0% | 0.0% | 0 | #DIV/0! | #DIV/0! | #DIV/0! |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Acute Stroke Unit (ASU) | 300 - GENERAL MEDICINE | | 1,800 | 1,530 | 1,440 | 1,506 | 1,080 | 1,044 | 1,080 | 1,128 | 85.0% | 104.6% | 96.7% | 104.4% | 646 | 3.98 | 4.08 | 8.06 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | B18 | 320 - CARDIOLOGY | | 1,752 | 1,524 | 1,080 | 1,260 | 1,080 | 1,068 | 720 | 960 | 87.0% | 116.7% | 98.9% | 133.3% | 721 | 3.60 | 3.08 | 6.67 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | B20 | 100 - GENERAL SURGERY | | 1,392 | 1,176 | 696 | 768 | 672 | 696 | 672 | 816 | 84.5% | 110.3% | 103.6% | 121.4% | 468 | 4.00 | 3.38 | 7.38 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | B22 | 110 - TRAUMA & ORTHOPAEDICS | | 1,440 | 1,266 | 2,160 | 2,046 | 720 | 720 | 1,800 | 1,932 | 87.9% | 94.7% | 100.0% | 107.3% | 640 | 3.10 | 6.22 | 9.32 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | B24 | 110 - TRAUMA & ORTHOPAEDICS | | 1,440 | 1,200 | 1,080 | 1,260 | 720 | 720 | 720 | 996 | 83.3% | 116.7% | 100.0% | 138.3% | 640 | 3.00 | 3.53 | 6.53 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | B4 | 430 - GERIATRIC MEDICINE | | 1,440 | 1,224 | 2,160 | 2,316 | 720 | 732 | 1,440 | 1,572 | 85.0% | 107.2% | 101.7% | 109.2% | 732 | 2.67 | 5.31 | 7.98 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Blackburn Birth Centre | 501 - OBSTETRICS | | 900 | 953 | 474 | 435 | 645 | 645 | 323 | 323 | 105.8% | 91.7% | 100.0% | 100.0% | 17 | 93.97 | 44.54 | 138.51 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C1 | 300 - GENERAL MEDICINE | | 1,800 | 1,566 | 1,080 | 1,116 | 720 | 720 | 360 | 852 | 87.0% | 103.3% | 100.0% | 236.7% | 448 | 5.10 | 4.39 | 9.50 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C10 | 300 - GENERAL MEDICINE | | 1,440 | 1,182 | 1,440 | 1,320 | 720 | 720 | 1,080 | 1,068 | 82.1% | 91.7% | 100.0% | 98.9% | 644 | 2.95 | 3.71 | 6.66 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C11 | 300 - GENERAL MEDICINE | | 1,440 | 1,176 | 1,440 | 1,572 | 720 | 732 | 1,080 | 1,128 | 81.7% | 109.2% | 101.7% | 104.4% | 647 | 2.95 | 4.17 | 7.12 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C14A | 100 - GENERAL SURGERY | | 1,260 | 1,176 | 720 | 714 | 720 | 732 | 360 | 420 | 93.3% | 99.2% | 101.7% | 116.7% | 479 | 3.98 | 2.37 | 6.35 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C14B | 100 - GENERAL SURGERY | | 1,260 | 1,098 | 720 | 804 | 720 | 720 | 360 | 672 | 87.1% | 111.7% | 100.0% | 186.7% | 486 | 3.74 | 3.04 | 6.78 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C18A | 100 - GENERAL SURGERY | | 1,260 | 1,194 | 720 | 846 | 720 | 720 | 360 | 732 | 94.8% | 117.5% | 100.0% | 203.3% | 507 | 3.78 | 3.11 | 6.89 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C18B | 100 - GENERAL SURGERY | | 1,260 | 1,236 | 720 | 810 | 720 | 732 | 360 | 504 | 98.1% | 112.5% | 101.7% | 140.0% | 520 | 3.78 | 2.53 | 6.31 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C2 | 301 - GASTROENTEROLOGY | MEDICINE | 1,440 | 1,158 | 1,080 | 1,104 | 1,080 | 1,080 | 1,080 | 1,092 | 80.4% | 102.2% | 100.0% | 101.1% | 718 | 3.12 | 3.06 | 6.18 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C22 | 101 - UROLOGY | 120 - ENT | 2,160 | 2,106 | 1,446 | 1,908 | 1,080 | 1,176 | 1,440 | 1,536 | 97.5% | 132.0% | 108.9% | 106.7% | 951 | 3.45 | 3.62 | 7.07 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C3 | 300 - GENERAL MEDICINE | | 1,620 | 1,512 | 1,440 | 1,398 | 1,080 | 1,056 | 1,080 | 1,392 | 93.3% | 97.1% | 97.8% | 128.9% | 786 | 3.27 | 3.55 | 6.82 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C4 | 301 - GASTROENTEROLOGY | MEDICINE | 1,440 | 1,176 | 1,080 | 1,134 | 1,080 | 1,080 | 1,080 | 1,056 | 81.7% | 105.0% | 100.0% | 97.8% | 708 | 3.19 | 3.09 | 6.28 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C5 | 430 - GERIATRIC MEDICINE | | 1,080 | 822 | 1,440 | 1,500 | 720 | 732 | 1,080 | 1,212 | 76.1% | 104.2% | 101.7% | 112.2% | 425 | 3.66 | 6.38 | 10.04 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C6 | 340 - RESPIRATORY MEDICINE | MEDICINE | 1,440 | 1,194 | 1,080 | 1,080 | 1,080 | 1,080 | 720 | 684 | 82.9% | 100.0% | 100.0% | 95.0% | 733 | 3.10 | 2.41 | 5.51 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C7 | 340 - RESPIRATORY MEDICINE | MEDICINE | 1,440 | 1,230 | 1,080 | 1,068 | 720 | 756 | 720 | 936 | 85.4% | 98.9% | 105.0% | 130.0% | 649 | 3.06 | 3.09 | 6.15 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C8 | 340 - RESPIRATORY MEDICINE | MEDICINE | 1,800 | 1,566 | 1,440 | 1,440 | 1,080 | 1,068 | 720 | 768 | 87.0% | 100.0% | 98.9% | 106.7% | 539 | 4.89 | 4.10 | 8.98 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C9 | 300 - GENERAL MEDICINE | | 1,440 | 1,188 | 1,440 | 1,380 | 720 | 720 | 1,080 | 1,068 | 82.5% | 95.8% | 100.0% | 98.9% | 664 | 2.87 | 3.69 | 6.56 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Children's Unit | 420 - PAEDIATRICS | | 4,500 | 4,116 | 1,080 | 884 | 3,465 | 3,238 | 315 | 294 | 91.5% | 81.9% | 93.4% | 93.3% | 834 | 8.82 | 1.41 | 10.23 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Coronary Care Unit (CCU) | 320 - CARDIOLOGY | | 1,440 | 1,194 | 720 | 606 | 1,080 | 1,080 | - | - | 82.9% | 84.2% | 100.0% | 0.0% | 252 | 9.02 | 2.40 | 11.43 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Critical Care Unit | 192 - CRITICAL CARE MEDICINE | | 6,384 | 6,360 | 1,080 | 864 | 6,204 | 6,168 | 372 | 216 | 99.6% | 80.0% | 99.4% | 58.1% | 604 | 20.74 | 1.79 | 22.53 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | D1 | 300 - GENERAL MEDICINE | | 1,440 | 1,170 | 1,080 | 1,176 | 720 | 732 | 720 | 888 | 81.3% | 108.9% | 101.7% | 123.3% | 609 | 3.12 | 3.39 | 6.51 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | D3 | 300 - GENERAL MEDICINE | | 1,440 | 1,134 | 1,080 | 1,146 | 720 | 732 | 720 | 960 | 78.8% | 106.1% | 101.7% | 133.3% | 581 | 3.21 | 3.62 | 6.84 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Medical Assessment Unit (AMUA) | 300 - GENERAL MEDICINE | | 3,600 | 3,528 | 2,160 | 2,448 | 3,240 | 3,168 | 1,440 | 1,620 | 98.0% | 113.3% | 97.8% | 112.5% | 1174 | 5.70 | 3.47 | 9.17 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Medical Assessment Unit (AMUB) | 300 - GENERAL MEDICINE | | 3,240 | 3,078 | 2,160 | 2,118 | 2,880 | 2,832 | 1,800 | 1,740 | 95.0% | 98.1% | 98.3% | 96.7% | 1183 | 5.00 | 3.26 | 8.26 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Neonatal Intensive Care Unit | 420 - PAEDIATRICS | | 4,680 | 4,494 | 360 | 264 | 4,320 | 3,804 | - | 228 | 96.0% | 73.3% | 88.1% | 22800.0% | 653 | 12.71 | 0.75 | 13.46 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Surgical Triage Unit | 100 - GENERAL SURGERY | | 2,520 | 2,394 | 1,800 | 1,758 | 1,572 | 1,602 | 1,440 | 1,440 | 95.0% | 97.7% | 101.9% | 100.0% | 685 | 5.83 | 4.67 | 10.50 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Antenatal Ward | 501 - OBSTETRICS | | 1,840 | 1,731 | 896 | 870 | 1,080 | 1,020 | 720 | 696 | 94.1% | 97.1% | 94.4% | 96.7% | 130 | 21.16 | 12.05 | 33.21 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Burnley Birth Centre | 501 - OBSTETRICS | | 1,350 | 1,340 | 360 | 381 | 1,080 | 1,080 | 360 | 348 | 99.2% | 105.7% | 100.0% | 96.7% | 57 | 42.45 | 12.78 | 55.23 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Central Birth Suite | 501 - OBSTETRICS | | 3,960 | 3,912 | 720 | 756 | 3,960 | 3,924 | 720 | 732 | 98.8% | 105.0% | 99.1% | 101.7% | 234 | 33.49 | 6.36 | 39.85 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Gynaecology and Breast Care Ward | 502 - GYNAECOLOGY | | 1,020 | 954 | 540 | 564 | 779 | 754 | 315 | 305 | 93.5% | 104.4% | 96.8% | 96.7% | 265 | 6.45 | 3.28 | 9.72 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Postnatal Ward | 501 - OBSTETRICS | | 2,304 | 2,328 | 1,080 | 1,044 | 2,160 | 2,154 | 1,440 | 1,308 | 101.0% | 96.7% | 99.7% | 90.8% | 715 | 6.27 | 3.29 | 9.56 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Rakehead | 314 - REHABILITATION | | 1,080 | 774 | 1,800 | 1,806 | 720 | 720 | 720 | 1,068 | 71.7% | 100.3% | 100.0% | 148.3% | 396 | 3.77 | 7.26 | 11.03 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Ward 15 | 110 - TRAUMA & ORTHOPAEDICS | | 1,212 | 1,080 | 900 | 798 | 720 | 720 | 600 | 600 | 89.1% | 88.7% | 100.0% | 100.0% | 430 | 4.19 | 3.25 | 7.44 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Ward 16 | 300 - GENERAL MEDICINE | | 1,800 | 1,446 | 1,440 | 1,908 | 720 | 720 | 1,440 | 1,740 | 80.3% | 132.5% | 100.0% | 120.8% | 811 | 2.67 | 4.50 | 7.17 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Ward 19 | 430 - GERIATRIC MEDICINE | MEDICINE | 1,440 | 1,230 | 1,440 | 1,464 | 720 | 720 | 720 | 1,080 | 85.4% | 101.7% | 100.0% | 150.0% | 698 | 2.79 | 3.64 | 6.44 |
| RXR70 | CLITHEROE COMMUNITY HOSPITAL - RXR70 | Ribblesdale | 314 - REHABILITATION | | 1,800 | 1,566 | 1,440 | 1,446 | 1,080 | 1,080 | 1,440 | 1,668 | 87.0% | 100.4% | 100.0% | 115.8% | 942 | 2.81 | 3.31 | 6.11 |
| RXR50 | PENDLE COMMUNITY HOSPITAL - RXR50 | Hartley | 314 - REHABILITATION | | 1,440 | 1,104 | 1,080 | 1,104 | 720 | 720 | 720 | 1,008 | 76.7% | 102.2% | 100.0% | 140.0% | 707 | 2.58 | 2.99 | 5.57 |
| RXR50 | PENDLE COMMUNITY HOSPITAL - RXR50 | Marsden | 314 - REHABILITATION | | 1,440 | 1,158 | 1,800 | 1,854 | 720 | 720 | 720 | 1,056 | 80.4% | 103.0% | 100.0% | 146.7% | 718 | 2.62 | 4.05 | 6.67 |
| RXR50 | PENDLE COMMUNITY HOSPITAL - RXR50 | Reedyford | 314 - REHABILITATION | | 1,440 | 1,128 | 1,080 | 1,284 | 720 | 720 | 720 | 972 | 78.3% | 118.9% | 100.0% | 135.0% | 683 | 2.71 | 3.30 | 6.01 |
| | | Total | | | 85,114 | 76,671 | 53,552 | 55,327 | 58,697 | 57,857 | 37,157 | 42,813 | 90.08% | 103.32% | 98.57% | 115.22% | 27129 | 4.96 | 3.62 | 8.58 |

