East Lancashire Hospitals

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

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East Lancashire Hospitals NHS Trust

TRUST BOARD PART 1 MEETING

14 MARCH 2018, 14:30, SEMINAR ROOM 6, ROYAL BLACKBURN HOSPITAL

AGENDA

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

OPENING MATTERS				
TB/2018/001	**Chairman's Welcome**	Chairman	v	
TB/2018/002	**Open Forum** To consider questions from the public	Chairman	v	
TB/2018/003	**Apologies** To note apologies.	Chairman	v	
TB/2018/004	**Declaration of Interest Report** To note the directors register of interests and note any new declarations from Directors.	Company Secretary	d✓	Information/ Approval
TB/2018/005	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 13 December 2017.	Chairman	d✓	Approval
TB/2018/006	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2018/007	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2018/008	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2018/009	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information
QUALITY AND SAFETY				
TB/2018/010	**Patient Story** To receive and consider the learning from a patient story.	Director of Nursing	p	Information/ Assurance
TB/2018/011	**Corporate Risk Register** To receive an update on the Corporate Risk Register and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Medical Director	d✓	Information
TB/2018/012	**Board Assurance Framework** To receive an update on the Board Assurance Framework and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Medical Director	d✓	Approval
TB/2018/013	**Serious Incidents Requiring Investigation Report** To receive information in relation to incidents in month or that may come to public attention in month and be assured about the associated learning.	Medical Director	d✓	Information/ Assurance

STRATEGY				
TB/2018/014	**National Staff Survey Results**	Director of HR and OD	d✓	Information
ACCOUNTABILITY AND PERFORMANCE				
TB/2018/015	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed: • Introduction (Chief Executive) • Performance (Director of Operations) • Quality (Medical Director) • Workforce (Director of HR and OD) • Safer Staffing (Director of Nursing) • Finance (Director of Finance)	Executive Directors	d✓	Information/ Assurance
GOVERNANCE				
TB/2018/016	**Finance and Performance Committee Update Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information Approval
TB/2018/017	**Audit Committee Update Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information Approval
TB/2018/018	**Standing Financial Instructions and Standing Orders** a) Standing Financial Instructions b) Standing Orders	Committee Chair (Audit Committee)	d✓ d✓	Approval
TB/2018/019	**Quality Committee Update Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information Approval
TB/2018/020	**Trust Charitable Funds Committee** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information Approval
TB/2018/021	**Remuneration Committee Update Report** To note the matters considered by the Committee in discharging its duties	Chairman	d✓	Information
TB/2018/022	**Trust Board Part Two Information Report** To note the matters considered by the Committee in discharging its duties	Chairman	d✓	Information
FOR INFORMATION				
TB/2018/023	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2018/024	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2018/025	**Board Performance and Reflection** To consider the performance of the Trust Board, including asking: • Has the Board focussed on the appropriate agenda items? Any item(s) missing or not given enough attention? • Is the Board shaping a healthy culture for the Board and	Chairman	v	

	the organisation and holding to account? • Are the Trust's strategies informed by the soft intelligence from local people's needs, trends and comparative information? • Does the Board give enough priority to engagement with stakeholders and opinion formers within and beyond the organisation?			
TB/2018/026	**Date and Time of Next Meeting** Wednesday 9 May 2018, 2.30pm, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.	Chairman	v	

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 4

14 March 2018

Purpose Information / Approval

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

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

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

Report linkages

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

Impact

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

(4) Directors' Register of Interests

Directors Register of Interests

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

Name and Title	Interest Declared	Date last updated
Professor Eileen Fairhurst Chairman	• Professor at Salford University - until 31.12.2016. • Trustee, Beth Johnson Foundation - until 31.3.2017. • Chairman of Bury Hospice – from 23.1.2017. • A member of the Learning, Training & Education (LTE) Group Higher Education Board – until 12.3.2017. • Chairman of the NHS England Performers Lists Decision making Panel (PDLP).	6.3.2018.
Kevin McGee Chief Executive	Positive Nil Declaration	7.3.2018.
Patricia Anderson Associate Non-Executive Director (appointed 1.1.2018.)	Chief Officer Wigan Borough CCG	7.3.2018
John Bannister Director of Operations	Positive Nil Declaration	7.3.2018.
Stephen Barnes Non-Executive Director	• Chair of Nelson and Colne College • Member of the National Board of the Association of Colleges - from 2.3.2017 • Vice Chair of the National Council of Governors of the Association of Colleges - from 2.3.2017	23.2.2018.

Name and Title	Interest Declared	Date last updated
Keith Griffiths Director of Sustainability	Positive Nil Declaration	23.2.2018.
Martin Hodgson Director of Service Development	Positive Nil Declaration	23.2.2018.
Christine Hughes Director of Communications and Engagement	Positive Nil Declaration	23.2..2018.
Naseem Malik Non-Executive Director (appointed 1 September 2016)	• Independent Assessor- Student Loans Company- Department for Education - Public Appointment • Fitness to Practice, Panel Chair: Health & Care Professions Tribunal Service (HCPTS) - Independent Contractor. • Investigations Committee Panel Chair - Nursing & Midwifery Council (NMC) - Independent Contractor • Member of the Law Society • Fellow of The Royal Society of Arts • NED and SID at Lancashire Care NHS Foundation Trust - until 29.07.2016. • Worked for Blackburn Borough Council (now Blackburn with Darwen Borough Council) in 1995/6. • NED at Blackburn with Darwen Primary Care Trust from 2004 until 2010. • Relative (first cousin) is a GP in the NHS (GP Practice) • Relative (brother-in-law) is a Mental Health Nurse	28.3.2018.

Name and Title	Interest Declared	Date last updated
Kevin Moynes Director of Human Resources & Organisational Development	• Governor of Nelson and Colne College – until 1.2.2018. • Spouse works for HEE (NW) as Head of Workforce Transformation.	5.3.2018
Christine Pearson Director of Nursing	Positive Nil Declaration	23.2.2018.
Damian Riley Executive Medical Director	• National Clinical Assessment Service (NCAS) Clinical Assessor and Trainer - small amounts of work are undertaken in this role and funded by NCAS • Member of British Medical Association Registered with General Medical Council • Spouse is and employee - GP in Dyneley House Surgery, Skipton • Sister is an employee of pharmaceutical company Novartis	23.2.2018.
Richard Slater Non-Executive Director	Positive Nil Declaration	6.3.2018.
Richard Smyth Non-Executive Director	• Consultant Solicitor with DLA Piper UK LLP Law Firm. DLA Piper undertakes work for the NHS • Spouse is a Lay Member of Calderdale CCG • Spouse is a Patient & Public Involvement and Engagement Lay Leader for the Yorkshire and Humber Patient Safety Translational Research Centre, based at Bradford Institute for Health Research, Bradford Royal Infirmary • Sister is an advanced clinical nurse practitioner with Pennine Acute Hospitals Trust based at the	5.3.2018

Name and Title	Interest Declared	Date last updated
	Royal Oldham hospital. • Member of the Law Society	
Professor Michael Thomas Non-Executive Director	• Vice-Chancellor of UCLAN	7.3.2018.
Michael Wedgeworth Associate Non-Executive Director	• Honorary Canon of Blackburn Cathedral in 2003 • Assistant Priest at Blackburn Cathedral since 1995 • Member of the Lancashire Health and Well-Being Board from 2011 to 2017 • Elected Public Governor at Lancashire Care Foundation Trust and Chair of the Patient Experience Group until April 2017 • Chair of Healthwatch Lancashire until December 2017 • Healthwatch Representative on NHS governing bodies and Trusts since 2015 • Member of the Lancashire and South Cumbria Sustainability and Transformation Programme Board and its workstream on Acute and Specialised Services since 2015 • NED Representative for the Pennine Lancashire system on the Lancashire and South Cumbria Sustainability and Transformation Partnership Board (now the Integrated Care Organisation Board)	23.2.2018.
David Wharfe Non-Executive Director	Positive Nil Declaration	23.2.2018.

Name and Title	Interest Declared	Date last updated
Jonathan Wood Director of Finance)	• Spouse is the Director of Finance at the Oldham Care Group Hospital, part of Pennine Acute Hospitals NHS Trust. Pennine Acute Hospitals currently form part of the 'hospital chain' with Salford Royal Hospitals Foundation Trust.	27.07.2017

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary, 31 August 2017

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 5

14 March 2018

Purpose Action

Title	Minutes of the Previous Meeting
Author	Miss K Ingham, Minute Taker
Executive sponsor	Mr D Wharfe, Non-Executive Director (Vice Chair)

Summary:

The draft minutes of the previous Trust Board meeting held on 13 December 2017 are presented for approval or amendment as appropriate.

Report linkages

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

Impact

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

Previously considered by: NA

(5) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 13 DECEMBER 2017

MINUTES

PRESENT

Mr D Wharfe	Non-Executive Director/Vice Chair	Chair
Mr K McGee	Chief Executive	
Mr J Bannister	Director of Operations	non-voting
Mr S Barnes	Non-Executive Director	
Mr K Griffiths	Director of Sustainability	non-voting
Mr M Hodgson	Director of Service Development	
Mrs C Hughes	Director of Communications and Engagement	non-voting
Miss N Malik	Non-Executive Director	
Mr K Moynes	Director of HR and OD	non-voting
Mrs C Pearson	Director of Nursing	
Mr R Slater	Non-Executive 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 J Butcher	Staff Guardian	Fir Item TB/2017159
Dr J Dean	Deputy Medical Director, Service Improvement	For Item TB/2017/155 and TB/2017/160
Miss K Ingham	Company Secretarial Assistant	Minutes
Ms F McFarlane	HR Graduate (Shadowing Mr K Moynes)	Observer/Audience
Dr I Stanley	Deputy Medical Director, Quality and Education	For Dr D Riley

APOLOGIES

Professor E Fairhurst	Chairman
Dr D Riley	Medical Director

TB/2017/146 CHAIRMAN'S WELCOME

Mr Wharfe welcomed the Directors and the members of public to the meeting and confirmed that he would be chairing today's meeting on behalf of Professor Fairhurst.

TB/2017/147 OPEN FORUM

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

TB/2017/148 APOLOGIES

Apologies were received as recorded above.

TB/2017/149 DECLARATIONS OF INTEREST

No declarations of interests were made.

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

TB/2017/150 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 September 2017 were approved as a true and accurate record.

TB/2017/151 MATTERS ARISING

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

TB/2017/152 ACTION MATRIX

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

RESOLVED: The position of the action matrix was noted.

TB/2017/153 CHAIRMAN'S REPORT

Mr Wharfe confirmed that this item would be taken alongside item TB/2017/154: Chief Executive's Report.

TB/2017/154 CHIEF EXECUTIVE'S REPORT

Mr McGee provided an update on behalf of the Chairman. He thanked members of staff and the public for attending the recent Annual General Meeting and thanked the Communications Team and Company Secretariat for arranging the event. He went on to report that he, Dr Riley and the Chairman had recently attended a conference to provide feedback on the process of being in special measures, the actions that the Trust undertook to improve and the learning gained.

Mr McGee referred the Directors to his previously circulated report and highlighted a number of items for information. He gave an overview of the work that was taking place on national level in relation to the publicity around nurses from EU countries leaving the NHS and confirmed that the Trust does not have a significant number of nurses from EU countries and as a result any impact on the Trust would be minimal. Mrs Pearson gave an overview of the work that had been undertaken to retain staff within the Trust and confirmed that no EU nurses had left the Trust to date.

Mr McGee went on to refer to the WRES report and confirmed there had been a significant amount of work undertaken during last year. Mr Moynes reported that 15% of the workforce was made up of staff from BME groups, which was just short of the regional average. He went on to provide an overview of the Trust's 'Unconscious Bias' programme that was aimed at helping to identify and tackle bias.

Directors noted that the Trust is the first in the country to be awarded the UNICEF Gold Award for being baby friendly. Mr McGee highlighted the work that the Trust was involved in with UCLan to provide a place of education and training for medical students from the American University of the Caribbean who had to be relocated from the island of St Maarten following the hurricanes and tropical storms that had hit the island earlier in the year.

Mr McGee went on to report that ward B20 had recently presented their portfolio of evidence to a SPEC panel in the hope of being awarded 'silver ward' status. Directors discussed the evidence presented and agreed to award the ward B20 a 'silver ward' status.

RESOLVED: Directors received the report and noted the content.

Directors agreed that ward B20 be awarded a silver ward status.

TB/2017/155 PATIENT STORY

Mrs Pearson confirmed that the patient story this month would take the form of a video commissioned by NHS England. The video featured a poem which related to the last 1000 days of life as told from a patient's point of view. The video can be found by clicking on the

following link: https://www.youtube.com/watch?v=HynytVepxZc.

In response to Mr Wedgeworth's question, Dr Stanley confirmed that the rights and wishes of the patient in relation to their preferred place of death was tied in with the work of the Future Hospitals Programme that was being reported later on the agenda. He added that the area that the Trust serves has a relatively high proportion of people who live alone and there is a general level of anxiety/apprehension amongst the population concerning ending their days in a care/nursing home. As such, there is significant work being carried out across the LDP area to address these issues.

Directors spent some time discussing the processes around discharge of patients, particularly those who were nearing the end of their life and the considerations that are made to respect their wishes.

In response to Miss Malik's question, Dr Dean suggested that there were a number of factors involved in developing a culture where people were less risk averse in relation to discharging medically fit patients, including the development of the knowledge and skills of the clinicians, the availability of good information from families and other care givers/colleagues.

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

TB/2017/156 CORPORATE RISK REGISTER

Mrs Bosnjak-Szekeres presented the report on behalf of Dr Riley. She provided an overview of the changes that had been proposed to the register for the Board's consideration. Directors noted that there had been no proposed changes to the risk ratings.

Mr Barnes asked for a better understanding of the links between the Corporate Risk Register and the Board Assurance Framework. Mrs Bosnjak-Szekeres provided an overview of the links between the two documents and commented that both documents would be due for their annual review in the first quarter of the next financial year.

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

TB/2017/157 BOARD ASSURANCE FRAMEWORK (BAF)

Mrs Bosnjak-Szekeres referred the Directors to the previously circulated report and provided an overview of the work carried out since the last meeting, including the presentation and discussion of BAF risks to the Trust Board's Sub-Committees. She provided and overview of the proposed change, including the increase of the risk rating of risk four (Finances) from

16 to 20, based on an increased likelihood score of five (likelihood 5 x consequence 4).

In response to Mr Smyth's question, Mr Griffiths confirmed that there had been discussion regarding the possibility of splitting BAF risk three into two separate risks and it was felt that the elements of the risk were closely linked and therefore would remain as one risk for the time being.

In response to Mr Barnes question regarding the inclusion of the risks to the Trust associated with the support offered to North Lincolnshire and Goole NHS Trust (NLAG), Mrs Bosnjak-Szekeres referred Directors to BAF risk three where this matter was included.

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

TB/2017/158 SERIOUS INCIDENTS REQUIRING INVESTIGATION REPORT

Dr Stanley presented the report to the Directors on behalf of Dr Riley and gave an overview of the content. He highlighted the change of format of the report and confirmed that it provided a categorised summary of the incidents, ensuring that individuals could not be identified. He drew the Directors' attention to the section of the document that provided an overview of the never events that had taken place within the Trust in the last six months and the outcome and recommendations from the recent never event summit. He went on to provide an overview of the actions being undertaken to learn from the events and change the behaviours/culture within the areas affected.

In response to Mr Wedgeworth's question, Dr Stanley confirmed that the never event concerning the patient with a gall bladder issue was the result of a series of very small irregularities which all happened in relation to the one patient experience.

Mr Smyth commented that issues around culture had been raised at a recent patient safety walkround and asked that the Trust Board receive additional assurance that those staff working within the theatres feel able to speak up.

Miss Malik commented that there had been significant discussion and debate at the last Quality Committee regarding the never events and the work being undertaken to address the action plans. She went on to comment that discussion had also been undertaken relating to the possibility of employing a Family Liaison Officer; however the end view was that this was not needed at this time.

Directors received and noted the information contained within the report.

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

TB/2017/159 RAISING CONCERNS REPORT

Mrs Butcher attended the meeting to give a presentation regarding her role as the Staff/Freedom to Speak-Up Guardian. Her presentation covered the following items: an overview of the role of the guardian, progress to date, an overview of the statistics and the future planned work. Directors noted that the biggest concern reported by staff related to bullying and harassment with the second most reported issue related to staff being aggrieved by HR processes.

In response to Miss Malik's question, Mrs Butcher provided greater detail regarding the issues reported relating to HR processes, including the support offered to staff when off sick and processes being unclear and at times slow.

Mr Griffiths asked whether there was a process in place for Mrs Butcher to reflect and review her work/interactions with staff. Mrs Butcher confirmed that Mrs Davey, Assistant Director, Patient Experience acted as her internal contact for such matters whilst a regional/national support was sought.

RESOLVED: Directors received the report and noted its contents.

TB/2017/160 FUTURE HOSPITALS FINAL REPORT

Dr Dean referred Directors to the previously circulated report and gave an overview of the programme. He confirmed that the programme was originally developed across four hospital Trusts, including ELHT and it was rolled out to a further four. The Trust's focus was on frail and older people and the support offered to them across the services. Directors noted that the key learning for the Trust from the programme included: how we involved patients and carers in care; how the teams are supported in the Trust and the levels of collaboration with other organisations; and how we use and review data.

Dr Dean reported that an additional benefit of the work was developing a number of good connections across a range of organisations.

Mr McGee thanked Dr Dean for sharing the work with the Board. The Board is supportive of the principles outlined in the report regarding putting patients and carers are the centre of their care and the support required for clinical teams to have allocated time away to undertake such work.

Dr Dean left the meeting at this point (3.05pm)

RESOLVED: Directors received the report and noted its content.

The Board is supportive of the principles outlined in the report regarding putting patients and carers are the centre of their care

and the support required for clinical teams to have allocated time away to undertake such work.

TB/2017/161 STRATEGIC FOCUS ON TRANSFORMATION

a) Workforce Transformation Update

Mr Moynes presented the report and provided a summary of the work undertaken to date and confirmed that all activity relating to workforce transformation was being carried out within the context of the wider health and care system workforce requirements. This will help to ensure that the vision of 'one workforce' to deliver health and care services across Pennine Lancashire is realised.

Directors noted the work being carried out at Trust level, including the development of the Physicians Associate role. Mr Moynes provided an overview of the STAR model which is being used, the model includes: the identification of future supply; the identification of opportunities to upskill current staff; development of new roles; development of new ways of working and a focus on leadership.

In response to Mr Barnes' question, Mr Moynes confirmed that training would be undertaken across a number of areas to ensure that individuals were equipped and supported to fulfil their new style roles, such as the Advanced Nurse Practitioners.

b) Compassionate Leadership Report

Mr Moynes presented the report and confirmed that the document had already been seen by executive colleagues who had offered their support for the programme. He confirmed that the work had a clear evidence base and was supported by the King's Fund and NHS Improvement. He provided an overview of the work being undertaken at a national level and the links that the work had with the Trust's vision, values and drive to deliver safe, personal and effective care.

Mr Barnes commented that he saw the benefits to the work; however he had not been able to learn a great deal about the programme as a Non-Executive Director member of the Board and asked that a Board Development Session be dedicated to developing a greater understanding of the work and how its success will be measured/assessed.

Professor Thomas suggested that UCLan would be willing to match any funding given to the project if it was done as a joint piece of work between the Trust and the University.

Mr Smyth suggested that if the tone of the work was not set correctly there was a risk that the whole programme may be seen as negative, but supported the work on the

understanding that the outcomes were clearly measurable.

Mr McGee commented that leadership across the Trust was of significant importance and the Board needed to set the tone in the way that it conducts its business.

It was agreed that a future Board Development Session would have dedicated time to the programme to present the detail behind the programme.

RESOLVED: **Directors received and noted the content of the report presented. A future Board Development Session would have dedicated time to present the detail behind the programme.**

TB/2017/162 INTEGRATED PERFORMANCE REPORT

Mr McGee introduced the report to the Directors and confirmed that the report related to the month of October 2017. The Directors noted that the overall performance was reasonable, however further work was required to ensure compliance with the four hour emergency care standard and financial compliance. Mr McGee confirmed that the Trust had received a congratulatory letter from the Secretary of State for Health relating to the performance within the Trust's emergency care pathway. He went on to report that the last few weeks have been particularly challenging for the staff working within the emergency care pathway and asked that the thanks of the Board to the staff be noted within the minutes.

a) Performance

Mr Bannister reported that the performance against the four hour A&E standard was 86.7% for October 2017 based on 19,263 attendances. He confirmed that there had been two 12 hour breaches in the month; both patients were noted to have required mental health assessment/treatment by Lancashire Care NHS Foundation Trust. Directors noted that the new Mental Health Decision Unit opened on 1 December 2017 and it is expected to have a positive impact on patients requiring assessment and on the overall performance.

Mr Bannister confirmed that the number of ambulance handovers over 30 minutes increased during October with the HAS compliance indicator not being met. During the period, 1470 handovers were within 15 minutes of arrival and a further 1207 were between 15 and 30 minutes.

Operational pressures around elective care pathways in six specialties were noted to have been a significant challenge in the reporting month, causing the RTT performance to fall below the 92% threshold. All cancer targets were achieved during September 2017, which reports one month behind the other indicators and for the second quarter (1 July to 30

September 2017).

Directors noted that overall delayed transfers of care had reduced in the month, however work was taking place to address a number of issues that were hampering performance, including: patient/family choice of home; completion of required assessments, including the Continuing Healthcare Assessment; discharge to assess and Home First implementation and embedding; and the time taken between the decision to discharge and the completion of assessments for non-NHS care.

Mr Bannister confirmed that emergency readmissions had reduced in September to 11.6%.

In response to Mr Wedgeworth's question, Mr Bannister gave an summary of the overarching position relating to delayed transfers of care across the Lancashire County Council area and confirmed that the majority of the delays were due to issues within the Central Lancashire part of the county and that the Pennine Lancashire area was performing relatively well in comparison.

Mr Barnes noted the significant number of areas rated as red in the performance dashboard and asked for a report or additional narrative in the report at the next meeting to provide further assurance that the matters were being managed and performance was improving. Mr Bannister confirmed that each area that was rated as red had a comprehensive action plan for improvement and work was being undertaken to improve performance. He offered to work with Mr Barnes outside the meeting to discuss the issues and the improvement work that was being carried out.

Professor Thomas left the meeting at this point (4.25pm)

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

b) Quality

Dr Stanley confirmed that there had been three cases of Clostridium Difficile (C-Diff) in October 2017 bringing the total number of cases to date to 21 against a year end tolerance of 28 cases. Directors noted that whilst there had been an increase in cases, the Trust continued to perform well against similar sized Trusts. Dr Stanley reported that there was a plan in place to reduce the number of cases in the future.

Directors noted that the Summary Hospital Mortality Indicator (SHMI) rates had risen slightly to 1.05 which was still within the tolerance limits. The Hospital Standardised Mortality Ratio (HSMR) also remained within the tolerance limits at 95.9 and had improved slightly since the last report.

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

c) Human Resources

Mr Moynes reported that sickness currently stands at 4.6%, compliance with the Trust's core skills training remains good with eight of the 11 modules being above the required level of performance. Directors noted that appraisal compliance remained good but acknowledged that there was work to be done to improve the meaningfulness of appraisals in some areas.

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

d) Safer Staffing

Mrs Pearson reported that the nursing and midwifery staffing continued to be a significant challenge to the Trust and confirmed that the position had deteriorated in October 2017. She provided an overview of the red flag incidents reported over the month and confirmed that no harms had been identified in the reported cases.

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

e) Finance

Directors noted that this item had been covered in detail in the closed Board session earlier in the day and there was nothing further to report.

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

TB/2017/163 PURCHASE ORDERS

Mr Wood presented the report, and provided a summary of the seven requisitions that required Trust Board approval. Following a brief discussion around the items, Directors approved the seven requisitions totalling £17,000,000.

RESOLVED: **Directors received the report and approved the purchase orders presented.**

TB/2017/164 FINANCE AND PERFORMANCE COMMITTEE UPDATE REPORT AND TERMS OF REFERENCE

Mr Barnes confirmed that he had chaired the October Committee meeting and provided an overview of the meeting and the discussions that had taken place. He went on to present the proposed revised terms of reference for the Committee that were ratified by the Board.

RESOLVED: Directors received the report and noted its content.
Directors approved the Committee's revised terms of reference.

TB/2017/165 AUDIT COMMITTEE UPDATE REPORT AND TERMS OF REFERENCE

Mr Smyth presented the report and confirmed that the Committee had received assurance on a range of matters, including the work being carried out to improve performance of clinical coding and VTE assessments. He went on to draw attention to the discussions that had taken place in relation to income generation from overseas trade. Directors noted the support of the Committee regarding the possible move towards expert determination in relation to the ongoing dispute between the Trust and its PFI partner. Mr Smyth highlighted the discussions that had taken place at the meeting concerning the feedback to be provided to the STP Board regarding the proposed STP governance arrangements.

Mr Smyth presented the Committee's revised terms of reference and commented that there were a small number of issues in the last paragraph that he had noticed that required further refinement prior to ratification by the Board. It was agreed that pending the amendments the revised terms of reference would be approved.

RESOLVED: Directors received the report and noted its content.
Pending the rectification of issues in the last paragraph the Directors approved the Committee's revised terms of reference.

TB/2017/166 QUALITY COMMITTEE UPDATE REPORT AND TERMS OF REFERENCE

Miss Malik presented the report for information and presented the Committee's proposed revised terms of reference for approval or further revision. Directors approved the Committee's revised terms of reference as requested.

RESOLVED: Directors received the report and noted its content.
Directors approved the Committee's revised terms of reference.

TB/2017/167 TRUST CHARITABLE FUNDS COMMITTEE UPDATE REPORT AND TERMS OF REFERENCE

Mr Barnes presented the report to Directors and provided an overview of the discussions that had been held at the last meeting. He went on to present the Committee's proposed revised terms of reference for approval or further revision. Directors approved the Committee's revised terms of reference as requested.

RESOLVED: Directors received the report and noted its content.
Directors approved the Committee's revised terms of reference.

TB/2017/168 REMUNERATION COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

TB/2017/169 TRUST BOARD PART TWO INFORMATION REPORT

The report was presented to the Board for information.

TB/2017/170 ANY OTHER BUSINESS

There were of further matters of business raised.

TB/2017/171 OPEN FORUM

There were no matters raised from the members of the public.

TB/2017/172 BOARD PERFORMANCE AND REFLECTION

Mr Wharfe invited comments and observations about the meeting from the Directors. Directors commented that the meeting had attended to a range of matters and had received good levels of assurance.

RESOLVED: Directors noted the feedback provided.

TB/2017/173 DATE AND TIME OF NEXT MEETING

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

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 7

14 March 2018

Purpose Information

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

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2017/154: Chief Executive's Report	Ward B20 to be awarded a silver ward status.	Director of Nursing	March 2018	Verbal Report
TB/2017/161: Strategic Focus on Transformation	The next Board Development Session would have dedicated time to the programme to present the detail behind the programme.	Director of HR and OD/Assoc. Director of Corporate Governance	April 2018	Board Development Session April 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 9

14 March 2018

Purpose Information

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

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

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

Report linkages

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

Impact

Legal	No	Financial	No

Equality	No	Confidentiality	No

Previously considered by: N/A

National Updates

1. **Ambulance delays skyrocket as A&E 'litmus test' reveals intolerable winter - W**inter pressures across the NHS have caused chaos for emergency services over the festive period, with delays of over 30 minutes hitting nearly one in five ambulances. Leading figures within the health service say the situation is "becoming intolerable" as adult bed occupancy figures for critical care have averaged more than 82% between Boxing Day and the New Year, rising to highs of 95% at certain points over winter. Figures from NHS England's winter daily reports show that more than 13% of ambulances were delayed on New Year's Eve by between 30 and 60 minutes, with a further 6% taking over an hour to reach patients.
2. **Funding to support employers with the nursing associate role** - Health Education England's (HEE) chief executive, Ian Cumming, has announced that it will be supporting the implementation of 5000 nursing associate places with additional funding support for employers. £15,000 has been agreed to cover the cost of providing the programme and to support practice placement preparation and supervision. HEE will also be releasing a support package of £3200 to support mentorship and supervision, quality assurance and developing provider readiness for the role.
3. **Winter pressures protocol kicks in -** NHS England has activated the NHS Winter Pressures Protocol, kicking into gear a number of widely reported recommendations intended to help hospitals deal with increased pressures on services. Niall Dickson, the head of the NHS Confederation, said the move, which includes deferring all non-urgent inpatient elective care, 'makes sense' given the strain on services, which members have long warned of.
4. **Pressures becoming 'intolerable'** - NHS England figures revealing an increasing number of people delayed in ambulances on arrival at A&E show pressures on services becoming 'intolerable', Niall Dickson said. "If the health service cannot cope at its front door, what lies behind it will also be struggling." View our full response to the latest winter SitRep stats.
5. **Join this year's celebrations as the NHS turns 70 -** The NHS is turning 70 on 5 July 2018. It is the perfect opportunity to get involved in national, regional and local celebrations to mark the achievements of one of the nation's most loved institutions, to appreciate the vital role it plays in people's lives, and to recognise and thank NHS staff – the everyday heroes – who are there to guide, support and care for us. NHS

England has created a short animation which details the achievements of the NHS over the last seven decades. More information on how to get involved in the celebrations is available on NHS England's website.

6. **More clinical pharmacists to boost GP services for patients and practices -** Nearly 34 million patients will benefit from improved GP services as NHS England boosts the number of surgery-based clinical pharmacists that can offer expert medication and treatment. Funding has been approved to increase the number of clinical pharmacists in general practice from around 580 to more than 1,100 pharmacists across over 3,200 GP practices. Clinical pharmacists work as part of the general practice team offering expertise on day-to-day medicine issues and providing consultations with patients directly. The final deadline for the next wave of applications is this Friday 19 January 2018.

7. **#SpeakUp – encouraging feedback to improve services -** Healthwatch has launched #SpeakUp, a campaign to encourage people to speak up and help make services better for their communities. The more people that share their ideas, experiences and concerns about NHS and social care, the more services can understand when improvements are needed. NHS services are able to download promotional materials, which can be used to direct people to their local Healthwatch, and the social media campaign using #SpeakUp, which is running for the rest of this month.

Local Developments

8. **Trust introduces skin-to-skin caesarean for better birth experiences** - Many of the 1,600 mothers who give birth each year via caesarean section at the Lancashire Women and Newborn Centre can now experience the magic of holding their baby skin-to-skin immediately following the birth thanks to a new initiative by maternity staff at East Lancashire Hospitals NHS Trust. 'Immediate skin-to-skin care' is a natural process that involves placing a newborn on the mother's chest directly after the birth. Previously, mothers in East Lancashire could not benefit from immediate skin-to-skin as they are separated from their babies following a caesarean birth.

9. **New Chemotherapy Suite and Breast Care Clinic** - East Lancashire's new £750,000 chemotherapy and breast care facilities at Burnley General Teaching Hospital are throwing open their doors and inviting patients, staff and the general public to come and view the fabulous new facilities. The new Primrose

Chemotherapy Suite and East Lancashire Breast Clinic were partly funded by £127,000 in public donations following a hugely successful fundraising campaign, organised by Rosemere Cancer Foundation. The four-hour Open Day follows the official opening event and is being held just four days before the new clinics welcome their first patients.

10. **Young patients soothed with a little TLC** - Sick and injured children being treated in the Urgent Care Centre at Burnley General Teaching Hospital are feeling less stressed and more comfortable thanks to a generous donation of Teddies for Loving Care [TLC] from Burnley and Pendle District Freemasons.

11. **Draft Pennine Plan** - We are publishing a draft plan for health and care services in the area. The draft plan is a blueprint to improve the health of people living in Pennine Lancashire (which covers Blackburn with Darwen and East Lancashire), as well as improving health and care services in the area. We are proud of the health and care services we have in Pennine Lancashire. Our doctors, nurses, and wider health and care staff provide high quality care for people who live and work here. We are equally proud of our communities and how residents across the area come together to provide friendship, encouragement and support to each other. However, people in Pennine Lancashire are more likely to experience ill health compared with people living in other parts of the country. We have high levels of deprivation, poor health outcomes and greater demand for health and care services. The good news is that we can prevent many of our illnesses and, by working together, we can help improve people's health and wellbeing, whilst continuing to provide effective and efficient health and care services.

12. Pennine Lancashire chosen to trail-blaze new ways of transforming the way sport and activity is offered in England - ELHT is delighted that the area it mainly covers has been chosen by Sport England as a pilot area to work with on a bold new approach to build healthier, more active communities across England. Around £100million of National Lottery funding will be invested in 12 pilot schemes over four years, to create innovative partnerships that make it easier for people in these communities to access sport and physical activity. Latest research[i] shows that a quarter of the general population (11.5 million people) are inactive, meaning they do less than 30 minutes of exercise that gets them slightly out of breath each week, with certain groups such as those in lower paid jobs, women and the disabled disproportionately affected. The local pilot area covers a population of 534,600. The partnership includes seven local authorities; Blackburn with Darwen, Burnley,

Hyndburn, Lancashire, Pendle, Ribble Valley, and Rossendale. Also Blackburn with Darwen and East Lancashire Clinical Commissioning Group, East Lancashire Hospitals NHS Trust and Lancashire Care Foundation NHS Trust. The area's strong, diverse community and voluntary sector and the many sports clubs will play a key role.

13. **Mayor Gives Seal of Approval for new Lancashire Elective Centre** - East Lancashire Hospitals NHS Trust (ELHT) officially opened the Lancashire Elective Centre at Burnley General Teaching Hospital on Wednesday 6 December. The new £1.5 million, 46-bedded unit is the latest development to be completed as part of ELHT's £18m investment into NHS services at Burnley General Teaching Hospital (BGTH).

14. **Response to Lancashire Telegraph staff sickness article** - Re: Your Article 'Hospital Staff Take 347,000 Days off Sick I am writing to express our frustration that this story made front page news with this screaming headline. Our staff sickness rates compare well with other trusts in the region and as said in our statement, are at their lowest in four years for October. This is the result of the great relationship between the Trust and our staff and the Trust investing heavily in staff health and wellbeing, and staff support measures. For example, we have a multi award winning 'Fast Physio' service; accredited Mental Health first aid training and 190 Mental Health First Aiders across the Trust; 24/7 free talking therapies service for staff to name but a few. I would also point out that it is well documented that 1 in 4 of the population will be affected by a mental health condition at some point. Our staff are no different than the general population. Working in the NHS at the present time, especially in clinical facing roles, can indeed be very stressful. This is not helped by shocking headlines that do not reflect the bigger picture and could be perceived as being critical. I am incredibly proud of all our staff, and like most if not all of your readers, I am very grateful for their compassion, skill and their resilience.

15. **Maternity Staff Shortlisted for Three National Awards** - East Lancashire Hospitals NHS Trust's (ELHT) reputation as one of the region's leading NHS maternity services has received a further boost following news that three staff/teams are shortlisted for the prestigious Royal College of Midwifery (RCM) Annual Midwifery Awards 2018. Widely respected as the 'Oscars' of the maternity and midwifery industry, East Lancashire is the only trust in the UK to be shortlisted in three categories in the RCM Annual Midwifery Awards 2018. **Midwife and Baby Friendly Team Co-ordinator Sue Henry** is shortlisted in the JOHNSON'S® Award for Excellence in Maternity

Care for the work in achieving UNICEF BFI sustainability standards. Earlier this year, ELHT became the first Trust in the UK to achieve UNICEF UK Baby Friendly 'gold' accreditation. The Trust's **Postnatal Maternity Support Workers** have been shortlisted in the RCM Maternity Support Worker of the Year category.

16. **Burnley Tesco Donate Sleigh-load of Toys to Urgent Care Centre Kids** - Customers and staff at the Tesco Extra store in Burnley have delivered a festive extravaganza of toys and gifts to bring smiles to the faces of young patients at Burnley General Hospital. Tesco Burnley customers donated over five pallets of much-needed toys that will keep sick and injured youngsters occupied in the hospital's Urgent Care Centre, as well as being shared with community organisations including Women's Refuge, East Lancashire Hospice, Salvation Army and the Chai Centre, Brierfield.

17. **Trust Opens World Class Cancer Care Facilities** - East Lancashire Hospitals NHS Trust (ELHT) is thrilled to announce the official opening of the Primrose Chemotherapy Suite and East Lancashire Breast Clinic at Burnley General Teaching Hospital. East Lancashire's new £750,000 chemotherapy and breast care facilities, located in the hospital's Edith Watson building (Area 3), will dramatically improve the treatment and care experience for patients across East Lancashire and Blackburn with Darwen. Partially paid for by £116,000 in public donations following a hugely successful fundraising campaign organised by Rosemere Cancer Foundation, the entire chemotherapy and breast care suites are far more spacious than previous facilities, enabling staff to create a calming, relaxed atmosphere enhanced by natural light with views to Pendle Hill. Named in honour of Primrose Farm which stood on the Burnley Hospital site as far back as the 1800s, the new facilities also provide patients 10 dedicated parking spaces directly outside the Edith Watson entrance.

18. **Football mums team up for NICU donation** - A team of Accrington-based footballing mums have scored with a £610 donation to the Neonatal Intensive Care Unit (NICU) at Burnley General Teaching Hospital. Twelve months ago, 17 mums whose kids play for Globe Bullough Park junior football club began training every Thursday as a way of staying fit. After playing several fundraising matches, the sporting mums nominated the NICU at Burnley General Teaching Hospital as their chosen charity.

19. **Guild members show caring side to comfort hospital families** - Family members and carers visiting critically ill loved ones at the Royal Blackburn Teaching Hospital can gain comfort thanks to a caring initiative by Lancashire East County Trefoil Guild.

Inspired by Guild members across Pennine Lancashire, the local group has provided more than 60 comfort packs containing a selection of toiletries for use by relatives who choose to stay in hospital to support critically ill loved ones, some of whom are nearing the end of their lives. And last week Guild members Helen Plummer, Irene Whittaker, Christine Jackson, Gill Feely and Barbara Davis visited the Royal Blackburn Teaching Hospital to personally hand over their comfort bags to Bereavement Care Senior Nurse, Erin Bolton.

20. **Ongoing calm professionalism – the essence of ELHT!** - It has certainly started with a bang, and the predicted increase in winter pressures has materialised. For us, this means that we have been incredibly busy throughout the hospital with impact being felt by everybody. I am very, very proud of every single member of staff – you have responded to the challenge (which I have no doubt will last for a few weeks more yet) with you usual skill, commitment and importantly, good humour. I simply cannot thank you enough. We have continued to receive lovely feedback from patients, directly to staff, some write to me, it's on social media and in some cases, like this one, it's on NHS Choices. The incessant media coverage of a 'crisis' in the NHS makes it easy to overlook the **ongoing calm professionalism – the very essence of our trust -** which prevails, even during winter! I was glad that we were given, and indeed took, the opportunity to highlight one of the jewels in our crown that is contributing to a continuation of 'business as usual' and minimising disruption for our patients through cancellations – the fantastic **Lancashire Elective Centre** at Burnley General Teaching Hospital. We were featured on BBC North West news last night (4 January) and you can take a look here (at 1:14). As ever, Damian Riley (medical director) was a picture of assurance and all the staff and patients featured were fab! Thanks to everyone involved.

21. **Letter from Professor Jane Mamelok, Postgraduate Dean, Health Education England North West –** The letter said: "The NHS in the North West is experiencing high levels of demand during the peak of winter pressures. A number of Trusts have triggered the highest crisis level and NHS England has instructed organisations to cancel elective surgical procedures until later in January. Health Education England North West (HEENW) recognizes there may be exceptional circumstances when doctors in training may be required to offer assistance/support outside of their usual training pathway and contracted duties as was the case for example in the Manchester Arena bomb in May 2017. This would not normally include predicted surges in demands due to winter pressures but given NHS England's directive this

might be considered as moving into exceptional circumstances. I am writing to you to remind you of the HEE guidance for cross cover. In particular that those arrangements should be discussed prospectively with the Postgraduate Dean (PGD); should be short term; and should not impact on doctors training longer term; subject to regular review and updates to the PGD; that trainees are adequately supervised in the host environment and specialty; and work within the limits of their competence appropriate to the stage of training". The Trust has put together a SOP to address these exact concerns 2 winters ago and will ensure again that it is re-circulated amongst the senior medical staff and senior clinician's on-call.

22. **Health Weight Declaration -** Accomplished on 9 January 2018, the East Lancashire Hospitals NHS Trust Chairman and Chief Executive signed-up to the Trust's Declaration on Healthy Weight. The Declaration, an adaptation of Food Active's Local Authority Declaration on Healthy Weight, signals a renewed and whole systems approach to prevention and expresses partnership with stakeholders to promote healthy weight across Pennine Lancashire. With reference to the UK Government's Foresight Programme, the Declaration aims to intervene on the obesity system and increase the level of physical activity, reduce the level of psychological ambivalence in deciding lifestyle (food, exercise) options, reduce the force of dietary habits and reduce the strength of lock-in to accumulate energy (for example, improving the quality and quantity of breast feeding).The Declaration also references support for those at risk of food poverty and adverse nutritional status.

23. **Trust surplus properties for sale -** To improve the way East Lancashire Hospitals NHS Trust delivers its clinical services, the Trust has undertaken a utilisation survey of all its community properties in-line with the Strategic Estates Group (SEG). The results of the survey revealed that a couple of the properties that transferred from the PCT where underutilised and held some significant backlog issues. In-line with the Trusts Estates Strategy to reduce backlog maintenance, improve utilisation and deliver savings the services within these properties have been relocated to better accommodation where care can be provide in a more safe, personal and effective way. The two clinics (Rishton Clinic and Stepping Stones) have been deemed as surplus to requirements and the Trust has taken the decision to sell the properties.

24. The Trust seal was applied to the following documents since the last reporting period:

    a) On 30 January 2018 – Car Parking Management Service Agreement between Empark UK Ltd and ELHT, signed by the Chief Executive and the Director of Operations

b) On 5 February 2018 – Escrow Agreement between Empark UK Ltd, ELHT and Prudential Trustee Company Limited, signed by the Director of Finance and Director of Service Development

c) On 28 February 2018 – Deed of Rights and Reservations - Haslingden Health Centre between NHS Property Services Ltd and ELHT, signed by the Director of Finance and the Director of Operations

25. **Hospitals benefit from Euro Garages support** - ELHT&me is the official charity of East Lancashire Hospitals NHS Trust and we are delighted to have secured the support of ISSA Foundation for local healthcare projects and initiatives. The charity is actively fundraising with donations enabling positive improvement of the hospital environment for patients, visitors and staff; provision of state-of-the-art medical equipment; funding invaluable research; and teaching programmes. This additional investment helps us go way beyond the NHS standard.

26. **East Lancashire NHS adopts hi tech solution to prevent falls in older people** - The STEADY On! Team at East Lancashire Hospitals NHS Trust's has turned to state of the art 'wearable technology' to predict and prevent falls among the local elderly population. Specifically chosen by the NHS Innovation Agency and Lancashire County Council to pilot this new technology, using **QTUG**™ (Quantative Timed Up and Go) the Community Falls Team based at Pendle Community Hospital are quickly and easily able to screen people for gait and mobility impairment, and identify those at risk. Wearing hi-tech sensor pads below both knees, walking just a few steps allows the **QTUG**™ technology to quickly tell whether a person has a low, medium or high risk of falling.

27. **Trust team 'secure' award for third year in a row** - Facilities and Security staff at East Lancashire Hospitals NHS Trust are celebrating after scooping a top award for the third year in a row. The team was successful in the 'Hospital Security' category at the Health Business Awards, which recognises excellence in NHS facilities. Members of the Facilities and Security teams received the award from media medical personality, Dr Phil Hammond at a London ceremony.

28. **Trust honours 7,000 years of loyal NHS service** - A staggering 7,000 years of NHS service by 280 members of staff from East Lancashire Hospitals NHS Trust has been honoured at a Long Service Awards ceremony. The Long Service Awards were presented by Chief Executive, Kevin McGee and Chair, Professor Eileen Fairhurst who shone the spotlight on staff who have reached a key milestone of 25 years' service at the Trust's five hospitals and numerous community health facilities.

29. **East Lancashire Hospitals Chooses Cerner as Preferred EPR Supplier** - East Lancashire Hospitals NHS Trust (ELHT) has chosen global health information technology leader Cerner as its Preferred Supplier of a new clinical information system that will help to improve the quality, safety and efficiency of patient care. The system, commonly known as 'Electronic Patient Record' (EPR), is the intelligent software which brings each patient's key clinical and administrative data together in one place.

30. **Advanced nurses celebrate graduation success** - Eight experienced nurses at East Lancashire Hospitals NHS Trust (ELHT) are celebrating after graduating from the University of Central Lancashire (UCLAN) with their Masters' degrees in advanced clinical practice. Advanced Clinical Practitioners (ACP) are qualified, highly experienced nurses who, after gaining additional qualifications, can now perform extra clinical duties such as taking patient medical history, carrying out physical examinations, requesting investigations, and referring patients directly to other specialists where appropriate.

31. **Placenta Clinic achieves impressive reduction in stillbirths** - A lifesaving initiative by medical staff at East Lancashire Hospitals NHS Trust (ELHT) has achieved a remarkable 20 per cent reduction in stillbirths….in just one year! Consultant Obstetrician Mr Martin Maher and his colleagues at Burnley General Teaching Hospital's Lancashire Women and Newborn Centre established the Placenta Clinic in January 2017 to reduce stillbirths by detecting and managing fetal growth restrictions (FGR) caused by problems with the placenta. And now a recent audit has shown the stillbirth rate at the Trust is at its lowest level for years and the Trust's detection rate for fetal growth restriction has increased from around 50 to 98 per cent.

32. **£1 million appeal to create better hospitals for all** - ELHT&Me, the official charity of East Lancashire Hospitals NHS Trust (ELHT), has launched a ground breaking £1 Million Appeal and is encouraging local businesses, institutions and individuals to support its work to improve the patient experience at its five hospitals. As the NHS celebrates its 70th birthday this year, the £1 Million Appeal aims to raise funds to invest in new equipment, improve facilities and enhance the patient environment at ELHT's two acute (Royal Blackburn and Burnley General) and three community hospitals (Accrington Victoria, Clitheroe and Pendle).

Summary of Chief Executive's Meetings for January 2018

03/01/18	Systems Teleconference - RBTH
03/01/18	Meeting with Dr Penny Morris, BwD CCG - RBTH
04/01/18	A&E Delivery Board – RBTH
05/01/18	Systems Teleconference – RBTH
05/01/18	NHSI/ELHT Catch Up Call – RBTH
08/01/18	Systems Teleconference – RBTH
08/01/18	DTOC Check and Challenge Panel – Preston
08/01/18	Conference Call with NHSE/NWAS/AEDB – RBTH
10/01/18	AO's/CEO's/STP Execs Meeting – Preston
10/01/18	Planning Meeting – RBTH
10/01/18	Coaching conversation with Shelly Rubenstein – RBTH
10/01/18	Long Service Awards – RBTH
11/01/18	ELHT/UCLan Joint Strategic Board – RBTH
11/01/18	Meeting with Newtons – RBTH
11/01/18	Long Service Awards – RBTH
12/01/18	Systems Teleconference – RBTH
12/01/18	Telephone Call with Liz Meer NW Coast AHSN - RBTH
15/01/18	Systems Teleconference – RBTH
15/01/18	AEDB prep Meeting – RBTH
16/01/18	PLACE CEOs and Leaders – Accrington
17/01/18	STP Board timeout Day – Poulton Le Fylde
17/01/18	Trust Board Strategy Session – RBTH
18/01/18	Winter Conference Call – RBTH
18/01/18	Russ McClean - RBTH
19/01/18	Systems Teleconference - RBTH
19/01/18	Conference Call with GGI – RBTH
19/01/18	NHSI/ELHT Catch Up Call - RBTH
19/01/18	Meeting with Director of Public Health for LCC – RBTH
22/01/18	Systems Teleconference – RBTH
23/01/18	Pennine Lancashire Health, Care and Wellbeing Transformation Programme – Blackburn
24/01/18	Systems Teleconference – RBTH
24/01/18	Telephone Call with NLAG – RBTH
24/01/18	Teleconference with IpSOS Mori – RBTH

24/01/18	NHS Confederation Dinner – Manchester
25/01/18	Diagnostics Project Meeting – Preston
26/01/18	Systems Teleconference – RBTH
26/01/18	Team Brief – RBTH
26/01/18	Meeting with Jake Berry MP – BGTH
26/01/18	Team Brief – BGTH
29/01/18	Systems Teleconference – RBTH
29/01/18	Russ McClean – RBTH
30/01/18	Meeting with Graham Burgess – RBTH
31/01/18	Systems Teleconference – RBTH
31/01/18	Employee of the Month – RBTH
31/01/18	Media Interview – RBTH
31/01/18	Vox Pops Session – Blackburn
31/01/18	Accountable Health and Care Partnership Leaders' Forum - Blackburn

Summary of Chief Executive's Meetings for February 2018

01/02/18	AE Delivery Board – RBTH
01/02/18	Meeting with Shelly Rubinstein – RBTH
01/02/18	Opportunities for Collaboration – Preston
05/02/18	Systems Teleconference – RBTH
05/02/18	Teleconference with NHSE/NWAS and AEDB Chairs
05/02/18	Meeting with Dr Helen Lowey, Consultant in Public Health – RBTH
06/02/18	Meeting with the GGI - RBTH
12/02/18	Systems Teleconference – RBTH
12/02/18	Task and Finish Group – RBTH
13/02/18	Meet with Dean Langton re District Council participation in the change programme for Health and Social Care - Nelson
14/02/18	Systems Teleconference – RBTH
14/02/18	STP Board - Preston
14/02/18	AO's/CEO's/STP Exec Meeting – Preston
14/02/18	Board Strategy Session – RBTH
15/02/18	Programme Executive Team Meeting – Nelson
15/02/18	Meeting with Julie Cooper MP – Burnley
15/021/8	Meeting with Graham Burgess – RBTH
15/02/18	Meeting with Penny Morris BWD - Blackburn

16/02/18	Systems Teleconference – RBTH
16/02/18	NHS/ELHT Catch Up Teleconference – RBTH
19/02/18	Systems Teleconference – RBTH
19/02/18	Russ McClean - RBTH
21/02/18	CQC Review Well Led Inspection – Surrey
22/02/18	CQC Review Well Led Inspection – Surrey
23/02/18	Charity Appeal Launch - Fence
23/02/18	NHSI/ELHT Teleconference – RBTH

Summary of Chief Executive's Meetings for March 2018

06/03/18	BwD Health and Wellbeing Board – Blackburn
07/03/18	Systems Teleconference – RBTH
07/03/18	White Paper Development Meeting – Birmingham
08/03/18	Lancashire and South Cumbria STP Acute and Specialised Workshop - Manchester
08/03/18	ELHT/UCLan Joint Strategic Board – RBTH
08/03/18	Burnley Borough Council – Policy Board - Burnley
09/03/18	Systems Teleconference – RBTH
09/03/18	NHSI/ELHT Catch Up Teleconference – RBTH
12/03/18	Systems Teleconference – RBTH
12/03/18	Meeting with GE Healthcare – Blackburn
13/03/18	NHSI and NHS Provider CEO Event - London
14/03/18	Systems Teleconference – RBTH
14/03/18	AO's, CEO's and STP executive meeting – Preston
14/03/18	Trust Board Closed Session – RBTH
14/03/18	Trust Board Public Session – RBTH
15/03/18	Meeting with Liz Meer NW Coast AHSN – RBTH
15/03/18	NHS Leadership Academy 'Being a CEO' – London
16/03/18	NHS Leadership Academy 'Being a CEO' - London
19/03/18	Systems Teleconference – RBTH
19/03/18	NLAG Buddying Teleconference - RBTH
21/03/18	Systems Teleconference – RBTH
21/03/18	Pennine Lancashire VCFS Event - Accrington
21/03/18	Invitation to next MSC Meeting - RBTH
22/03/18	Programme Executive Team Meeting – Nelson

22/03/18	NHS Providers Chairs and CEO's Executive Network - London
22/03/18	Meeting with Sue McGraw, CEO St Johns Hospice – RBTH
23/03/18	Systems Teleconference – RBTH
23/03/18	NHSI/ELHT Catch Up Teleconference – RBTH
23/03/18	Team Brief – BGTH
23/03/18	Team Brief – Pendle
26/03/18	Systems Teleconference – RBTH
26/03/18	Team Brief – Accrington
26/03/18	HSJ Roundtable – Manchester
26/03/18	Russ McClean – RBTH
27/03/18	Lancs and South Cumbria Winter Review Event - Blackpool
28/03/18	Systems Teleconference – RBTH
28/03/18	Joint Working Meeting – Nelson
28/03/18	Accountable Health and Care Partnership Leaders Forum – Blackburn
29/03/18	Diagnostic Project Group Meeting – Preston

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 11

14 March 2018

Purpose Action

Title	Corporate Risk Register Report
Author	Mrs F Murphy, Head of Legal Services
Executive sponsor	Dr D Riley, Medical Director

Summary: The report presents the outcome of the monthly review of the Corporate Risk Register. The Corporate Risk Register is presented for approval with changes in month highlighted in the body of the report.

Recommendation: Members are requested to receive the report.

Report linkages

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

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by:

1. Introduction

The Risk Assurance Meeting has delegated responsibility for verifying and monitoring the Corporate Risk Register. The changes recommended by the RAM to the Corporate Risk Register are set out in this report. Directors have also reviewed their risks to reflect any changes in the current risk profile.

2. Risks de-escalated and removed from the Corporate Risk Register:

3. Risks to be incorporated on Corporate Risk Register:

7457 Failure to have PACS operating effectively adversely impacts patient care and performance

7583 Loss of facility for Containment Level 3 in pathology

4. Corporate Risk Register (Appendix 1)

The current Corporate Risk Register is attached at Appendix 1. The following changes have been made:

- The current risk score for the aggregated risks is now included in brackets following the risk identification number
- Aggregated risk 6487 (aggregated to 5790, 7010 and 5791) has been closed as this was a duplicate risk to the main risk 5790
- Aggregated risk 6095 (aggregated to 7067) has been closed as a duplicate to the main risk 7067
- Risk 7587 was opened on 27/11/17 (scoring 15) has been aggregated to risk 1810 at the recommendation of the Risk Assurance Meeting
- Risk 7067 has decreased in score from 15 to 12 in light of the controls in place and lack of incidents related to this risk.

Conclusion

Members are asked to note the assurances provided in relation to the ongoing management of the risks on the Corporate Risk Register and approve the paper. Members are requested to receive and review the report.

Frances Murphy, Head of Legal Services, March 2018

East Lancashire Hospitals NHS Trust

Title:	Failure to meet service needs due to lack of Trust capacity impacts adversely on patient care				
ID	1810	Current Status	Live Risk Register – all risks accepted	Opened	05/07/13
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 3 Total: 9
Risk Handler:	Tony McDonald	Risk Owner:	John Bannister	Linked to Risks:	2310(16), 908(20), 3835(16), 7587(15)

What is the Hazard:	• Lack of bed capacity across the Trust can lead to extreme pressure resulting in a delayed delivery of the optimal standard of care across departments. • At times of extreme pressure this increase in the numbers of patients within the emergency pathway makes medical/nursing care difficult and impacts on clinical flow	What are the risks associated with the Hazard:	• Patients being managed on trolleys in the corridor areas of the emergency /urgent care departments impacting on privacy and dignity. • Delay in administration of non-critical medication. • Delays in time critical patient targets (four hour standard, stroke target) • Delay in patient assessment • Potential complaints and litigation. • Potential for increase in staff sickness and turnover. • Increase in use of bank and agency staff to backfill. • Lack of capacity to meet unexpected demands. • Delays in safe and timely transfer of patients
What controls are in place:	• Daily staff capacity assessment • Daily Consultant ward rounds • Establishment of specialised flow team • Bed management teams • Delayed discharge teams • Ongoing recruitment • Ongoing discussion with commissioners for health economy solutions • ED/UCC/AMU will take stable assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley	Where are the gaps in control:	Trust has no control over the number of attendees accessing ED/UCC services

	• ED/UCC/AMU will take stable assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley • Introduction of Full Capacity Protocol • Refined 2 hourly patient flow meetings		
What assurances are in place:	• Regular reports to a variety of specialist and Trust wide committees • Consultant recruitment action plan • Escalation policy and process • Monthly reporting as part of Integrated Performance Report • Weekly reporting at Exec Team • System Oversight by Pennine Lancashire A+E Delivery Board	What are the gaps in assurance:	None identified
Actions to be carried out			
Numerous actions are incorporated within the Emergency Care Pathway Redesign Programme which forms part of the Trust's Transformation Programme Review the impact of the newly introduced Full Capacity Protocol and refined patient flow meetings			
Notes: Mitigating actions are deployed on a daily basis at an operational level to reduce the risk to patient care.			

East Lancashire Hospitals NHS Trust

Title:	Aggregated risk – Failure to reduce medical locum costs will adversely impact financial sustainability and patient care				
ID	5790	Current Status	Live Risk Register – All risks accepted	Opened	11/09/15
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 3 Total: 9
Risk Handler:	Simon Hill	Risk Owner:	Damian Riley	Linked to Risks:	908 (20), 4488 (12), 7268 (9), 5557 (12), 3835 (16),

What is the Hazard:	Gaps in medical rotas require the use of locums to meet service needs at a premium cost to the Trust	What are the risks associated with the Hazard:	• Escalating costs for locums • Breach of agency cap • Unplanned expenditure • Need to find savings from elsewhere in budgets
What controls are in place:	• Divisional Director sign off for locum usage • Ongoing advertisement of medical vacancies • Consultant cross cover at times of need	Where are the gaps in control:	Availability of medical staff to fill permanent posts due to national shortages in specialties
What assurances are in place:	• Directorate action plans to recruit to vacancies • Reviews of action plans and staffing requirements at Divisional meetings • Reviews of action plans and staffing requirements at trust Board meetings and Board subcommittees • Reviews of plans and staffing requirements at performance meetings	What are the gaps in assurance:	

Actions to be carried out	Action assigned to	Anticipated completion date	Progress Report
Per individual linked risks		On-going	Reduction in agency staffing costs already demonstrated. Analysis of detailed monthly report through AMG (Agency Monitoring Group). Areas for targeted action understood

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.

East Lancashire Hospitals NHS Trust

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

	patients • Exercise of professional judgement on a daily basis to allocate staff appropriately • Monthly report at Trust Board meeting on planned to actual nurse staffing levels • Active progression of recruitment programmes in identified areas		

Actions to be carried out	Action assigned to	Anticipated completion date	Progress Report
All current planned actions completed as shown in "what controls are in place"	Non-Medical Bank and Agency Group		
Risk mitigation action plans are appended to each of the linked risks and are reviewed by the Divisions on an on-going basis with assurances being provided to Divisional meetings.			

East Lancashire Hospitals NHS Trust

Title:	Aggregated Risk – Failure to meet internal and external financial targets in year will adversely impact the Continuity of Service Risk Rating				
ID	7010	Current Status	Live Risk Register – all risks accepted	Opened	25/08/16
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 5 Consequence: 4 Total: 20	Target Rating:	Likelihood: 4 Consequence: 3 Total: 12
Risk Handler:	Allen Graves	Risk Owner:	Jonathan Wood	Linked to Risks:	1487 (12), 1489 (12), 4118 (6), 6115 (6), 6229 (4), 6230 (4), 6509 (6)

What is the Hazard:	Failure to meet the targets will result in the Trust having an unsustainable financial position going forward and the likely imposition of special measures	What are the risks associated with the Hazard:	• If Divisions deliver their SRCP and meet their Divisional financial plans the Trust will achieve its agreed control total. • Breach of control totals will likely result in special measures for the Trust, adverse impact on reputation and loss of autonomy for the Trust • Sustainability and Transformational funding would not be available to the Trust • Cash position would be severely compromised
What controls are in place:	• Standing Orders • Standing Financial Instructions • Procurement standard operating practice and procedures • Delegated authority limits at appropriate levels • Training for budget holders • Availability of guidance and policies on Trust intranet • Monthly reconciliation • Daily review of cash balances • Finance department standard operating procedures and segregation of duties	Where are the gaps in control:	Individual acting outside control environment in place

Safe | Personal | Effective

What assurances are in place:	• Variety of financial monitoring reports produced to support planning and performance • Monthly budget variance undertaken and reported widely • External audit reports on financial systems and their operation • Monthly budget variance undertaken by Directorate and reported at Divisional Meeting • Monthly budget variance report produced and considered by corporate and Trust Board meetings • internal audit reports on financial system and their operation	What are the gaps in assurance:	

Actions to be carried out	Action assigned to	Anticipated completion date	Progress Report
Per individual linked risks			

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

East Lancashire Hospitals NHS Trust

Title:	Aggregated Risk - Failure to provide timely Mental Health treatment impacts adversely on patient care & safety and quality				
ID	7067	Current Status	Live Risk Register – all risks accepted	Opened	06/10/2016
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 4 Consequence: 3 Total: 12	Target Rating:	Likelihood: 2 Consequence:3 Total: 6
Risk Handler:	Jill Wild	Risk Owner:	John Bannister	Linked to Risks:	2161 (12) 7582 (15)
What is the Hazard:	Mental Health patients with decision to admit may have extended waits for bed allocation.		What are the risks associated with the Hazard:	• Breach of 4 hour standard in ED • Breach of 12 hour trolley wait standard in ED • Impact on patient care • Risk of harm to other patients • Impact on staffing to monitor/ manage patient with MH needs	
What controls are in place:	• Frequent meetings to minimise risk between senior LCFT managers and Senior ELHT managers to discuss issues and develop pathways to mitigate risk including; • Mental Health Shared care policy, • OOH Escalation pathway for Mental health patients, • Instigation of 24hrs a day Band 3 MH Observation staff. • Ring fenced assessment beds within LCFT bed base (x1Male, x1Female). • In Family Care – liaison with ELCAS • Monthly performance monitoring • Monitoring through Pennine Lancashire improvement pathway • Monitoring by Lancashire and Cumbria Mental Health Group • Twice weekly review of performance at Executive		Where are the gaps in control:	• Unplanned demand • ELCAS only commissioned to provide weekday service • Limited appropriately trained agency staff available	

	Team teleconference • Discussion and review at four times daily clinical flow meeting • Introduction of mental health triage service within ED • Development of mental health Clinical Decision Unit on the RBH site		
What assurances are in place:	• Ongoing meetings with LCFT and commissioners • Regular review at Divisional and Executive team level • Appropriate management structures in place to monitor and manage performance • Appropriate monitoring and escalation processes in place to highlight and mitigate risks • Ongoing monitoring of patient feedback through a variety of sources • Escalation of adverse incidents through internal & external governance processes • Appropriate escalation and management policies and procedures • Joint working with external partners • Daily system teleconferences • A&E Delivery Board monitoring	What are the gaps in assurance:	None identified

Actions to be carried out	Action assigned to	Anticipated completion date	Progress Report
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.			

East Lancashire Hospitals NHS Trust

Title:	Failure to have PACS operating effectively adversely impacts patient care and services				
ID	7457	Current Status	Live Risk Register – all risks accepted	Opened	30/08/17
Initial Rating	Likelihood: 5 Consequence: 4 Total: 20	Current Rating:	Likelihood: 4 Consequence: 4 Total: 16	Target Rating:	Likelihood: 3 Consequence: 4 Total: 12
Risk Handler:	Neil Fletcher	Risk Owner:	Johnathon Wood	Linked to Risks:	7552 (16)

What is the Hazard:	• Lack of data available while treating patient could cause harm	What are the risks associated with the Hazard:	• Delays in patient pathway. • Downtime in clinics and theatres • Poor patient experience • Failure of backup systems • Increased complaints.
What controls are in place:	• Discussions with Managed Equipment Service • Backup systems involving getting physical or disk copies of images	Where are the gaps in control:	Unpredictable unavailability
What assurances are in place:	• Regular reports to a variety of specialist and Trust wide committees	What are the gaps in assurance:	None identified

Actions to be carried out
Ongoing discussions with supplier being led by Director of Finance

East Lancashire Hospitals NHS Trust

Title:	Loss of facility for Containment Level 3 in pathology				
ID	7583	Current Status	Live Risk Register – all risks accepted	Opened	26/11/17
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 1 Consequence: 3 Total: 12
Risk Handler:	Pamela Henderson	Risk Owner:	Johnathon Wood	Linked to Risks:	7342 (8)

What is the Hazard:	• Changes to air pressure have caused rips and bubbling of the vinyl wall covering. If the wall covering integrity is damaged beyond immediate repair the CL3 facility will be put out of use.	What are the risks associated with the Hazard:	• Chemicals used to treat contaminants will not be contained within the L3 facility
What controls are in place:	• Ongoing daily inspection and remedial action in response to vinyl covering issues	Where are the gaps in control:	None identified
What assurances are in place:	• Ongoing discussions and reporting with PFI partners on a daily basis	What are the gaps in assurance:	None identified

Actions to be carried out
Discussion with PFI partners and specialists progressing to remedy issues

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 12

14 March 2018

Purpose Approval

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

Summary:
The Executive Directors have reviewed the risks monitored on the BAF and updated the controls, assurances and actions in relation to each risk where appropriate. The Finance and Performance Committee and the Quality Committee discussed the BAF risks at their last meetings.

Recommendation:

The Board is asked to discuss the risks and approve the proposed changes.

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: NA

(12) Board Assurance Framework

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

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

1. The **risk score remains** 12 (likelihood 3 x consequence 4).
2. The following potential source of assurance has been included:
   a) LDP system level aiming to prioritise health improvements that can deliver beneficial outcomes more quickly.
   b) Reinforcing the Clinical Champion Role of the Care Professionals Board members.
   c) There is an increased consensus at LCP level around moving to a shadow Integrated Care Partnership (ICP) from 1 April 2018 and what it would entail for the organisations involved. There are still risks around delivery.
3. The gaps in assurance have been updated to include:
   a) Ability to model the system gain from each transformation scheme is only partial. Planning guidance 2018/19 may force some of it and ensure a joint approach.
   b) Joint control totals for local organisations to be agreed.
4. The actions section has been updated to include the following information:
   a) Revised planning guidance issued (February 2018) to be signed by 23 March 2018.