# Safe Staffing (Rota Fill Rates and CHPPD ) Collection

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

Trust Website where staffing information is available

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

| Hospital Site Details | | Ward name | Main 2 Specialties on each ward | | Day | | | | Night | | | | Day | | Night | | Care Hours Per Patient Day (CHPPD) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | midwives/nurses | | Care Staff | | midwives/nurses | | Care Staff | | | | | | | | | |
| Site code | Hospital Site name | Ward Name | Specialty 1 | Specialty 2 | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Average fill rate - nurses/midwives (%) | Average fill rate - care staff (%) | Average fill rate - nurses/midwives (%) | Average fill rate - care staff (%) | Cumulative count over the month of patients at 23:59 each day | Nurses & Midwives | Care staff | Overall |
| RXR60 | ACCRINGTON VICTORIA HOSPITAL - RXR60 | Ward 2 | 314 - REHABILITATION | | - | - | - | - | - | - | - | - | 0.0% | 0.0% | 0.0% | 0.0% | 0 | | | |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Acute Stroke Unit (ASU) | 300 - GENERAL MEDICINE | | 1,860 | 1,674 | 1,488 | 1,578 | 1,116 | 1,104 | 1,116 | 1,332 | 90.0% | 106.0% | 98.9% | 119.4% | 666 | 4.17 | 4.37 | 8.54 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | B18 | 320 - CARDIOLOGY | | 1,812 | 1,620 | 1,116 | 1,428 | 1,116 | 1,104 | 1,116 | 1,032 | 89.4% | 128.0% | 98.9% | 92.5% | 775 | 3.51 | 3.17 | 6.69 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | B20 | 100 - GENERAL SURGERY | | - | - | - | - | - | - | - | - | 0.0% | 0.0% | 0.0% | 0.0% | 0 | | | |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | B22 | 110 - TRAUMA & ORTHOPAEDICS | | 1,488 | 1,296 | 2,232 | 2,064 | 744 | 744 | 1,860 | 1,908 | 87.1% | 92.5% | 100.0% | 102.6% | 666 | 3.06 | 5.96 | 9.03 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | B24 | 110 - TRAUMA & ORTHOPAEDICS | | 1,488 | 1,242 | 1,116 | 1,608 | 744 | 744 | 744 | 1,320 | 83.5% | 144.1% | 100.0% | 177.4% | 666 | 2.98 | 4.40 | 7.38 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | B4 | 430 - GERIATRIC MEDICINE | | 1,488 | 1,260 | 2,232 | 2,238 | 744 | 744 | 1,488 | 1,476 | 84.7% | 100.3% | 100.0% | 99.2% | 734 | 2.73 | 5.06 | 7.79 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Blackburn Birth Centre | 501 - OBSTETRICS | | 930 | 965 | 495 | 456 | 667 | 656 | 333 | 332 | 103.8% | 92.1% | 98.4% | 99.6% | 14 | 115.77 | 56.29 | 172.05 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C1 | 300 - GENERAL MEDICINE | | 1,860 | 1,632 | 1,116 | 1,134 | 744 | 780 | 372 | 828 | 87.7% | 101.6% | 104.8% | 222.6% | 436 | 5.53 | 4.50 | 10.03 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C10 | 300 - GENERAL MEDICINE | | 1,488 | 1,236 | 1,488 | 1,662 | 744 | 744 | 1,116 | 1,128 | 83.1% | 111.7% | 100.0% | 101.1% | 649 | 3.05 | 4.30 | 7.35 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C11 | 300 - GENERAL MEDICINE | | 1,488 | 1,254 | 1,488 | 1,608 | 744 | 744 | 1,116 | 1,188 | 84.3% | 108.1% | 100.0% | 106.5% | 670 | 2.98 | 4.17 | 7.16 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C14A | 100 - GENERAL SURGERY | | 1,302 | 1,266 | 744 | 768 | 744 | 744 | 372 | 444 | 97.2% | 103.2% | 100.0% | 119.4% | 514 | 3.91 | 2.36 | 6.27 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C14B | 100 - GENERAL SURGERY | | 1,302 | 1,224 | 744 | 864 | 744 | 768 | 372 | 648 | 94.0% | 116.1% | 103.2% | 174.2% | 503 | 3.96 | 3.01 | 6.97 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C18A | 100 - GENERAL SURGERY | | 1,302 | 1,266 | 744 | 960 | 744 | 792 | 372 | 756 | 97.2% | 129.0% | 106.5% | 203.2% | 521 | 3.95 | 3.29 | 7.24 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C18B | 100 - GENERAL SURGERY | | 1,302 | 1,260 | 744 | 954 | 744 | 744 | 372 | 708 | 96.8% | 128.2% | 100.0% | 190.3% | 518 | 3.87 | 3.21 | 7.08 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C2 | 301 - GASTROENTEROLOGY | MEDICINE | 1,488 | 1,248 | 1,116 | 1,194 | 1,116 | 1,128 | 1,116 | 1,212 | 83.9% | 107.0% | 101.1% | 108.6% | 748 | 3.18 | 3.22 | 6.39 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C22 | 101 - UROLOGY | 120 - ENT | 2,232 | 2,166 | 1,488 | 2,232 | 1,116 | 1,368 | 1,488 | 1,968 | 97.0% | 150.0% | 122.6% | 132.3% | 990 | 3.57 | 4.24 | 7.81 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C3 | 300 - GENERAL MEDICINE | | 1,674 | 1,644 | 1,488 | 1,578 | 1,116 | 1,116 | 1,116 | 1,440 | 98.2% | 106.0% | 100.0% | 129.0% | 809 | 3.41 | 3.73 | 7.14 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C4 | 301 - GASTROENTEROLOGY | MEDICINE | 1,488 | 1,224 | 1,116 | 1,182 | 1,116 | 1,116 | 1,116 | 1,152 | 82.3% | 105.9% | 100.0% | 103.2% | 731 | 3.20 | 3.19 | 6.39 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C5 | 430 - GERIATRIC MEDICINE | | 1,116 | 918 | 1,488 | 1,464 | 744 | 756 | 1,116 | 1,452 | 82.3% | 98.4% | 101.6% | 130.1% | 431 | 3.88 | 6.77 | 10.65 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C6 | 340 - RESPIRATORY MEDICINE | MEDICINE | 1,488 | 1,206 | 1,116 | 1,116 | 1,116 | 1,116 | 744 | 768 | 81.0% | 100.0% | 100.0% | 103.2% | 753 | 3.08 | 2.50 | 5.59 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C7 | 340 - RESPIRATORY MEDICINE | MEDICINE | 1,488 | 1,254 | 1,116 | 1,188 | 744 | 816 | 744 | 936 | 84.3% | 106.5% | 109.7% | 125.8% | 654 | 3.17 | 3.25 | 6.41 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C8 | 340 - RESPIRATORY MEDICINE | MEDICINE | 1,860 | 1,590 | 1,488 | 1,434 | 1,116 | 1,116 | 744 | 744 | 85.5% | 96.4% | 100.0% | 100.0% | 576 | 4.70 | 3.78 | 8.48 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | C9 | 300 - GENERAL MEDICINE | | 1,488 | 1,224 | 1,488 | 1,716 | 744 | 744 | 1,116 | 1,332 | 82.3% | 115.3% | 100.0% | 119.4% | 680 | 2.89 | 4.48 | 7.38 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Children's Unit | 420 - PAEDIATRICS | | 4,650 | 4,268 | 1,116 | 930 | 3,581 | 3,315 | 326 | 305 | 91.8% | 83.3% | 92.6% | 93.5% | 800 | 9.48 | 1.54 | 11.02 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Coronary Care Unit (CCU) | 320 - CARDIOLOGY | | 1,488 | 1,290 | 744 | 744 | 1,116 | 1,116 | - | - | 86.7% | 100.0% | 100.0% | 0.0% | 248 | 9.70 | 3.00 | 12.70 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Critical Care Unit | 192 - CRITICAL CARE MEDICINE | | 6,408 | 6,456 | 1,200 | 1,092 | 6,222 | 6,246 | 960 | 756 | 100.7% | 91.0% | 100.4% | 78.8% | 569 | 22.32 | 3.25 | 25.57 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | D1 | 300 - GENERAL MEDICINE | | 1,488 | 1,278 | 1,116 | 1,098 | 744 | 756 | 744 | 960 | 85.9% | 98.4% | 101.6% | 129.0% | 632 | 3.22 | 3.26 | 6.47 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | D3 | 300 - GENERAL MEDICINE | | 1,488 | 1,308 | 1,116 | 1,158 | 744 | 744 | 744 | 924 | 87.9% | 103.8% | 100.0% | 124.2% | 600 | 3.42 | 3.47 | 6.89 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Medical Assessment Unit (AMUA) | 300 - GENERAL MEDICINE | | 3,720 | 3,684 | 2,232 | 2,580 | 3,348 | 3,300 | 1,488 | 1,452 | 99.0% | 115.6% | 98.6% | 97.6% | 1239 | 5.64 | 3.25 | 8.89 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Medical Assessment Unit (AMUB) | 300 - GENERAL MEDICINE | | 3,348 | 3,192 | 2,232 | 2,148 | 2,976 | 2,916 | 1,860 | 1,740 | 95.3% | 96.2% | 98.0% | 93.5% | 1219 | 5.01 | 3.19 | 8.20 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Neonatal Intensive Care Unit | 420 - PAEDIATRICS | | 4,836 | 4,776 | 372 | 270 | 4,464 | 3,909 | - | 167 | 98.8% | 72.6% | 87.6% | 16650.0% | 619 | 14.03 | 0.71 | 14.74 |
| RXR20 | ROYAL BLACKBURN HOSPITAL - RXR20 | Surgical Triage Unit | 100 - GENERAL SURGERY | | 2,604 | 2,586 | 1,860 | 1,920 | 1,488 | 1,464 | 1,488 | 1,416 | 99.3% | 103.2% | 98.4% | 95.2% | 648 | 6.25 | 5.15 | 11.40 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Antenatal Ward | 501 - OBSTETRICS | | 1,904 | 1,984 | 912 | 814 | 1,116 | 1,116 | 744 | 732 | 104.2% | 89.3% | 100.0% | 98.4% | 109 | 28.44 | 14.18 | 42.62 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Burnley Birth Centre | 501 - OBSTETRICS | | 1,439 | 1,362 | 370 | 347 | 1,140 | 1,056 | 372 | 312 | 94.7% | 93.8% | 92.6% | 83.9% | 65 | 37.20 | 10.13 | 47.33 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Central Birth Suite | 501 - OBSTETRICS | | 4,092 | 4,020 | 744 | 774 | 4,092 | 3,828 | 744 | 768 | 98.2% | 104.0% | 93.5% | 103.2% | 249 | 31.52 | 6.19 | 37.71 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Gynaecology and Breast Care Ward | 502 - GYNAECOLOGY | | 1,068 | 1,038 | 564 | 540 | 801 | 784 | 326 | 326 | 97.2% | 95.7% | 97.9% | 100.0% | 238 | 7.65 | 3.64 | 11.29 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Postnatal Ward | 501 - OBSTETRICS | | 2,388 | 2,424 | 1,116 | 1,128 | 2,232 | 2,220 | 1,488 | 1,488 | 101.5% | 101.1% | 99.5% | 100.0% | 767 | 6.05 | 3.41 | 9.47 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Rakehead | 314 - REHABILITATION | | 1,116 | 798 | 1,860 | 1,788 | 744 | 744 | 744 | 1,176 | 71.5% | 96.1% | 100.0% | 158.1% | 376 | 4.10 | 7.88 | 11.98 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Ward 15 | 110 - TRAUMA & ORTHOPAEDICS | | 1,236 | 1,152 | 882 | 822 | 744 | 738 | 660 | 636 | 93.2% | 93.2% | 99.2% | 96.4% | 449 | 4.21 | 3.25 | 7.46 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Ward 16 | 300 - GENERAL MEDICINE | | 1,860 | 1,554 | 1,488 | 1,962 | 744 | 744 | 1,488 | 1,884 | 83.5% | 131.9% | 100.0% | 126.6% | 826 | 2.78 | 4.66 | 7.44 |
| RXR10 | BURNLEY GENERAL HOSPITAL - RXR10 | Ward 19 | 430 - GERIATRIC MEDICINE | MEDICINE | 1,488 | 1,230 | 1,488 | 1,656 | 744 | 744 | 744 | 1,296 | 82.7% | 111.3% | 100.0% | 174.2% | 622 | 3.17 | 4.75 | 7.92 |
| RXR70 | CLITHEROE COMMUNITY HOSPITAL - RXR70 | Ribblesdale | 314 - REHABILITATION | | 1,860 | 1,638 | 1,488 | 1,692 | 1,116 | 1,116 | 1,488 | 1,608 | 88.1% | 113.7% | 100.0% | 108.1% | 925 | 2.98 | 3.57 | 6.54 |
| RXR50 | PENDLE COMMUNITY HOSPITAL - RXR50 | Hartley | 314 - REHABILITATION | | 1,488 | 1,158 | 1,116 | 1,140 | 744 | 744 | 744 | 912 | 77.8% | 102.2% | 100.0% | 122.6% | 675 | 2.82 | 3.04 | 5.86 |
| RXR50 | PENDLE COMMUNITY HOSPITAL - RXR50 | Marsden | 314 - REHABILITATION | | 1,488 | 1,170 | 1,860 | 1,776 | 744 | 744 | 744 | 1,116 | 78.6% | 95.5% | 100.0% | 150.0% | 733 | 2.61 | 3.95 | 6.56 |
| RXR50 | PENDLE COMMUNITY HOSPITAL - RXR50 | Reedyford | 314 - REHABILITATION | | 1,488 | 1,176 | 1,116 | 1,272 | 744 | 744 | 744 | 1,020 | 79.0% | 114.0% | 100.0% | 137.1% | 640 | 3.00 | 3.58 | 6.58 |
| | | Total | | | 86,377 | 79,211 | 54,643 | 58,077 | 59,654 | 58,775 | 38,688 | 45,097 | 91.70% | 106.28% | 98.53% | 116.56% | 26952 | 5.12 | 3.83 | 8.95 |

# Ward Staff Summary - Apr 2019

Executed on: 29/05/2019 at: 11:05:36 AM

**Division:** All 3 Available Divisions Selected
**Directorate:** All 17 Available Directorates Selected
**Site:** All 4 Available Hospital Sites Selected
This report is based on the 44 wards which submitted data for the monthly Safer Staffing return