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

5. The **risk score remains** 12 (likelihood 3 x consequence 4).
6. New updates include:
   a) As at 27 December 2017 there are 70 candidates in the nurse pipeline with start dates up to September 2018.
   b) The National Staff Survey for 2017 had a final response rate 43.3%. A full report is due in quarter 4 of 2017/18. Initial findings from the Picker report are now being analysed in readiness for the full NHS Staff Survey Report. Draft benchmark reports will be sent to organisations during the week commencing 19 February 2018. The embargo on the results will be lifted on Tuesday 6 March 2018 at 9:30am with the full results published the same date/time. The Picker Institute are scheduled to deliver divisional staff survey workshops on 14 and 15 March 2018

which will enable Divisions to fully understand the results. The Big Culture and Leadership Conversations are scheduled to commence on 19th March and will run through to the end of April 2018.

c) Significant progress has been made with WRES action plan. The NHS National Workforce Race Equality Standard (WRES) 2017 data analysis report December 2017 demonstrated continued improvement. ELHT are highlighted as better than average in Indicator 6: a decrease in the overall percentage of staff experiencing harassment, bullying or abuse from other colleagues. Review of internal data in January demonstrates further improvements in WRES indicators 1, 2 and 3. Work continues with Diversity by Design to pilot joint selection process.

d) The 2018-19 Business Planning approach includes a Workforce Planning and Transformation return from each Division which will inform the Trusts and Pennine Lancashire Transformation and Workforce priorities. Will be ready in April 2018.

e) Physician Associate posts: the second cohort of interviews took place on 16 January 2018. We now have all 9 appointed with start dates in March 2018 assuming they all pass their exams. We are in the process of ensuring that they have appropriate supervisors allocated.

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

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

8. Gaps in assurance now include:

a) Support for NLAG is growing organically and therefore assurances are reviewed regularly to reflect the work on the ground.

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

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

10. The actions section has been updated to include:

a) Trust to consider control total and implications for the financial year 2018/19 at the March 2018 Board meeting.

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

11. The **risk score** remains at 16 (likelihood 4 x consequence 4).

12. Key controls have been updated to include:

    a) System wide approach as part of the A&E Delivery Board supported operationally by the A&E Delivery Group.

    b) Weekly operational meeting covering RTT, cancer, 4 hour performance and holding list management.

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

    a) Four hour target at 90% achieved by end of September 2018 and to achieve 95% by the end of March 2019.The Trust is continuing to recruit for substantive medical posts within ED and Urgent Care.

    b) Report by the CQC Task and Finish Group, including the findings of the CQC Mini Visits was presented to the Quality Committee in January 2018. Regular reports of the Task and Finish Group will be presented to the Quality Committee.

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary, 6 March 2018.

Our Strategic Objectives

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

Reference Number: BAF/01

Responsible Director(s): Director of Service Development and Medical Director

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

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

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

Key Controls *What controls/ systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2017/18**				**Gaps in Control** *Where we are failing to put controls/ systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/ systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	Q2	Q3	Q4			
The Trust has agreed the Transformation Schemes for 2017/18: 1) Emergency Care System 2) Productivity and Efficiency 3) Support Services, Efficiency and Cost 4) Discharge and recovery (Pennine Lancashire LDP) Each scheme has an associated governance structure with senior responsible officers and key milestones. Divisional Transformation Boards report into the Transformation Board that reports into the Finance & Performance Committee. Membership of the Pennine Lancashire Partnership Leaders Forum and Care Professionals Board. Transformation/business plans linked to the clinical strategy, high level workforce and estate interdependencies identified. Two year contract with commissioners (local and specialist) agreed and signed. Emergency Care Programme Board meets regularly and reports are submitted to the A&E Delivery Board.	Monthly report demonstrating progress against key targets reported to the Transformation Board and the Finance & Performance Committee System Leaders Forum committed to work as an Accountable Care System from 2017/18. Director of Sustainability chairing the system wide (Pennine Lancashire) Finance and Investment Group. Divisional plans linked to the operational and transformational plans. Agreed pathway developments part of the transformation plan. Clinical Effectiveness Committee acting as a governance mechanism for the agreement of internal pathways .ELHT continues to have provider to provider discussion (e.g. GP federations) with the aim of refining clinical pathways Trust SRCP and transformation plans for 2017-19 developed and linking into local delivery plans. Direct link between the Trust programme and the Pennine Lancashire Local Delivery Plan. Internally, divisional transformation leads embedded into the programme Revised leadership in the PMO - allowing ELHT schemes to gain traction and improve delivery Hosting the Providers Programme Director for the STP Provider Board who will report 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 for consideration by the Chief Executive. Pennine Lancashire Organisational Programme has been agreed. LDP system level aiming to prioritise health improvements that can deliver beneficial outcomes more quickly. Reinforcing the Clinical Champion Role of the Care Professionals Board members. There is an increased concensus at LCP level around moving to a shadow Integrated Care Partnership (ICP) frm 1 April 2018 and what it would entail for the organisations involved. There are still risks around delivery.	15	10	12	3x4	12	12	12	12	Capacity for delivery of transformation programme Service redesign methodology developed by the Trust (accepted by Pennine Lancashire). Workshops held at system level and plans for ownership due to the changed structures at Pennine Lancashire level are now being put in place. Capacity and resilience building in relation to the service redesign is in early phase. Workforce issues/senior clinical and managerial staff ability to balance the operational and strategic requirements/demands Increased number of tenders issued. Concerns expressed to the Commissioners in writing about the tendering activity.	Assurance in place about the process, but assurance about the delivery and benefits is still work in progress at this stage. Dependency on stakeholders to deliver key pieces of transformation. Linking between clinical effectiveness and the transformation programme needs to be developed. Ability to model the system gain from each transformation scheme is only partial. Planning guidance 2018/19 may force some of it and ensure a joint approach. Joint control totals for local organisations to be agreed.	Using the Transformation Board meetings and our membership of Pennine Lancashire to influence delivery of transformation. Review of the full PMO to be carried out going into the new financial year 2018/19 (quarter 1) Care Professionals Board - detailed work to examine the effectiveness of HIMPs in supporting the delivery of new models of care for Pennine Lancashire - report due in March 2018. Service Improvement training is being developed will be delivered by the OD team. Timeline for completion of the revision has been changed to the end of quarter 4 of 2017/18. Clinical engagement progressed at both Pennine Lancashire and Healthier Lancashire level and the Care Professionals Board continues to meet regularly. TheProvider Programme Director for the STP is in place and the Providers' Operational Board meets on a monthly basis. 2018/19 planning guidance issued to the divisions, dovetailing into the wider system working (LDP). Plan on a page for ELHT presented to the Commissioners and accepted. Revised planning guidance issued (February 2018) to be signed by 23 March 2018.

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 use of agency staff

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2017/18**				**Gaps in Control** *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	**Q2**	**Q3**	**Q4**			
Transformation plans relating to workforce in place monitored through Transformation Board. Divisional Workforce Plans aligned to Business & Financial Plans, Divisional Performance Meetings, Reports to Finance & Performance Committee. Workforce Controls Group, One Workforce Planning Methodology across Pennine Lancashire. Joint SRO at Pennine Lancashire LDP level.	Performance measures, time limited focus groups with action plans, board and committee reports, regulatory and inspection agencies, stakeholders, internal audit. National staff survey 2016/17. Employee sponsor group monitored the staff survey action plan and all actions have been completed. WRES action plan with timelines in place. Regular reporting to the Board on progress. Work with the Fanshawe Report. Workforce Control Group regularly reports to the Executive on workforce control measures and indicators. Dashboard developed. Annual report to the Quality Committee. Medical and Non-Medical Agency Group in place. Dashboard presented to the executive monthly. The Trust ensures that all staff are involved, included and engaged with on key changes within the Trust using the Employee Engagement Strategy.	16	10	12	3x4	12	12	12	12	National recruitment shortages, capacity for delivery of transformation programmes, financial restrictions. Reduction of CPD monies from HEE (could be off-set by the apprenticeship levy). Implications of Brexit on the workforce - uncertainty/workforce are yet to be determined.	Assurances in place in the IPR, Safer Staffing Report and Quality Dashboard. Assurance through the HR governance processes.	As at 27 December 2017, 70 candidates in the nurse pipeline with start dates up to Sept 2018. The Trusts recruitment and retention plan continues to be in place. We continue to embed to the 'Retire and Return' approach, 23 between Jan-Dec 2017 nursing staff returned to practice after retirement. National Staff Survey for 2017 final response rate 43.3%. Full report due in quarter 4 of 2017/18. Initial findings from the Picker report now being analysed in readiness for the full NHS Staff survey report. Draft benchmark reports will be sent to organisations: w/c 19 February 2018. Embargo lifted: Tuesday 6 March 2018 9:30am. Full results published: Tuesday 6 March 2018 9:30am. The Picker Institute scheduled to deliver staff survey workshops for divisions 14th and 15th March enabling divisions to fully understand results. The Big culture and Leadership Conversations scheduled from 19th March – end of April. Significant progress made with WRES action plan. The NHS National Workforce Race Equality Standard (WRES) 2017 data analysis report December 2017 demonstrated continued improvement and ELHT are highlighted as better than average in Indicator 6: a decrease in the overall percentage of staff experiencing harassment, bullying or abuse from other colleagues. Review of internal data in January demonstrates further improvements in WRES indicators 1, 2 and 3. Work continues with Diversity by Design to pilot joint selection process. The Workforce Transformation Strategy addresses the future workforce supply pipeline, opportunities to up skill current staff, introducing new competencies, e.g. Physicians Associates and Associate Nurses and establishing new ways of working. The 2018-19 Business Planning approach includes a Workforce Planning and Transformation return from each Division which will inform the Trusts and Pennine Lancashire Transformation and Workforce priorities. Will be ready April 18. Workforce Transformation Team in place. First cohort of Associate Nurses pilot started in Trust recently. Physician Associate, second cohort of interviews 16 Jan 18. We now have all 9 appointed. Start dates are in March 18 assuming they all pass their exams. We are in the process of ensuring that they have appropriate supervisors allocated. We have purchased a Global Medical Careers Jobs Board in order to provide a greater reach globally. Included in the package is a Premium Microsite, Integrated with Social Recruiting (Twitter, LinkedIn, and Facebook), Branded Ad Template, Unlimited Job Credits and newsletter as well as all jobs uplifted from NHS jobs and advertised and posted on Global Medical Careers Job Board which reaches over 50+ countries worldwide

Reference Number: BAF/03

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

Aligned to Strategic Objectives: 3 and 4

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

Consequences of the Risk Materialising:

1. Failure to secure key services for Pennine Lancashire
2. Failure to develop as an Accountable Care System (ACS)
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. Distraction of management and clinical capacity as a consequence of supporting other partners.

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2017/18**				**Gaps in Control** *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	Q2	Q3	Q4			
Senior Leaders' Forum meets to discuss strategy. Engagement by senior leaders in wider transformation programmes. Regular Board updates and decisions on key actions. Strengthen links between internal transformation and external change processes. Care Professional Group of Pennine Lancashire reporting to the Transformation Steering Group. Care Professionals Group at STP level also formed. At Pennine Lancashire level health improvement priorities agreed (HIMPs). HIMPs reporting to the Care Professionals Board. Number of senior clinicians involved with STP work groups. System Leaders Forum. STP Finance Group. Defined gateway process sponsored by NHS Improvement and supported by the Good Governance Institute (GGI) in relation to supporting NLAG, LDP Finance and Investment Group.	Verbal and written updates, where appropriate Board approvals will be established and permissions will be provided by the Board to let Executives to progress the generations of ideas and options with external stakeholders. The Pennine Lancashire and STP Cases for Change have been published. Pennine Lancashire resource in post working on developing models of care against specific improvement priorities (paediatrics, respiratory and frailty). Health and Wellbeing Improvement Partnerships (HIMPs) at Pennine Lancashire level reviewed around the health improvement priorities and the majority are relatively well established with minor changes need to link into the new structures. STP governance oversight forms part of the Audit Committee standing agenda for 2017/18. Fostering good relationships with GP practices and Federations e.g. service pilots and as a result of tenders and general dialogue. These are the most advanced at STP level Pennine Lancashire Memorandum of Understanding agreed by stakeholders. ELHT Chief Executive chairing the STP Providers' Forum. Programme Director in post - foundations of the work programme started to be designed. Component business cases at Pennine Lancashire level forming a draft overarching LDP plan. Plan on a page for the LDP being worked on connecting to the Plan on a page for ELHT that was presented to the Commissioners. Structures in place for the Out of Hospital stream with the Trust significantly contributing to the workstream. Agreement across system leaders about the next steps to move to ACP. CEO of ELHT and Accountable Officer of East Lancashire CCG jointly chairing the Pennine Lancashire LDP Programme with the aim to create a shadow ACP from 1 April 2018. Potential gains in strengthened reputation with regulators and across the STP footprint with regular reporting to the Board via the Finance and Performance Committee on progress, milestones and risks linked to the gateway process. STP architecture on clinical services is developing (eg pathology, stroke and frailty).	16	12	16	4x4	16	16	16	16	System leaders agreed a process to develop the governance system for an ACP across Pennine Lancashire; however this is still in development STP System Management model is in early stages of development. Significant external interest and influence from external stakeholders in relation to NLAG could affect scope, pace and impact. NLAG formal response to ELHT offer pending whilst work is progressing.	Timeline for consultation with public - uncertainty about the detail of the consultation for the component business case at LDP level. Lack of unified approach in relation to procurement by Commissioners. Priorities of CCGs starting to be aligned with priorities for pathway redesign (e.g. stroke) but this work is still in the early phases. Programme Lead for Pennine Lancashire LDP to be appointed following the departure of the postholder. Support for NLAG is growing organically and therefore assurances are reviewed regularly to reflect the work on the ground. GP Clinical and managerial relationships still developing.	Regular updates provided to Board and the Audit Committee. Pennine Lancashire project solution design phase completed and case for change published Prioritisation mechanism to be resolved externally as part of the Pennine Lancashire HIMPs reporting to the Care Professionals Board each month as part of the Pennine Lancashire Transformation Programme. This work is ongoing. Across the STP footprint the Medical Directors of the four Trusts agreed to focus on urology, vascular services, stroke, emergency department, interventional radiology and gastrointestinal bleed, and neonatology. At STP level all providers met to formulate work programme - 3 categories of services agreed a)services that are fragile now, b) services where there is no immediate risk but possible in the not too distant future and c) services that need to be managed across the whole footprint. Agreement on the way of taking this forward to be agreed. Component Business Cases were submitted. The Executives reviewed the In Hospital Business Case before submission and shaping and influencing the Business Case. Presented to the System Leaders Forum at the end of September 2017. Feedback received. Pennine Lancashire LDP draft component business case prepared and consultation planned. Focus on developing at LDP level wider deliverables - a shadow Accountable Care Partnership from April 2018. Plan on a page for the LDP being worked on connecting to the Plan on a page for ELHT that was presented to the Commissioners. First Providers Operational Board at STP level held in October 2017. Monthly meetings planned in 2018. STP development of provider programme to be reported back to the February Provider Group. First stage review of NLAG mobilised and completed by 31 October 2017. Governance review outcomes reported to the ELHT Board in November 2017. Regular reports to the ELHT Board planned regarding progress.

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

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2017/18**				**Gaps in Control** *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	**Q2**	**Q3**	**Q4**			
Budgetary controls (income & expenditure) in place including virement authorisation, workforce control, monthly performance meetings, variance analysis as described in the recovery plan. Measures to mitigate financial risk overseen by Finance and Performance Committee.	Monthly reporting to Finance and Performance reports and the Board to reflect financial position. Separate reporting available to support assurances on the transformation programme. Regular Performance Review meetings between Executives and Divisions. Financial recovery plans developed and agreed. Financial objectives are included in individual appraisals. Action taken when personal objectives are not delivered.	16	12	16	5x4	16	16	20	20	Additional workforce controls to remain in place. policies and procedures may require amendments where they are no longer fit for purpose. Controls around transformation schemes and SRCP to be monitored by the PMO and the Finance Department with Division to be held to account via the PMO. Gaps in control regarding funding for A&E and STF Funding - recovery plan underway. Weaknesses in appraisals and accountability framework. Weaknesses in rostering controls. Weaknesses in discretionary non-pay spend deterioration in the underlying financial position requiring additional transformation schemes in 2018/19. SRCP being delivered non-recurrently. Financial recovery plan to be approved by the Trust Board in March 2018.	Utilise the internal audit programme to test for assurance on core controls, SRCP and transformation plans. External audit view on value for money. Review of divisional governance processes. Understanding the changes in income services (NHS and private).	Regular updates to Board and Finance and Performance Committee Finance risk around A&E and STF funding identified and operational plans to recover are ongoing. Risks in relation to the impact of the changes to CQUIN and STF arrangements for the next two years are being managed and reporting to the Quality Committee and Finance and Performance Committee. External review of Divisional Transformational governance processes has been undertaken in quarter 4 of 2017/18, report has been received by the Audit Committee in March 2018. Revised Governance Process going to the Trust Board which suggests the development of a Financial Assurance Board. Trust to consider control total and implications for the financial year 2018/19 at the March 2018 Board meeting.

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 regulatory requirements

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.

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2017/18**				**Gaps in Control** *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	Q2	Q3	Q4			
Divisional business plans, weekly operational performance meetings, monthly divisional performance meetings feeding into the ODB and Finance and Performance Committee, emergency pathway and elective pathway work linking into the broader Trust wide transformation. Engagement meetings with CQC, quality and safety compliance assessed by each division, divisional assurance boards feeding into the operational sub-committees and the Quality Committee. Nursing Assessment Performance Framework received significant assurance from internal audit System wide approach as part of the A&E Delivery Board supported operationally by the A&E Delivery Group. Emergency Care Pathway redesign programme monitored through Finance Assurance Board. Established an emergency pathway improvement programme with agreed priorities and support from NHSI started during the month of January and is ongoing. Weekly operational meeting covering RTT, cancer, 4 hour performance and holding list management. Weekly Medical Staffing Review. Monthly divisional performacne meetings. Two hourly operational flow meetings.	IPR reporting to the ODB and at Board/Committee level, regular deep dive into the IPR through Finance and Performance Committee. Regular reporting to the NHSI, monthly integrated delivery meeting with the NHSI and A&E Delivery Board. Regular reporting from the divisions into the operational sub-committees and the Quality Committee. Alignment with national priorities through the quality and safety governance mechanisms. Trust rated 'Good' by CQC. ED performance improvement action plan aligned with the NHSI Rapid Improvement Collaborative and agreed by NHS England. Opening of Respiratory Assessment Unit to support the delivery of the four hour standard as part of the wider emergency care pathway redesign programme. Silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments continues. Five Silver Accreditation of a ward pproved by the Trust Board. 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 2017/18. Significant reduction in the number of complaints upheld by the Ombudsman. Comprehensive system for addressing complaints. PLACE assessments - percentage improved in all areas. Positive patient survey with improvement areas identified. CQC Task and Finish Group established and chaired by the Medical Director and Director of Nursing. Mini CQC visits carried out and focussing on community hospitals, reporting back to the Quality Committee. Reduction in use of bank and agency staff continues, revisiting the specialing policy with further reduction in spend. Delivery of RTT and cancer standards.	15	9	16	4x4	16	16	16	16	Staffing gaps due to vacancies/inabilities to secure locum staff means that on occasions that some slots/rota's are not filled. Still high number of medical, nursing and midwifery vacancies. Lack of control over out of hospital and mental health service capacity. Complaints are a potential source of action by the CQC. Wider system analysis of capacity in primary care and care sector needed. Risk of not being able to deliver 7 day services.	Risks around some of the national trajectories identified. Recovery plans are being implemented. Continued non-elective activity is placing pressure on the elective care and the RTT standard. Funding to resource Nursing Assessment Performance Framework not agreed, impacting on the plans to expand the workplan. Assessments under the Framework to go through the Patient Safety & Risk Assurance Committee before presentation to the Quality Committee.	Reduction on overall number of complaints, 50+ and 40+ days continues. Review of the complaints element of the Patient Experience Strategy to be completed by September 2018. Challenges of achieving the four hour standard are being worked on, measures put in place to address performance and action plan has been submitted to NHSI with a view to improve performance and sustain it in the longer term. NHSI/ECIP review received and Concordat to support implementation agreed. Board receives regular SRCP and transformation updates. Work on the Emergency Care Pathway and Model Wards continues. Implementation of red to green days and criteria led discharge now in place. Discharge to assess extended to support 50 patients per week and now in place. Work ongoing with NHSI and AQUA. Plans for estates and staffing changes are in place so that the four hour target can be acvhieved at 90% by end of September 2018 and 95% by the end of March 2019. Recovery plans being implemented around achievement of national trajectories. Improvement trajectory for Delayed Transfers of Care (DTOC) to deliver 3.5% by March 2018. Improvement trajectory to reduce complex care trigger list is in place. Nursing Assessment and Performance Framework assessments are continuing. Five Silver Accreditation of a ward approved by the Trust Board. further inspections planned for a number of wards awaiting third assessment following two green assessments. 110 new registered nurses joining the Trust by the end of October 2017. Continuing to recruit for substantive medical posts within ED and Urgent Care. Report by the CQC Task and Finish Group, including the findings of the CQC Mini Visits was presented to the Quality Committee in January 2018. Regular reports of the Task and Finish Group will be presented to the Quality Committee. Next steps of the emergency care pathway are underway - development of the outline business case (OBC) for the emergency care village. OBC presented to the Trust Board on 17 January 2018 and agreed for submission to NHSI.

TRUST BOARD REPORT

Item 13

14 March 2018

Purpose Information Assurance

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

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

The report also provides a summary of the New Never Event Framework and updated Never Event Action Plan.

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

Report linkages

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

Previously considered by: N/A

Contents:

Executive Summary

Trust has reported 18 STEIS incidents in January and February 2018:

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

Trust has requested 11 internal RCA investigations within the Divisions:

- All duty of candours have been served in appropriate cases
- RCA Investigations are in progress

Update Never Event Framework published 2018 has identified 2 new never event criteria's.

- Unintentional connection of a patient requiring oxygen to an air flowmeter
- Undetected oesophageal intubation *(Feb 2018 put on hold until further notice)*

Never Event action plan update is provided for information and clearly states:

- actions completed
- actions outstanding with work ongoing to complete these
- Assurance on any actions overdue for completion by Division(s)

East Lancashire CCG have completed a thematic review fishbone diagram of all ELHT StEIS reportable incidents from August 2017 which they have shared with the trust that identifies a number of key themes.
This is now being used as a prompt to review all future SIRI reports and action planning. (page 29)

Part 1: Overview of SIRIs Reported since last Board report

STEIS SIRIs reported in January and February 2018

There have been 18 serious incidents requiring investigation which have been reported through Strategic Executive Information System (STEIS). Each incident has had a rapid review undertaken and a copy has been sent to the commissioner and regulatory bodies. The Associate Director of Quality and Safety has commissioned a root cause analysis investigation (RCA) for each incident and on completion these will be presented to the SIRI panel. The table on the following pages provides details of these incidents:

	eIR1	Division	Incident reported	Description	Duty of candour served	Rapid Review done?	Any immediate changes initiated	Next steps
1	eIR1139525	SAS	23/01/18	Grade 4 Pressure ulcer identified on transfer to Liverpool Hospital	**Y**	Y	Pressure Ulcer QI work ongoing	RCA to SIRI
2	eIR1137853	ICG	20/12/17	Unwitnessed fall sustaining fracture neck of femur	Y	Y	Falls QI work ongoing	RCA to SIRI
3	eIR1136915	ICG	02/12/17	NG Tube incident – identified pneumothorax on chest x-ray (not a Never Event)	**Y**	Y	Clinician review of technique	RCA to SIRI
4	eIR1139223	ICG	17/01/18	Ng Tube incident which was discovered on post-mortem that it was in the wrong place – Never Event	Y	Y	Reminder to staff not to initiate feeding via NG tubes out of hours.	RCA to SIRI
5	eIR1138148	FC	27/12/17	Baby developed Hemo-pneumothorax and pericardial effusion secondary to chest drain insertion	Y	Y	Transferred to cardiac centre for surgery	RCA to SIRI
6	eIR1139284	ICG	18/01/18	Grade 3 Pressure ulcer	Y	n	Pressure ulcer QI work ongoing	RCA to SIRI
7	eIR1129458	FC	21/07/17	Unexpected transfer to NICU – Mother had signs of sepsis but not given antibiotics – baby born completely flat, intubated and	Y	Y	Informed staff	RCA to SIRI

				transferred for cooling and treatment for sepsis				
8	eIR1138467	SAS	03/01/18	Missed medication (adjuvant therapy) which has possibly contributed recurrent breast cancer	Y	Y	Pt seen in clinic / treatment to be commenced	RCA to SIRI
9	eIR1130531	ICG	10/08/17	Pt admitted with diverticulitis then developed hospital acquired pneumonia. Pt also had swallowing difficulties, SALT assessment which advised ENT referral, medical history showed OGD 2016 with advice to refer to ENT due to pharyngeal mass, this was missed, tumour is inoperable and pt is on palliative care.	Y	Y	ELHT liaised with CCG to ask for round table meeting with GP surgery to complete RCA Message to all medical staff to refer Cons to Cons instead of asking GP to refer onwards	RCA was presented at DSIRG in November 17 and sent back for further work and presented again January 18, added to SIRI January 18 and STEIS reported, further information needs adding from GP surgery and will be re-presented at March 18 SIRI panel
10	eIR1138502	SAS	04/01/18	Grade 3 Pressure ulcer	**Y**	N	Pressure ulcer QI work ongoing	RCA to SIRI
11	eIR1134197	ICG	16/10/17	Failure to recognise and treat deteriorating patient – Admitted with a stroke and catheterised, rehab and discharge plans in place. On medical review stated possible sepsis but no care bundle started, pt deteriorated with poor urine output and transferred to ED with EWS of 10	Y	Y	Informed staff	RCA presented to DSIRG, patient later died with possible uro-sepsis, panel felt that this was STEIS reportable – action taken and added to SIRI
12	eIR1139452	SAS	22/01/18	Grade 3 pressure ulcer	Y	N	Pressure ulcer QI work ongoing	RCA to SIRI
13	eIR1137839	ICG	19/12/17	Grade 3 pressure ulcer	Y	N	Pressure ulcer QI work ongoing	RCA to SIRI
14	eiR1140542	DCS	09/02/18	Patient was taken from ED to CT – wrong	N	Y	Round table meeting with	RCA to SIRI and reported to CQC

				patient taken and underwent CT scan			staff to discuss and look at process	for radiation incident
15	eiR1141518	ICG	28/02/18	Added in retrospect, recently dealt as a complaint – misdiagnosis of cancer	Y	Y	Complaint procedure stopped and proceeded to investigation	RCA to SIRI
16	eiR1140847	ICG	Feb18	Allegation of assault by member of staff – under police investigation	N/A	Y	Member of staff not undertaking clinical duties and police contacted	RCA to SIRI once police investigation has been completed
17	eiR1141185	ICG	Feb18	Patient had a fall sustaining a fracture neck of femur	Y	Y	Falls collaborative QI work ongoing	RCA to SIRI
18	eiR1140905	FC	Feb18	Baby has been found to have multiple bruising at home visits. Safeguarding involved and baby admitted to hospital and taken in to care. Further investigations being carried out to determine NAI or underlying condition	N/A	Y	Round table with safeguarding lead/team leader and Quality and Safety Lead	RCA to SIRI

Part 2: Non STEIS SIRIs reported in January and February 2018

There were 11 non-STEIS incidents deemed to be serious incidents requiring investigation. A rapid review has been undertaken where further information was required and Duty of Candour completed on all moderate and above incidents in line with trust policy. A full root cause analysis investigations have been requested and once complete will be presented to each divisional SIRG panel.

	eIR1	Division	Incident reported	Description	Duty of candour served	Rapid Review done?	Any immediate changes initiated	Next steps
1	eIR1138937	SAS	11/01/18	Pt had surgery for perineal abscess, discharged with pack insitu. Pt returned to HOT clinic 2 weeks later with pack still insitu and hadn't been changed	N/A	Y	Team informed	RCA to DSIRG
2	eIR1136260	SAS	21/11/17	Delay in diagnosis of elbow fracture	**Y**	Y	Team informed	RCA to DSIRG
3	eIR1139705	ICG	26/01/18	IG Breach – handover sheet found in a public area by a member of staff	N/A	Y	logged	Reported to ICO who felt that this scored low therefore RCA to D SIRG
4	EiR1139538	ICG	23/01/18	Pt admitted with a fall from home CT head confirmed spread of disease, pt had another fall and sustained laceration to forehead and skin tear above eye. Pt later died due to underlying condition	N/A	Y	Falls collaborative QI work ongoing	RCA to DSIRG
5	eIR1141206	DCS	22/02/18	Delay in diagnosis of dislocated hip	N/A	Y		RCA to DSIRG
6	eIR1138455	SAS	03/01/18	Pt undergoing neoadjuvant chemo 6 cycles, supposed to continues after breast surgery, pt was to ring after	Y	Y	Pt restarted on neoadjuvant therapy in January. Review of	RCA to DSIRG

				surgery to restart which wasn't done. 18 cycles in total were to be completed however this was not continued. Progressive disease was noted from surgery.			pathway was immediately undertaken	
7	eIR1140555	ICG	10/02/18	Pt had a fall and sustained a fracture to ankle	Y	Y	Falls collaborative QI work ongoing	RCA to DSIRG
8	eIR1139490	ICG	23/01/18	Pt deteriorated rapidly on admission, Penicillin was given although pt had a red band on and known allergy within the case notes, 3 doses given. Pt admitted to ITU ? adverse reaction, bloods sent for testing which showed no allergic reaction to penicillin	Y	Y	Update reported to Clinical Leaders Forum	RCA to DSIRG – STEIS reported but then de-escalated due to blood results not showing allergic reaction
9	eIR1131652	SAS	31/08/17	Pt presented with leg swelling (3 times) under assessment for DVT and treated with Warfarin– recently underwent cut out left DHS and implant removed. Re-attended with what thought to be an abscess for ortho to drain but this was a mass CT confirmed. ? misdiagnosis	Y	Y	Biopsies sent to another hospital for second opinion Scan reviewed by radiology and addendum added	RCA to DSIRG
10	eiR1140369	DCS	02/02/18	Pt attended x-ray for imaging of right upper limb, left limb was x-rayed by mistake	N/A	N	Staff informed	Concise report to DSIRG
11	eIR1140532	ICG	09/02/18	Pt had a fall and sustained a wrist fracture	Y	Y	Falls collaborative work ongoing	RCA to DSIRG

Duty of Candour

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

Duty of candour has been delivered to all applicable STEIS and non-STEIS reportable incidents. Of these 4 where not completed within the timescale of 10 working days. Reasons as below –

- eIR1136260 – Breached by 1 day - letter not having signature of Consultant which had to then go back for signing.
- eIR1138502 – Breached by 1 day - Offer of apology on 4th January, letter was chased and on 18th January received feedback that patient declined letter
- eIR1136915 –Apology offered on 2nd December, rapid review requested to determine level of harm which was confirmed on 26th January 18, letter still outstanding. (remains on daily DoC report)
- eIR1139525 – Breached by 5 days - Incident reported from Liverpool and case note had been lost in the post, could not offer apology until the right documentation was received in the notes to discuss with the patient

Part 3

This section of the Board SIRI report contains:

1. Update on new national Never Event Framework (Jan 2018)
2. ELHT Never Events 2017-18: Action Plans Overview – Updated to 20/02/18
3. ELHT Never Events 2017-18: detailed SIRI RCA Action Plan Updates – Updated to 20/2/18

Definition of Never Event

Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Summary of changes to Never Event Framework

Removal of the option for commissioners to impose financial sanctions associated with Never Events – this is to help emphasise the importance of learning from their occurrence, not blaming.

The revised Never Events framework will be aligned with a new Serious Incident Framework due to be published later this year (2018)

Two **new** types of Never Events have been added

- Unintentional connection of a patient requiring oxygen to an air flowmeter
    - This applies when a patient who requires oxygen is connected to an air flowmeter when the intention was to connect them to an oxygen flowmeter.

Excludes: unintentional connection to an air cylinder instead of an oxygen cylinder as robust barriers to prevent this have not yet been identified.

- Undetected oesophageal intubation *(on hold until further notice)*
    - Ventilation of a patient following oesophageal intubation instead of the intended tracheal intubation, which is not identified because capnography is not used or capnography readings indicating the need for tracheal intubation are not acted on.

Below is a list of Safety Alerts that NHS Improvement has stated that remain relevant to the Never Events list 2018.

Safer Practice Notice

- Wristbands for hospital inpatients improves safety (2005)
- Standardising wristbands improves safety (2007)
- Reducing the risk of retained throat packs after surgery (2009)

Patient Safety Alert

- WHO surgical safety checklist (2009)
- Potassium chloride concentrate solutions (2002; updated 2003)

- Promoting safer measurement and administration of liquid medicines via oral and other enteral routes (2007)
- Safer practice with epidural injections and infusions (2007)
- Improving compliance ih oral methotrexate guidelines (2006)

Rapid Response Report

- Reducing the risk of retained swabs after vaginal birth and perineal suturing (2010)
- Safer administration of insulin (2010)
- Reducing risk of overdose with midazolam injection in adults (2008)

Definitions of existing Never Events which have been revised

Never Event	Amendment	Rationale
Wrong site surgery	Include pain relief blocks	New guidance is available form the Faculty of Pain Medicine – *Safety checklist for interventional pain procedures under local anaesthesia or sedation (2017)*
Wrong site surgery	Clarification that the extraction of primary (milk) teeth is excluded unless done under a general anaesthetic.	The extraction of milk teeth is extremely unlikely to result in severe harm/death unless it is done under a general anaesthetic when the potential risks of anaesthesia could apply
Wrong site surgery	Exclude spinal surgery	There is no specific guidance available relating to preoperative identification/marking of the spinal level. NHS Improvement will be working with the British Orthopaedic Association to develop guidance.
Wrong site surgery	Exclude contraceptive hormone in the wrong arm.	Severe harm/death is extremely unlikely
Wrong implant/ prosthesis	Includes the implantation of an intrauterine contraceptive device that differs from the one in the procedural plan.	The existing barriers to prevent implantation of the wrong implant/prosthesis also apply to intrauterine devices.
Wrong implant/prosthesis	Excludes where the implant/prosthesis differs from the one intended due to incorrect pre-procedural measurements or incorrect interpretation of the pre-procedural data, e.g. wrong intraocular lens due to wrong biometry or using the wrong dataset from correct biometry.	There are currently no robust barriers to prevent this from occurring.
Overdose of insulin due to abbreviations or incorrect device	Include when a healthcare professional withdraws insulin from an insulin pen or an pen refill and then administers it using a syringe and needle.	New guidance is available in the Patient Safety Alert – *Risk of severe harm and death due to withdrawing insulin form pen devices (2016)*
Unintentional connection of a patient requiring oxygen to an air flowmeter	New Never Event	New guidance is available in the Patient Safety Alert – *Reducing the risk of oxygen tubing being connected to air flowmeters (2016)*
Undetected oesophageal intubation	New Never Event	New guidance is available to prevent the ventilation of a patient following intended tracheal intubation and subsequent oesophageal intubation that is not recognised or acted on: Association of Anaesthetists of Great Britain and Ireland – *Standards of monitoring during anaesthesia and recovery*

ELHT Never Events 2017-18: Action Plans Overview – Updated to 20/02/18

eIR1 No.	Type of incident	Level of harm caused	Date of Incident	Division	DoC	Rapid Review Done	RCA Approved Date	Action Plan Due RAG
1124845	Wrong Site Surgery	No harm	19/04/17	SAS	Yes	Yes	June 2017	July 2017
1124541	Wrong Site Surgery	Moderate	12/04/17	SAS	Yes	Yes	June 2017	March 2018
1129342	Retained foreign object post procedure	Severe / Major	18/07/17	SAS	Yes	Yes	Oct 2017	Mar 2018
1133635	Wrong Site Surgery	Low / Minor	06/10/17	SAS	Yes	Yes	Jan 2018	Mar 2018
1133948	Wrong Site Surgery	Moderate	11/10/17	DCS	Yes	Yes	Feb 2018	July 2018
1139223	Misplaced naso gastric tube	Severe: likely contributing to death	31/10/17	ICG	Yes	Yes	awaiting	Report / action plan due at SIRI 15th March 2018

a. SIRI RCA action plan eIR1124845 (SAS) - completed

No	Action	By whom	By when	Evidence	RAG status
Reflective Learning					
1	Consultant 1 to reflect on the learning from this incident and discuss within the appraisal.	Consultant	May 2017 for reflected learning	Appraisal	Green
2	Share the report with the Theatre Team in the Share to Care meetings	Theatre Matron	June 2017	1) Minutes of share to care. 2) Every member of theatre staff will receive a copy of the 'share to care' special edition bulletin on 'never events'. (Jan 2018)	Green
Improving Culture and quality of WHO/5 steps to safer surgery					
1	As part of the review and re-launch of WHO and 5 Steps to Safer Surgery Surgeon take into consideration guidance around consultant confirming before injection / incision which side. This should be then confirmed by the theatre team. *(will be picked up in line with action plan for eIR1124541)*	CD for SAS	July 2017 (completion due end Nov 2017)	New guidance / policies Update – Policy progressed through D-SIRG on 29.11.17 and to be presented at Policy Council in December. This will go to SAS DMB January 2018 then will be uploaded on OLI and communicated to all theatre staff.	Green

b. SIRI RCA action plan eIR1124541 (SAS)

No	Action	By whom	By when	Evidence	RAG status
Heading 1 – Patients to be reviewed by surgeon prior to entering theatre					
1	Communication with all Surgeons that patient's should be reviewed by the operating Surgeon before the patient is anaesthetised.	CD for Theatres	31st May 17	Communication to all surgeons/anaesthetists via email/letter on 26th June 2017	Green
Heading 2 –5 steps to safer surgery including the WHO checklist					
1	Review of the WHO and ensure it is in line with NPSA standards. Printed copies of the validated original WHO checklist now in use in GAD document.	Matron - JB	30th June 17	1. New WHO launched 2. May 2017 3. Re-reviewed and re-launched in December 2017	Green
2	Re-launch of the 5 steps to safer surgery (First meeting scheduled for 31st May)	Matrons	10th July 2017	Launch week agreed 10th July 2017	Green
3.	Trust Comms to be sent out on the 10th July re launch – Trust Facebook, Twitter, and Message of the Day.	JB	10th July 2017	Message sent out 28th June 2017	Green
4.	Spot observations of the 5 steps to safer surgery and WHO checklist to be completed.	Matrons Band 7's GM	Frequent on-going observations	Record of Observations Thematic action plan	Green
5.	Cluster review of all incidents which have the 5 steps as acontributory factors with the theatre team.	Band 7's	July audit	Action plans developed by theatre teams *(see appendix one)*	Green
6.	Review of 5 Steps to Safer Surgery policy, to include escalation process for non –compliance.	Matrons	September 2017	Policy review – Discussed at Sign up to Safer Surgery.	Green

No	Action	By whom	By when	Evidence	RAG status
7	All surgeons , anaesthetists and theatre staff communicated with by the Clinical Director re the need for compliance with the 5 Steps to Safer Surgery and the escalation process for non- compliance .	Divisional Director and Divisional Nurse	June 2017	Email/Letter dated 26th June 2017	Green
8.	Formal education for all new starters the 5 Steps to Safer Surgery	Training and Development Manager for Theatres	September 2017	1. Theatre staff training records 2. Inclusion in Junior Doctor rotation Trust induction	Green
9.	Educational posters re 5 Steps to Safer Surgery displayed around the theatre department. Staff to be emailed the video link for 5 Steps to Safer Surgery video	Matrons	September 2017	Display of posters and email of video link	Green
10.	Brief document to be reviewed and trialled then implemented across both sites	Matrons Documentation Group	October 2017	New brief/ debrief launched	Green
Heading 3 –Site marking policy					
1	Review of the site marking policy and ensure it is in line with national standards.	CD for Theatres	30th June 17 (Expected completion end of November)	For approval DMB 17th January 2018	Green
2	Launch of site marking policy	Matrons CD Theatres	30th June 17 (Expected completion end of 1st December)	Policy implemented and online (as above)	Green
Heading 4 – Emergency theatre review					

No	Action	By whom	By when	Evidence	RAG status
1	As part of the Theatre Productivity and Efficiency Programme – review of Emergency Theatre. **<u>15.01.18 Update</u>** – Daily Emergency Theatre Briefing meeting being trialled as of 08.01.18 to improve list order prioritisation and intra case turnaround time. Scoping use of theatre reception as a planned 2nd stage recovery to ensure main recovery remains available to emergency theatre during peak flows of activity. **<u>22/1/18 update</u>** Trialling morning meetings at 7:55AM(as from 22/1/18) to see if this make any divergence to productivity of meeting	Rob Salaman	October 17 (expected completion end of March 2018)	Theatre P&E programme group set up with lead nominated meetings started 10/10/17 held bi-weekly. The process has been mapped and issues identified. The policies have been collated and reviewed with the view to amalgamating into one. Morning emergency scheduling meeting to be instigated.	Amber
Heading 5 –Surgical workforce model					
1	Short term – Implement short term options to address rota gaps at all levels.	General Surgery CD & Paula Garstang	On-going	Regular feedback at DMB	Green
2	Long term – Undertake a long term workforce review for the emergency pathway and identify skills and staff required.	Paula Garstang	October 17 (due to be completed Dec 18)	WRAPT first draft of LT workforce/ processes proposal being presented to Directorates in November WRAPT presentation to DMB in end November WRAPT presentation to Exec team in December 2017, followed by paper	Amber

No	Action	By whom	By when	Evidence	RAG status
				with recommendations from WRAPT team SAS Division paper to Exec team in response to WRAPT proposal in January 2018	
Heading 6 – Communication					
1.	Ensure this incident is discussed with all staff. Ensure staff are made aware if a patient raises concerns these are to be listened too and taken seriously.	Matron	June 17	Information cascaded to staff – Day Case Audit Meeting	Green
2.	Ensure all staff are made aware that electronic discharge summary should not be altered by hand. Any concerns or discrepancies raised should be raised and investigated.	Matron	June 17	Information cascaded to staff – Day Case Audit Meeting	Green

c. SIRI RCA action plan eIR1129342 (SAS)

No	Action	By whom	By when	Evidence	RAG status
Specimen Retrieval Bags					
1	Instructions issued that retrieval bags must be included in the Instrument/swab count	JP	31/08/2017	Observation of Practice Theatre swab policy	Green
2	A verbal statement to be made during the procedure that the retrieval bag has been inserted into the patient and a verbal acknowledgment that it has been removed	JP	31/08/2017	Theatres Swab Policy Observation of Practice via theatre spot check observation process	Green
3	Incident bag description and serial number to be recorded, and the MHRA to be informed	DT	06/10/2017	Completed notification form and acknowledgement response	Green

No	Action	By whom	By when	Evidence	RAG status
Specimens					
1	Enquire if path lab can purchase the clear histology pots in a larger size, so the specimen can be seen and checked before being sent out of theatre without opening the pot and risking hazardous spills	DS	December 2017 (due to be completed 29/1/18)	• Amended Specimen Management Policy (see below) includes requirement for specimen pots to be opened and confirmed specimen in situ prior to accepting at reception. Immediate escalation to surgeon/theatre specified if specimen not located. • Craig Rodgers(path lab) confirmed via email that clear specimen pots as requested are now being ordered as standard and theatres will only now receive clear pots	Green
2	The Specimen Management Policy to be reviewed with actions outlined to ensure traceability of specimen from patient to pot	CR (DCS)	October 2017 (due to be completed end of Nov 2017)	DCS Divisional Policy Only - Amended draft version completed. Approved at DCS Division Quality Group 14th Nov 2017. Presented at SAS PS&Q in November 17 and approved.	Green
3	Staff instructed not to pre label specimen pots	JP	October 2017	Minutes of team meetings – Safety Huddles and formal band 7 Meetings. Work is on-going with	Green

No	Action	By whom	By when	Evidence	RAG status
				raising awareness with theatre staff.	
4	The surgeon to countersign the specimen register at the end of the procedure confirming the specimen has been placed in the pot.	All surgeons	31/08/2017	Counter signatures present in specimen register Regular audit of compliance to be carried out.	Green
5	A Trust Policy on Missing Specimens must include surgeon of the operation being informed about missing specimen, or if not available the Clinical Director, along with an alert added to patient notes/PAS	DS	December 2017	DCS Divisional Policy Only - Amended draft version completed, approved at DCS Division Quality Group 14th Nov 2017 .	Green
5 Steps to Safer Surgery including the WHO checklist					
1	Senior management reviews (with Clinical Commissioning Group (CCG) involvement twice weekly of clinical practice, challenging culture where necessary; and auditing completion of the different sections of the WHO Checklist. **20.12.17 Update** – Process currently paused whilst learning from initial process reviewed.	Senior Management Team SAS	On going	Written findings of review and feedback	Green
2	Identification of roles allocated at briefing to be written on a white board in the operating room **Update (15.12.17):** Roles are identified currently through briefing process however pilot of use of whiteboard with assigned roles taking place. Awaiting Engie work to install board in Theatre 4. **Update (15.01.18):** Trial of whiteboard in Vascular theatre taking place and sourcing of providers for pre-printed boards being looked in to. Feedback	JP	December 2017	Observation of Practice	Red

No	Action	By whom	By when	Evidence	RAG status
	on use of mock up board to be provided w/c 15.01.18 **19/2/18 update** • Trial of "Briefing Boards" in RBTH and BGTH theatre. • Tendering process in place to secure pre-printed brief boards				
3	Team debrief to be utilised consistently	JP	December 2017	Use of WHO Checklist and theatre senior team observations	Green
Culture and Environment					
1	Increased NAPF/PLACE (Nursing Assessment Performance Framework) assessment Visits planned	NAPF/PLACE Teams	On going	RBH Theatres undergone NAPF assessment in Dec 17. Red status awarded. Action plan development and weekly follow up checks in place to ensure actions completed in a timely manner.	Green

d. **SIRI RCA action plan eIR1133635 (SAS)**

No	Action	By whom	By when	Evidence	RAG status
Staffing Issues					
1	Review Theatres staff establishment and produce list of suggested specialist teams **19/3/18 Update**	Julie Payne Dominic Sebastian	28/02/2018	Specialist Team lists available	Amber

No	Action	By whom	By when	Evidence	RAG status
	Restructure of theatre staffing. Each theatre has an allocated band 6 to take responsibility for the area. Specialist anaesthetic teams identified to take effect from 16/4/18				
2	Equipment Competencies to be reviewed and appropriate training provided	Team Leaders Practice Educators	31/03/2018	Training Records	Amber
Surgical Site marking					
1	The current Surgical Site Marking Policy to be reviewed with the opportunity for all specialities to identify and record their specific requirements	Julie Payne Surgeons	31/12/2017	Revised Surgical Site Marking Policy published and disseminated across the Trust	Green
Unavailability of appropriate Scanner					
1	To be included on the Risk register and a Business Plan for the purchase of a dedicated Vascular Scanner is required.	Theatre Procurement Lead	31/03/2018	Divisional Risk Register and outcome of Business Plan	Amber
Use of the WHO Safer Surgery checklist					
1	Continuing Senior management reviews and audits of clinical practice relating to compliance of completion of WHO checklist. Themes are to be discussed at local Governance Meetings on a monthly basis and action plans produced if required.	Senior Management Team SAS	On going	Written findings of review and feedback. Audit results Minutes of Theatre Governance meetings.	Green
2	Guidelines/SOP to be developed relating to actions required when a delay is encountered between Time Out and Incision.	Senior Management Theatres	28/02/2018	Production of Guidelines/SOP Record of training for staff	Green

No	Action	By whom	By when	Evidence	RAG status
Communication and Documentation					
1	Staff to be reminded of Information Governance Policy and the need for confidentiality	Team Leaders Senior Management	31/01/2018	Minutes of Team meetings Policy shared in team huddle and a copy provided to each theatre	Green
2	Documentation Guidelines to be reiterated to staff to include requirements to record Date and Time for all entries along with making a record of all aspects of the patients care.	Team Leaders Senior Management Theatres	31/03/2018	Minutes of Team meetings	Amber
3	A SOP to be developed relating to actions required when a serious incident has occurred. This should include removal of the staff involved from clinical duties to give them the opportunity to reflect on the incident and recover from any emotional distress along with "Round Table" support	Patient Safety & Risk Lead	31/03/2018	Production of Guidelines/SOP Record of training for staff	Amber
Whiteboards					
1	**19/2/18 update** • Trial of "Briefing Boards" in RBTH and BGTH theatre. • Tendering process in place to secure pre-printed brief boards	Clinical Quality and Safety Lead for Anaesthetics	31/01/2018	Installation of appropriate whiteboards	Red
Medical Staff Learning					
1	Consultant Involved to reflect on the incident and the need for use of surgical site marking policy	Vascular surgeon	Designated appraisal date	Consultant to provide evidence of learning at appraisal	Amber

e. **SIRI RCA action plan eIR1133948 (DCS)**

No	Action	By whom	By when	Evidence	RAG status
Estates and Facilities (Porters)					
1	Undertake a review of the computer systems used by portering staff, with the purpose of including a unique patient identifier across all systems.	SC / PT / AH	February 16th 2018	Presentation of review and actions to Estates and Facilities QSB February 2018. IT provided system to include search facility for patient identification. (e-mail PT logistics Manager 25/1/18)	G
2	Undertake a review of the methods by which porters communicate with one another and the helpdesk, including the communication of patient information, location, destination and special instructions, with the purpose of acquiring/developing a robust system for porting communications.	SC / PT / MJ	June 30th 2018	Presentation of review and actions to Estates and Facilities QSB February 2018. 19-2-18 Review complete. Action to be forwarded to IMT (Electronic Patient Record Team) for progressing further re procurement of porters communication system.	G
3	Develop a standardised operating procedure to guide porters it the process of collecting a patient from a ward area.	SC / PT	December 1st 2017	SOP in use	G
4	Include the standardised operating procedure in mandatory training with written confirmation that the process has been discussed and understood.	SC / PT	January 19th 2018	Training documentation ratified at Estates and Facilities QSB (signature list of staff)	G
5	Undertake a review of the workload of portering helpdesk operators, with specific reference to hours of work and task management, with recommendations identified and an action plan formulated.	SC / PT	February 16th 2018	Presentation of review and actions to Estates and Facilities QSB February 2018. (email from PT – Logistics Manager 25/1/18)	G

No	Action	By whom	By when	Evidence	RAG status
6	Provide assurance that portering staff are compliant with information governance training, with exceptions reported to Estates and Facilities QSB.	SC / PT	Ongoing (staff have different dates re completion)	Estates and Facilities QSB minutes (copy of IG training compliance)	G
7	Reiterate to portering staff that the sharing of usernames and passwords contravenes information governance policy.	SC / PT	November 1st 2017	Team brief	G
8	Provide assurance that all portering helpdesk operators have changed passwords	PT	December 15th 2017	Signature list to confirm changes	G
Clinical areas (wards)					
9	Develop a standardised procedure and proforma (Registered Nurse and Porter ID/Procedure Checklist) for use by registered ward and portering staff when patients are transferred by porters from ward areas for investigations.	JP	December 1st 2017	Proforma in use	G
10	Communicate to all ward staff the need for a registered member of staff to give permission for a patient to leave the ward for a procedure in line with the newly developed proforma.	Divisional Directors of Nursing	December 1st 2017	Electronic communications, share to care.	G
11	Undertake monthly audits of the use of the Registered Nurse and Porter ID/Procedure Checklist until practice has embedded, continuing 6-montly thereafter, with all exceptions addressed in real time and reported to Divisional QSBs	Directors of Nursing	Ongoing from December 1st 2017	Divisional QSB minutes	G
12	Trust-wide wristband audit to evaluate use of wristbands and legibility, with reports presented to Divisional QSBs and Trust Board.	Directors of Nursing	December 8th 2017	QSB and Trust Board minutes	G
13	Monthly wristband audit to continue for all ward areas, with exceptions reported to Divisional QSBs.	Ward managers	Ongoing	QSB minutes	G
14	Ongoing assessment of wristbands as part of the Nursing Assessment Performance Framework (NAPF) and 'mini NAPF' processes.	Ward managers	Ongoing	NAPF reports	G
Radiology					
15	Review and update the Customer Care Procedure to include	MR / KW	December 1st 2017	Updated Customer Care	G

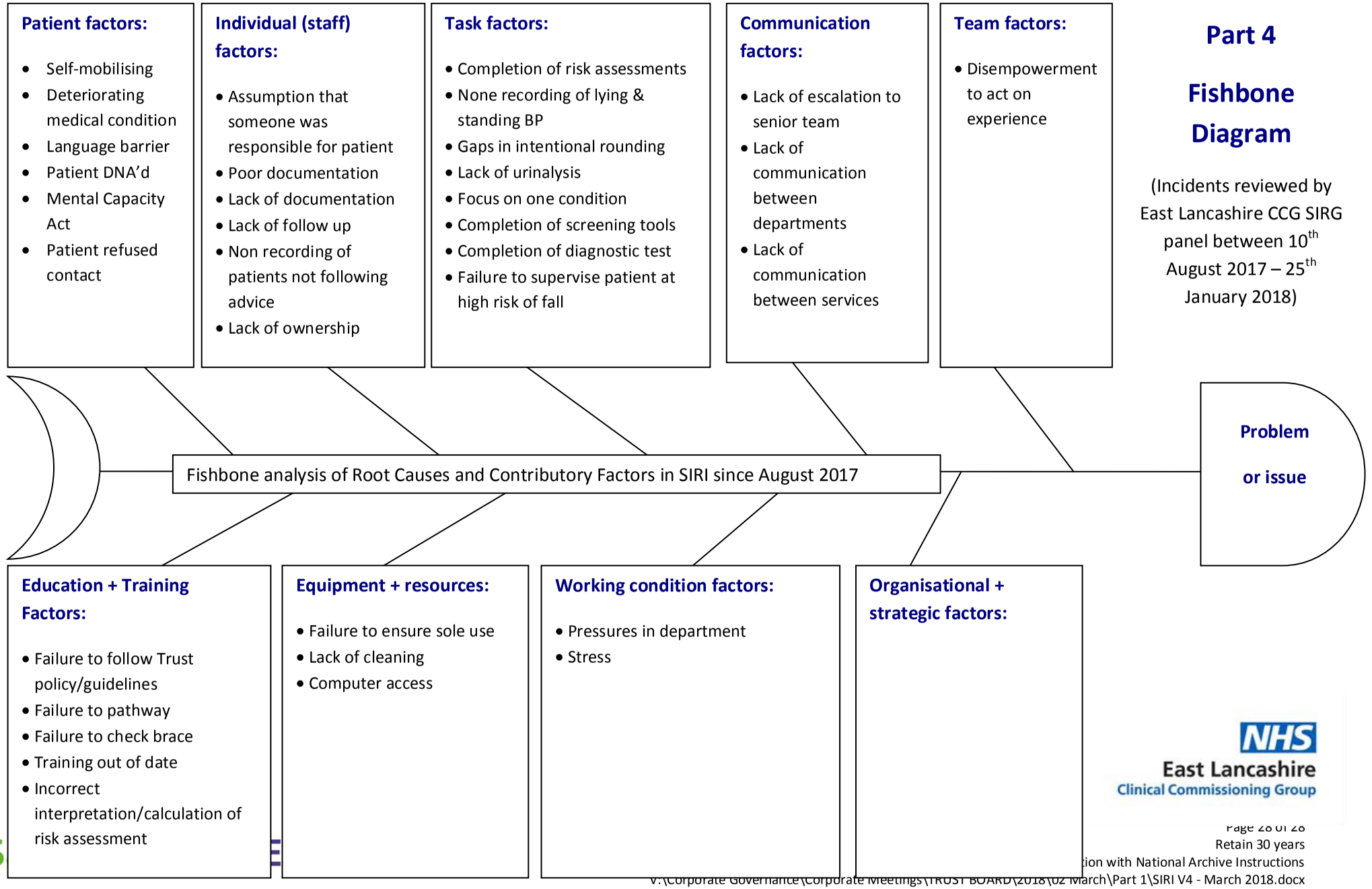
No	Action	By whom	By when	Evidence	RAG status
	reference to inpatient arrivals at reception and the checking of demographics against accompanying notes/records.			Procedure ratified and in use.	
16	Communicate to all clerical staff the updated Customer Care Procedure and provide assurance that staff have read the document.	MR / KW	December 1st 2017	QPulse electronic register	G
17	Devise a formal process for observing and auditing observations of the clerical team, with exception reporting to DCS QSB.	MR / KW	January 15th 2018	Radiology HFC/DCS QSB minutes	G
18	Develop guidance for the use of the WHO Surgical Safety Checklist for Radiological Interventions Only for all interventional radiology procedures	MR / CW / YN	December 1st 2017	Guidance ratified and in use	G
19	Undertake monthly audits of the WHO checklists. Data to be pulled each month for all interventional procedures and 5% to be audited against guidance on a monthly basis until practice has embedded, 6-monthly thereafter. Exceptions to be addressed on an individual basis should guidance not be followed, and then reported to the DCS Quality and Safety Board.	MR / CW / YN	Ongoing from December 1st 2017	DCS QSB minutes	G
20	20a - Provide assurance that the clinician involved in the event has reflected on the incident, and that the incident will be addressed in their annual consultant appraisal.	YN	January 30th 2018	Consultant appraisal documentation. Meeting request in CD and Radiologist diary (9:30am 11th June 2018	G
	20b - Deputy Medical Director Professional Standards to review Consultant Appraisal	RS	July 30th 2018		A
Organisational					
21	Trust guidelines and standard operating procedures pertaining to the transfer of patients to be reviewed and updated to include transfer proforma and portering standard operating procedure to ensure comparability and minimise confusion.	JS/TM	March 30th 2018	Transfer proforma in use on wards. Updated Adult transfer policy reviewed at Policy Council 31/10/18.	G

No	Action	By whom	By when	Evidence	RAG status
				Awaiting paediatric transfer policy review	
	(Follow up actions to check the above) 1. ID Checks by Porter 2. Wristband Audits 3. Radiology WHO Checklist Audit 4. Radiology ID procedure Audit	SC/JP Divisional Director of Nursing (FC SAS ICG)	Feb 2019 Quarterly Monthly Quarterly Quarterly	Assurance of all audits will be provided to Moira Rawcliffe to monitor for a period of 12 months	ONGOING

Part 4

Fishbone Diagram

(Incidents reviewed by East Lancashire CCG SIRG panel between 10th August 2017 – 25th January 2018)



East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

14 March 2018

Item 14

Purpose Information
Action

Title	National Staff Survey Results
Author	Mrs L Barnes, Head of Staff Health Wellbeing & Engagement
Executive sponsor	Mr K Moynes, Director of HR & OD

Summary: Board members are asked to note the 2017 National Staff Survey report and the key findings identified. Members are also asked to support the outlined recommendations and next steps.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce
Related to key risks identified on assurance framework	Recruitment and workforce planning fail to deliver the Trust objective Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by: NA

Executive summary

1. This report summarises the findings from the 2017 NHS Staff Survey for East Lancashire Hospitals NHS Trust (ELHT). Members are asked to note the current findings and support the recommendations detailed within the report.

Introduction

2. The Trust undertook a full census in 2017 and a total of 7788 staff were eligible to complete the survey. 3375 staff returned a completed questionnaire*, giving a response rate of 43% which is average for Acute Trusts in England, and compares with a response rate of 48% in the 2016 survey, which is a decrease on the previous year's response rate.
3. Figure 1 below details the return rate by division/directorate and compares with 2016 response rates.

Figure 1: Return rate by division/directorate

Locality	Response rate 2016	Response rate 2017
Trust Head Quarters	71.7%	63.8% ↓
Diagnostics & Clinical Support	60.8%	61.8% ↑
Estates and Facilities	72.3%	44.4% ↓
Family Care	48.4%	31.1% ↓
Finance and Informatics	83.9%	76.9% ↓
Governance	89.6%	78.4%↓
Integrated Care Group	32.3%	33.8% ↑
Human Resources & Organisational Development	70.8%	72.6% ↑
Research and Development	83.9%	70.6% ↓
Surgical and Anaesthetics Services	34.4%	33.9% ↓
Overall	**48%**	**43%** ↓

* When calculating response rates, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

4. The National Staff Survey report is presented in the form of 32 key findings (see appendix 1 for summary report and appendix 2 for full report). The key findings are presented in the feedback reports under the following nine themes:
   a) Appraisal and support for development.
   b) Equality and diversity.
   c) Errors and incidents.
   d) Health and wellbeing.
   e) Working patterns.
   f) Job satisfaction.
   g) Managers.
   h) Patient care and experience.
   i) Violence, harassment and bullying.
5. As in previous years the key findings are presented in percentage scores and scale summary scores (1 minimum and 5 maximum) unless stated otherwise.

Overall indicator for staff engagement at East Lancashire Hospitals NHS Trust

6. The staff engagement indicator score is 3.86. A score of 1 indicates that staff are poorly engaged (with their work, their team and their Trust) and 5 indicates that staff are highly engaged. The Trusts score of 3.86 is above average when compared with other Acute Trusts (Acute Trust average 3.79). The ELHT score has remained the same from the 2016 Staff Survey result.
7. The overall indicator of staff engagement is calculated using questions that make up key findings 1, 4 and 7.
8. Key finding 1: Staff recommendation of the Trust as a place to work or receive treatment has been maintained when compared with 2016 and the score remains above (better than) average when compared with other Acute Trusts.
9. Key finding 4: Staff motivation at work has been maintained when compared with 2016 and the score remains above (better than) average when compared with other Acute Trusts.

10. Key finding 7: Staff ability to contribute towards improvements at work has been maintained when compared with 2016 and the score remains in the highest (best) 20% of Acute Trusts.

Summary of Key Findings (KF)

11. The East Lancashire Hospitals NHS Trust staff satisfaction responses were in the highest 20% (best) in 16 key findings. This equates to 50% of all key findings being in the highest (best) 20%. This compares to 14 key findings being in the highest 20% in the 2016 survey.

    The 16 key findings in which East Lancashire Hospitals NHS Trusts were in the highest (best) 20% compared to other Acute Trusts are the following:

    a) KF2: Staff satisfaction with the quality of work and care they are able to deliver. Theme: Patient care and experience
    b) KF7: Percentage able to contribute towards improvements at work. Theme Job satisfaction.
    c) KF9: Effective team working. Theme Job satisfaction.
    d) KF11: Percentage appraised in last 12 months. Theme Appraisals and support for development.
    e) KF14: Staff satisfaction with resourcing and support. Theme Job satisfaction.
    f) KF16: Percentage working extra hours. Theme Working patterns.
    g) KF17: Percentage feeling unwell due to work related stress in the last 12 months. Theme Health and Wellbeing.
    h) KF19: Organisation and management interest in and action on health and wellbeing. Theme Health and Wellbeing.
    i) KF22: Percentage experiencing physical violence from patients, relatives or the public in last twelve months. Theme Violence, harassment and bullying.
    j) KF24: Percentage reporting most recent experience of violence. Theme Violence, harassment and bullying.
    k) KF26: Percentage experiencing harassment, bullying or abuse from staff in the last 12 months. Theme Violence, harassment and bullying.
    l) KF27: Percentage reporting most recent experience of harassment, bullying or abuse. Theme Violence, harassment and bullying.
    m) KF29: Percentage reporting errors, near misses or incidents witnessed in last month. Theme Errors and incidents.

n) KF30: Fairness and effectiveness of procedures for reporting errors, near misses and incidents. Theme Errors and incidents.

o) KF31: Staff confidence and security in reporting unsafe clinical practice. Theme Errors and incidents.

p) KF32: Effective use of patient/service user feedback. Theme Patient care and experience.

11. The Trust demonstrated above (better than) average staff satisfaction responses in 12 key findings. This compares to 13 key findings being above average in the 2016 survey. The 13 key findings in which East Lancashire Hospitals NHS Trusts were above (better than) average compared to other Acute Trusts are the following:

a) KF1: Staff recommendation of the organisation as a place to work or receive treatment. Theme Job satisfaction

b) KF3: Percentage agreeing that their role makes a difference to patients/service users. Theme Patient care and experience.

c) KF4: Staff motivation at work. Theme Job satisfaction.

d) KF5: Recognition and value of staff by managers and the organisation. Theme Managers.

e) KF6: Percentage reporting good communication between senior management and staff. Theme Managers.

f) KF8: Staff satisfaction with level of responsibility and involvement. Theme Job satisfaction.

g) KF10: Support from immediate managers. Theme Managers.

h) KF13: Quality of non-mandatory training, learning or development. Theme Appraisals and support for development.

i) KF15: Percentage satisfied with the opportunities for flexible working patterns. Theme Working patterns.

j) KF20: Percentage experiencing discrimination at work in last twelve months. Theme Equality and diversity.

k) KF23: Percentage experiencing physical violence from staff in the last twelve months. Theme Violence, harassment and bullying.

l) KF25: Percentage experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. Theme Violence, harassment and bullying.

12. The Trust demonstrated average staff satisfaction responses in the following 4 areas:

a) KF12: Quality of appraisals. Theme Appraisals and support for development.
b) KF18: Percentage attending work in last 3 months despite feeling unwell because they felt pressure. Theme Health and Wellbeing.
c) KF21: Percentage believing the organisation provides equal opportunities for career progression/promotion. Theme Equality and diversity.
d) KF28: Percentage witnessing potentially harmful errors, near misses or incidents in last month. Theme Errors and incidents.

13. The Trust demonstrated zero key findings worse than average, this compares with 1 key finding in the previous year, (KF21: Percentage believing the organisation provides equal opportunities for career progression or promotion). This demonstrates an improvement of this key finding from worse than average to average over the last year.

14. The Trust staff satisfaction responses were in the lowest (worst) 20% in zero key finding, this compares with 1 key finding in the previous year, (KF11: Percentage appraised in last 12 months). This demonstrates an improvement of this key finding from the lowest (worst) 20% to the highest (best) 20% over the last year.