R: ≥ ±10% | A: ≥ ±5% | G: < ±5% — R: > 0 | G: = 0 — R:≥ 5% | G:< 5% — R:≥ 4.75% | G:< 4.50%

| Site | Cost Centre Code | Ward | Day Shift | | | | | | Night Shift | | | | | | Pressure Ulcers Acquired | | | Falls with Harm (Mod & Above) | Infections Acquired | | Vacancies WTE (RegN/M + HCA)* | | Sickness/Absence RegN/M + HCA)* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Registered Nurses / Midwives | | | Care Staff | | | Registered Nurses / Midwives | | | Care Staff | | | | | | | | | | | | |
| | | | Planned Hours | Actual Hours | Average Fill Rate | Planned Hours | Actual Hours | Average Fill Rate | Planned Hours | Actual Hours | Average Fill Rate | Planned Hours | Actual Hours | Average Fill Rate | G2 | G3 | G4 | | C Diff | MRSA | WTE Vacant | % Vacant | WTE Days | % Abs Rate |
| **EC: Surgical & Anaes Services** | | | | | | | | | | | | | | | | | | | | | | | | |
| **EC02: General Surg Services** | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5142 | Ward C14A | 1,260 | 1,176 | 79.03% | 720 | 714 | 119.89% | 720 | 732 | 100.00% | 360 | 420 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.64 | 18.60% | 18.91 | 3.38% |
| | 5143 | Ward C18A | 1,260 | 1,194 | 79.03% | 720 | 846 | 119.89% | 720 | 720 | 100.00% | 360 | 732 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | -0.77 | -3.07% | 26.00 | 3.51% |
| | 5144 | Surgical Triage Unit | 2,520 | 2,394 | 79.03% | 1,800 | 1,758 | 119.89% | 1,572 | 1,602 | 100.00% | 1,440 | 1,440 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | -3.41 | -10.70% | 45.00 | 4.52% |
| | 5145 | Ward C14B | 1,260 | 1,098 | 79.03% | 720 | 804 | 119.89% | 720 | 720 | 100.00% | 360 | 672 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.72 | 18.92% | 14.20 | 2.45% |
| | 5146 | Ward C18B | 1,260 | 1,236 | 79.03% | 720 | 810 | 119.89% | 720 | 732 | 100.00% | 360 | 504 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 3.68 | 14.55% | 13.23 | 2.14% |
| **EC03: Urology** | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5128 | Ward C22 | 2,160 | 2,106 | 79.03% | 1,446 | 1,908 | 119.89% | 1,080 | 1,176 | 100.00% | 1,440 | 1,536 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 1.76 | 5.49% | 66.00 | 7.75% |
| **EC04: Orthopaedic Services** | | | | | | | | | | | | | | | | | | | | | | | | |
| BGH | 4393 | Ward 15 | 1,212 | 1,080 | 79.03% | 900 | 798 | 119.89% | 720 | 720 | 100.00% | 600 | 600 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.93 | 13.59% | 49.20 | 5.46% |
| RBH | 5366 | Ward B24 | 1,440 | 1,200 | 79.03% | 1,080 | 1,260 | 119.89% | 720 | 720 | 100.00% | 720 | 996 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.71 | 14.82% | 33.68 | 4.27% |
| | 5367 | Ward B22 | 1,440 | 1,266 | 79.03% | 2,160 | 2,046 | 119.89% | 720 | 720 | 100.00% | 1,800 | 1,932 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 3.17 | 6.79% | 79.99 | 6.33% |
| **EC05: Head & Neck** | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5119 | Ward B20 Max Fac | 1,392 | 1,176 | 79.03% | 696 | 768 | 119.89% | 672 | 696 | 100.00% | 672 | 816 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 2.58 | 9.03% | 78.08 | 10.52% |
| **EC09: Anaesth & Critical Care** | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5362 | Elht Critical Care | 6,384 | 6,360 | 79.03% | 1,080 | 864 | 119.89% | 6,204 | 6,168 | 100.00% | 372 | 216 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 25.71 | 18.94% | 226.35 | 6.94% |
| **ED: Family Care** | | | | | | | | | | | | | | | | | | | | | | | | |
| **ED07: General Paediatrics** | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5210 | Inpatient | 4,500 | 4,116 | 79.03% | 1,080 | 884 | 119.89% | 3,465 | 3,238 | 100.00% | 315 | 294 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | -1.53 | -5.31% | 55.04 | 6.04% |
| **ED08: Gynae Nursing** | | | | | | | | | | | | | | | | | | | | | | | | |
| BGH | 4169 | Gynae And Breast Care Ward | 1,020 | 954 | 79.03% | 540 | 564 | 119.89% | 779 | 754 | 100.00% | 315 | 304.50 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 3.33 | 11.20% | 67.61 | 8.85% |
| **ED09: Obstetrics** | | | | | | | | | | | | | | | | | | | | | | | | |
| BGH | 4165 | Birth Suite | 3,960 | 3,912 | 79.03% | 720 | 756 | 119.89% | 3,960 | 3,924 | 100.00% | 720 | 732 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | -1.76 | -2.29% | 59.16 | 2.61% |
| | 4192 | Burnley Birth Centre | 1,350 | 1,339.50 | 79.03% | 360 | 380.50 | 119.89% | 1,080 | 1,080 | 100.00% | 360 | 348 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 3.45 | 7.47% | 8.51 | 0.69% |
| | 4200 | Antenatal Ward 12 | 1,840 | 1,731 | 79.03% | 896 | 870 | 119.89% | 1,080 | 1,020 | 100.00% | 720 | 696 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | -2.81 | -8.29% | 112.53 | 10.76% |
| | 4203 | Postnatal Ward 10 | 2,304 | 2,328 | 79.03% | 1,080 | 1,044 | 119.89% | 2,160 | 2,154 | 100.00% | 1,440 | 1,308 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | -6.00 | -10.81% | 155.92 | 8.71% |
| RBH | 5256 | Blackburn Birth Centre | 900 | 952.50 | 79.03% | 474 | 434.75 | 119.89% | 645 | 645 | 100.00% | 322.50 | 322.50 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 7.39 | 15.09% | 39.72 | 3.33% |
| **ED11: Neonates** | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 4215 | Nicu | 4,680 | 4,494 | 79.03% | 360 | 264 | 119.89% | 4,320 | 3,804 | 100.00% | 0 | 228 | - | 0 | 0 | 0 | 0 | 0 | 0 | -3.50 | -4.25% | 154.12 | 6.18% |
| **EH: Integrated Care Group** | | | | | | | | | | | | | | | | | | | | | | | | |
| **EH05: Business Support Unit** | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 6078 | Ward C3 | 1,620 | 1,512 | 79.03% | 1,440 | 1,398 | 119.89% | 1,080 | 1,056 | 100.00% | 1,080 | 1,392 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 20.46 | 47.69% | 31.72 | 4.71% |



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

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

# Ward Staff Summary - Apr 2019

Executed on: 29/05/2019 at: 11:05:36 AM

**Division:** All 3 Available Divisions Selected
**Directorate:** All 17 Available Directorates Selected
**Site:** All 4 Available Hospital Sites Selected
This report is based on the 44 wards which submitted data for the monthly Safer Staffing return

R: ≥ ±10% | A: ≥ ±5% | G: < ±5% — R: > 0 | G: = 0 — R:≥ 5% | G:< 5% — R:≥ 4.75% | G:< 4.50%

| Site | Cost Centre Code | Ward | Day Shift | | | | | | Night Shift | | | | | | Pressure Ulcers Acquired | | | Falls with Harm (Mod & Above) | Infections Acquired | | Vacancies WTE (RegN/M + HCA)* | | Sickness/Absence RegN/M + HCA)* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Registered Nurses / Midwives | | | Care Staff | | | Registered Nurses / Midwives | | | Care Staff | | | | | | | | | | | | |
| | | | Planned Hours | Actual Hours | Average Fill Rate | Planned Hours | Actual Hours | Average Fill Rate | Planned Hours | Actual Hours | Average Fill Rate | Planned Hours | Actual Hours | Average Fill Rate | G2 | G3 | G4 | | C Diff | MRSA | WTE Vacant | % Vacant | WTE Days | % Abs Rate |
| EH15: Acute Medicine | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5058 | AMU A | 3,600 | 3,528 | 79.03% | 2,160 | 2,448 | 119.89% | 3,240 | 3,168 | 100.00% | 1,440 | 1,620 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 12.47 | 13.55% | 71.83 | 3.43% |
| | 6092 | AMU B | 3,240 | 3,078 | 79.03% | 2,160 | 2,118 | 119.89% | 2,880 | 2,832 | 100.00% | 1,800 | 1,740 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 9.49 | 10.39% | 76.16 | 3.41% |
| EH20: Respiratory | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5063 | Ward C6 | 1,440 | 1,194 | 79.03% | 1,080 | 1,080 | 119.89% | 1,080 | 1,080 | 100.00% | 720 | 684 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 0.78 | 2.29% | 153.60 | 16.53% |
| | 5064 | Ward C8 | 1,800 | 1,566 | 79.03% | 1,440 | 1,440 | 119.89% | 1,080 | 1,068 | 100.00% | 720 | 768 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 6.66 | 16.86% | 3.92 | 0.41% |
| | 6027 | Ward C7 | 1,440 | 1,230 | 79.03% | 1,080 | 1,068 | 119.89% | 720 | 756 | 100.00% | 720 | 936 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.02 | 12.99% | 94.04 | 11.76% |
| EH25: Cardiology | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5095 | Coronary Care | 1,440 | 1,194 | 79.03% | 720 | 606 | 119.89% | 1,080 | 1,080 | 100.00% | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | 0 | 2.66 | 10.56% | 15.48 | 2.32% |
| | 5097 | Ward B18 | 1,752 | 1,524 | 79.03% | 1,080 | 1,260 | 119.89% | 1,080 | 1,068 | 100.00% | 720 | 960 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | -0.36 | -1.03% | 9.80 | 0.97% |
| EH30: Gastroenterlogy | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5050 | Ward C2 | 1,440 | 1,158 | 79.03% | 1,080 | 1,104 | 119.89% | 1,080 | 1,080 | 100.00% | 1,080 | 1,092 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 9.77 | 26.49% | 97.32 | 12.91% |
| | 5062 | Ward C4 | 1,440 | 1,176 | 79.03% | 1,080 | 1,134 | 119.89% | 1,080 | 1,080 | 100.00% | 1,080 | 1,056 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 8.56 | 24.02% | 106.48 | 13.16% |
| | 6103 | Ward C11 | 1,440 | 1,176 | 79.03% | 1,440 | 1,572 | 119.89% | 720 | 732 | 100.00% | 1,080 | 1,128 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 7.31 | 20.18% | 34.85 | 4.16% |
| | 6106 | C1 (Gastro) | 1,800 | 1,566 | 79.03% | 1,080 | 1,116 | 119.89% | 720 | 720 | 100.00% | 360 | 852 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 11.87 | 34.91% | 38.00 | 6.57% |
| EH35: Mfop & Complex Needs | | | | | | | | | | | | | | | | | | | | | | | | |
| BGH | 4613 | Rakehead Nursing Staff | 1,080 | 774 | 79.03% | 1,800 | 1,806 | 119.89% | 720 | 720 | 100.00% | 720 | 1,068 | 145.16% | 0 | 0 | 0 | 0 | 2 | 0 | 3.64 | 10.62% | 87.88 | 9.96% |
| | 6094 | Ward 16 Sept 13 | 1,800 | 1,446 | 79.03% | 1,440 | 1,908 | 119.89% | 720 | 720 | 100.00% | 1,440 | 1,740 | 145.16% | 0 | 0 | 0 | 0 | - | 0 | 5.41 | 12.77% | 109.24 | 10.21% |
| PCH | 4581 | Marsden Ward | 1,440 | 1,158 | 79.03% | 1,800 | 1,854 | 119.89% | 720 | 720 | 100.00% | 720 | 1,056 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.17 | 11.29% | 26.64 | 2.75% |
| | 4582 | Reedyford Ward | 1,440 | 1,128 | 79.03% | 1,080 | 1,284 | 119.89% | 720 | 720 | 100.00% | 720 | 972 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 3.99 | 13.20% | 33.60 | 4.56% |
| | 4583 | Hartley Ward | 1,440 | 1,104 | 79.03% | 1,080 | 1,104 | 119.89% | 720 | 720 | 100.00% | 720 | 1,008 | 145.16% | 0 | 0 | 0 | 1 | 0 | 0 | 5.68 | 17.92% | 50.08 | 6.67% |
| RBH | 5023 | Ward D1 | 1,440 | 1,170 | 79.03% | 1,080 | 1,176 | 119.89% | 720 | 732 | 100.00% | 720 | 888 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 6.58 | 21.32% | 37.64 | 5.45% |
| | 5036 | Acute Stroke Unit (B2) | 1,800 | 1,530 | 79.03% | 1,440 | 1,506 | 119.89% | 1,080 | 1,044 | 100.00% | 1,080 | 1,128 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 7.17 | 14.79% | 36.08 | 3.04% |
| | 5037 | Ward B4 | 1,440 | 1,224 | 79.03% | 2,160 | 2,316 | 119.89% | 720 | 732 | 100.00% | 1,440 | 1,572 | 145.16% | 0 | 0 | 0 | 1 | 0 | 0 | 9.18 | 20.37% | 124.20 | 11.73% |
| | 5048 | Ward C10 | 1,440 | 1,182 | 79.03% | 1,440 | 1,320 | 119.89% | 720 | 720 | 100.00% | 1,080 | 1,068 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 5.43 | 14.31% | 47.76 | 4.89% |
| | 6096 | Ward C5 | 1,080 | 822 | 79.03% | 1,440 | 1,500 | 119.89% | 720 | 732 | 100.00% | 1,080 | 1,212 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 3.73 | 10.93% | 135.04 | 15.29% |
| | 6105 | Ward C9 | 1,440 | 1,188 | 79.03% | 1,440 | 1,380 | 119.89% | 720 | 720 | 100.00% | 1,080 | 1,068 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 2.56 | 7.13% | 95.52 | 10.16% |
| EH44: Speciality Medicine | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5040 | Ward D3 | 1,440 | 1,134 | 79.03% | 1,080 | 1,146 | 119.89% | 720 | 732 | 100.00% | 720 | 960 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 3.36 | 11.02% | 63.40 | 8.01% |
| EH70: Comm In Patient Care | | | | | | | | | | | | | | | | | | | | | | | | |
| CLI | R141 | Ribblesdale Ward | 1,800 | 1,566 | 79.03% | 1,440 | 1,446 | 119.89% | 1,080 | 1,080 | 100.00% | 1,440 | 1,668 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 3.41 | 7.46% | 123.80 | 10.38% |
| **Total for 44 wards shown** | | | | | **90.16%** | | | **103.36%** | | | **98.55%** | | | **114.54%** | **0** | **0** | **0** | **2** | **2** | **0** | **208.29** | **11.18%** | **3,007.33** | **6.33%** |



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

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

# Ward Staff Summary - May 2019

Executed on: 25/06/2019 at: 11:34:52 AM

**Division:** All 3 Available Divisions Selected
**Directorate:** All 16 Available Directorates Selected
**Site:** All 4 Available Hospital Sites Selected
This report is based on the 43 wards which submitted data for the monthly Safer Staffing return

R: ≥ ±10% | A: ≥ ±5% | G: < ±5% | R: > 0 | G: = 0 | R:≥ 5% | G:< 5% | R:≥ 4.75% | G:< 4.50%

| Site | Cost Centre Code | Ward | Day Shift | | | | | | Night Shift | | | | | | Pressure Ulcers Acquired | | | Falls with Harm (Mod & Above) | Infections Acquired | | Vacancies WTE (RegN/M + HCA)* | | Sickness/Absence RegN/M + HCA)* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Registered Nurses / Midwives | | | Care Staff | | | Registered Nurses / Midwives | | | Care Staff | | | | | | | | | | | | |
| | | | Planned Hours | Actual Hours | Average Fill Rate | Planned Hours | Actual Hours | Average Fill Rate | Planned Hours | Actual Hours | Average Fill Rate | Planned Hours | Actual Hours | Average Fill Rate | G2 | G3 | G4 | | C Diff | MRSA | WTE Vacant | % Vacant | WTE Days | % Abs Rate |
| **EC: Surgical & Anaes Services** | | | | | | | | | | | | | | | | | | | | | | | | |
| **EC02: General Surg Services** | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5142 | Ward C14A | 1,302 | 1,266 | 79.03% | 744 | 768 | 119.89% | 744 | 744 | 100.00% | 372 | 444 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.80 | 19.12% | 0.64 | 0.10% |
| | 5143 | Ward C18A | 1,302 | 1,266 | 79.03% | 744 | 960 | 119.89% | 744 | 792 | 100.00% | 372 | 756 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | -0.84 | -3.35% | 23.39 | 2.92% |
| | 5144 | Surgical Triage Unit | 2,604 | 2,586 | 79.03% | 1,860 | 1,920 | 119.89% | 1,488 | 1,464 | 100.00% | 1,488 | 1,416 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | -4.41 | -13.84% | 22.44 | 2.00% |
| | 5145 | Ward C14B | 1,302 | 1,224 | 79.03% | 744 | 864 | 119.89% | 744 | 768 | 100.00% | 372 | 648 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.72 | 18.92% | 14.20 | 2.26% |
| | 5146 | Ward C18B | 1,302 | 1,260 | 79.03% | 744 | 954 | 119.89% | 744 | 744 | 100.00% | 372 | 708 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 3.68 | 14.55% | 41.36 | 6.17% |
| **EC03: Urology** | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5128 | Ward C22 | 2,232 | 2,166 | 79.03% | 1,488 | 2,232 | 119.89% | 1,116 | 1,368 | 100.00% | 1,488 | 1,968 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 0.78 | 2.51% | 53.44 | 5.78% |
| **EC04: Orthopaedic Services** | | | | | | | | | | | | | | | | | | | | | | | | |
| BGH | 4393 | Ward 15 | 1,236 | 1,152 | 79.03% | 882 | 822 | 119.89% | 744 | 738 | 100.00% | 660 | 636 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.40 | 12.13% | 30.49 | 3.11% |
| RBH | 5366 | Ward B24 | 1,488 | 1,242 | 79.03% | 1,116 | 1,608 | 119.89% | 744 | 744 | 100.00% | 744 | 1,320 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.75 | 14.94% | 49.60 | 5.92% |
| | 5367 | Ward B22 | 1,488 | 1,296 | 79.03% | 2,232 | 2,064 | 119.89% | 744 | 744 | 100.00% | 1,860 | 1,908 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 2.17 | 4.65% | 133.83 | 9.78% |
| **EC09: Anaesth & Critical Care** | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5362 | Elht Critical Care | 6,408 | 6,456 | 79.03% | 1,200 | 1,092 | 119.89% | 6,222 | 6,246 | 100.00% | 960 | 756 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 30.37 | 22.38% | 190.51 | 5.72% |
| **ED: Family Care** | | | | | | | | | | | | | | | | | | | | | | | | |
| **ED07: General Paediatrics** | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5210 | Inpatient | 4,650 | 4,268 | 79.03% | 1,116 | 930 | 119.89% | 3,580.50 | 3,314.50 | 100.00% | 325.50 | 304.50 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | -0.53 | -1.84% | 67.64 | 7.19% |
| **ED08: Gynae Nursing** | | | | | | | | | | | | | | | | | | | | | | | | |
| BGH | 4169 | Gynae And Breast Care Ward | 1,068 | 1,038 | 79.03% | 564 | 540 | 119.89% | 800.50 | 783.50 | 100.00% | 325.50 | 325.50 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.92 | 16.55% | 22.93 | 2.95% |
| **ED09: Obstetrics** | | | | | | | | | | | | | | | | | | | | | | | | |
| BGH | 4165 | Birth Suite | 4,092 | 4,020 | 79.03% | 744 | 774 | 119.89% | 4,092 | 3,828 | 100.00% | 744 | 768 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | -2.60 | -3.38% | 83.76 | 3.40% |
| | 4192 | Burnley Birth Centre | 1,438.50 | 1,362.20 | 79.03% | 369.50 | 346.50 | 119.89% | 1,140 | 1,056 | 100.00% | 372 | 312 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 3.65 | 7.90% | 93.08 | 7.01% |
| | 4200 | Antenatal Ward 12 | 1,904 | 1,984 | 79.03% | 912 | 814 | 119.89% | 1,116 | 1,116 | 100.00% | 744 | 732 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | -2.89 | -8.53% | 74.25 | 6.39% |
| | 4203 | Postnatal Ward 10 | 2,388 | 2,424 | 79.03% | 1,116 | 1,128 | 119.89% | 2,232 | 2,220 | 100.00% | 1,488 | 1,488 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | -0.13 | -0.23% | 126.36 | 7.10% |
| RBH | 5256 | Blackburn Birth Centre | 930 | 965 | 79.03% | 495 | 456 | 119.89% | 666.50 | 655.75 | 100.00% | 333.25 | 332 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.63 | 9.46% | 62.24 | 4.69% |
| **ED11: Neonates** | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 4215 | Nicu | 4,836 | 4,776 | 79.03% | 372 | 270 | 119.89% | 4,464 | 3,909 | 100.00% | 0 | 166.50 | - | 0 | 0 | 0 | 0 | 0 | 0 | -3.50 | -4.25% | 135.12 | 5.08% |
| **EH: Integrated Care Group** | | | | | | | | | | | | | | | | | | | | | | | | |
| **EH05: Business Support Unit** | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 6078 | Ward C3 | 1,674 | 1,644 | 79.03% | 1,488 | 1,578 | 119.89% | 1,116 | 1,116 | 100.00% | 1,116 | 1,440 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 17.30 | 41.49% | 48.12 | 6.87% |
| **EH15: Acute Medicine** | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5058 | AMU A | 3,720 | 3,684 | 79.03% | 2,232 | 2,580 | 119.89% | 3,348 | 3,300 | 100.00% | 1,488 | 1,452 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 10.56 | 11.48% | 108.08 | 4.32% |
| | 6092 | AMU B | 3,348 | 3,192 | 79.03% | 2,232 | 2,148 | 119.89% | 2,976 | 2,916 | 100.00% | 1,860 | 1,740 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 10.85 | 11.88% | 96.04 | 3.80% |



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

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

# Ward Staff Summary - May 2019

Executed on: 25/06/2019 at: 11:34:52 AM

**Division:** All 3 Available Divisions Selected
**Directorate:** All 16 Available Directorates Selected
**Site:** All 4 Available Hospital Sites Selected
This report is based on the 43 wards which submitted data for the monthly Safer Staffing return

R: ≥ ±10% | A: ≥ ±5% | G: < ±5% | R: > 0 | G: = 0 | R:≥ 5% | G:< 5% | R:≥ 4.75% | G:< 4.50%

| Site | Cost Centre Code | Ward | Day Shift | | | | | | Night Shift | | | | | | Pressure Ulcers Acquired | | | Falls with Harm (Mod & Above) | Infections Acquired | | Vacancies WTE (RegN/M + HCA)* | | Sickness/Absence RegN/M + HCA)* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Registered Nurses / Midwives | | | Care Staff | | | Registered Nurses / Midwives | | | Care Staff | | | | | | | | | | | | |
| | | | Planned Hours | Actual Hours | Average Fill Rate | Planned Hours | Actual Hours | Average Fill Rate | Planned Hours | Actual Hours | Average Fill Rate | Planned Hours | Actual Hours | Average Fill Rate | G2 | G3 | G4 | | C Diff | MRSA | WTE Vacant | % Vacant | WTE Days | % Abs Rate |
| EH20: Respiratory | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5063 | Ward C6 | 1,488 | 1,206 | 79.03% | 1,116 | 1,116 | 119.89% | 1,116 | 1,116 | 100.00% | 744 | 768 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 1.58 | 4.65% | 91.04 | 8.96% |
| | 5064 | Ward C8 | 1,860 | 1,590 | 79.03% | 1,488 | 1,434 | 119.89% | 1,116 | 1,116 | 100.00% | 744 | 744 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.74 | 12.00% | 10.76 | 1.04% |
| | 6027 | Ward C7 | 1,488 | 1,254 | 79.03% | 1,116 | 1,188 | 119.89% | 744 | 816 | 100.00% | 744 | 936 | 145.16% | 0 | 0 | 0 | 0 | 1 | 0 | 3.98 | 12.86% | 46.68 | 5.55% |
| EH25: Cardiology | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5095 | Coronary Care | 1,488 | 1,290 | 79.03% | 744 | 744 | 119.89% | 1,116 | 1,116 | 100.00% | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | 0 | 2.87 | 11.33% | 3.67 | 0.53% |
| | 5097 | Ward B18 | 1,812 | 1,620 | 79.03% | 1,116 | 1,428 | 119.89% | 1,116 | 1,104 | 100.00% | 1,116 | 1,032 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | -1.36 | -3.99% | 8.00 | 0.73% |
| EH30: Gastroenterlogy | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5050 | Ward C2 | 1,488 | 1,248 | 79.03% | 1,116 | 1,194 | 119.89% | 1,116 | 1,128 | 100.00% | 1,116 | 1,212 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 10.93 | 29.64% | 70.40 | 8.50% |
| | 5062 | Ward C4 | 1,488 | 1,224 | 79.03% | 1,116 | 1,182 | 119.89% | 1,116 | 1,116 | 100.00% | 1,116 | 1,152 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 6.36 | 17.85% | 96.04 | 10.62% |
| | 6103 | Ward C11 | 1,488 | 1,254 | 79.03% | 1,488 | 1,608 | 119.89% | 744 | 744 | 100.00% | 1,116 | 1,188 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 7.31 | 20.18% | 39.96 | 4.46% |
| | 6106 | C1 (Gastro) | 1,860 | 1,632 | 79.03% | 1,116 | 1,134 | 119.89% | 744 | 780 | 100.00% | 372 | 828 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 10.67 | 31.38% | 10.96 | 1.55% |
| EH35: Mfop & Complex Needs | | | | | | | | | | | | | | | | | | | | | | | | |
| BGH | 4613 | Rakehead Nursing Staff | 1,116 | 798 | 79.03% | 1,860 | 1,788 | 119.89% | 744 | 744 | 100.00% | 744 | 1,176 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 3.65 | 10.65% | 79.26 | 8.35% |
| | 6094 | Ward 16 Sept 13 | 1,860 | 1,554 | 79.03% | 1,488 | 1,962 | 119.89% | 744 | 744 | 100.00% | 1,488 | 1,884 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 7.73 | 18.24% | 91.24 | 8.39% |
| PCH | 4581 | Marsden Ward | 1,488 | 1,170 | 79.03% | 1,860 | 1,776 | 119.89% | 744 | 744 | 100.00% | 744 | 1,116 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.58 | 11.80% | 46.04 | 4.42% |
| | 4582 | Reedyford Ward | 1,488 | 1,176 | 79.03% | 1,116 | 1,272 | 119.89% | 744 | 744 | 100.00% | 744 | 1,020 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 2.95 | 9.77% | 75.96 | 9.12% |
| | 4583 | Hartley Ward | 1,488 | 1,158 | 79.03% | 1,116 | 1,140 | 119.89% | 744 | 744 | 100.00% | 744 | 912 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 4.22 | 13.96% | 31.80 | 3.94% |
| RBH | 5023 | Ward D1 | 1,488 | 1,278 | 79.03% | 1,116 | 1,098 | 119.89% | 744 | 756 | 100.00% | 744 | 960 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 6.58 | 21.32% | 10.00 | 1.35% |
| | 5036 | Acute Stroke Unit (B2) | 1,860 | 1,674 | 79.03% | 1,488 | 1,578 | 119.89% | 1,116 | 1,104 | 100.00% | 1,116 | 1,332 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 6.21 | 12.81% | 38.08 | 2.92% |
| | 5037 | Ward B4 | 1,488 | 1,260 | 79.03% | 2,232 | 2,238 | 119.89% | 744 | 744 | 100.00% | 1,488 | 1,476 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 8.18 | 18.15% | 145.80 | 12.89% |
| | 5048 | Ward C10 | 1,488 | 1,236 | 79.03% | 1,488 | 1,662 | 119.89% | 744 | 744 | 100.00% | 1,116 | 1,128 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 6.43 | 16.95% | 53.00 | 5.43% |
| | 6096 | Ward C5 | 1,116 | 918 | 79.03% | 1,488 | 1,464 | 119.89% | 744 | 756 | 100.00% | 1,116 | 1,452 | 145.16% | 0 | 0 | 0 | 1 | 0 | 0 | 3.73 | 10.93% | 101.00 | 10.72% |
| | 6105 | Ward C9 | 1,488 | 1,224 | 79.03% | 1,488 | 1,716 | 119.89% | 744 | 744 | 100.00% | 1,116 | 1,332 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 3.36 | 9.35% | 64.00 | 6.41% |
| EH44: Speciality Medicine | | | | | | | | | | | | | | | | | | | | | | | | |
| RBH | 5040 | Ward D3 | 1,488 | 1,308 | 79.03% | 1,116 | 1,158 | 119.89% | 744 | 744 | 100.00% | 744 | 924 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 2.36 | 7.74% | 38.40 | 4.40% |
| EH70: Comm In Patient Care | | | | | | | | | | | | | | | | | | | | | | | | |
| CLI | R141 | Ribblesdale Ward | 1,860 | 1,638 | 79.03% | 1,488 | 1,692 | 119.89% | 1,116 | 1,116 | 100.00% | 1,488 | 1,608 | 145.16% | 0 | 0 | 0 | 0 | 0 | 0 | 2.44 | 5.34% | 161.07 | 12.11% |
| **Total for 43 wards shown** | | | | | **91.86%** | | | **106.14%** | | | **98.51%** | | | **115.43%** | **0** | **0** | **0** | **1** | **1** | **0** | **202.18** | **11.03%** | **2,790.68** | **5.53%** |



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Report Location: /Operational Reports/Ward Scorecard Monthly Trend/Ward Staff Summary

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

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**Item** 94

**10 July 2019**

**Purpose** Information

| | |
|---|---|
| **Title** | Raising Concerns Annual Report |
| **Author** | Mrs J Butcher, Staff Guardian |
| **Executive sponsor** | Mr K Moynes, Director of Human Resources and Organisational Development |

**Summary:** This is the third annual report on raising concerns since the appointment of the Staff Guardian role in September 2015. It details the background on the guardian role, outlines progress to date, numbers of concerns raised, emerging themes, actioned taken to address themes and information from the National Guardian Office.

## Report linkages

| | |
|---|---|
| Related strategic aim and corporate objective | Put safety and quality at the heart of everything we do<br>Invest in and develop our workforce<br>Work with key stakeholders to develop effective partnerships<br>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<br>Recruitment and workforce planning fail to deliver the Trust objectives<br>Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways<br>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<br>The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.<br>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 | Yes | Confidentiality | Yes |

Previously considered by: Quality Committee (June 2019)

## Raising Concerns Annual Report

### Background

1. The importance of listening to staff cannot be overemphasised. When staff raise concerns they want to know that they are encouraged to do so and can do it safely in a protected environment. Sir Francis recommended that Trusts as a minimum should appoint "someone to whom staff can go to, who is recognised as independent and impartial, has authority to speak to anyone within or outside the Trust, is expert in all aspects of raising and handling concerns, has the tenacity to ensure safety issues are addressed and has dedicated time to perform this role".

### Introduction

2. This report has been prepared to advise the Trust Board of progress made since the last annual report in May 2018, the number of staff who have raised concerns, emerging themes, actions taken and the latest news from the National Guardian Office.

### Progress to Date

3. Jane Butcher was appointed 15th May 2017 as the new Staff Guardian and the communication strategy regarding raising awareness of the post has now been in place for 2 year.
   a) Staff Guardian Section on Corporate Induction continues to be embedded and presented personally by Jane or an Executive Director.
   b) Staff Guardian monthly walkabouts to all sites take.
   c) Close working relationships are established with the HRBP's to give feedback on reoccurring themes in relation to HR policies and to address these themes the newly implemented Early Resolution Policy will provided further support and guidance to staff.
   d) Suspension letters have been amended to include the Staff Guardian contact details to ensure that staff have direct access whilst under suspension.
   e) Strong links with the mediation manager are embedded and Jane has referred many cases directly.
   f) In November 2018 the Trust won of the HSJ Award for creating a supportive culture which was sponsored by the National Guardian Office. Since this date

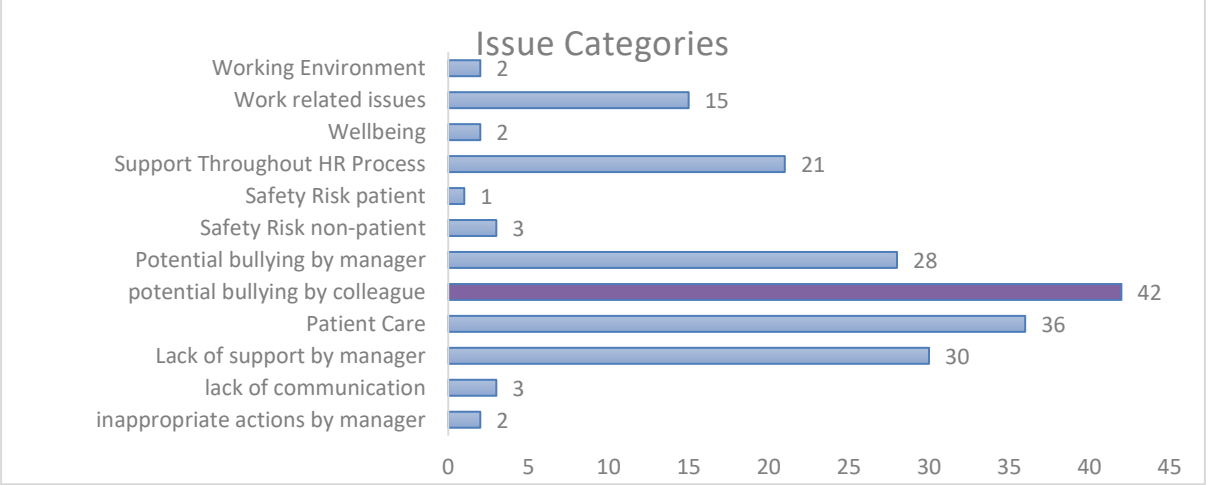
Jane and Kevin where asked to present "how speaking up and assisted creating a supportive culture" at the National Guardians annual conference in May 19

g) In the past 12 months Mrs Butcher has undertaken 6 Staff Guardian Reviews within areas across the Trust. 1 in Estate and Facilities, 2 within the ICG division and 3 within the SAS division. 3 of these reviews are still ongoing.