Workforce Race Equality Standard (WRES) Indicators

15. Four of the WRES indicators are drawn from the national NHS staff survey (see appendix 3). Within the last 2 years BME staff have been engaged in meaningful and sustained ways, to start exploring why there are such differences between the treatment and experiences of white and BME staff – and importantly, how the existing gaps can be closed.

16. In the spirit of continuous learning and transparency, the Trust have held a WRES group, held Big conversations, 1:1 interviews, training, communications which in turn has given confidence to BME colleagues to have their say by voicing their concerns in the staff survey without reprisals.

a) **WRES Metric Five** - KF 25 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. This has remained fairly static from the previous year for both BME and White staff. White and BME staff are equally likely to experience harassment, bullying or abuse from patients, relatives and members of the public in the last 12 months (see appendix 3).

b) **WRES Metric Six -** KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. BME staff remain more likely than white staff to experience harassment, bullying or abuse from other staff this increased by 4% on last year (see appendix 3).

c) **WRES Metric Seven-** KF21. Percentage believing that the Trust provides equal opportunities for career progression or promotion. BME staff remain less likely than white staff to believe that their trust provides equal opportunities for career progression. The gap between white and BME staff on this indicator increased from 13% in 2016 to 19% in 2017 (see appendix 3).

d) **WRES Metric Eight-** Q17B. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues? BME staff remain significantly more likely to experience discrimination at work from colleagues and their managers, the percentage of BME staff reporting that in the last 12 months they have personally experienced discrimination at work from staff increased by 2% (see appendix 3).

External benchmarking

17. Based on benchmarking data from the NHS Staff Survey Co-ordination Centre Guy's and St Thomas NHS Foundation Trust achieved the highest overall engagement score of all combined acute and community trusts with a score of 3.99.

18. Regionally based on the overall engagement score when compared with North West Trusts ELHT is joint 4th out of 25. (see appendix 4)

Recommendations

19. All senior leaders to champion the benefits of appraisals/personal development reviews; and ensure all staff have a quality appraisal/personal development review within the organisation on an annual basis (KF12).

20. Staff that have a high quality appraisal/personal development review and meaningful discussion around their role, objectives, development, talent and career progression will contribute to improve the quality of care for patients.

    Investing time on quality appraisals may also contribute to improvements in perceptions of equal opportunities for career progression and promotion (KF21).

Given the importance and benefits of high quality appraisals for all staff it is recommended that a task and finish group with the key objective of improving the quality of appraisal is initiated.

21. Consider a greater investment in health and wellbeing interventions in 2018/19 as part of the Health and Wellbeing Strategy. Review and recognise our hotspots and those of the wider Integrated Care System. Maximising economies of scale to design an offer which aims to improve the health and wellbeing of our staff population.
22. Design and deliver training and development which enables managers to deliver supportive and compassionate management practices to minimise work related stress and conflict and build resilience in the workforce. Along with encouraging staff and managers to access the opportunities available to improve their leadership skills and management practices.
23. Continued support by the Trust Board / Senior Management to work with the Staff Guardian to embed the culture of speaking out safely. Further promotion of the "if you see something, say something" campaign to raise awareness and assurance to all staff that the Trust encourages and supports staff who raise concerns if they feel safety is at risk.
24. Continued focus and effort to increase visibility and communication from senior managers on all sites at East Lancashire Hospitals NHS Trust for example: back to the floor visits; meet the board events and patient safety walkabouts on sites beyond the Royal Blackburn site.
25. Progress ELHTs Trust wide action plan on the Workforce Race and Disability Equality standards to ensure all staff have equal opportunities and support work towards a more representative and diverse workforce
26. Divisions to understand their divisional data, particularly divisional strengths and areas for improvement. This will be supported by feedback workshops facilitated by the Staff Engagement Team and the Picker Institute scheduled to take place on the 13th and 14th March 2018. It is recommended that as many line managers as possible along with the senior management team of all divisions/directorates attend these sessions.
27. Divisions to utilise this year's Big Conversations specifically focusing on culture and leadership and the Culture and leadership diagnostic as a mechanism to discuss the current culture at ELHT during the discovery phase. Using a participative approach

together with the workforce divisions will formulate divisional action plans to target areas of improvement and celebrate successes.

28. The development of a corporate action plan with supporting Divisional action plans facilitating a joined up approach to addressing the survey findings. Presentation of these plans to the Employee Engagement Sponsor Group in quarter one of 2018/19 with ongoing oversight and monitoring during 2018/19.

29. It is recommended that if there are any directorate teams that were identified as hot spots for poor staff experience in the 2016 National Staff Survey and remain hotspots in the 2017 National Staff Survey, further diagnostics, support and interventions are agreed and implemented.

30. It is recommended that the vast majority of 2018 staff surveys are sent via electronic survey rather than paper survey. This has proven to be more successful in Trusts that have consistently maintained high response rates across their organisations.

Conclusion

31. The staff survey results for 2017 are really positive and pleasingly staff engagement and experience continues to improve despite significant challenges and pressures seen across the organisation.

32. Nationally and regionally East Lancashire Hospitals NHS Trust benchmarks very well with other Acute Trusts and is in the top/best 20 percent for 50% of the key findings, nevertheless we will strive to make further improvements over the coming year.

33. The improvements demonstrated in the 2017 National Staff Survey along with improvements seen in the quarterly Staff Friends and Family Test are indicators that the long term approach that the organisation committed to is having the desired effect throughout the Trust. However there is still room for improvement and enhancing communication and engagement continues to remain a key improvement priority in 2018. The culture and leadership programme that the board has committed to will further enhance and enable our commitment to move from good to outstanding with staff engagement at the heart of ELHTs progress.

Next steps

34. Dates have now been circulated to provide sessions to support Divisions in developing a ‘bespoke’ action plan led by the Staff Engagement Team and The

Picker Institute via the Staff Survey Workshops being held on the 13th and 14th March 2017.

35. Culture and leadership will be the focus for the 2018 round of 'Big Conversations' commencing in March through to May of this year.

Once the Divisional Staff Survey action plans have been formulated they will be a standing agenda item on the Divisional performance meetings and also monitored via the Employee Engagement Sponsor Group.

36. The findings from the discovery phase of the Culture and Leadership programme will be presented at the September Trust board following the implementation of the 6 diagnostic tools from the programme.

2017 National NHS staff survey

Brief summary of results from East Lancashire Hospitals NHS Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2017 national NHS staff survey conducted in East Lancashire Hospitals NHS Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured thematically so that Key Findings are grouped appropriately. There are nine themes within this report:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

Please note, two Key Findings have had their calculation changed and there have been minor changes to the benchmarking groups for social enterprises since last year. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2017 survey results for East Lancashire Hospitals NHS Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

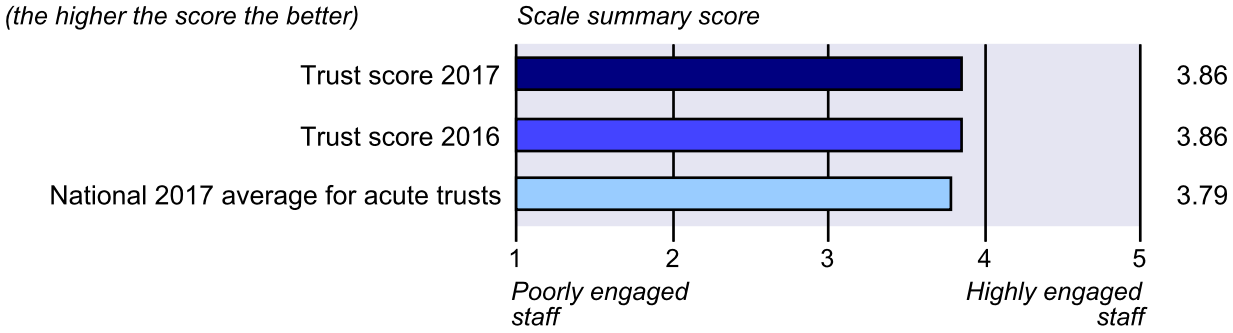
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	80%	76%	80%
Q21b	"My organisation acts on concerns raised by patients / service users"	77%	73%	78%
Q21c	"I would recommend my organisation as a place to work"	66%	61%	65%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	72%	71%	70%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.83	3.76	3.82

2. Overall indicator of staff engagement for East Lancashire Hospitals NHS Trust

The figure below shows how East Lancashire Hospitals NHS Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.86 was above (better than) average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how East Lancashire Hospitals NHS Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2016 survey.

	Change since 2016 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	• No change	✓ Above (better than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	• No change	✓ Above (better than) average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	✓ Above (better than) average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	✓ Highest (best) 20%

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

3. Summary of 2017 Key Findings for East Lancashire Hospitals NHS Trust

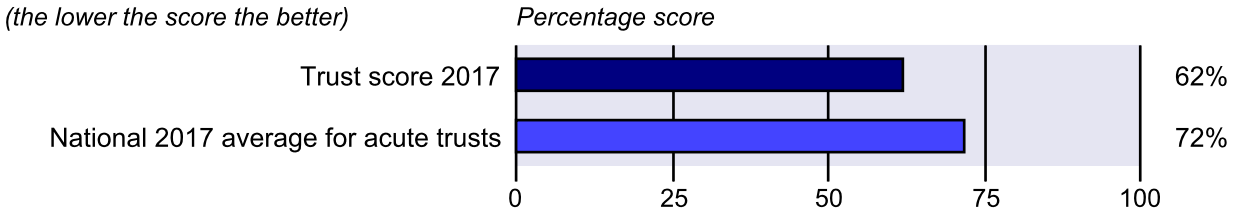
3.1 Top and Bottom Ranking Scores

This page highlights the five Key Findings for which East Lancashire Hospitals NHS Trust compares most favourably with other acute trusts in England.

TOP FIVE RANKING SCORES

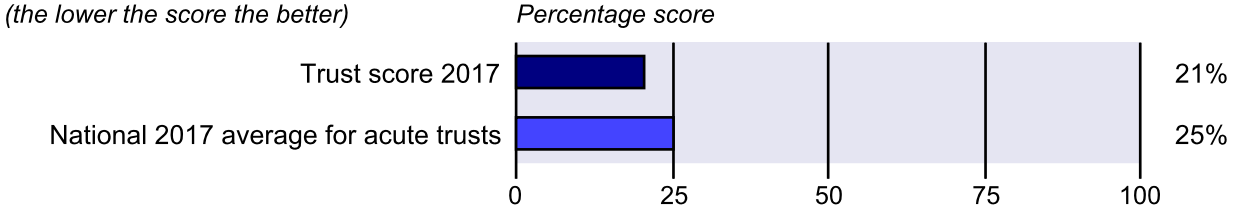
✓KF16. Percentage of staff working extra hours

(the lower the score the better)



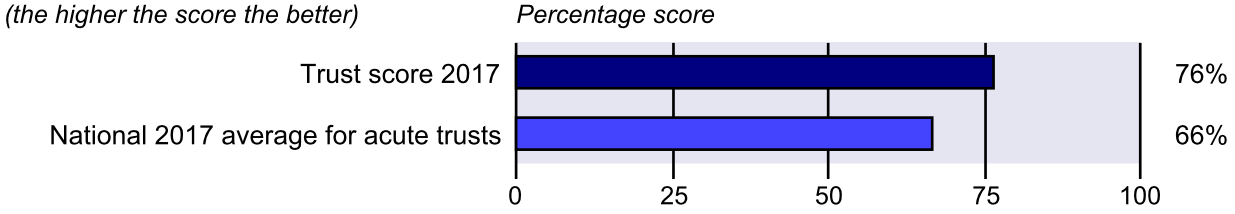
✓KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



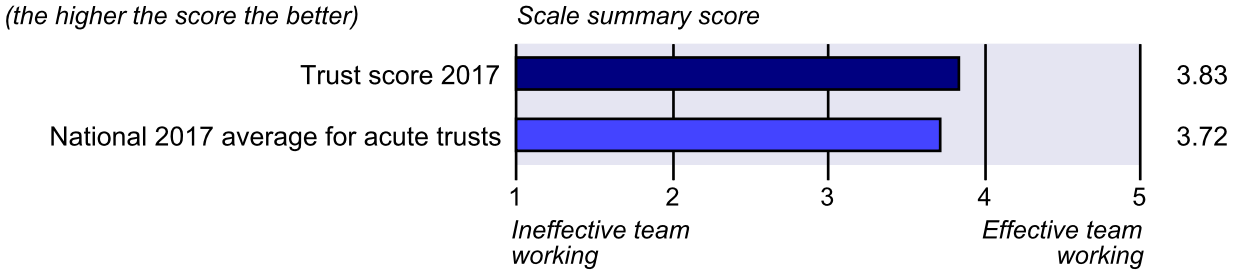
✓KF24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



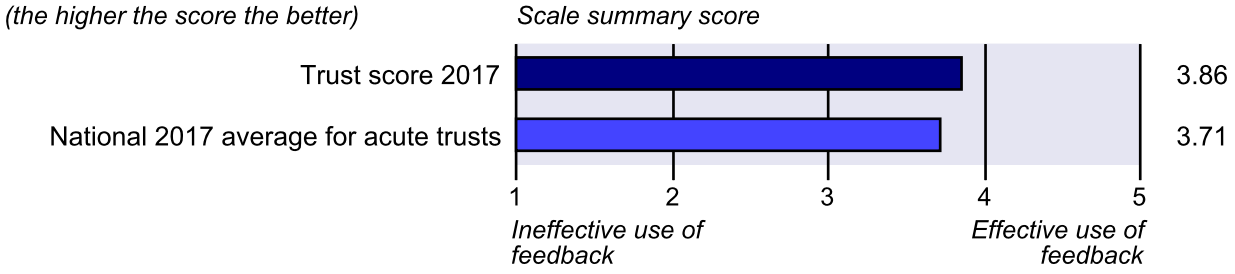
✓KF9. Effective team working

(the higher the score the better)



✓KF32. Effective use of patient / service user feedback

(the higher the score the better)



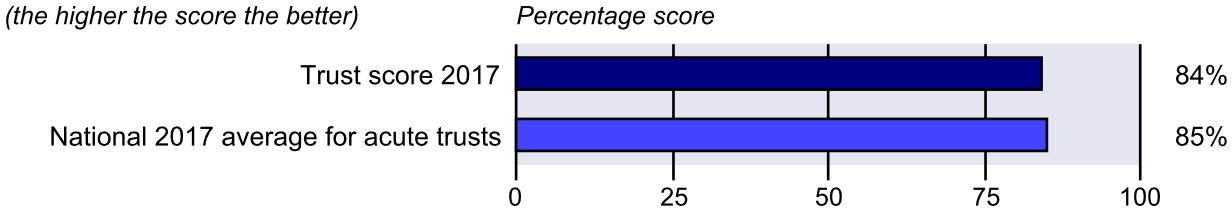
For each of the 32 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 93 (the bottom ranking score). East Lancashire Hospitals NHS Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the four Key Findings for which East Lancashire Hospitals NHS Trust compares least favourably with other acute trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FOUR RANKING SCORES

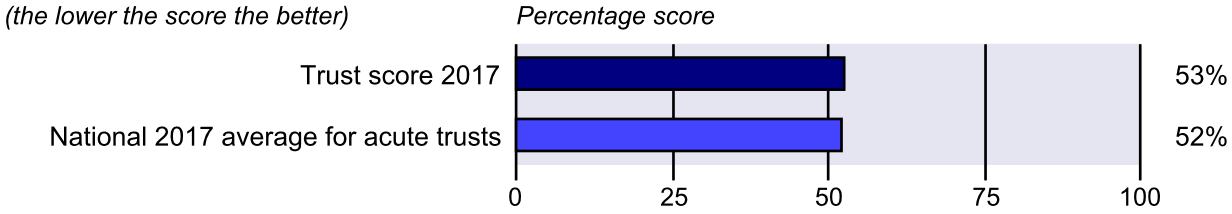
! KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

(the higher the score the better)



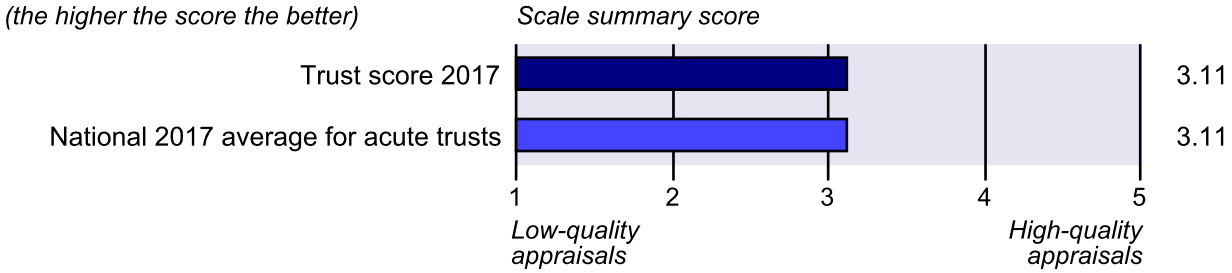
! KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



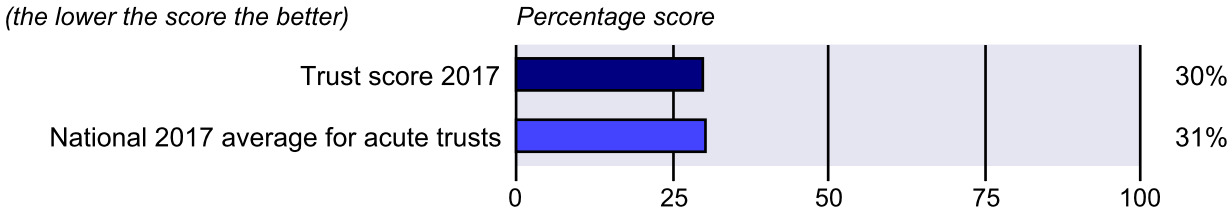
! KF12. Quality of appraisals

(the higher the score the better)



! KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



For each of the 32 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 93 (the bottom ranking score). East Lancashire Hospitals NHS Trust's four lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 93. Further details about this can be found in the document ***Making sense of your staff survey data***.

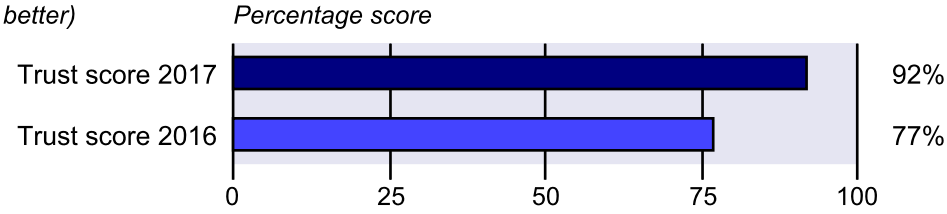
3.2 Largest Local Changes since the 2016 Survey

This page highlights the three Key Findings where staff experiences have improved at East Lancashire Hospitals NHS Trust since the 2016 survey.

WHERE STAFF EXPERIENCE HAS IMPROVED

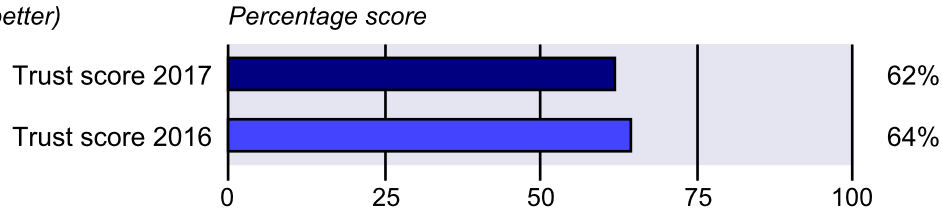
✓KF11. Percentage of staff appraised in last 12 months

(the higher the score the better)



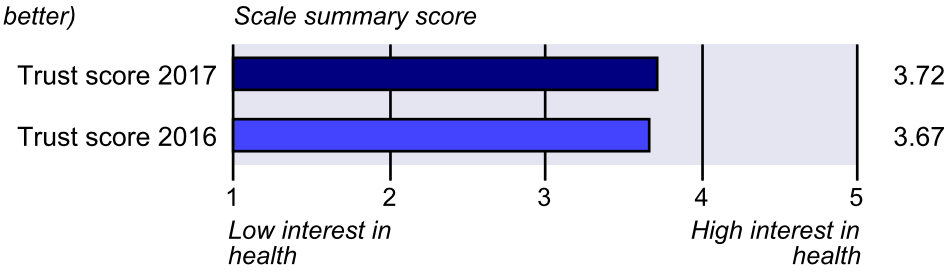
✓KF16. Percentage of staff working extra hours

(the lower the score the better)



✓KF19. Organisation and management interest in and action on health and wellbeing

(the higher the score the better)



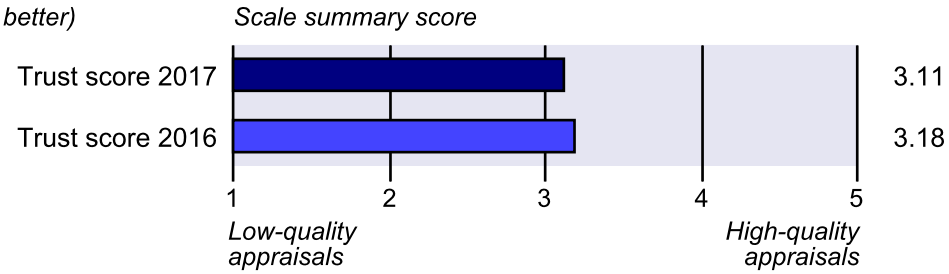
Because the Key Findings vary considerably in terms of subject matter and format (e.g. some are percentage scores, others are scale scores), a straightforward comparison of score changes is not the appropriate way to establish which Key Findings have improved the most. Rather, the extent of 2016-2017 change for each Key Finding has been measured in relation to the national variation for that Key Finding. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the Key Finding that has deteriorated at East Lancashire Hospitals NHS Trust since the 2016 survey. It is suggested that this might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

! KF12. Quality of appraisals

(the higher the score the better)



Because the Key Findings vary considerably in terms of subject matter and format (e.g. some are percentage scores, others are scale scores), a straightforward comparison of score changes is not the appropriate way to establish which Key Findings have deteriorated the most. Rather, the extent of 2016-2017 change for each Key Finding has been measured in relation to the national variation for that Key Finding. Further details about this can be found in the document ***Making sense of your staff survey data***.

3.3. Summary of all Key Findings for East Lancashire Hospitals NHS Trust

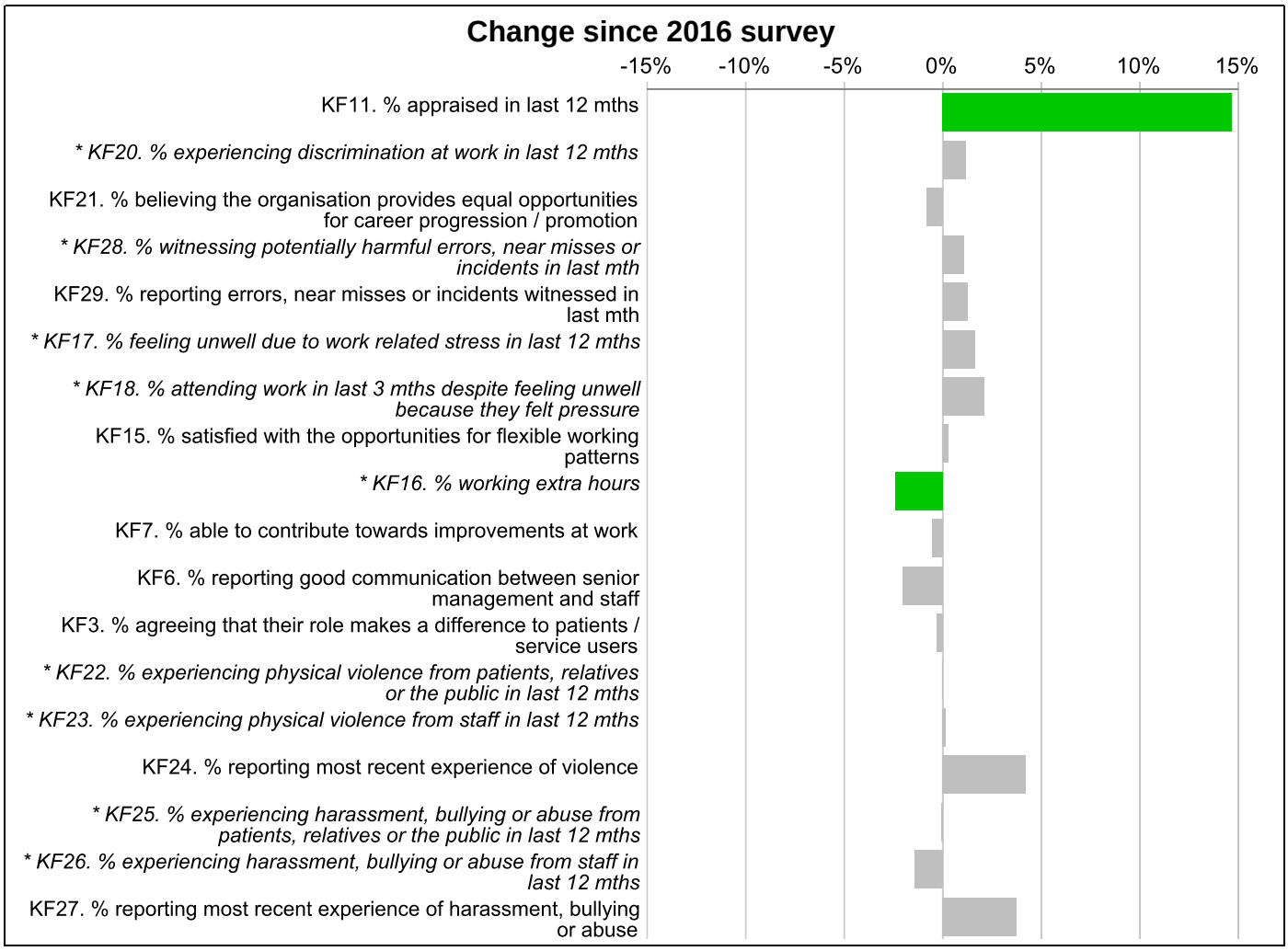
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2016 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



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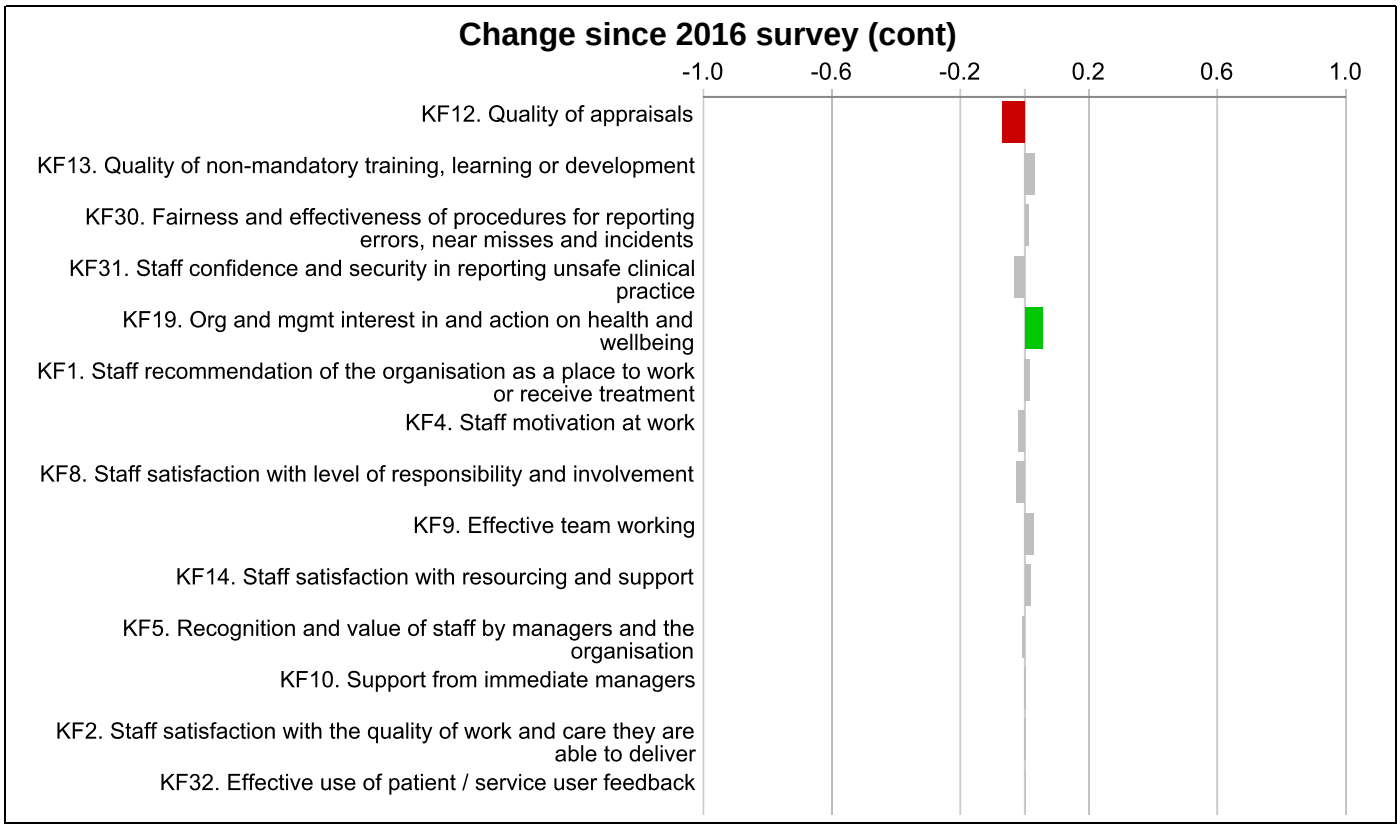


3.3. Summary of all Key Findings for East Lancashire Hospitals NHS Trust

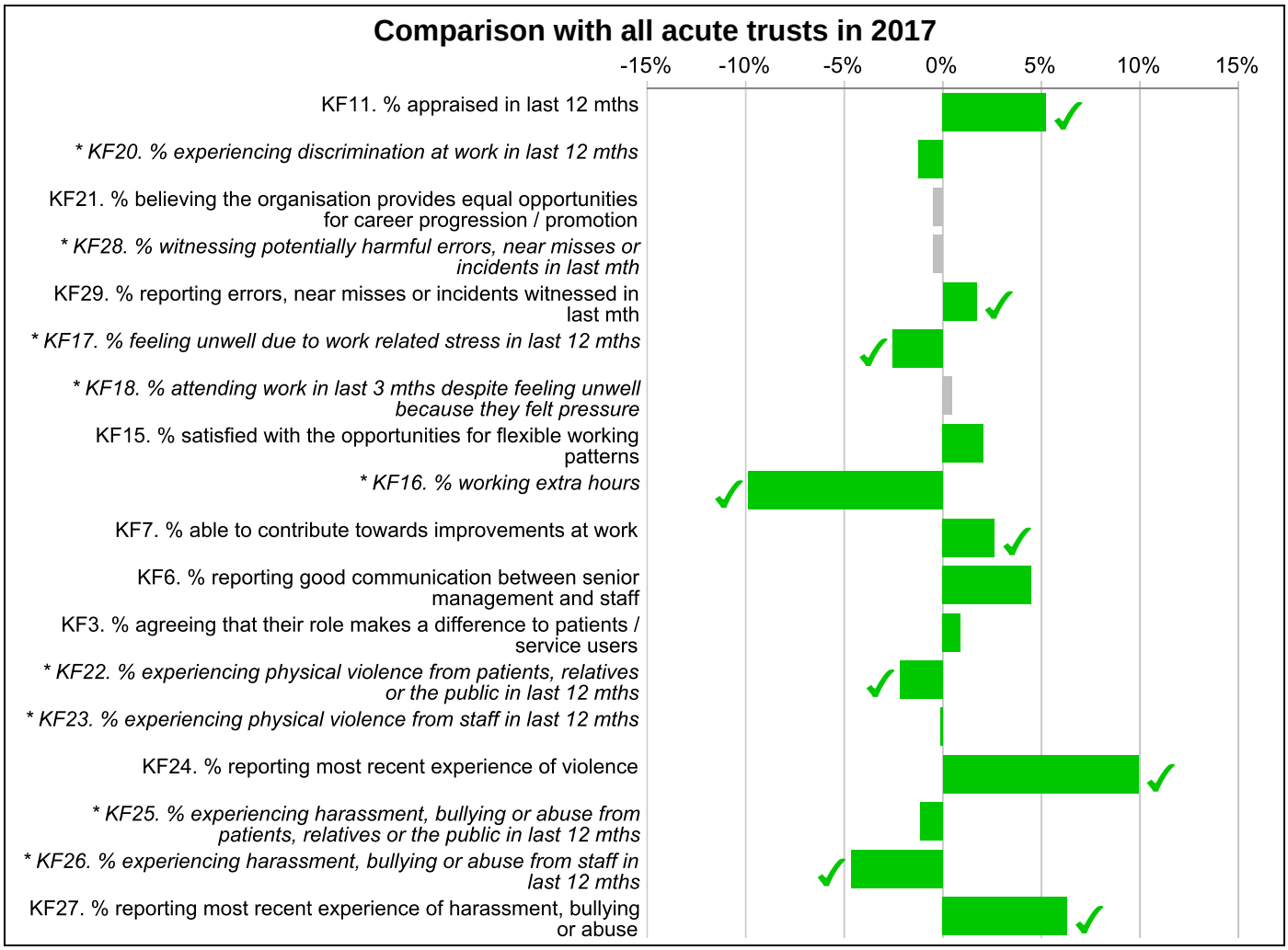
KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



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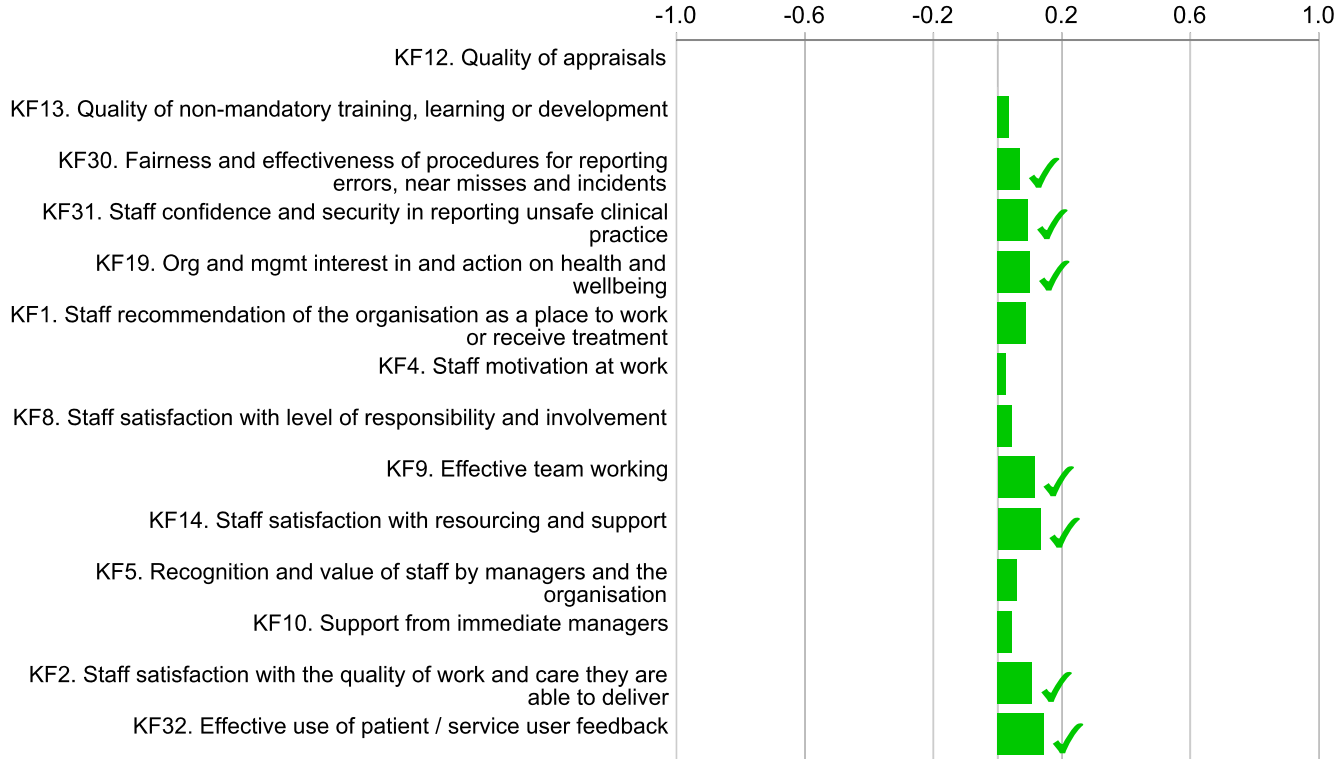
Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all acute trusts in 2017 (cont)



3.4. Summary of all Key Findings for East Lancashire Hospitals NHS Trust

KEY

✓ Green = Positive finding, e.g. in the best 20% of acute trusts, better than average, better than 2016.