**The Fourth Annual Report – Themes and Actions taken to address**

4. For the period May 18 to April 19 there have been 185 concerns raised which is an increase of 26% from the previous year's figure of 143 May 17 to April 18. We have not received any concerns under Whistle blow within the last 12 months.

5. Emerging Themes May 18 to April 19:




6. The Staff Guardian works closely with the Senior HR team, Head of Occupational Health and Staff Wellbeing and the Unions to address support for staff who have reported experiencing forms of bullying and harassment. The newly introduced Resolution Policy is starting to address these concerns in a more supportive and satisfactory way for all parties involved.

7. 18 of the patient care concerns were raised collectively within an area were a Staff Guardian review was undertaken. The Review was shared with Senior Management of the area and the Executive Director. An action plan was immediately drawn up to resolve these concerns and a feedback meeting was held with all staff. A further 9 were also collectively raised in relation to staff shortages and 1 to 1 care of patients. This concern was resolved within the day. A follow up meeting was then held with all

the staff within this area which resolved concerns and gave staff full assurance that they could escalate any further concerns to the senior nursing team.

8. The senior nursing team or senior clinicians are directly involved with all patient safety issues raised. Every staff member raising a concern about patient safety is offered a face to face conversation with a relevant senior person should they so wish or Jane is offered the opportunity to speak up on their behalf. Staff are encouraged regularly within their areas to raise concerns to management if they feel able to do so. In one area we have introduced an identifiable person on each shift who staff can raise concerns directly during shift. If this proves to be effect then we will look to role this out across all patient areas.

9. Concerns raised under lack of support from managers are been regarding a variety of different issues from communication to managers appearing to lack compassion.

   To address these concerns overall, the Trust is in the process of delivering the ELHT Culture and Leadership Programme following completion of the initial discovery phrase. A change team have been working collectively on this programme and the Staff Guardian is a member of this team. Also the Engaging Managers course continues to run successfully looking at effective styles of communication and engagement with staff.

**Recommendation**

10. The Trust Board is asked to note and approve the content of the report. Once approved the report will be made available to managers and staff.

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**10 July 2019**

**Item** 95

**Purpose** Information / Approval

| | |
|---|---|
| **Title** | 7 Day Services Report |
| **Author** | Dr J Dean, Deputy Medical Director |
| **Executive sponsor** | Dr I Stanley, Acting Executive Medical Director |

**Summary:** This report summarises the progress and performance of East Lancashire Hospitals NHS Trust against the NHS England 7 day standards. Significant progress continues both with the priority standards and in other areas. Monitoring of progress is through 6 monthly reporting of a standardised Board reporting template recommended by NHS England/Improvement. This report is also returned to NHS Improvement.

Within ELHT, Divisions are collecting data against standard 2 (Consultant review within 14 hours of non-elective admission) and standard 8 (Daily of twice daily consultant review of non-elective inpatients). A Standard of 90% for standards 2 and 8 is set by NHS England. Specific reporting for specialised services is also required. We continue to develop ongoing continuous monitoring of time to consultant review as a professional standard within each acute speciality.

For June 2019 within Medicine 91% of acutely admitted patients are seen by a consultant within 14 hours of admission, with 95.2% on weekdays and 78.6% at weekends. The target of 90% is met for all patients admitted between 8pm and midday, 7 days a week. This is an improvement from 76% in February 2019. Further improvements would be gained by increasing the consultant acute medicine workforce and extending shift length in the evenings.

In Surgery on 64.2% of patients had consultant review within 14 hours of admission, this is not significantly different between weekdays and weekends, it is an improvement from 47% overall in April 2018. Planned consultant expansion with 3 new appointments and new working rotas from October 2019 will improve this performance.

In Paediatrics 77% of children had consultant review with 14 hours (65% in February 2019), this was 79% at weekends and 76% on weekdays. Consultant expansion would be required for further improvements,

Stroke services as demonstrated by SSNAP data 77% of patients with suspected stroke had a Stroke Consultant review within 14 hours of admission to the Stroke Unit, 41% had review before admission.

Standards are fully met for vascular services.

Electronic real time recording and reporting via an EPR would enable prioritisation, and help achieve the standard.

We have available investigations and interventions for all modalities 7 days a week for emergencies.

Significant increases in weekend multi-professional working were delivered within Medicine during the winter period, funded by winter pressures. Acute radiological imaging at weekends increase by 6% in 2019.

More detail including data on length of stay, mortality and readmission rates are given in the full report here.

Comparative data has not been published by NHS England since 2017.

**Recommendation:** The Board is asked to note:

1. The progress that is being made against the NHS 7 day emergency standards.
2. The consultant and AHP expansions that would be required to fully meet these standards.
3. The benefits that would be gained from real time monitoring via an Electronic Patient Record.

The Board will continue to receive 6 monthly updates in this format.

**Report linkages**

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

communities.

**Impact**

| | | | |
|---|---|---|---|
| Legal | No | Financial | No |
| Equality | No | Confidentiality | No |

Previously considered by: Simultaneously reported to Divisional Boards. Previous report to Operational Delivery Board.

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**Item** 96

**10 July 2019**

**Purpose** Information

| | |
|---|---|
| **Title** | People Strategy/ Creating Supportive Staff Culture |
| **Author** | Ms E Schofield, Deputy Director of HR & OD and<br>Mrs E Davies, Deputy Director of HR & OD |
| **Executive sponsor** | Mr K Moynes, Executive Director of HR & OD<br>Mrs K Quinn, Operational Director of HR & OD |

**Summary:** This paper outlines the Trusts intentions in relation to delivering a workforce strategy that will support Clinical, Quality and ICP priorities

**Recommendation:** To receive the strategy and note the activity planned to develop underpinning delivery plans

**Report linkages**

| | |
|---|---|
| Related strategic aim and corporate objective | Put safety and quality at the heart of everything we do<br>Invest in and develop our workforce |
| Related to key risks identified on assurance framework | Recruitment and workforce planning fail to deliver the Trust objective<br>The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework |

**Impact**

| | | | |
|---|---|---|---|
| Legal | No | Financial | Yes |
| Equality | No | Confidentiality | No |

Previously considered by: NA

**Executive Summary**

1. The Human Resources & Organisational Development (HR&OD) Directorate will be developing a People Strategy over the coming months. This paper sets out the strategic ambition, with a final strategy and plan to come back to Board in September. Our People Strategy aims to recognise the value brought to the Trust by its people and the link that exists between an engaged, happy workforce who feel valued and the quality of the care they are able to deliver for patients.
2. Whilst this will be an organisational wide People Strategy, the owner and leader of the strategy is the Director of HR&OD who will ensure it is implemented across the Trust/System. The Quality Committee will provide the Board assurance on the delivery of the plan and Finance and Performance will assure Board on impact.

**Context**

3. East Lancashire Hospitals NHS Trust (ELHT), like all NHS Trusts, is critically reliant on its staff. To ensure the ongoing delivery of safe, personal and effective care we must both look after and manage our workforce, as well as planning a sustainable workforce for the future.
4. Given that the Trust spends approximately 70% of its budget on its workforce, along with the growing focus on 'culture', the quality of leadership and how we engage with staff, it's vital that we have a dynamic People Strategy that sets out how we intend to deliver our ambition.
5. The People Strategy will support the delivery of the Trusts Clinical and Quality Strategies and the priorities of the Lancashire & South Cumbria Integrated Care System (ICS) and the Pennine Lancashire Integrated Care Partnership (ICP).
6. It is also crucial that the People Strategy is aligned to the aims and recommendations of key publications:
    a. NHS Long Term Plan
    b. Interim NHS People Plan
    c. NHS Improvement Developing Workforce Safeguards
    d. Letter to Chairs and CEOs May 2019 "Improving Our People Practices"
7. It is intended that the People Strategy will replace the following existing plans and frameworks:
    a. OD Strategy
    b. Workforce Transformation Strategy
    c. Employee Health and Wellbeing Strategy

d. Employee Engagement Strategy

**Where We Are Now**

8. ELHT is facing a number of key workforce challenges which the People Strategy will aim to address.

- Significant and persistent clinical vacancies across a range of professions
- Demography of our workforce presents a number of particular challenges around diversity, opportunity to progress, freedom to speak up, health and wellbeing and the impact of ill health and age on vacancy levels.
- Sickness absence consistently remains above the Trust target of 4.5%, placing us in the upper quartile on Model Hospital dashboard.
- Creation of compassionate and inclusive leadership culture
- Over reliance on bank and agency staff

**Our Ambition**

9. Our overall ambition is to use this People Strategy to enable East Lancashire Hospitals to recruit the best people, with the right skills and values to an organisation that supports staff to be the best they can be in a culture of community, compassion, inclusion, innovation and improvement to deliver safe Personal and Effective Care to the population it serves

10. This ambition will be delivered through the following six key People Priorities, each with underpinning delivery plans which will be shaped and developed with the workforce through a series of Big Conversations.

11. **People Priority 1: Recruitment and Retention – To develop the very best recruitment processes and most innovative working arrangements to attract and retain a skilled workforce who are able to demonstrate behaviours that support a culture of continual improvement and of compassion that will make ELHT the best place to work.**

Key activities that will enable delivery of this ambition include:

- Use of data to undertake proactive and targeted recruitment
- Improve recruitment processes building on Hire to Retire VSA
- Explore innovative employment models to meet new expectations of work and attract future workforce
- Recruit to a behavioural framework to ensure we recruit for skills and behaviours

12. **<u>People Priority 2: Engagement and Communication</u> – To provide every possible opportunity to engage our workforce to be the best they can be, ensuring everyone has a voice, control and influence. To create the right culture to encourage everyone to speak up in order to continually improves the staff and patient experience.**

Building on the existing staff engagement approach, staff survey data and the Culture and Leadership Programme diagnostic, we will:

- Utilise 'Big Conversation' approach to enable staff to input in to strategy development, provide feedback on issues and help shape service delivery
- Develop a behavioural framework with staff, for staff, to support a culture that is supportive and engaging and align our reward and recognition to support this
- Enable participation in shaping and changing service delivery by building QI skills across the organisation
- Improve the quality of appraisal and objective setting process to ensure colleagues are clear about expectations and have the best opportunity to give and receive feedback about their role
- Continue to promote and support the Staff Guardian service to enable staff to feel confident that their feedback will be listened to and acted upon
- Support multiple, varied mediums of communication, especially opportunities for face to face but in particular to explore how digital technology might support effective communications

13. **<u>People Priority 3: Leadership, organisational development and talent management</u> – To create the right environment for all staff to flourish at work through the very best leaders at all levels of the organisation, creating a culture of supportive, positive attitudes and behaviours that support improved patient care and create fulfilling roles.**

It is recognised that excellent leadership at all levels will be key to the delivery of better health outcomes and healthcare for the population we serve and the following will enable us to ensure this:

- Review and refresh leadership development offer to ensure we are growing collaborative, compassionate, inclusive leaders

- Recruit future leaders who are able to demonstrate how they meet the ELHT behavioural framework
- Build leadership capability around QI skills to support a culture of innovation and improvement
- Develop a coaching culture to support performance of individuals, teams and the organisation
- Continue to build on resolution approach as an effective and compassionate method of managing issues quickly and supportively for staff and review HR policies and procedures to further support 'Just Culture'
- Create a robust and inclusive talent management strategy to ensure succession planning and create opportunities to progress

14. **People Priority 4: Workforce Transformation – To develop system wide workforce plans to take account of our future needs aligned to quality and financial plans to create our future workforce. To maximise the use of technology to best support our workforce.**

To meet the workforce challenges, our workforce now needs to transform like never before, which means attracting and securing a vibrant future supply, upskilling our existing staff, creating and embracing new roles, mobilising innovation and new ways of working and being considered employer of choice. To achieve this we will**:**

- Develop meaningful workforce plans based on a population centric approach and using nationally recognised tools to support workforce redesign, such as the HEE STAR tool supported by WRaPT ( Workforce Repository and Planning Tool)
- To work with partners across the Pennine Lancashire ICP to develop the 'One Workforce' approach to ensure we are able to utilise the collective skills of our Primary, Secondary, Local Authority and VCFS workforce, to deliver integrated, new models of care.
- Explore opportunities to utilise digital technology to support productivity of the existing workforce and to consider opportunities where technology bridges skills gaps such as use of AI
- Create a skilled and agile workforce with the skills to enable delivery of new models of care in innovative ways that support service delivery and enhance the work experience

- To launch and further develop the Care Academy approach to promote ELHT and Pennine Lancashire partners as employers of choice and to encourage a future pipeline of staff not only from within the Pennine Lancashire geography but from the wider ICS and region.
- To work with the ICS to explore collaborative working in the following areas which will benefit the whole area: Global Learners Exchange, Primary Care Workforce Development, Workforce mobility opportunities, Development of a Careers Hub, Temporary Workforce

15. **People Priority 5: Equality and Inclusion – To create a culture of opportunity for all supported by a sense of equity and inclusivity that recognises, supports and values the difference that our individual differences makes.**

Only by valuing diversity and ensuring all staff have a voice within the Trust will we truly become the employer of choice. To achieve this we must create the cultural conditions that prevent discrimination and actively encourage our workforce to seek out and reap the benefit from views that differ from their own.

- We will use the nationally recognised Equality Delivery System to benchmark ourselves and to shape our Equality and Inclusion priorities alongside our network of champions spread across the Trust.
- We will establish an Equality and Inclusion Committee to oversee delivery of our priorities with the aim of creating the best place to work for all.
- We will develop a reverse mentoring scheme to promote learning from different perspectives and developing understanding of issues facing colleagues of difference.
- We will deliver ongoing improvements on WRES and WDES indicators
- We will continue to develop wider understanding and tolerance between colleagues from a range of backgrounds and groups through an annual Festival of Inclusion
- We will ensure that talent and succession strategies are developed to ensure inclusion of colleagues from across the organisation.

16. **People Priority 6: Health and Wellbeing – To create an organisational culture with HR policies and procedures that actively support the health and wellbeing of staff. We will encourage our staff to make healthy decisions and proactively support them as individuals in the event of ill-health.**

Having staff that are well and at work means we can deliver high quality, effective and compassionate care. We will ensure that our workforce is provided with an environment and opportunities that encourage and enable all staff to thrive. This is because there is a proven link between a healthy workforce and positive outcomes for patients.

- Our Health and Wellbeing Plan will continue to take steps to help staff make the best possible lifestyle choices in support of their health and wellbeing which, as a major employer within the area will not only contribute to the health and wellbeing of the workforce but of the wider population we serve.
- Recognising we have an aging workforce, the importance of supporting staff to continue to work at times of ill health (chronic and long term condition or acute episode of ill health).
- We will implement a new approach to managing sickness absence to ensure that staff are supported at the earliest opportunity, thereby reducing the potential length of time an individual is absent from work.
- Where a team, division or directorate is demonstrating consistent issues with sickness absence, we will work with those areas with a diagnostic and culture piece to identify root cause of sickness.
- We will continue to embed our 'resolution' approach because we know this helps to improve retention, reduce stress related absence and leads to better staff performance.

**Strategy Development**

17. The next steps in the development of the People Strategy will involve engagement around the 6 key People Priorities with key stakeholders across the Trust. This engagement will take the form of "big conversations" and will take place during summer 2019.

18. It is intended that the final People Strategy and associated action plans, with key metrics, will be presented to Trust Board in September for ratification and that once agreed, it will be reviewed bi-annually or earlier in the event of any significant national or organisational change.

19. The strategy and key lines of work will be aligned with ICS and ICP strategies in order to ensure that there is no duplication of effort and ensure coherence. A breakdown of key activity at ICS/ICP and Trust level is included in appendix 1.

**HR&OD Service Offer**

20. Following ratification of the People Strategy, the HR & OD "service offer" will be reviewed to ensure that it supports its delivery. Opportunities for workforce transformation within HR & OD will be explored to ensure that it has the capacity and capability moving forward to deliver what is required. This will include a review of HR & OD systems and processes which are seen as a key enabler in delivering the People Strategy.

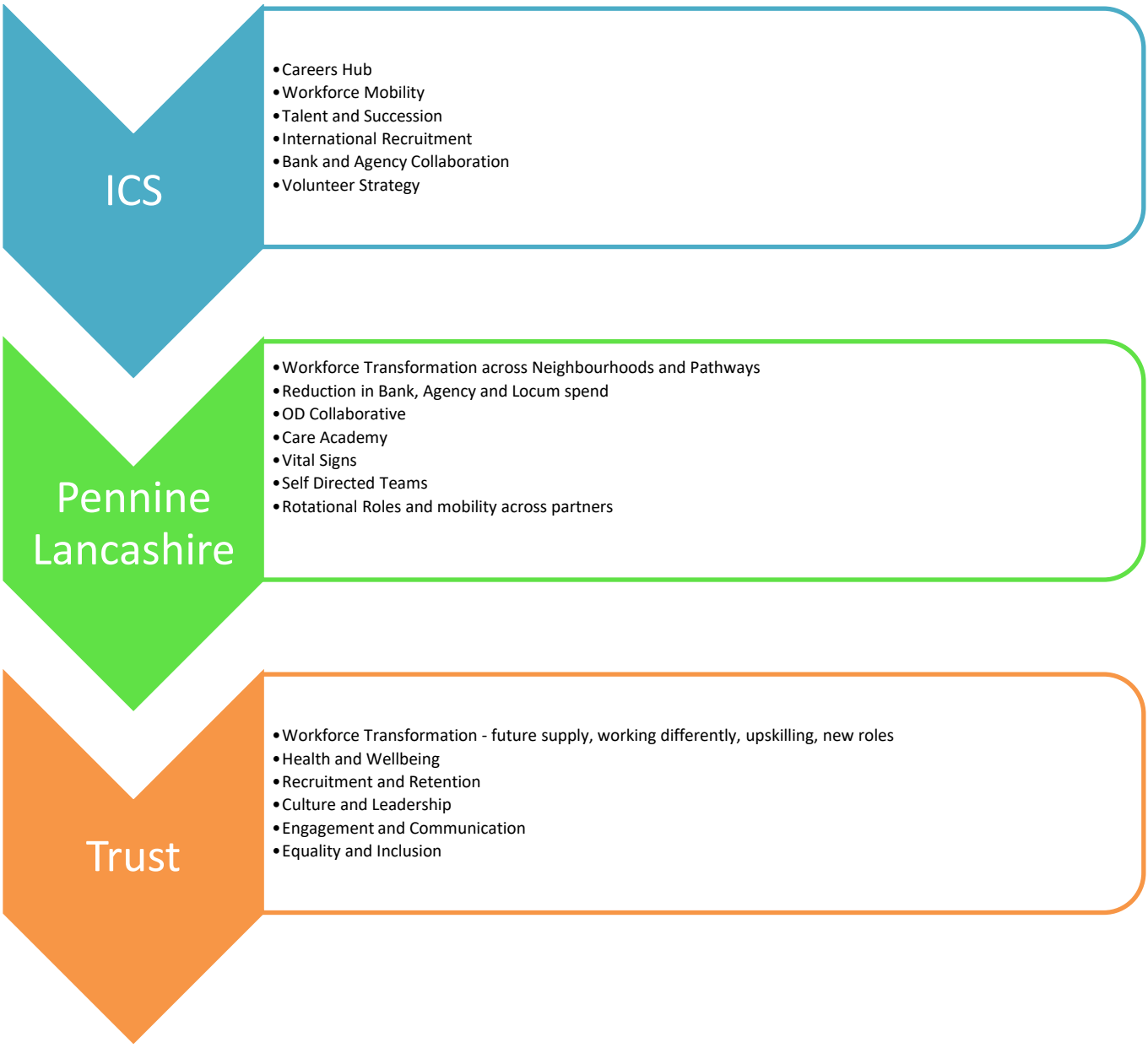
21. In order to provide assurance of the effectiveness of the People Strategy, key measures linked to the strategy will be regularly reported as part of the Workforce Dashboard.

**Recommendation**

22. It is recommended that the Trust Board note the content of this paper and associated agree the actions proposed.

23. To receive a full strategy and associated plans at Trust Board in September.

**Appendix 1** – ICS, ICP and Trust Workforce Priorities



East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**10 July 2019**

**Item** 97

**Purpose** Information Assurance

| | |
|---|---|
| **Title** | Annual Audit Letter |
| **Author** | Mr G Kelly, Associate Director, Grant Thornton UK LLP |
| **Executive sponsor** | Mr J Wood, Executive Director of Finance |

**Summary:** The Annual Audit Letter, which summarises the key findings arising from the work carried out by Grant Thornton UK LLP, as external auditors for the Trust for the year ended 31 March 2019.

The Board is asked to note and approve the document.

**Report linkages**

| | |
|---|---|
| Related strategic aim and corporate objective | - |
| Related to key risks identified on assurance framework | The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating. |

**Impact**

| | | | |
|---|---|---|---|
| Legal | No | Financial | No |
| Equality | No | Confidentiality | No |

(97) Annual Audit Letter

# The Annual Audit Letter for East Lancashire Hospitals NHS Trust

**Year ended 31 March 2019**

**June 2019**

# Contents


**Your key Grant Thornton team members are:**

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# Executive Summary

## Purpose

Our Annual Audit Letter (Letter) summarises the key findings arising from the work that we have carried out at East Lancashire Hospitals NHS Trust (the Trust) for the year ended 31 March 2019.

This Letter is intended to provide a commentary on the results of our work to the Trust and external stakeholders, and to highlight issues that we wish to draw to the attention of the public. In preparing this letter, we have followed the National Audit Office (NAO)'s Code of Audit Practice and Auditor Guidance Note (AGN) 07 – 'Auditor Reporting'. We reported the detailed findings from our audit work to the Trust's Audit Committee as those charged with governance in our Audit Findings Report on 22 May 2019.

## Respective responsibilities

We have carried out our audit in accordance with the NAO's Code of Audit Practice, which reflects the requirements of the Local Audit and Accountability Act 2014 (the Act). Our key responsibilities are to:

- give an opinion on the Trust's financial statements (section two); and
- assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (the value for money conclusion - section three).

In our audit of the Trust's financial statements, we comply with International Standards on Auditing (UK) (ISAs) and other guidance issued by the NAO.

## Our work

| | |
|---|---|
| **Materiality** | We determined materiality for the audit of the Trust's financial statements to be £7,729,000, which is 1.5**%** of the Trust's gross revenue expenditure. |
| **Financial Statements opinion** | We gave an unqualified opinion on the Trust's financial statements on 24 May 2019. |
| **NHS Group consolidation template (WGA)** | We also reported on the consistency of the financial statements consolidation template provided to NHS England with the audited financial statements. We concluded that these were consistent. |
| **Use of statutory powers** | We did not identify any matters which required us to exercise our additional statutory powers. |
| **Value for Money arrangements** | We were satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources. We reflected this in our audit report to the Audit Committee of the Trust on 22 May 2019. |
| **Quality Accounts** | We completed a review of the Trust's Quality Account and issued our report on this on 24 June 2019. We concluded that the Quality Account and the indicators we reviewed were prepared in line with the regulations and guidance. |
| **Certificate** | We certified that we have completed the audit of the financial statements of East Lancashire Hospitals NHS Trust in accordance with the requirements of the Code of Audit Practice on 24 May 2019. |

# Executive Summary

### Working with the Trust

During the year we have delivered a number of successful outcomes with you:

- An efficient audit – we delivered an efficient audit with you in May, delivering the financial statements 4 days before the deadline, releasing your finance team for other work.
- Understanding your operational health – through the value for money conclusion we provided you with assurance on your operational effectiveness.
- Sharing our insight – we provided regular audit committee updates covering best practice. We also shared our thought leadership reports
- Providing training – we provided your teams with training on financial statements and annual reporting via the chief accountant workshops and the benchmarking of annual reports review.

We would like to record our appreciation for the assistance and co-operation provided to us during our audit by the Trust's staff.

**Grant Thornton UK LLP**
**June 2019**

# Audit of the Financial Statements

## Our audit approach

### Materiality

In our audit of the Trust's financial statements, we use the concept of materiality to determine the nature, timing and extent of our work, and in evaluating the results of our work. We define materiality as the size of the misstatement in the financial statements that would lead a reasonably knowledgeable person to change or influence their economic decisions.

We determined materiality for the audit of the Trust's financial statements to be £7,729,000, which is 1.5% of the Trust's gross revenue expenditure. We used this benchmark as, in our view, users of the Trust's financial statements are most interested in where the Trust has spent its revenue in the year.

We set a lower threshold of £300,000, above which we reported errors to the Audit Committee in our Audit Findings Report.

### The scope of our audit

Our audit involves obtaining sufficient evidence about the amounts and disclosures in the financial statements to give reasonable assurance that they are free from material misstatement, whether caused by fraud or error. This includes assessing whether:

- the accounting policies are appropriate, have been consistently applied and adequately disclosed;
- the significant accounting estimates made by management are reasonable; and
- the overall presentation of the financial statements gives a true and fair view.

We also read the remainder of the Annual Report to check it is consistent with our understanding of the Trust and with the financial statements included in the Annual Report on which we gave our opinion.

We carry out our audit in accordance with ISAs (UK) and the NAO Code of Audit Practice. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based.

We identified key risks and set out overleaf is the work we performed in response to these risks and the results of this work.

# Audit of the Financial Statements

## Significant Audit Risks

These are the significant risks which had the greatest impact on our overall strategy and where we focused more of our work.

| Risks identified in our audit plan | How we responded to the risk | Findings and conclusions |
|---|---|---|
| **Fraud in revenue recognition**<br>We have rebutted this presumed risk for the revenue streams of the Trust that are principally derived from contracts, which are agreed in advance at a fixed price. We have determined these to be:<br>• monthly payment by result contract invoices included in patient care revenues; and<br>• contract element of education and training revenues.<br>We did not deem it appropriate to rebut this presumed risk for all other material streams of patient care revenue, including contract variation and quarterly reconciliation invoices and other operating revenue.<br>We therefore identified the occurrence and accuracy of these income streams of the Trust and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement and a key audit matter. | As part of our audit work we have:<br>• evaluated the Trust's accounting policy for recognition of income from patient care activities and other operating revenue for appropriateness and compliance with the DHSC Group Accounting Manual 2018/19;<br>• updated our understanding of the Trust's system for accounting for income from patient care activities and other operating revenue, and evaluated the design of the associated controls;<br>• investigated unmatched revenue and receivable balances over the NAO £0.3m threshold, using the DHSC mismatch report, corroborating the unmatched balances used by the Trust to supporting evidence;<br>• agreed, on a sample basis, revenue from contract variations, quarterly variations and year end receivables to signed contract variations, invoices or other supporting evidence such as correspondence from the Trust's commissioners;<br>• evaluated the Trust's estimates and the judgments made by management in order to arrive at the total revenue from contract variations recorded in the financial statements;<br>• agreed on a sample basis, revenue and year end receivables from other operating revenue to invoices and cash payment or other supporting evidence; and<br>• agreed provider support funding recognised to NHS Improvement notifications. | Our audit work has not identified any issues in respect of revenue recognition. We have verified the year-end position with the Trust's main commissioners to invoices raised, amounts disclosed in the agreement of balances exercise and confirmation of commissioner agreement. We are satisfied that the Trust has achieved its year-end control total and is appropriately recognising its PSF core allocation of £5.6 million and incentive allocation of £6.3 million.<br>Included in the Trust's Trade and other receivables balance is a PFI lifecycle cost prepayment of £4.3 million. The Trust should seek assurances from the PFI operator around the plan for future lifecycle costs to help demonstrate that there will be increased lifecycle cost expenditure to support the continued inclusion of a prepayment in its accounts. |

# Audit of the Financial Statements

## Significant Audit Risks - continued

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

| Risks identified in our audit plan | How we responded to the risk | Findings and conclusions |
|---|---|---|
| **Fraud in expenditure recognition**<br>Practice Note 10 suggests that, the risk of material misstatement due to fraudulent financial reporting which may arise from the manipulation of expenditure recognition needs to be considered, especially where the body is required to meet targets. | As part of our audit work we have:<br>• documented the goods received not invoiced accrual process and the processes management have put in place, challenging any key assumptions, the appropriateness of the source data used and the basis for calculations;<br>• tested substantively a sample of expenditure and agreed to supporting documentation to confirm correct accounting treatment;<br>• obtained a listing from the cash book of non-pay payments made in April to ensure they have been charged to the appropriate year; and<br>• tested substantively a sample of year-end creditor and accrual balances. | Our audit work has not identified any issues in respect of expenditure recognition. Our substantive testing of; non-pay operating expenditure, non-pay after date payments and year-end creditor and accrual balances did not identify any errors. We have reviewed the agreement of balances exercise and are satisfied that the balances submitted by the Trust are accurate. |
| **Management override of controls**<br>Under ISA (UK) 240 there is a non-rebuttable presumed risk that the risk of management over-ride of controls is present in all entities. The Trust faces external pressures to meet agreed targets, and this could potentially place management under undue pressure in terms of how they report performance.<br>Management over-ride of controls is a risk requiring special audit consideration. | As part of our audit work we have:<br>• evaluated the design effectiveness of management controls over journals;<br>• analysed the journals listing and determined the criteria for selecting high risk unusual journals;<br>• tested unusual journals made during the year and the accounts production stage for appropriateness and corroboration; and<br>• gained an understanding of the accounting estimates and critical judgements applied by management and considered their reasonableness. | Our audit work has not identified any issues in respect of management override of controls. |