! Red = Negative finding, e.g. in the worst 20% of acute trusts, worse than average, worse than 2016.

'Change since 2016 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2016 survey.

-- No comparison to the 2016 data is possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2016 survey	Ranking, compared with all acute trusts in 2017
Appraisals & support for development		
KF11. % appraised in last 12 mths	✓ Increase (better than 16)	✓ Highest (best) 20%
KF12. Quality of appraisals	! Decrease (worse than 16)	• Average
KF13. Quality of non-mandatory training, learning or development	• No change	✓ Above (better than) average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	✓ Below (better than) average
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	• Average
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	• Average
KF29. % reporting errors, near misses or incidents witnessed in last mth	• No change	✓ Highest (best) 20%
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	• No change	✓ Highest (best) 20%
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	✓ Highest (best) 20%
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	• No change	✓ Lowest (best) 20%
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	• No change	• Average
KF19. Org and mgmt interest in and action on health and wellbeing	✓ Increase (better than 16)	✓ Highest (best) 20%
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	✓ Above (better than) average
* *KF16. % working extra hours*	✓ Decrease (better than 16)	✓ Lowest (best) 20%

3.4. Summary of all Key Findings for East Lancashire Hospitals NHS Trust (cont)

	Change since 2016 survey	Ranking, compared with all acute trusts in 2017
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	✓ Above (better than) average
KF4. Staff motivation at work	• No change	✓ Above (better than) average
KF7. % able to contribute towards improvements at work	• No change	✓ Highest (best) 20%
KF8. Staff satisfaction with level of responsibility and involvement	• No change	✓ Above (better than) average
KF9. Effective team working	• No change	✓ Highest (best) 20%
KF14. Staff satisfaction with resourcing and support	• No change	✓ Highest (best) 20%
Managers		
KF5. Recognition and value of staff by managers and the organisation	• No change	✓ Above (better than) average
KF6. % reporting good communication between senior management and staff	• No change	✓ Above (better than) average
KF10. Support from immediate managers	• No change	✓ Above (better than) average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	✓ Highest (best) 20%
KF3. % agreeing that their role makes a difference to patients / service users	• No change	✓ Above (better than) average
KF32. Effective use of patient / service user feedback	• No change	✓ Highest (best) 20%
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	✓ Lowest (best) 20%
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	✓ Below (better than) average
KF24. % reporting most recent experience of violence	• No change	✓ Highest (best) 20%
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	✓ Below (better than) average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	✓ Lowest (best) 20%
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	✓ Highest (best) 20%

4. Key Findings for East Lancashire Hospitals NHS Trust

East Lancashire Hospitals NHS Trust had 3375 staff take part in this survey. This is a response rate of 43%[1] which is average for acute trusts in England (44%), and compares with a response rate of 48% in this trust in the 2016 survey.

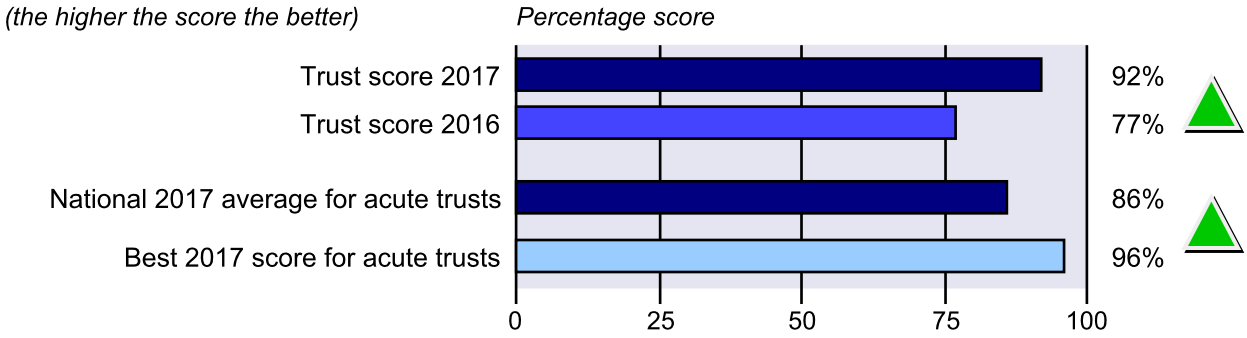
This section presents each of the 32 Key Findings, using data from the trust's 2017 survey, and compares these to other acute trusts in England and to the trust's performance in the 2016 survey. The findings are arranged under nine themes: appraisals and support for development, equality and diversity, errors and incidents, health and wellbeing, working patterns, job satisfaction, managers, patient care and experience , and violence, harassment and bullying.

Positive findings are indicated with a green arrow (e.g. where the trust is in the best 20% of trusts, or where the score has improved since 2016). Negative findings are highlighted with a red arrow (e.g. where the trust's score is in the worst 20% of trusts, or where the score is not as good as 2016). An equals sign indicates that there has been no change.

Appraisals & support for development

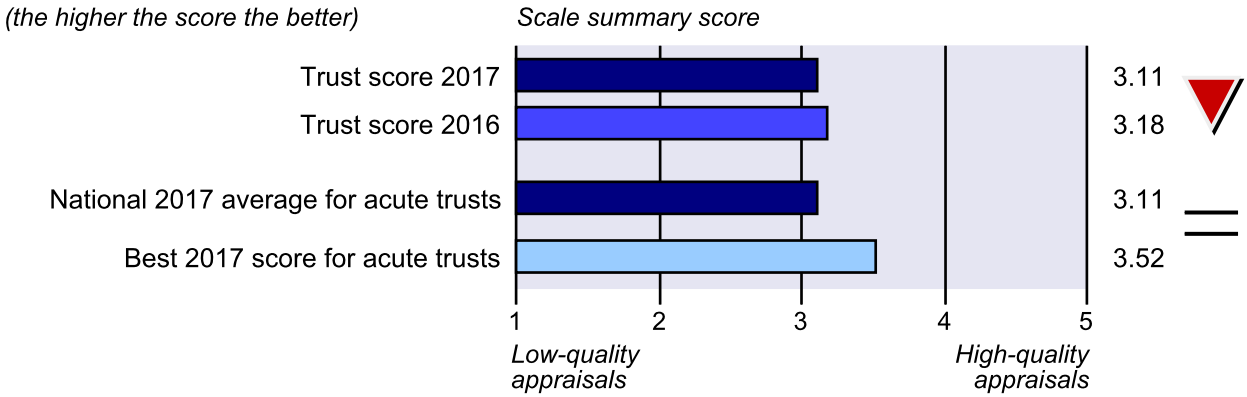
KEY FINDING 11. Percentage of staff appraised in last 12 months

(the higher the score the better)



KEY FINDING 12. Quality of appraisals

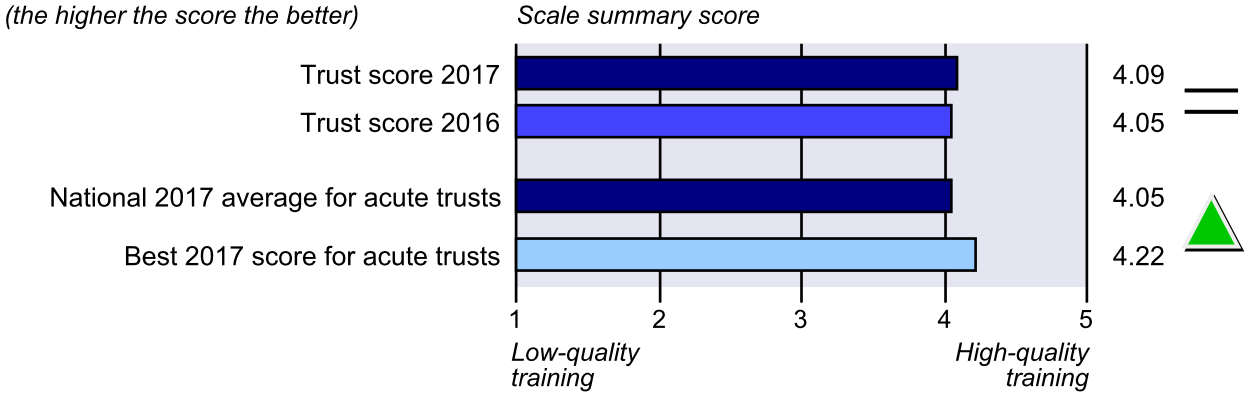
(the higher the score the better)



[1]Questionnaires were sent to all 7788 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

KEY FINDING 13. Quality of non-mandatory training, learning or development

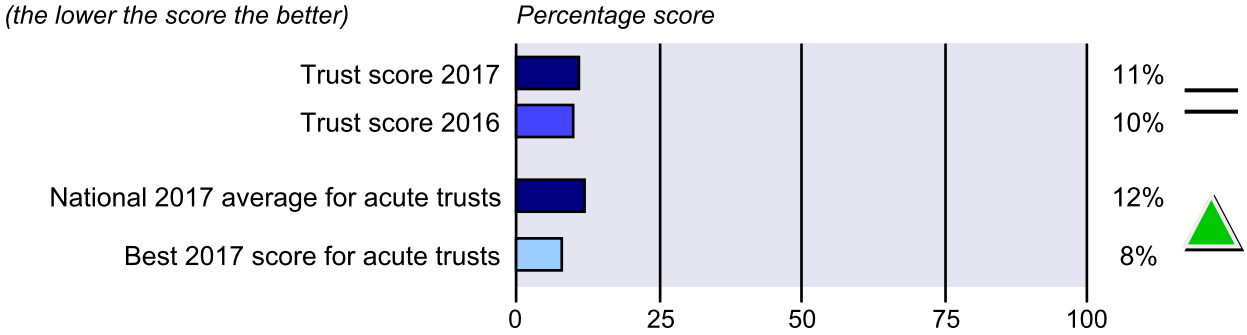
(the higher the score the better)



Equality & diversity

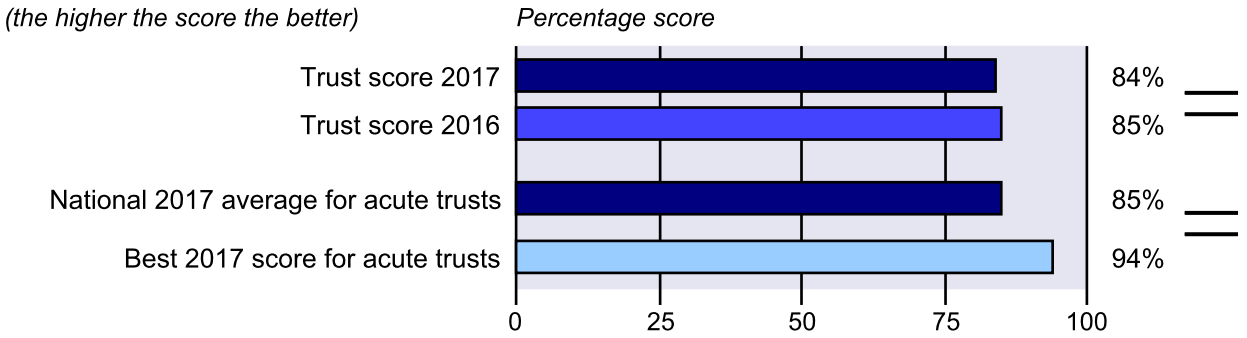
KEY FINDING 20. Percentage of staff experiencing discrimination at work in the last 12 months

(the lower the score the better)



KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

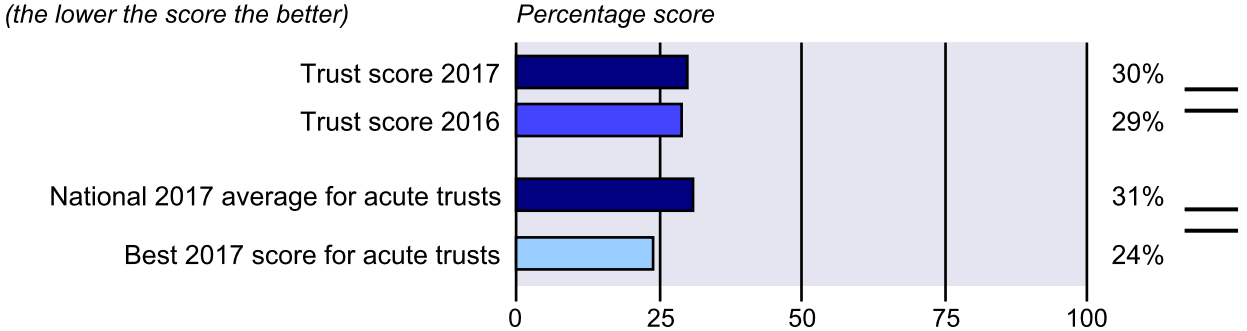
(the higher the score the better)



Errors & incidents

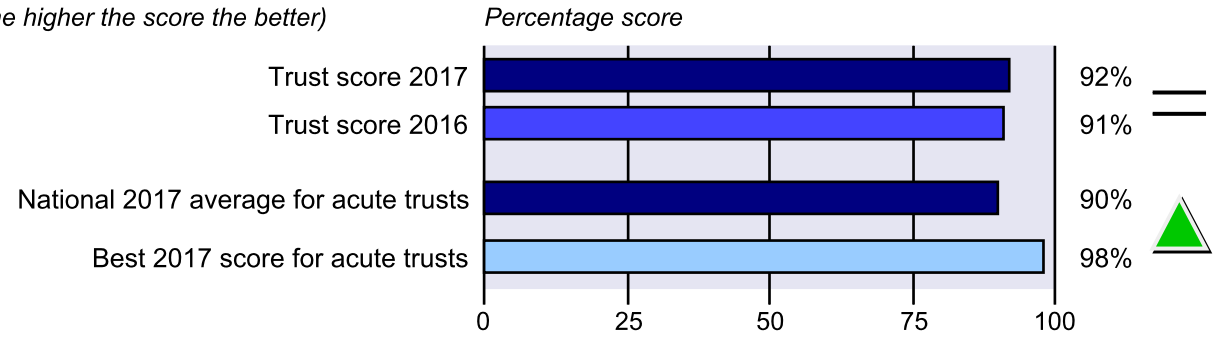
KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



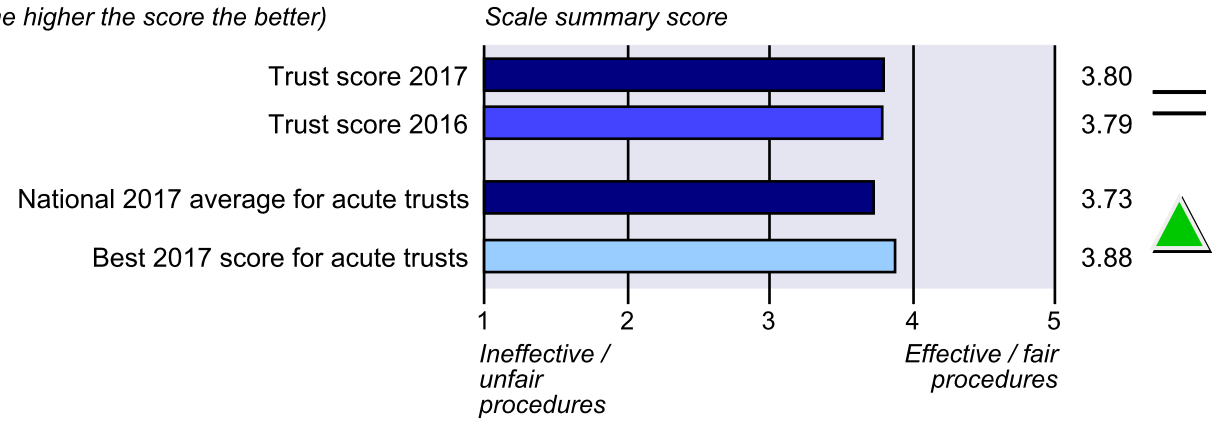
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



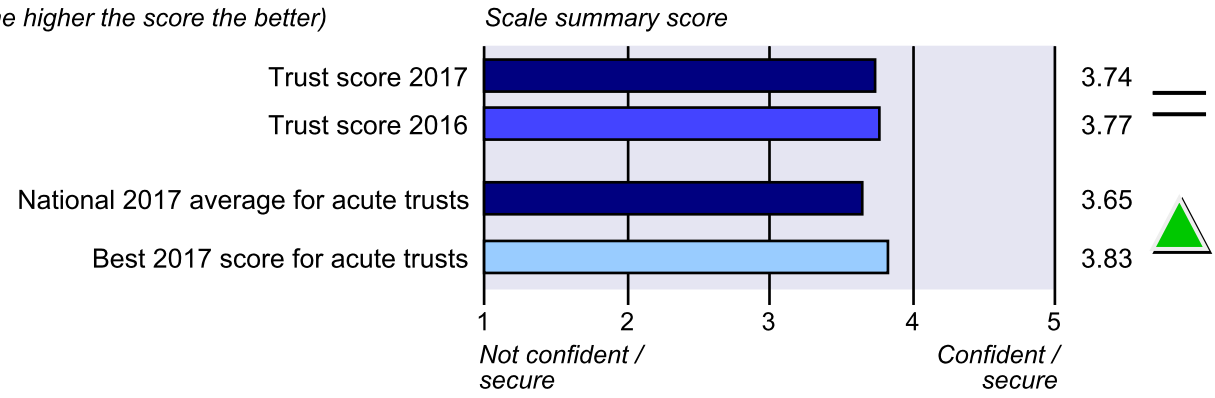
KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice

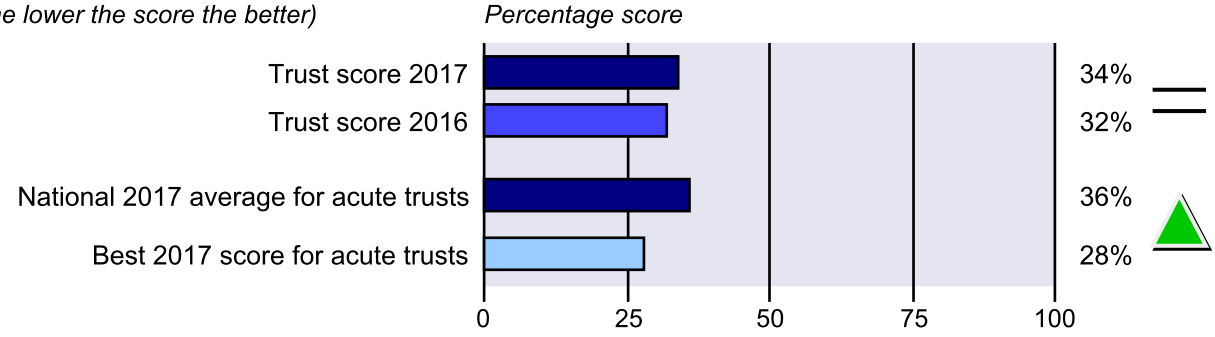
(the higher the score the better)



Health and wellbeing

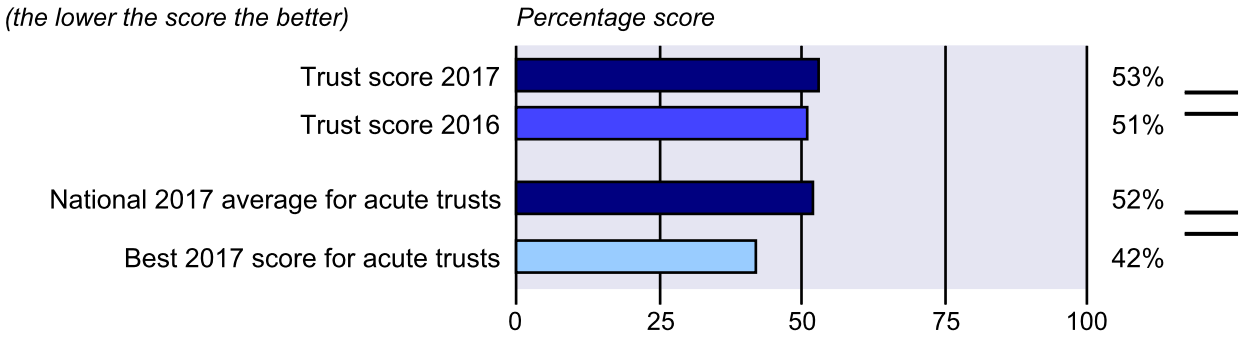
KEY FINDING 17. Percentage of staff feeling unwell due to work related stress in the last 12 months

(the lower the score the better)



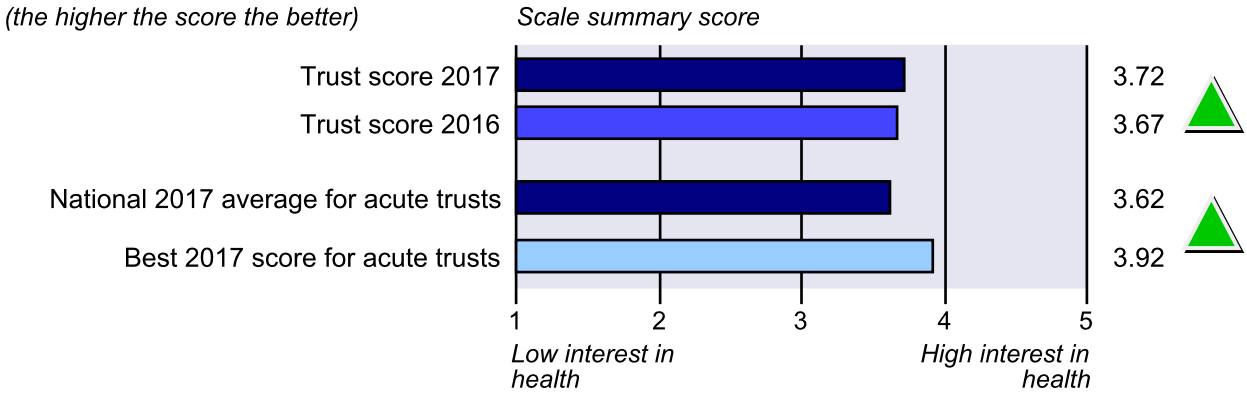
KEY FINDING 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

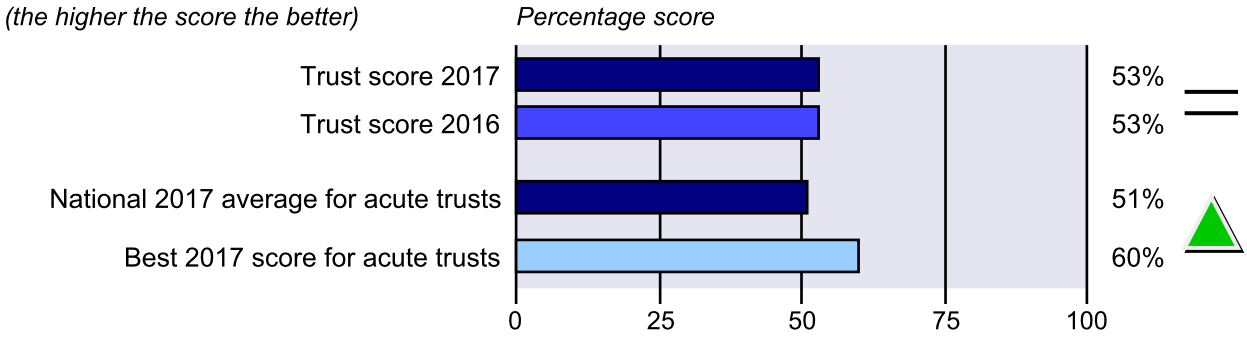
(the higher the score the better)



Working patterns

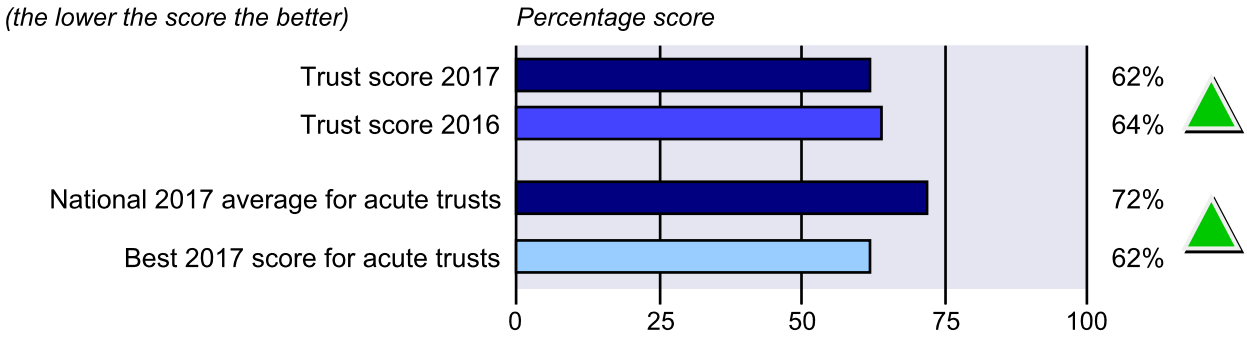
KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns

(the higher the score the better)



KEY FINDING 16. Percentage of staff working extra hours

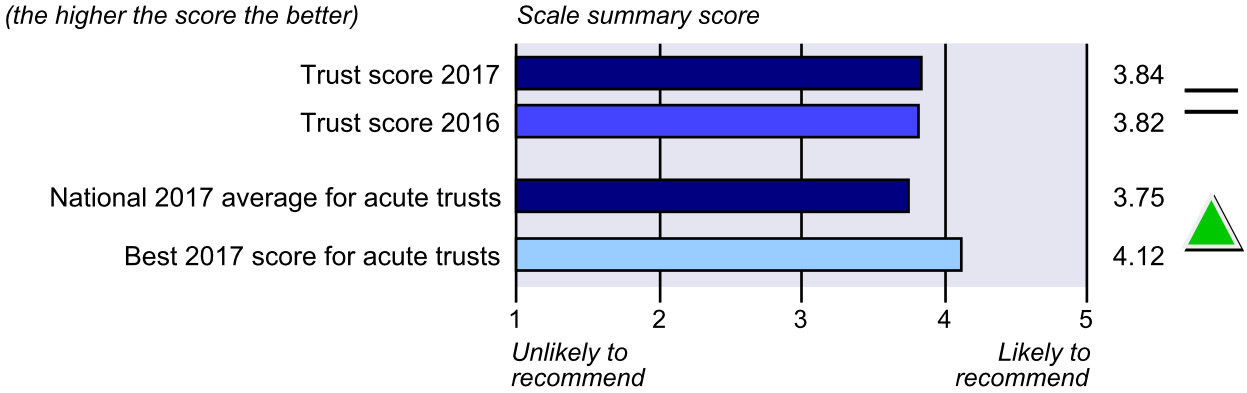
(the lower the score the better)



Job satisfaction

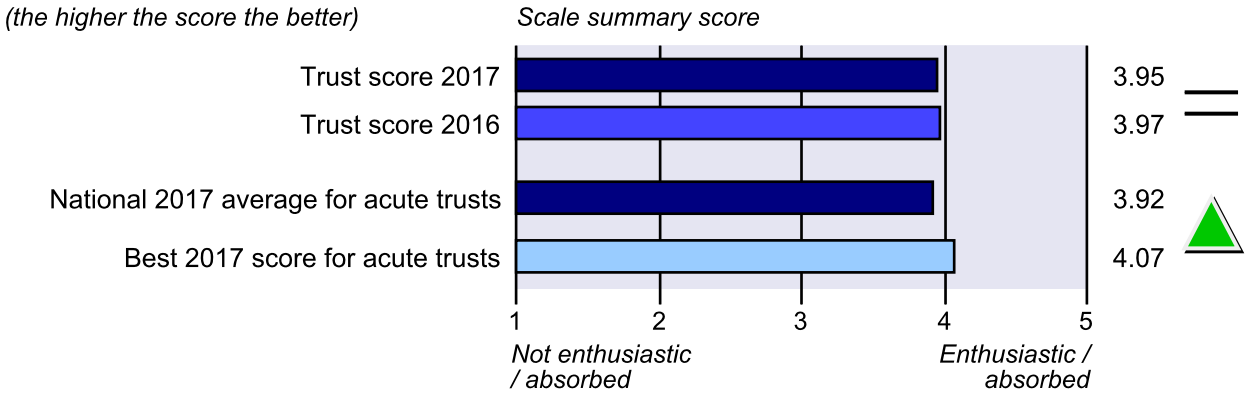
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



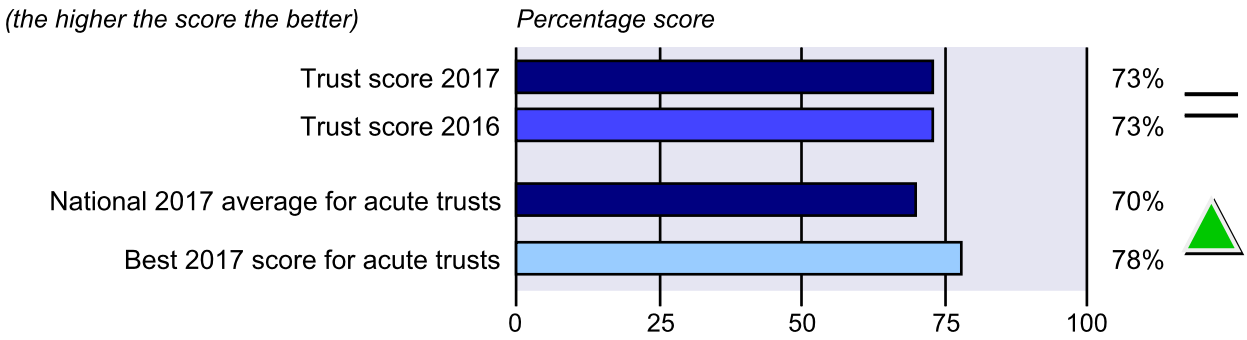
KEY FINDING 4. Staff motivation at work

(the higher the score the better)



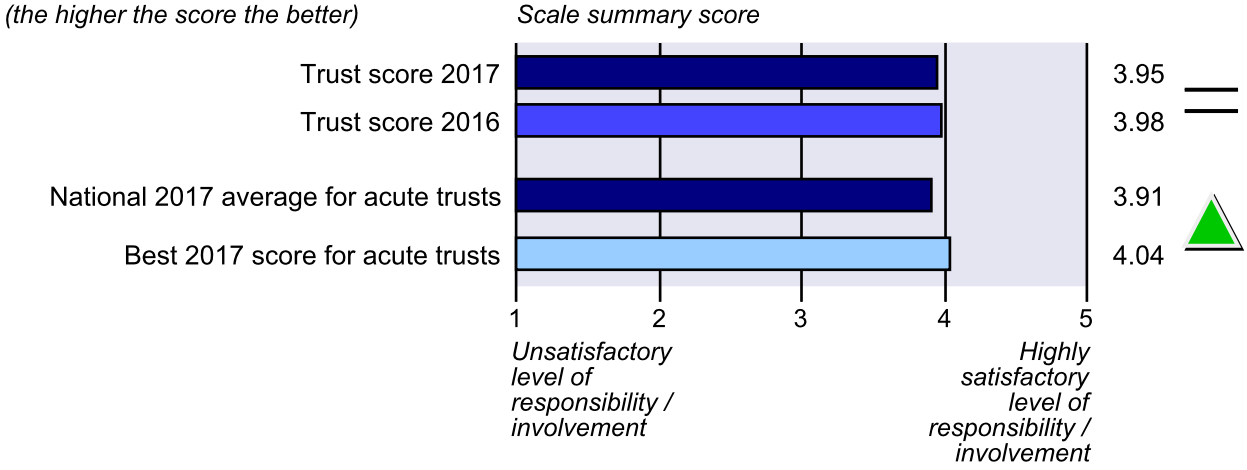
KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)



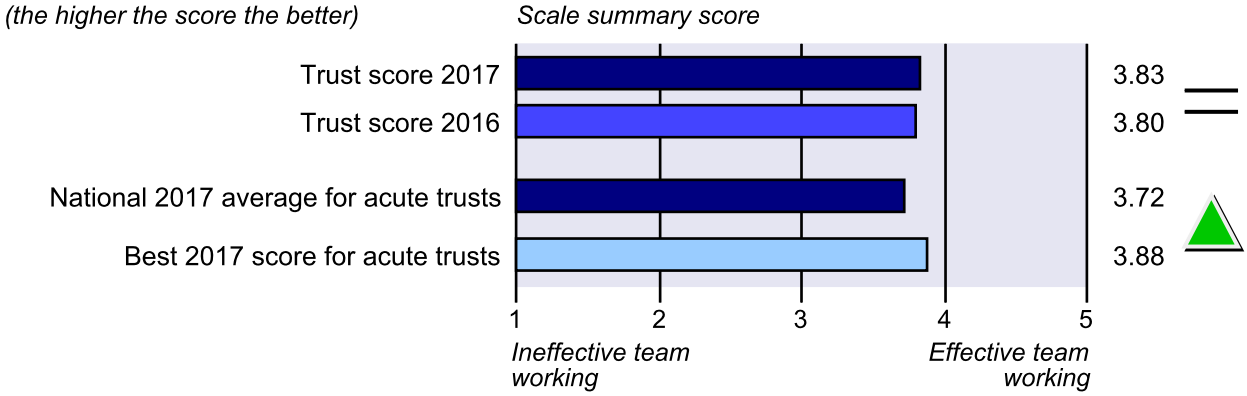
KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

(the higher the score the better)



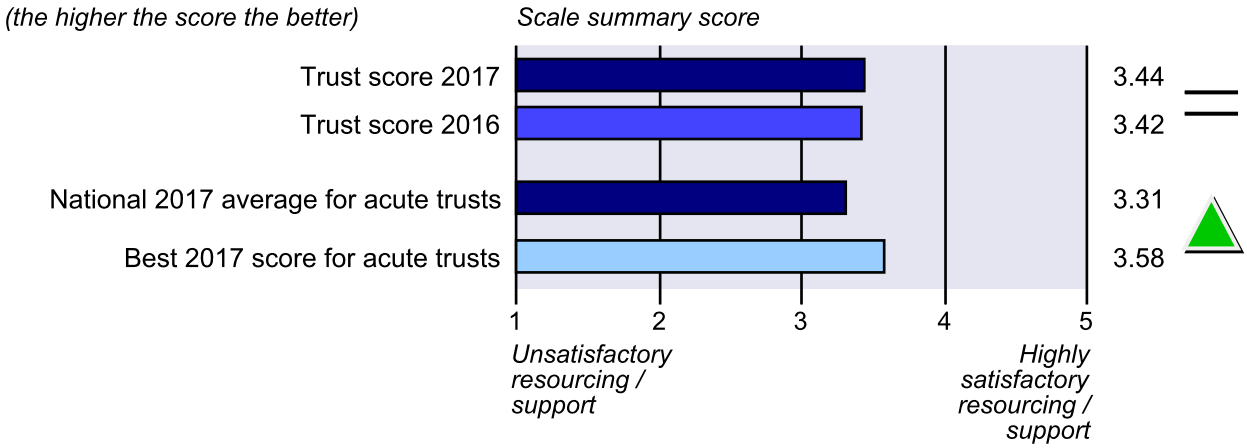
KEY FINDING 9. Effective team working

(the higher the score the better)



KEY FINDING 14. Staff satisfaction with resourcing and support

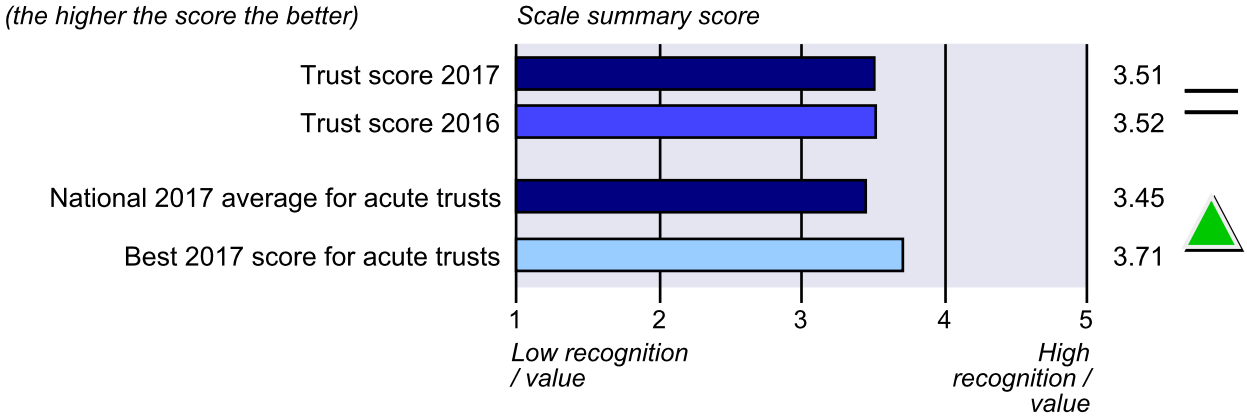
(the higher the score the better)



Managers

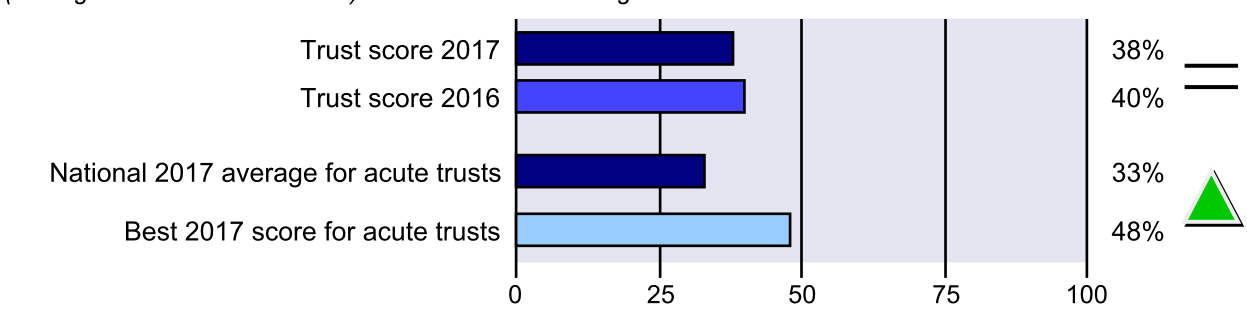
KEY FINDING 5. Recognition and value of staff by managers and the organisation

(the higher the score the better)



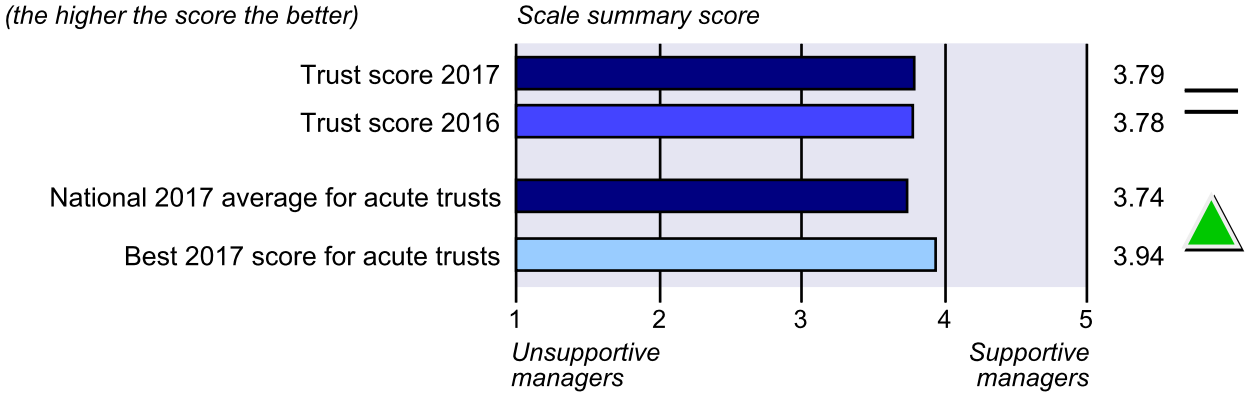
KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



KEY FINDING 10. Support from immediate managers

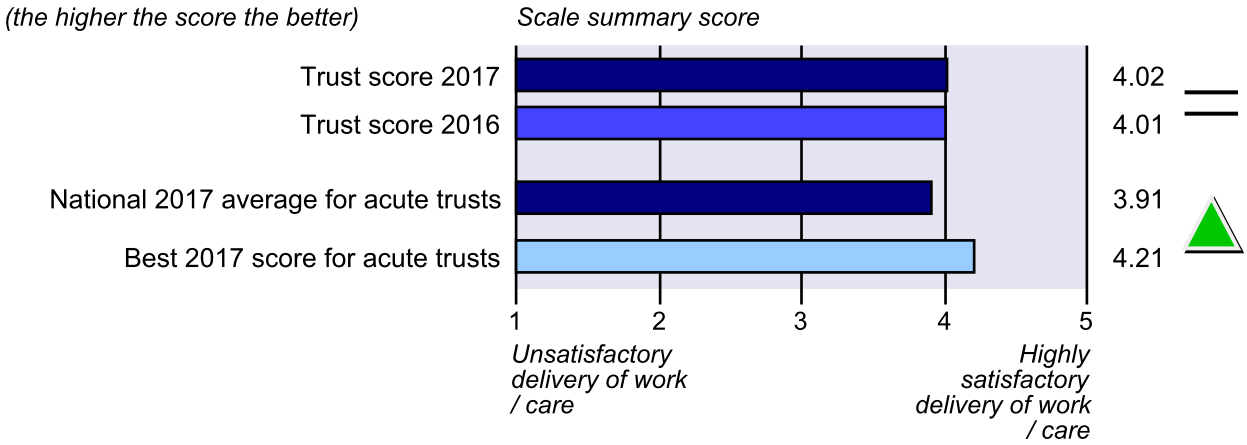
(the higher the score the better)



Patient care & experience

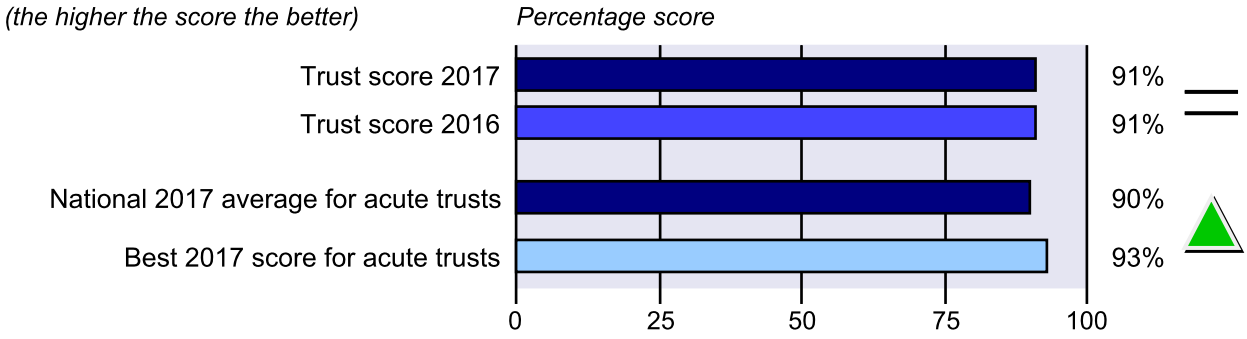
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver

(the higher the score the better)



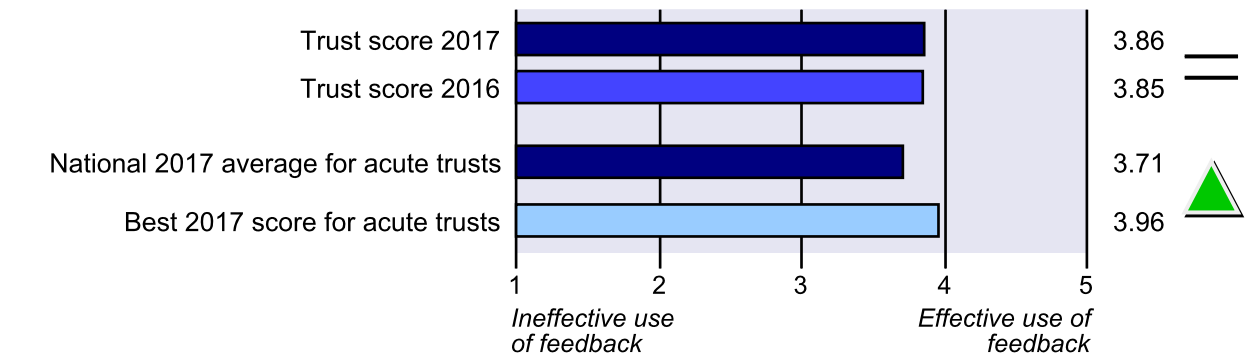
KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



KEY FINDING 32. Effective use of patient / service user feedback

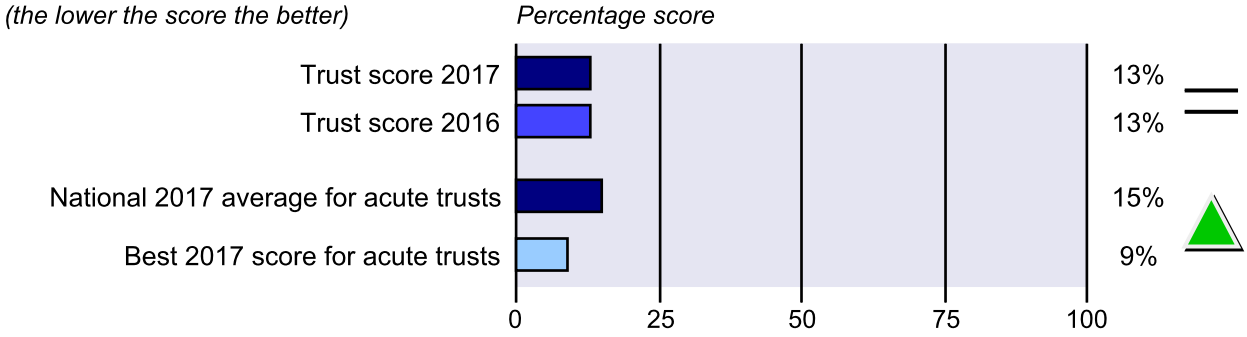
(the higher the score the better)



Violence, harassment & bullying

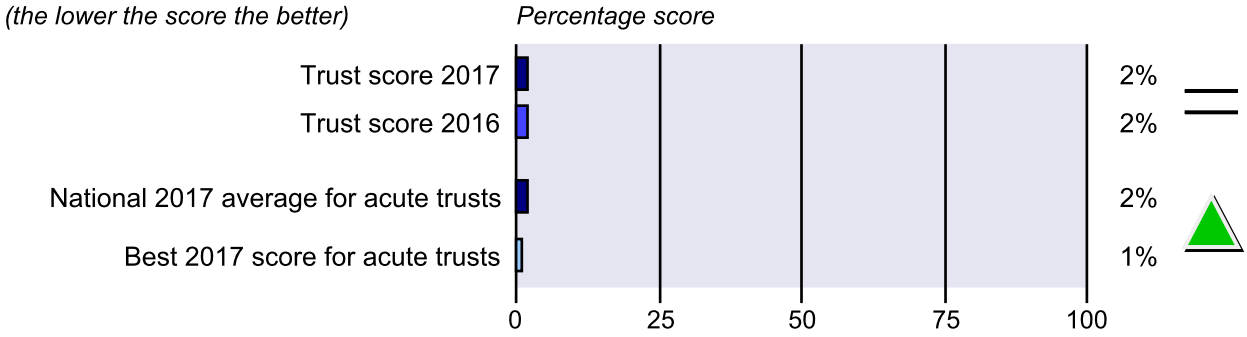
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



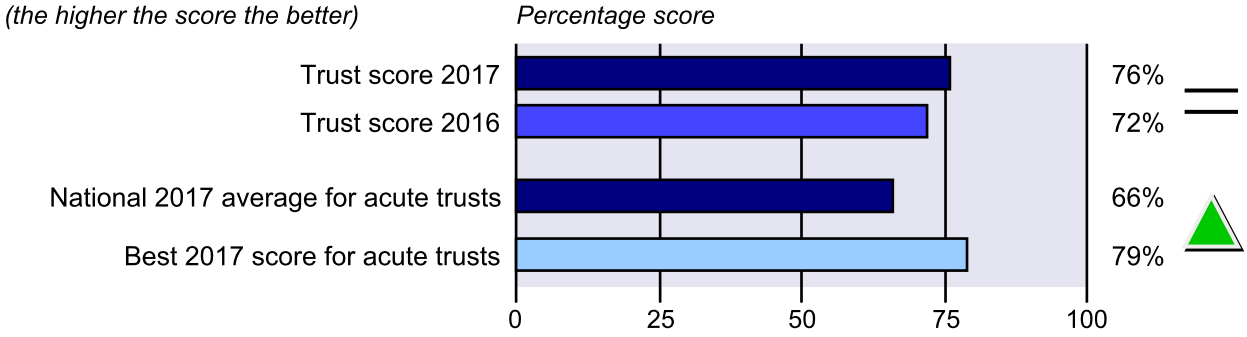
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



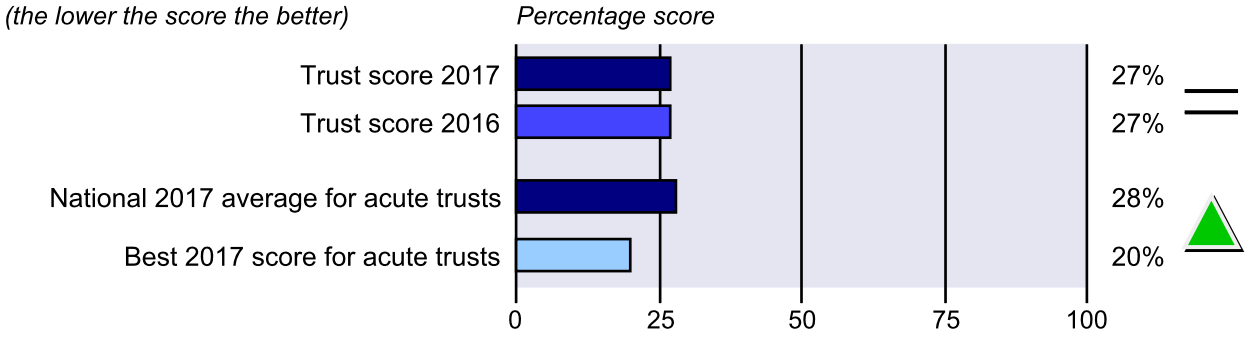
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



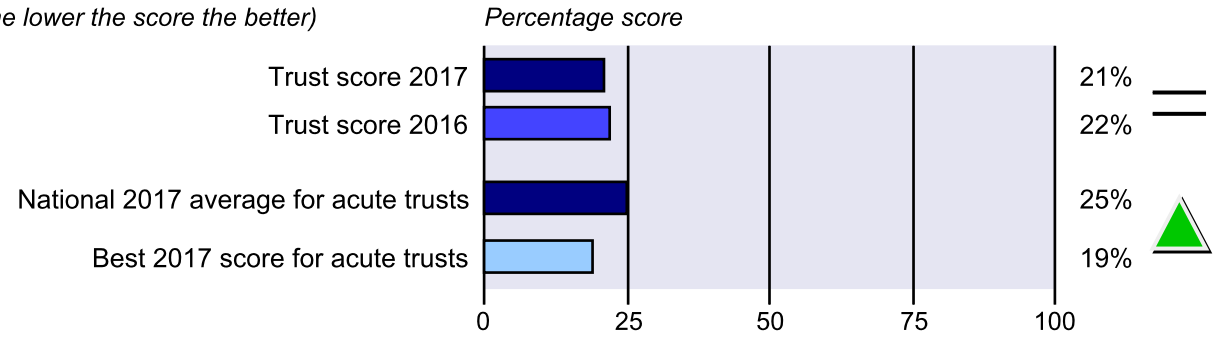
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



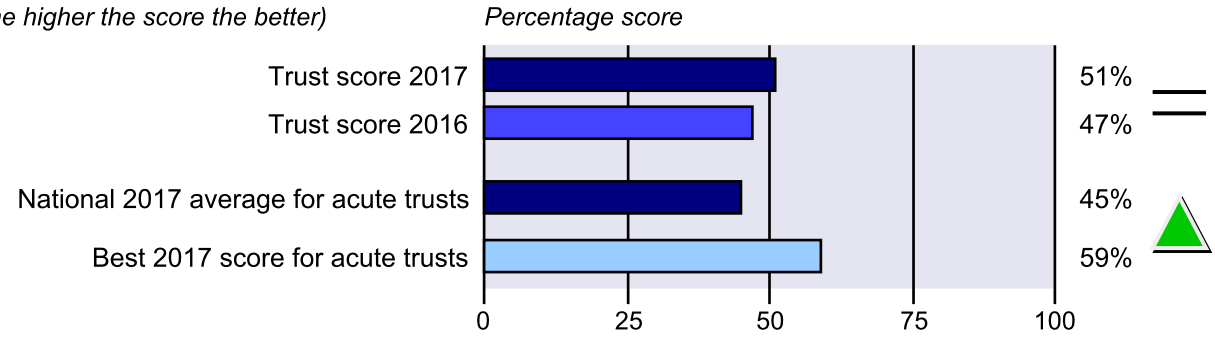
KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



2017 National NHS staff survey

Results from East Lancashire Hospitals NHS Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2017 national NHS staff survey conducted in East Lancashire Hospitals NHS Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3, 4, 6 and 7 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

In section 5 of this report, the data required for the Workforce Race Equality Standard (WRES) is presented.

These sections of the report have been structured thematically so that Key Findings are grouped appropriately. There are nine themes within this report:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

Please note, two Key Findings have had their calculation changed and there have been minor changes to the benchmarking groups for social enterprises since last year. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

Responses to the individual survey questions can be found in Appendix 3 of this report, along with details of which survey questions were used to calculate the Key Findings.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

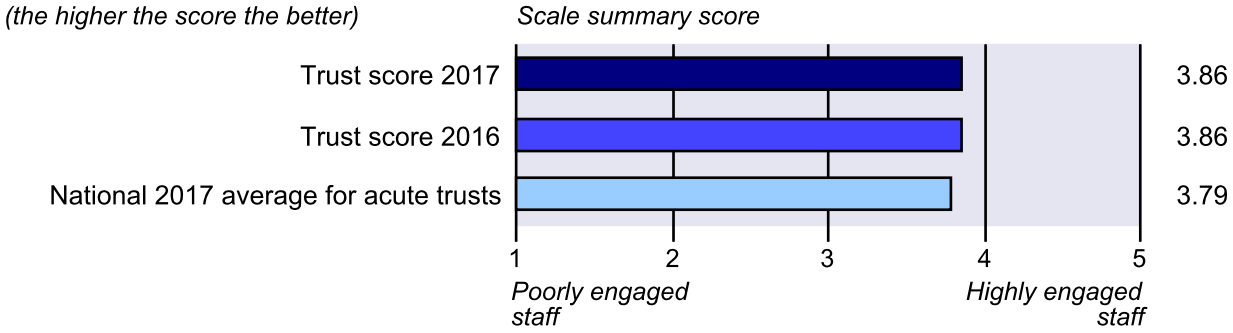
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	80%	76%	80%
Q21b	"My organisation acts on concerns raised by patients / service users"	77%	73%	78%
Q21c	"I would recommend my organisation as a place to work"	66%	61%	65%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	72%	71%	70%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.83	3.76	3.82

2. Overall indicator of staff engagement for East Lancashire Hospitals NHS Trust

The figure below shows how East Lancashire Hospitals NHS Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.86 was above (better than) average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how East Lancashire Hospitals NHS Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2016 survey.

	Change since 2016 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	• No change	✓ Above (better than) average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	• No change	✓ Above (better than) average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	✓ Above (better than) average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	✓ Highest (best) 20%

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

3. Summary of 2017 Key Findings for East Lancashire Hospitals NHS Trust

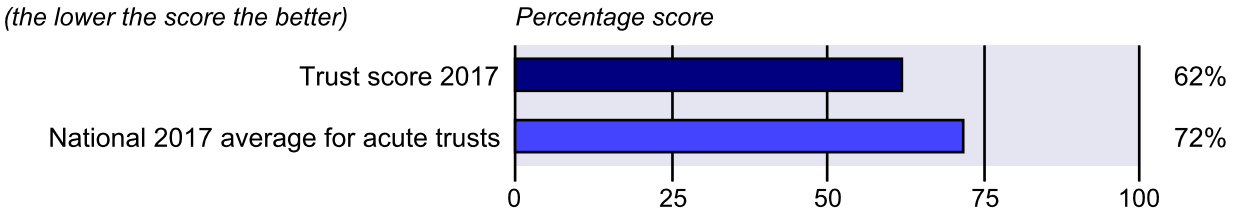
3.1 Top and Bottom Ranking Scores

This page highlights the five Key Findings for which East Lancashire Hospitals NHS Trust compares most favourably with other acute trusts in England.

TOP FIVE RANKING SCORES

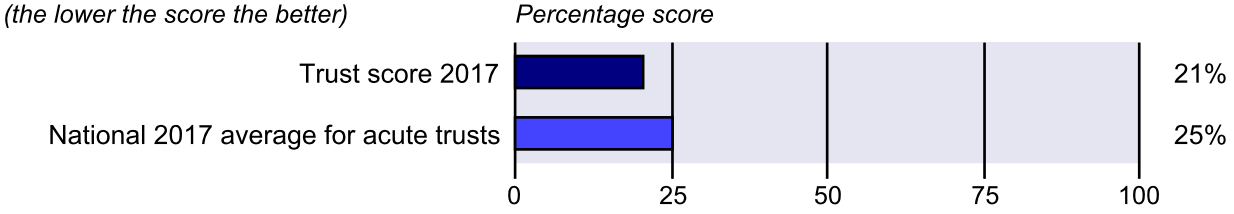
✓KF16. Percentage of staff working extra hours

(the lower the score the better)



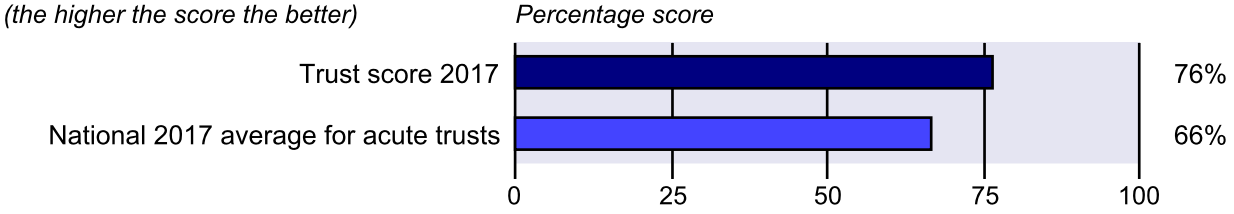
✓KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



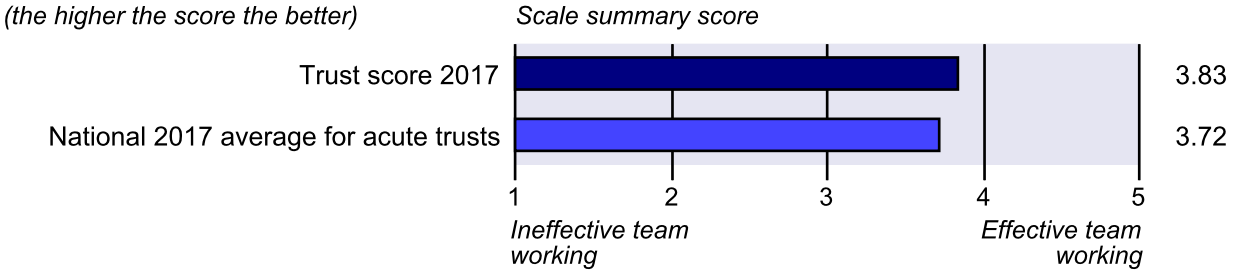
✓KF24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



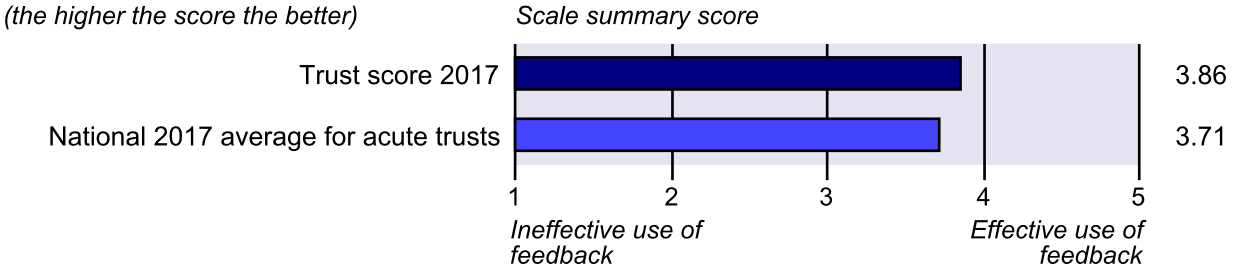
✓KF9. Effective team working

(the higher the score the better)



✓KF32. Effective use of patient / service user feedback

(the higher the score the better)



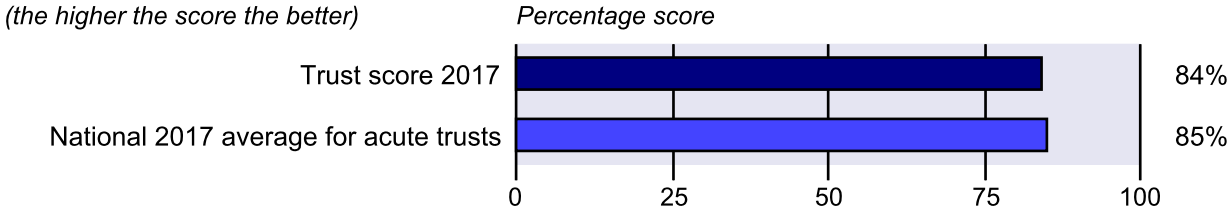
For each of the 32 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 93 (the bottom ranking score). East Lancashire Hospitals NHS Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the four Key Findings for which East Lancashire Hospitals NHS Trust compares least favourably with other acute trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FOUR RANKING SCORES

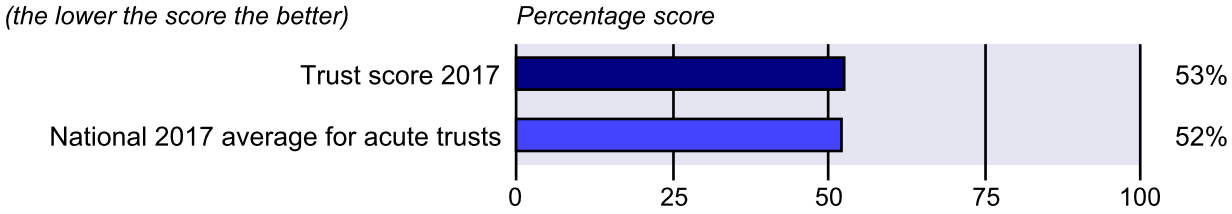
! KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

(the higher the score the better)



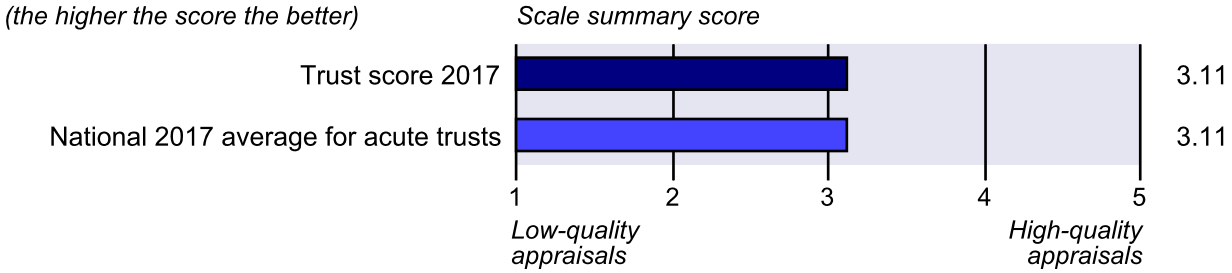
! KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



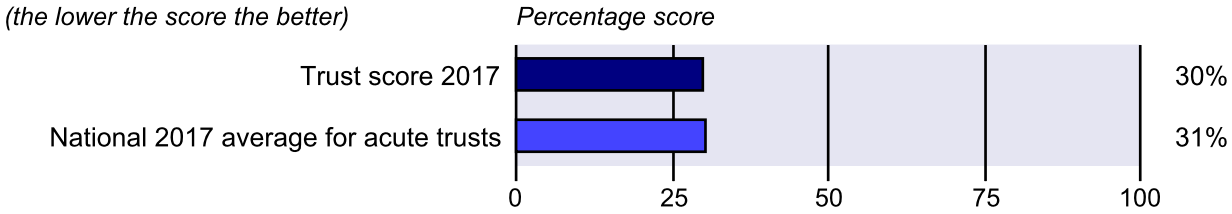
! KF12. Quality of appraisals

(the higher the score the better)



! KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



For each of the 32 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 93 (the bottom ranking score). East Lancashire Hospitals NHS Trust's four lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 93. Further details about this can be found in the document ***Making sense of your staff survey data***.