# Audit of the Financial Statements

## Significant Audit Risks - continued

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

| Risks identified in our audit plan | How we responded to the risk | Findings and conclusions |
|---|---|---|
| **Valuation of land and buildings**<br><br>The Trust revalues its land and buildings on an annual basis to ensure that the carrying value is not materially different from the current value at the financial statements date. This valuation represents a significant estimate by management in the financial statements.<br><br>Management has engaged the services of a valuer to estimate the current value as at 31 March 2019. Since 2017-18, the Trust has adopted an alternative site valuation model, whereby the valuation of its estate is based on the value of the modern equivalent asset required to deliver the services the Trust currently provides without taking account of the existing estate and its current utilisation.<br><br>The valuation of land and buildings is a key accounting estimate, which is sensitive to changes in assumptions and market conditions.<br><br>We therefore identified valuation of land and buildings, particularly revaluations and impairments, as a significant risk, which was one of the most significant assessed risks of material misstatement. | As part of our audit work we have:<br><br>• reviewed management's processes and assumptions for the calculation of the estimate, the instructions issued to valuation experts and the scope of their work;<br><br>• considered the competence, expertise and objectivity of the Trust's valuer;<br><br>• considered the basis on which the valuation is carried out and challenged the key assumptions;<br><br>• reviewed and challenged the information used by the valuer to ensure it is robust and consistent with our understanding; and<br><br>• tested revaluations made during the year to ensure they are input correctly into the Trust's asset register. | Our audit work has not identified any issues in respect of the valuation of the Trust's land and building. We are satisfied that the alternative site valuation model continues to be a reasonable basis to value the Trust's estate. We have challenged key assumptions used in the valuation, including the assumption that the replacement hospital would be carried out under a special purchase vehicle where VAT would be recoverable. We are satisfied that management's assumptions are reasonable. We have reviewed information provided to the Trust's valuer and have confirmed it was accurate and complete. We have confirmed that the valuations provided have been appropriately reflected in the Trust's asset register and disclosed correctly in the accounts. |
| | | |

# Audit of the Financial Statements

## Significant Audit Risks - continued

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

| Risks identified in our audit plan | How we responded to the risk | Findings and conclusions |
|---|---|---|
| **Going concern material uncertainty disclosures**<br>The Trust met its control total in 2017/18, incurring a £10.763m operating deficit in delivering its services after receipt of £14.870m of STF funding. The revised 2018-19 underlying control total for the Trust is a deficit of £15.798m. Management anticipates that it may take a number of years before the Trust's income equals or exceeds its expenditure.<br><br>It is anticipated that, the Trust will require cash support via interim revenue support loans to pay its expenses in 2019/20 and 20/21. The source and value of the loans has yet to be confirmed.<br><br>We therefore identified the adequacy of disclosures relating to material uncertainties that may cast doubt on the Trust's ability to continue as a going concern in the financial statements as a significant risk.<br><br>Given the sensitive nature of these disclosures, this is one of the most significant assessed risks of material misstatement. | As part of our audit work we have:<br>• discussed the Trust's financial standing with executives to understand the latest position and pressures;<br>• reviewed management's assessment of the going concern assumptions and supporting information, including key assumptions around efficiency savings included in its 2019/20 financial plan;<br>• reviewed the Trust's forecast reliance on revenue support in 2019/20;<br>• reviewed the completeness and accuracy of the disclosure on going concern in note 1.3; and<br>• moderated our judgements with a national Grant Thornton Public Services going concern panel. | In 2018/19, the Trust delivered its planned financial control total and £18 million Safely Releasing Cost Programme (SRCP) savings. However, £8.8 million of these saving were recurrent against a plan of £16.9 million.<br><br>The Trust has received a financial control total for 2019/20 from NHS Improvement (NHSI) and has submitted an initial financial plan, which agrees to the £6.7 million projected surplus. The plan assumes SRCP savings of £16.4 million in 2019/20.<br><br>The forecast deficit position for 2018-19 meant that the Trust required £9.3 million of revenue support loans from the Department of Health and Social Care in order to maintain cash balances above the minimum level required by NHSI. The Trust's 2019-20 financial plan submitted to NHSI includes a net increase in loans in 2019/20 of £ 1.9 million.<br><br>Our work has demonstrated that there is not a material uncertainty in relation to the Trust continuing as a going concern. This is informed by, the Trust's favourable outturn 2018/19 position that included £11.9m of NHSI support and the forecast 2019/20 surplus. This has been further supported by our review of key assumptions around planned efficiency savings and the Trust's budgeted reduced reliance on revenue support loans in 2019/20. |

# Audit of the Financial Statements

## Significant Audit Risks – other issues

These are the risks which were identified during the course of the audit that were not previously communicated in the Audit Plan.

| Issue | Commentary | Auditor view |
|---|---|---|
| **Clarification of RICS guidance**<br>During the 2018/19 year, RICS issued clarification to its guidance on the estimation of useful lives of assets. This clarification has led the Trust's valuer to revise their estimates in this area. | There has been a lot of debate in the sector regarding whether this change constitutes a change in estimate or an accounting error.<br>Management's view is that this is a change in the estimate of the useful lives used, and should be corrected prospectively in the Trust's financial statements.<br>When assets are revalued, the accumulated depreciation is reversed out, so there is no cumulative depreciation error to be considered.<br>However the amount of depreciation charged against an asset in previous years will change how any gains or losses from the revaluation of that asset affect the Trust's reserve balances. | Management has performed an analysis to demonstrate that, had the revised economic lives provided by the valuer as part of the valuation at 31 March 2019 been used as the basis for the depreciation charge in 2018/19, this charge would have been £1.47 million higher. We have reviewed this analysis, and consider this to be a reasonable estimate.<br>We have considered the potential impact of any errors in depreciation in previous years on the Trust's reserve balances. and have satisfied ourselves that there is not a risk of material error.<br>We have identified the impact in respect of financial year 2018/19 as an unadjusted error of £1.47m.<br>We have gained assurance that the potential impact of this change, both in the 2018/19 year and cumulatively, is not material, and so are not minded to challenge management's view. |

# Audit of the Financial Statements

### Audit opinion
We gave an unqualified opinion on the Trust's financial statements on 24 May 2019.

### Preparation of the financial statements
The Trust presented us with draft financial statements in accordance with the national deadline, and provided a good set of working papers to support them. The finance team responded promptly and efficiently to our queries during the course of the audit.

### Issues arising from the audit of the financial statements
We reported the key issues from our audit to the Trust's Audit Committee on 22 May 2019. We agreed two recommendations with management. The Trust should prepare a monthly payroll reconciliation and consider annually whether the full amount of the prepayment of PFI lifecycle costs is recoverable and determine if any amount deemed irrecoverable should be written off.

### Annual Report, including the Annual Governance Statement
We are also required to review the Trust's Annual Report, including the Annual Governance Statement. It provided these on a timely basis with the draft financial statements and supporting evidence. We suggested a number of amendments to both the Annual Report and Annual Governance Statement, which management did change to ensure compliance with the relevant requirements.

### Certificate of closure of the audit
We certified that we have completed the audit of the financial statements of East Lancashire Hospital NHS Trust in accordance with the requirements of the Code of Audit Practice on 24 May 2019.

# Value for Money conclusion

## Background

We carried out our review in accordance with the NAO Code of Audit Practice, following the guidance issued by the NAO in November 2017 which specified the criterion for auditors to evaluate:

*In all significant respects, the audited body takes properly informed decisions and deploys resources to achieve planned and sustainable outcomes for taxpayers and local people.*

## Key findings

Our first step in carrying out our work was to perform a risk assessment and identify the risks where we concentrated our work.

The risks we identified and the work we performed are set out overleaf.

As part of our Audit Findings report agreed with the Trust in May 2019, we agreed recommendations to address our findings. The Trust should ensure appropriate reporting mechanisms are in place to monitor delivery against joint CIP and QIP programmes and continue to develop governance arrangements within the Improvement Office to ensure adequate and timely oversight and accountability frameworks are in place.

## Overall Value for Money conclusion

We are satisfied that in all significant respects the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2019.

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# Value for Money conclusion

## Value for Money Risks

| Risks identified in our audit plan | How we responded to the risk | Findings and conclusions |
|---|---|---|
| **Financial outturn and sustainability**<br>The Trust's underlying control total for 2018-19 was a £15.8 million deficit. At month 9, the forecast outturn was a £15.8 million deficit before provider support funding (PSF) and a £10.2 million deficit after receiving £5.6 million of the available £8.0 million PSF. The Safely Releasing Cost Programme (SRCP) was £18 million for 2018-19. £11.6 million had been actioned to month 9, of which £5.1 million was recurrent. The Trust continues to require cash support via interim revenue support loans to pay its expenses and this is likely to continue in 2019/20 and 2020/21.<br>The Trust's has an Improvement office, which is delivering transformation schemes to support the financial sustainability of the Trust. The Trust is also working with partners in the local health economy to address long term financial challenges. Effective joint working with the emerging integrated care partnership in Pennine Lancashire and integrated care system for Lancashire and South Cumbria can have a significant influence on financial delivery in 2018/19 and into the future.<br>The financial outturn and sustainability of the Trust represents a significant risk to our Value for Money conclusion. | During 2018/19, the Trust Board monitored its financial position including delivery of the SRCP with more detailed reporting of the financial position and SRCP provided to the Finance and Performance Committee.<br>The Trust delivered its planned financial control total and received its core PSF allocation of £5.6 million and its incentive allocation of £6.3 million. The Trust has achieved its planned SRCP savings of £18 million, however £8.8 million was recurrent against a plan of £16.9 million.<br>The Trust has received a financial control total for 2019/20 from NHS Improvement (NHSI) and has submitted an initial financial plan, which agrees to the projected £6.7 million surplus. The plan assumes SRCP savings of £16.4 million 2019/20.<br>The forecast deficit position for 2018-19 meant that the Trust required £9.3 million of revenue support loans from Department of Health and Social Care in order to maintain cash balances above the minimum level required by NHSI. The Trust's 2019-20 financial plan submitted to NHSI includes a net increase in loans in 2019/20 of £1.9 million.<br>The Trust has put arrangements in place to support delivery of its saving programmes. It has established an Improvement Office and in 2019/20 the Trust is working with partners in the Pennine Lancashire health economy towards a system control total, with developing joint QIP and CIP programmes. | The Trust has delivered its control in 2018/19 and is planning a surplus in 2019/20. The Trust has achieved its savings target of £18m in year, although 50% was non-recurrent, which will be carried forward as a pressure into 2019/20. Whilst the level of non-recurrent savings achieved is higher than planned, the delivery of the 2018/19 control total and forecast 2019/20 surplus indicates that the arrangements put in place by the Trust to supports its financial sustainability are effective.<br>The Improvement Office will play a key role in the achievement of the planned £16.4 million recurrent savings in 2019/20. Schemes are expected to deliver tangible quality and financial benefits. The Trust should continue to develop its governance arrangements in this area, ensuring they provide adequate oversight and accountability.<br>The Trust continues to work collaboratively with Pennine/ Lancashire Health Economy partners in 2018/19 to confront the challenges facing the system. The move to joint QIP and CIP programmes in 2019/20 is indicative of strong arrangements in this area. The Trust should ensure appropriate reporting mechanisms are in place to monitor delivery against these joint programmes.<br>We are satisfied that the Trust has proper arrangements in place for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions. |

# Quality Accounts

## The Quality Account

The Quality Account is an annual report to the public from an NHS Trust about the quality of services it delivers. It allows Trust Boards and staff to show their commitment to continuous improvement of service quality, and to explain progress to the public.

## Scope of work

We carry out an independent assurance engagement on the Trust's Quality Account, following Department of Health (DH) guidance. We give an opinion as to whether we have found anything from our work which leads us to believe that:

- the Quality Account is not prepared in line with set DH criteria;
- the Quality Account is not consistent with other documents, as specified in the DH guidance; and
- the two indicators in the Quality Account where we have carried out testing are not compiled in line with DH regulations and do not meet expected dimensions of data quality.

## Quality Account Indicator testing

We tested the following indicators:

- Rate of clostridium difficile infections: selected from the subset of mandated indicators after discussions with the Trust; and
- Percentage of patients risk-assessed for venous thromboembolism (VTE): selected from the subset of mandated indicators after discussion with the Trust.

For each indicator tested, we considered the processes used by the Trust to collect data for the indicator. We checked that the indicator presented in the Quality Account reconciled to underlying Trust data. We then tested a sample of cases included in the indicator to check the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation of the indicator was in accordance with the defined indicator definition.

## Key messages

- We confirmed that the Quality Account had been prepared in line with the requirements of the Regulations.
- We confirmed that the Quality Account was consistent with the sources specified in the DH Guidance.
- We confirmed that the commentary on indicators in the Quality Account was consistent with the reported outcomes
- Based on the results of our procedures, nothing came to our attention that caused us to believe that the indicators we tested were not reasonably stated in all material respects.

## Conclusion

As a result of this we issued an unqualified conclusion on the Trust's Quality Account on 24 June 2019.

# A. Reports issued and fees

We confirm below our final reports issued and fees charged for the audit and provision of non-audit services.

## Reports issued

| Report | Date issued |
|---|---|
| Audit Plan | March 2019 |
| Audit Findings Report | May 2019 |
| Annual Audit Letter | June 2019 |

## Fees

| | Planned £ | Actual fees £ | 2017/18 fees £ |
|---|---|---|---|
| Statutory audit | 47,600 | 47,600 | 58,000 |
| Charitable fund | 2,000 | 2,000 | 2,000 |
| **Total fees** | **49,600** | **49,600** | **60,000** |

## Fees for non-audit services

| Service | Fees £ |
|---|---|
| **Audit related services** | |
| - Quality Accounts | 6,000 |
| **Non-Audit related services** | |
| - Mortality review | 11,742 |

## Non- audit services

- For the purposes of our audit we have made enquiries of all Grant Thornton UK LLP teams providing services to the Trust. The table above summarises all non-audit services which were identified.
- We have considered whether non-audit services might be perceived as a threat to our independence as the Trust's auditor and have ensured that appropriate safeguards are put in place.

The above non-audit services are consistent with the Trust's policy on the allotment of non-audit work to your auditor.

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**Item** 98

**10 July 2019**

**Purpose** Information
Assurance

| | |
|---|---|
| **Title** | Audit Committee Update Report |
| **Author** | Miss K Ingham, Corporate Governance Manager/ Assistant Company Secretary |
| **Executive sponsor** | Mr R Smyth, Non-Executive Director, Committee Chair |

**Summary:** The report sets out the matters discussed and decisions made at the Audit Committee meetings held on 22 May and 24 June 2019.

**Recommendation:** The Board is asked to note the content of the report and agree the revision to SFI's that are recommended by the Committee.

## Report linkages

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

## Impact

| | | | |
|---|---|---|---|
| Legal | No | Financial | No |

| | | | |
|---|---|---|---|
| Equality | No | Confidentiality | No |

Previously Considered by: NA

**Audit Committee Update**

At the meeting of the Audit Committee held on 22 May 2019 members considered the following matters:

1. It was noted that the Board had given delegated authority to the Committee for the approval and sign off of the Annual Accounts, Annual Report, Annual Governance Statement and Quality Account prior to submission to the regulators in line with the specified timeframes.
2. The Committee received the Head of Internal Audit Opinion for the Trust for review and approval. Members received a summary of the document, and noted that the Trust had received a rating of 'substantial assurance' and approved the document.
3. The Committee received the Response from Those Charged with Governance for information and final approval. Following a brief discussion the Committee members approved the submission of the response to Grant Thornton (external auditors).
4. The Committee members received the going concern report from external audit colleagues and noted that the draft statement that had been discussed at the last meeting had been slightly revised to show the improved year end position following receipt of Provider Sustainability Funds (PSF) from NHS Improvement as the Trust was able to reach an agreeable control total for the 2019/20 financial year. The Committee also noted that, for the 2018/19 financial year, Grant Thornton had taken the report to an internal national moderation panel who had agreed to lift material uncertainties which had been included in the previous year's report.
5. The Committee members received the Annual Report, including the Annual Governance Statement, for review and approval for submission to the regulator by no later than 29 May 2019. Pending a number of minor typographical errors being corrected, none of which were noted to be material changes to the document, the Committee approved the annual report for submission to the regulator.
6. Members received and approved the revised Modern Slavery and Human Trafficking statement for signature and publication on the Trust website.
7. The Committee received the audited annual accounts and financial statements for approval prior to submission to the regulator by 29 May 2019. An overview of the accounts was provided, including the changes that had been made to the accounts following the conclusion of the audit, none of which were maternal changes. Members noted the majority of the adjustments made to the accounts were out of the

control of the Trust and included an allocation of PSF monies which the Trust were notified about following the closing down of the accounts.

8. The Committee received and approved the letter of representation for signature and submission.

9. Committee members were presented with the audit findings report of the external auditors who had proposed an unqualified opinion on the accounts and financial statements.

At the meeting of the Audit Committee held on 24 June 2019 members considered the following matters:

11. The Committee received the Quality Account of the Trust for review and approval as part of the delegated authority from the Board referred to in paragraph 1. The quality account was approved for submission to the regulators pending a small number of immaterial revisions, such as typographical errors.

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 1 July 2019

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**Item** 99

**10 July 2019**

**Purpose** Information Assurance

| | |
|---|---|
| **Title** | Finance and Performance Committee Update Report |
| **Author** | Miss K Ingham, Corporate Governance Manager/Assistant Company Secretary |
| **Executive sponsor** | Mr D Wharfe, Non-Executive Director |

**Summary:** The report sets out the matters discussed and decisions made at the Finance and Performance Committee meeting held on 13 May 2019.

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

## Report linkages

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

## Impact

| | | | |
|---|---|---|---|
| Legal | No | Financial | No |
| Equality | No | Confidentiality | No |

**Finance and Performance Committee Update Report**

At the meeting of the Finance and Performance Committee held on 13 May 2019 members considered the following matters:

1. The members noted that, due to the need to revise the meeting date for this Committee, some of the reports presented to the Committee had already been presented and discussed at the Trust Board earlier in the month (8 May 2019).
2. The Committee received the Integrated Performance Report, including an overview of the current financial position to the end of March 2019 and noted that this report was one of the papers that had been reported to the Trust Board earlier in the month. The members spent some time discussing the most appropriate ways in which to internally measure and monitor the performance of the Trust against the constitutional targets and internal trajectories to improve performance against the targets that were not currently being met on a consistent basis. The Non-Executive members of the Committee requested that internal improvement trajectories, for those standards not currently being met be brought to the next meeting for information.
3. The members received the financial performance report for the month of March 2019 and noted that the Trust had achieved the required 2018/19 financial year end position. In addition the Trust had received additional bonus monies after the end of the financial year which had improved the financial position further. Non-Executive Director members received an overview of the recent revisions to the pension tax for upper level earners, and the potential impact that these changes may have on the willingness of Trust's consultant body to undertake additional NHS work, such as capacity clinics. Non-Executive members raised concerns about the high level of non-recurrent efficiency schemes in the 2018/19 financial year and the underlying impact this will have on the financial position in 2019/20.
4. Committee members received an update on the financial plan and contract for 2019/20 and noted that as a result of the discussions and negotiations after the last meeting the Trust had been able to sign up to a financial control total for 2019/20. The Committee were informed that there was a national issue in relation to volume of capital resources being requested and the funds that were available. As a result Trusts had been asked to recast their capital plans and reduce it where possible, although the Committee suggested that the Trust should not revise their plans. The Committee members discussed the agreement of the control total at ICS level and it

was confirmed that should any constituent NHS organisation within the ICS be unable to meet its financial requirements in the year, 15% of the PSF monies would be in jeopardy. Members noted that whilst the Trust's Safely Releasing Costs Programme (SRCP) target for the year was deemed to be high risk at around 3% of revenue, other Trusts were looking to make SRCP efficiencies of in excess of 5% of revenue.

5. The Committee were provided with an update on the Trust's IM&T Strategy, specifically information on the current situation; the progress towards introducing Electronic Patient Records (EPR); and health system led investments. In relation to the development of the EPR business case, members noted that the initial costing submission had been identified as being unaffordable and therefore the Trust was seeking an alternative approach, including the potential of partnering with another Trust in the north which would save approximately £2,000,000. As a result the business case has been revised and resubmitted including the aforementioned proposal. Non-Executive members of the Committee raised concerns about the timescale of the programme slipping and the risk scoring of the current system on the Trust's risk register and suggested that the scoring should be revised to in excess of 15 and therefore be included on the Corporate Risk Register.

6. The Committee were updated on the progress against the Trust's Estates Strategy, particularly the development of the phase 6 emergency care village on the Royal Blackburn Teaching Hospital site and the phase eight developments at the Burnley General Teaching Hospital site. The Committee members noted the development of a business case, with the support of the ICS, to develop the Victoria building at the Burnley site to include a urology investigation unit, wards and private hospital wing. It was also noted that the next wave of ICS capital monies had been discussed at a recent ICS level meeting and it was confirmed that there were a number of Trust bids to be considered including an integrated theatre, Victoria wing, replacement of radiology equipment, expansion of the MRI fleet, development of the endoscopy room and replacement of the pharmacy robot, all of which totalled in excess of £20,000,000. The Committee members also received an overview of the bid scoring process and guidelines.

7. The Committee also received a review of the Board Assurance Framework risks associated with the Committee; the tenders report; a proposed outline of future workforce reports; Costing Submission 2018/19 Pre-Submission Planning Report; the

results of the Committee Effectiveness Self-Assessment review; and the minutes of the Financial Assurance Board and Contract and Data Quality meeting for information.

At the meeting of the Finance and Performance Committee held on 24 June 2019 members considered the following matter which is recommended to the Trust Board for consideration:

8. The Committee were informed that following a review of the Safely Releasing Cost Programme with divisional teams that about £4,000,000 of schemes were now forecast to slip into 2020/21 and that additional schemes would need to be delivered to meet the in-year control total. The Committee discussed this matter at length and raised concerns about the likelihood of suitable and achievable schemes being identified and actioned in the 2019/20 financial year. The Committee agreed to bring this matter to the Board's attention and will be closely monitoring the delivery of the SRCP schemes.

A more detailed report from the meeting held on 24 June 2019 will be provided to the next Trust Board meeting in September 2019.

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 2 July 2019

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**Item** 100

**10 July 2019**

**Purpose** Information

| | |
|---|---|
| **Title** | Quality Committee Update Report |
| **Author** | Miss K Ingham, Corporate Governance Manager/Assistant Company Secretary |
| **Executive sponsor** | Ms N Malik, Committee Chair |

**Summary:** The report sets out the summary of the papers considered and discussions held at its meeting on 2 May 2019.

**Recommendation:** The Board is asked to note the report.

## Report linkages

| | |
|---|---|
| Related strategic aim and corporate objective | Put safety and quality at the heart of everything we do<br>Invest in and develop our workforce<br>Work with key stakeholders to develop effective partnerships<br>Encourage innovation and pathway reform, and deliver best practice |
| Related to key risks identified on assurance framework | Recruitment and workforce planning fail to deliver the Trust objectives<br>Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities.<br>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 |

(100) Quality Committee Update Report

**Quality Committee Update**

At the meeting of the Quality Committee held on 2 May 2019 members considered the following matters:

1. The Committee briefly discussed a recent article in the Health Service Journal concerning the admission and treatment of patients with mental health needs. During the discussion, Executive Committee members reported that a number of the issues considered within the article/potential national proposal had been discussed in detail the A&E Delivery Board prior to the Committee. Furthermore, the general consensus across the medical profession was that the potential recommendation to admit mental health patients to medical inpatient beds would not be in either the patients' or clinicians' best interests and that any such instruction would be strongly opposed.
2. The Committee received the Doctors and Dentists in Training Safe Working Hours Report and noted that after the initial process of introduction and embedding of reporting, where clinicians had been actively encouraged to submit exceptions, the overall number had tailed off to a relatively low level. The members noted that the Medical Director was satisfied that the report showed the process was being used when needed. The Committee were informed that there had been a recent incident where a group of dentists had been unaware of the reporting process and had instead raised their concerns directly to the Deanery; however this matter had been quickly identified and resolved.
3. The Committee received the Maternity Services Floor to Board Report and noted a number of recent successes, including positive ratings as part of the Nursing Assessment and Performance Framework (NAPF), national recognition as being one of the top Trusts regarding the improvements made to its maternity services, the securing of funding for a Deputy Head of Midwifery and the high achievement against the national booking target for maternity services. In addition the Committee noted that they would receive a formal update on the progress made against ensuring all 10 safety standards were being met at its next meeting. The Committee noted that only one safety standard was not currently being achieved, due to the Trust's inability to submit information for the national maternity data sets, but received confirmation that the matter was being addressed as a priority. A risk of lost funding was noted in relation to the failure to ensure full compliance, and this matter would be raised at the next Risk Assurance Management (RAM) meeting. Members also noted that a new

scheme to develop a 'digital midwife' was being considered to provide support to clinicians and plans were also underway to appoint a new lead for obstetrics.

4. The Committee received the Serious Investigations Requiring Investigation (SIRI) report and noted the incidents that had been reported through the Strategic Executive Information System (StEIS). Committee members noted that there had been an increase in the number of reported incidents over the same period the previous year and a more detailed analysis of the incidents in question would be brought to the next meeting to ascertain the reasons for this and any action that was required to mitigate any further risks. The three most common types of incident reported were noted to be falls, pressure ulcers and diagnostic errors. The members also noted the incidents that had occurred that the Trust determined to be serious but did not meet the criteria for reporting on StEIS. The Committee also noted that a new framework for reporting pressure ulcers had been issued.

5. The Committee members received the Medicines and Healthcare Products Regulatory Agency (MHRA) Action Plan for the Trust's Transfusion Service. The action plan was developed to address a series of recommendations made by the MHRA following audit visits in 2012 and 2018 relating to the need to achieve 100% traceability of infusions. Members noted that the Trust's current traceability compliance was 96% and that an enforcement notice had been issued that could potentially prevent the Trust from performing future procedures if this did not improve. The Committee members noted that among the recommendations made by the MHRA was improved communications between pathology and IT services and changes to the Patient Administration System (PAS) when merging patients. Committee members acknowledged the urgency of the situation and gave the Committee's support and approval for any further actions needed to achieve compliance by the end of June 2019. It was agreed that IR1 forms would be completed for each case where complete traceability had not been achieved. The Committee requested a further update report from the Transfusion Committee at the next meeting.

6. The Committee received a report regarding learning from deaths which summarised the efforts that had been made by the Trust to address the recommendations made by NHS England and the Trust's internal auditors a number of years earlier to improve communication with bereaved families. The report highlighted the work carried out to date and the areas where improvements were still required. The

Committee observed the good progress made to date. The members noted the refinements that had been made to the care after death literature provided to families and that information about the recently implemented mortality review process was now included as was information regarding the Trust's duty of candour process. However the decision had been made not to include the latest information regarding post-mortem CT scans in order to ensure that the booklet was user friendly. Versions of the document have been developed for a range of service areas, including community, maternity and paediatric services as well as additional funding had been secured to improve the service even further. The Non-Executive Director members of the Committee enquired if the care after death booklet was available in other languages, but it was confirmed that they were not currently available in other languages, but this option could be explored further.

7. The Committee received an update on the Trust's holding lists which is a system used to manage follow up appointments for patients. The members noted that a risk stratification process had been in place for a number of years, but that it had become apparent towards the end of January 2019 that it was not being applied consistently and as such it had not been clear which patients were being managed appropriately according to their needs. The Committee received an overview of the actions that had been taken since January to alleviate the issues, including each speciality had conducted urgent reviews of patients currently on their lists to rate them in terms of risk. Following this process, it had been determined that no patients had come to harm. The Committee noted that there were specific concerns around the volume of patients currently on the holding lists for Ophthalmology and as a result it had been agreed that consultants would book additional clinics to see the patients in person rather than undertake a desk top review approach. There has been a Trust wide Standard Operating Procedure (SOP) developed to facilitate the review and rating process and regular reporting is provided on this matter through the Trust's weekly Operational Executive Briefing meetings. In addition a risk relating to holding lists has been included on the corporate risk register and that the associated rating on the board assurance framework had been raised.

8. Committee members received the draft Quality Account for information and comment/feedback prior to being approved by the Audit Committee in June 2019. It was noted that the Trust had achieved a significant amount of good work over the course of the year which was to be celebrated.

9. The Committee received an update on CQC compliance, Quality Dashboard; an update report on the Nursing Assessment Performance Framework; the Committee specific elements of the Board Assurance Framework; Corporate Risk Register; results of the Committee effectiveness self-assessment; and Summary Reports from the following Sub-Committee Meetings:

   a) Patient Safety and Risk Assurance Committee (March 2019)
   b) Infection Prevention and Control Committee (January, February and March 2019)
   c) Health and Safety Committee (March 2019)
   d) Internal Safeguarding Board (February 2019)
   e) Patient Experience Committee (February 2019)
   f) Clinical Effectiveness Committee (April 2019)
   g) Education Directorate Strategic Board (January 2019)

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 28 June 2019

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**Item** 101

**10 July 2019**

**Purpose** Information

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

**Summary:** The list of matters discussed at the Remuneration Committee held on 8 May 2019 are presented for Board members' information.

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

## Report linkages

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

## Impact

| | | | |
|---|---|---|---|
| Legal | No | Financial | No |
| Equality | No | Confidentiality | No |

**Remuneration Committee Information Report**

1. At the meeting of the Remuneration Committee held on 8 May 2019 members considered the following matter:
   a) Chief Executive Officer's Annual Appraisal 2017/18 Outcome Letter from NHS Improvement
   b) Acting Joint Chief Executive Officer (Blackpool) Arrangements
   c) Executive Director's Remuneration Annual Review
   d) Pension Update

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 28 June 2019

East Lancashire Hospitals NHS Trust

# TRUST BOARD REPORT

**Item** 102

**10 July 2019**

**Purpose** Information

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

**Summary:** The report details the agenda items discussed in closed session of the Board meetings held on 8 May 2019.

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

**Report linkages**

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

**Impact**

| | | | |
|---|---|---|---|
| Legal | No | Financial | No |
| Equality | No | Confidentiality | No |

**Trust Board Part Two Information Report**

1. At the meeting of the Trust Board on 8 May 2019, the following matters were discussed in private:
   a) Round Table Discussion: ICS/ICP Update
   b) Round Table Discussion: Holding Lists
   c) Finance and Performance Update 2018/19
   d) Operational and Financial Planning Submission 2019/20
   e) Tender Update
   f) Draft Annual Accounts and Report 2018/19
   g) Draft Annual Governance Statement 2018/19
   h) Draft Quality Account 2018/19
   i) Serious Untoward Incident Report
   j) Doctors with Restrictions
2. The matters discussed were private and confidential and/or identified individuals and/or were commercially sensitive at this time and so the decision was taken that these items should not be discussed in the public domain. As these items progress, reports will be presented to Part 1 of Board Meetings at the appropriate time.

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 28 June 2019