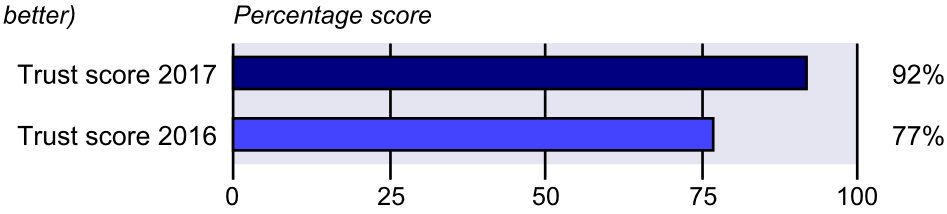
3.2 Largest Local Changes since the 2016 Survey

This page highlights the three Key Findings where staff experiences have improved at East Lancashire Hospitals NHS Trust since the 2016 survey.

WHERE STAFF EXPERIENCE HAS IMPROVED

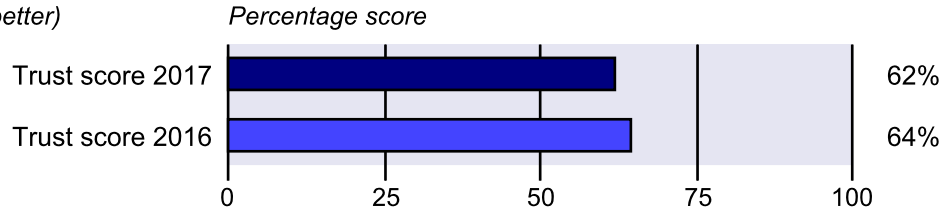
✓KF11. Percentage of staff appraised in last 12 months

(the higher the score the better)



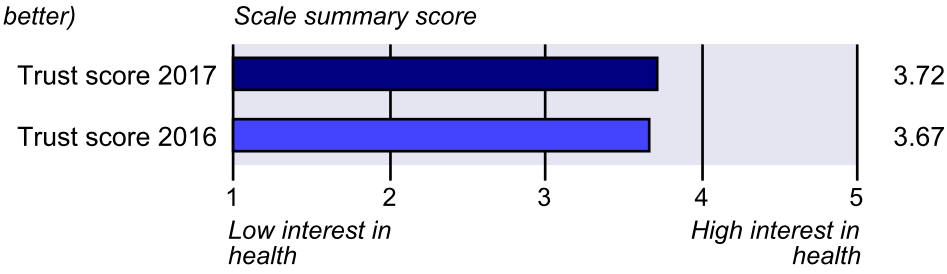
✓KF16. Percentage of staff working extra hours

(the lower the score the better)



✓KF19. Organisation and management interest in and action on health and wellbeing

(the higher the score the better)



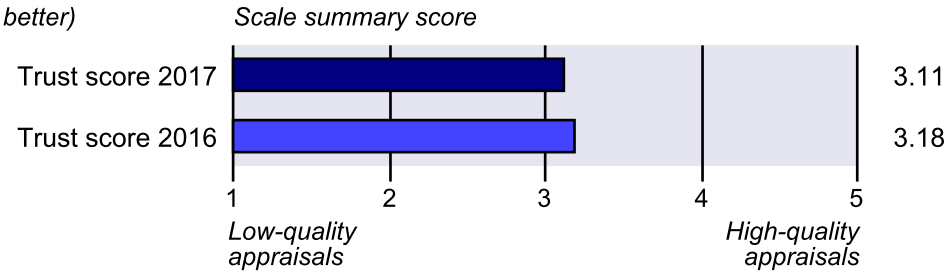
Because the Key Findings vary considerably in terms of subject matter and format (e.g. some are percentage scores, others are scale scores), a straightforward comparison of score changes is not the appropriate way to establish which Key Findings have improved the most. Rather, the extent of 2016-2017 change for each Key Finding has been measured in relation to the national variation for that Key Finding. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the Key Finding that has deteriorated at East Lancashire Hospitals NHS Trust since the 2016 survey. It is suggested that this might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

! KF12. Quality of appraisals

(the higher the score the better)



Because the Key Findings vary considerably in terms of subject matter and format (e.g. some are percentage scores, others are scale scores), a straightforward comparison of score changes is not the appropriate way to establish which Key Findings have deteriorated the most. Rather, the extent of 2016-2017 change for each Key Finding has been measured in relation to the national variation for that Key Finding. Further details about this can be found in the document ***Making sense of your staff survey data***.

3.3. Summary of all Key Findings for East Lancashire Hospitals NHS Trust

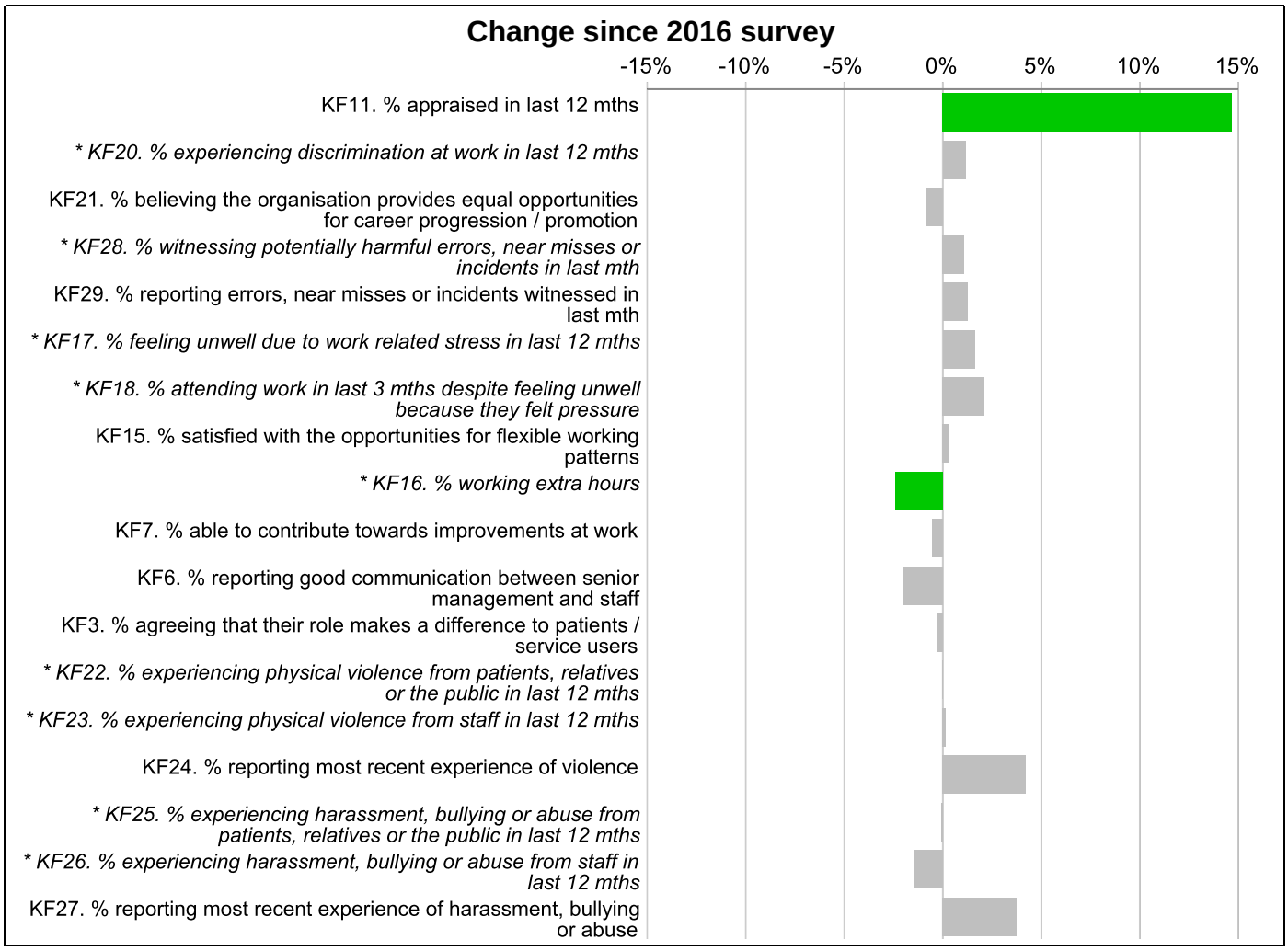
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2016 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



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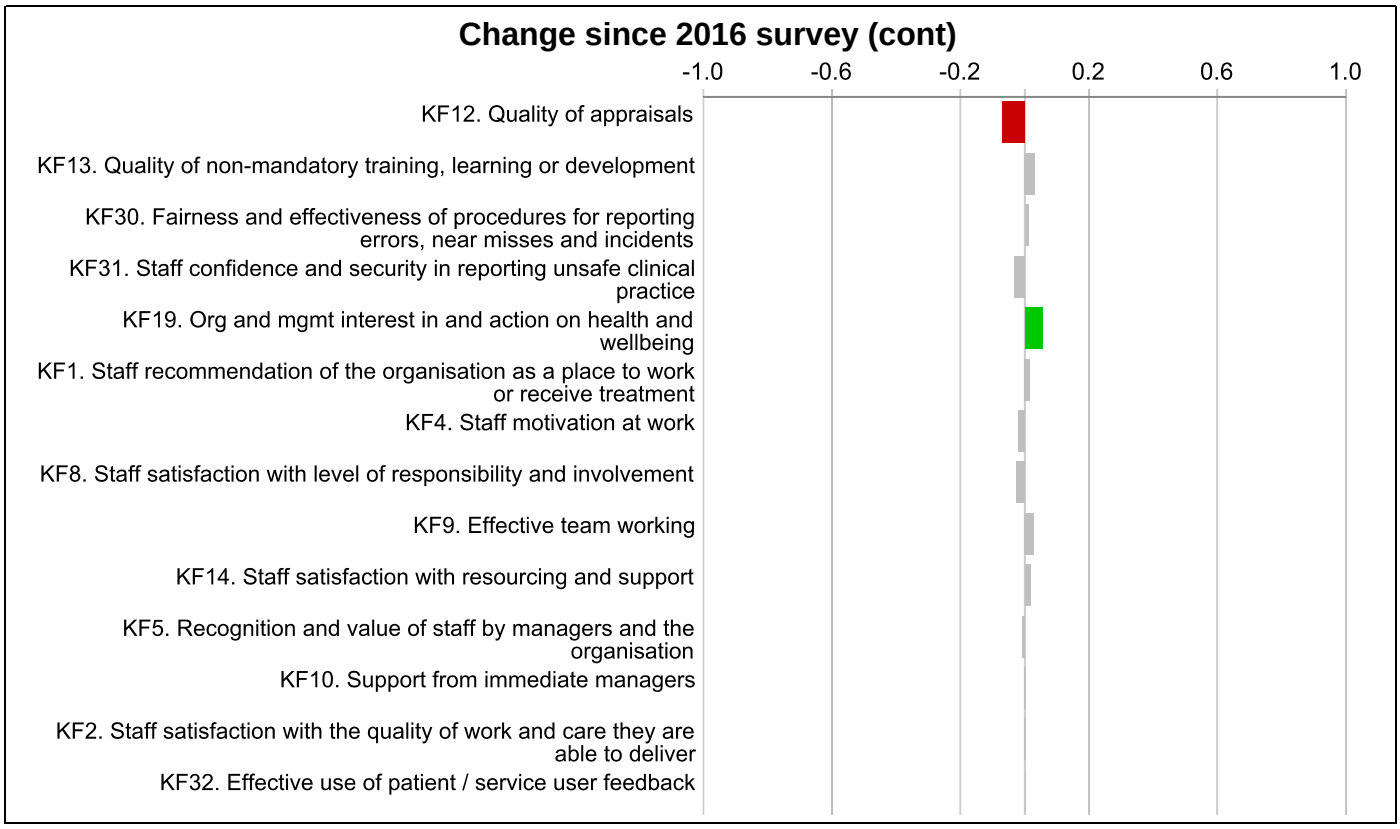


3.3. Summary of all Key Findings for East Lancashire Hospitals NHS Trust

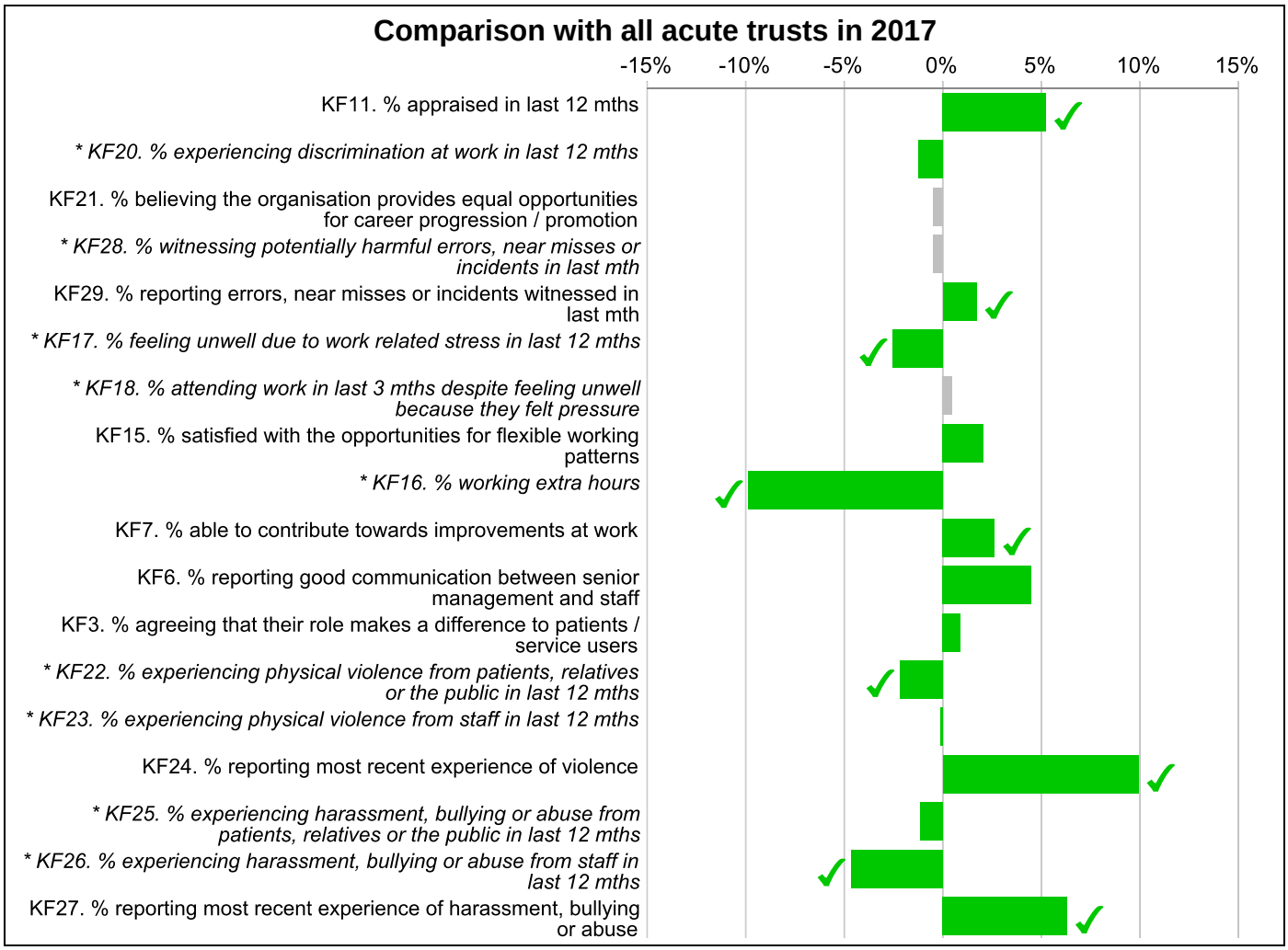
KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



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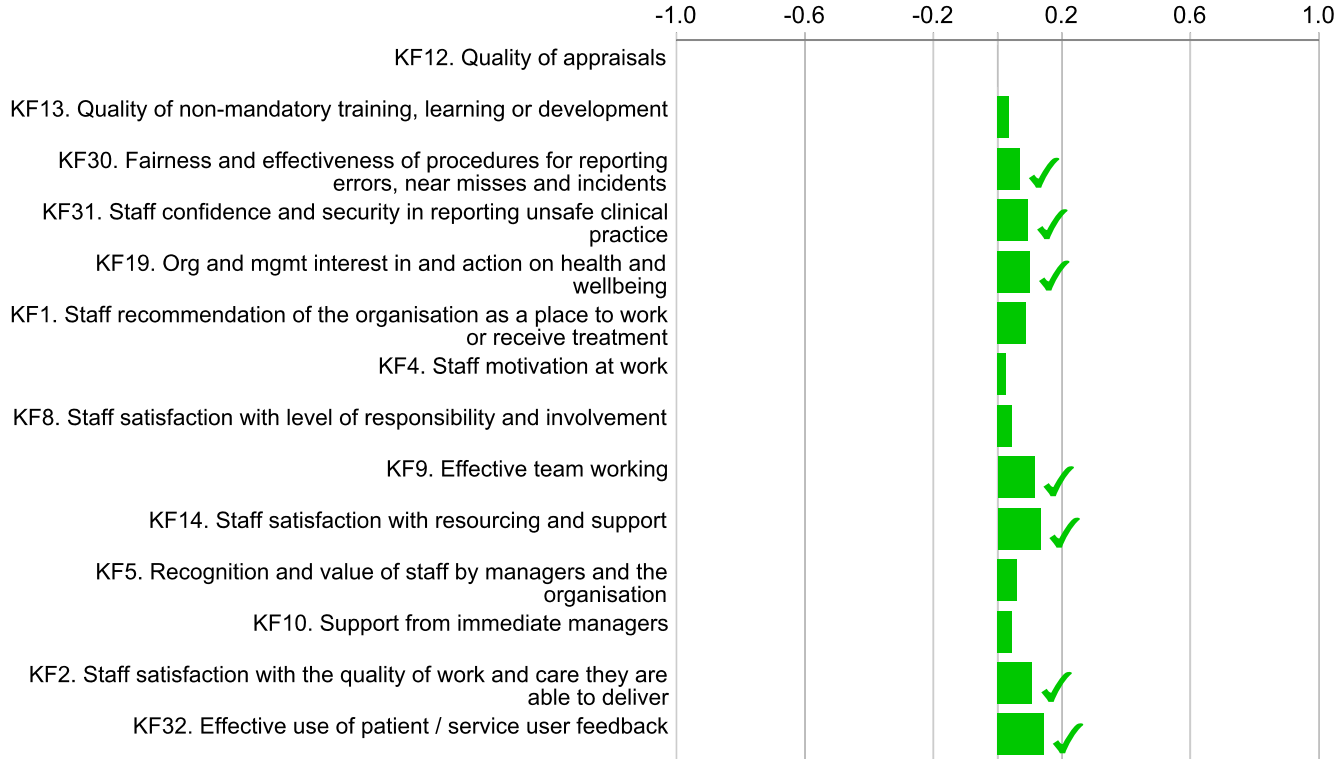
Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all acute trusts in 2017 (cont)



3.4. Summary of all Key Findings for East Lancashire Hospitals NHS Trust

KEY

✓ Green = Positive finding, e.g. in the best 20% of acute trusts, better than average, better than 2016.

! Red = Negative finding, e.g. in the worst 20% of acute trusts, worse than average, worse than 2016.

'Change since 2016 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2016 survey.

-- No comparison to the 2016 data is possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2016 survey	Ranking, compared with all acute trusts in 2017
Appraisals & support for development		
KF11. % appraised in last 12 mths	✓ Increase (better than 16)	✓ Highest (best) 20%
KF12. Quality of appraisals	! Decrease (worse than 16)	• Average
KF13. Quality of non-mandatory training, learning or development	• No change	✓ Above (better than) average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	✓ Below (better than) average
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	• Average
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	• Average
KF29. % reporting errors, near misses or incidents witnessed in last mth	• No change	✓ Highest (best) 20%
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	• No change	✓ Highest (best) 20%
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	✓ Highest (best) 20%
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	• No change	✓ Lowest (best) 20%
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	• No change	• Average
KF19. Org and mgmt interest in and action on health and wellbeing	✓ Increase (better than 16)	✓ Highest (best) 20%
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	✓ Above (better than) average
* *KF16. % working extra hours*	✓ Decrease (better than 16)	✓ Lowest (best) 20%

3.4. Summary of all Key Findings for East Lancashire Hospitals NHS Trust (cont)

	Change since 2016 survey	Ranking, compared with all acute trusts in 2017
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	✓ Above (better than) average
KF4. Staff motivation at work	• No change	✓ Above (better than) average
KF7. % able to contribute towards improvements at work	• No change	✓ Highest (best) 20%
KF8. Staff satisfaction with level of responsibility and involvement	• No change	✓ Above (better than) average
KF9. Effective team working	• No change	✓ Highest (best) 20%
KF14. Staff satisfaction with resourcing and support	• No change	✓ Highest (best) 20%
Managers		
KF5. Recognition and value of staff by managers and the organisation	• No change	✓ Above (better than) average
KF6. % reporting good communication between senior management and staff	• No change	✓ Above (better than) average
KF10. Support from immediate managers	• No change	✓ Above (better than) average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	✓ Highest (best) 20%
KF3. % agreeing that their role makes a difference to patients / service users	• No change	✓ Above (better than) average
KF32. Effective use of patient / service user feedback	• No change	✓ Highest (best) 20%
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	✓ Lowest (best) 20%
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	✓ Below (better than) average
KF24. % reporting most recent experience of violence	• No change	✓ Highest (best) 20%
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	✓ Below (better than) average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	✓ Lowest (best) 20%
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	✓ Highest (best) 20%

4. Key Findings for East Lancashire Hospitals NHS Trust

East Lancashire Hospitals NHS Trust had 3375 staff take part in this survey. This is a response rate of 43%[1] which is average for acute trusts in England (44%), and compares with a response rate of 48% in this trust in the 2016 survey.

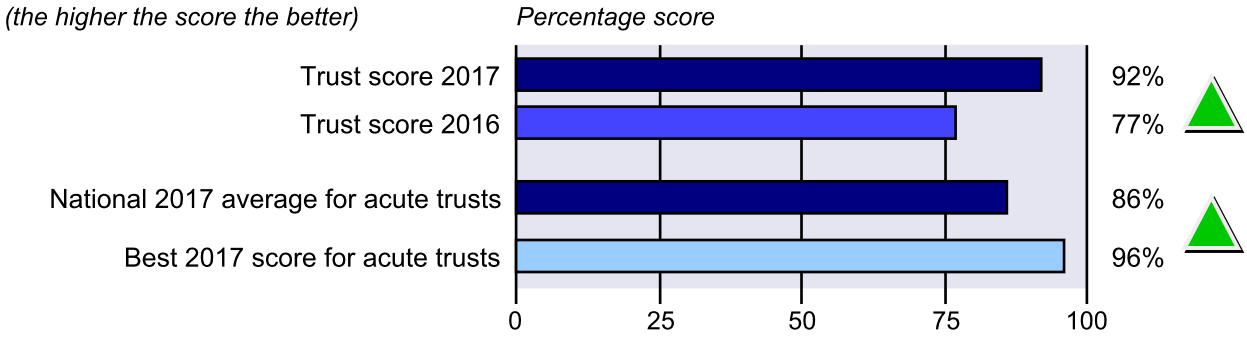
This section presents each of the 32 Key Findings, using data from the trust's 2017 survey, and compares these to other acute trusts in England and to the trust's performance in the 2016 survey. The findings are arranged under nine themes: appraisals and support for development, equality and diversity, errors and incidents, health and wellbeing, working patterns, job satisfaction, managers, patient care and experience , and violence, harassment and bullying.

Positive findings are indicated with a green arrow (e.g. where the trust is in the best 20% of trusts, or where the score has improved since 2016). Negative findings are highlighted with a red arrow (e.g. where the trust's score is in the worst 20% of trusts, or where the score is not as good as 2016). An equals sign indicates that there has been no change.

Appraisals & support for development

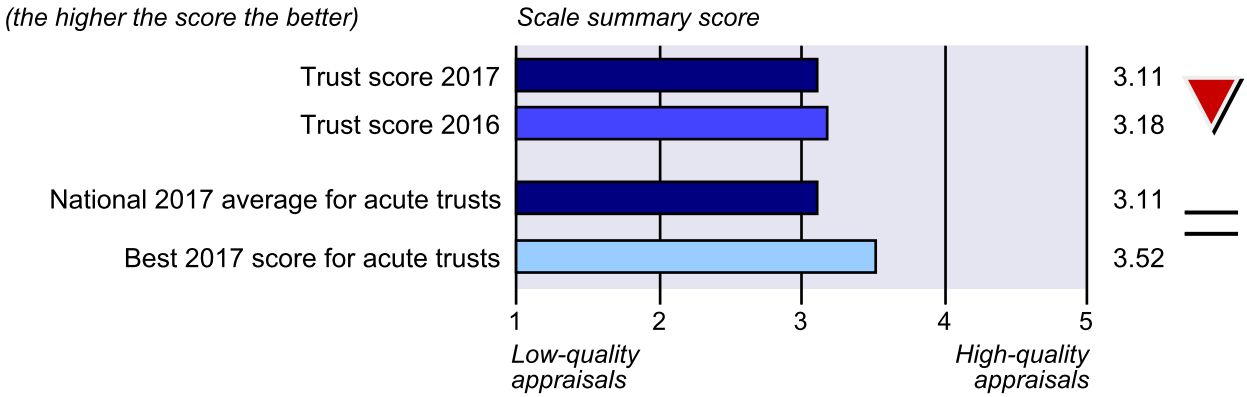
KEY FINDING 11. Percentage of staff appraised in last 12 months

(the higher the score the better)



KEY FINDING 12. Quality of appraisals

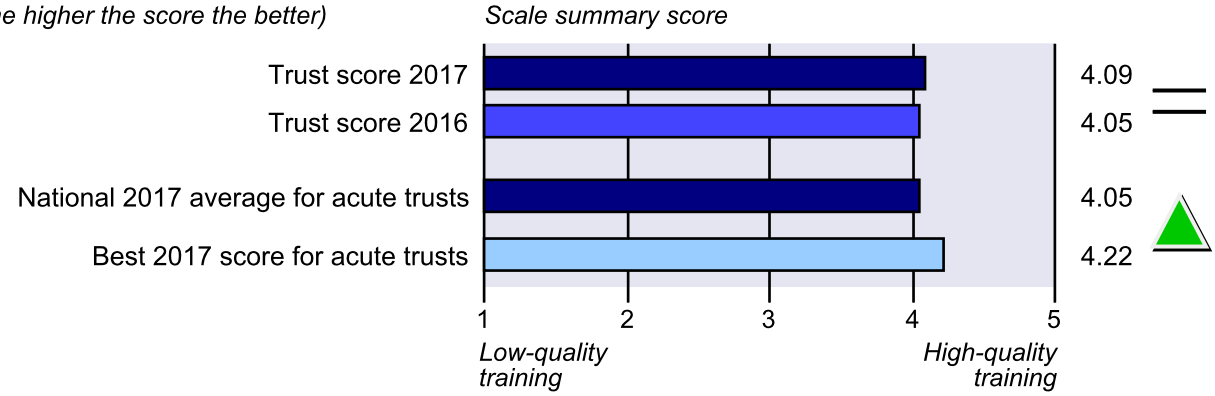
(the higher the score the better)



[1]Questionnaires were sent to all 7788 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

KEY FINDING 13. Quality of non-mandatory training, learning or development

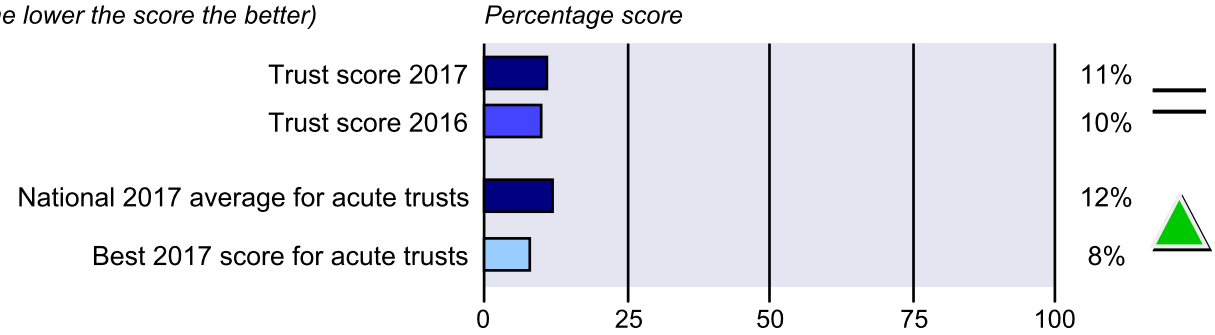
(the higher the score the better)



Equality & diversity

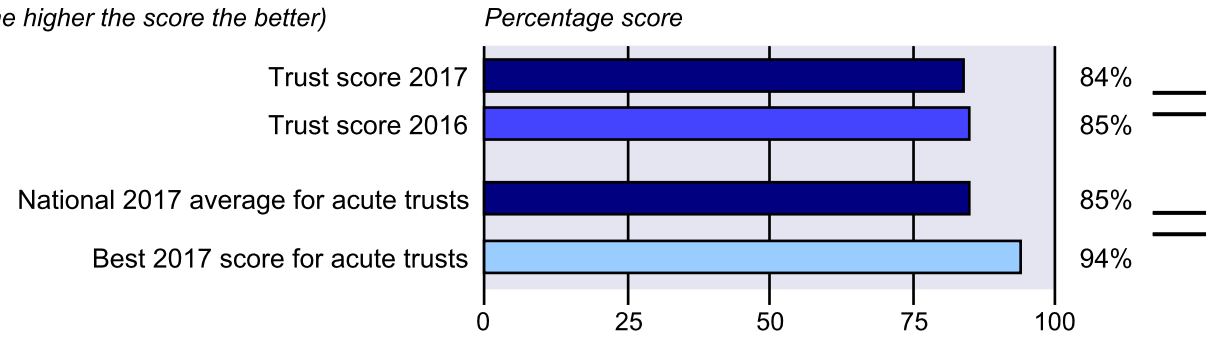
KEY FINDING 20. Percentage of staff experiencing discrimination at work in the last 12 months

(the lower the score the better)



KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

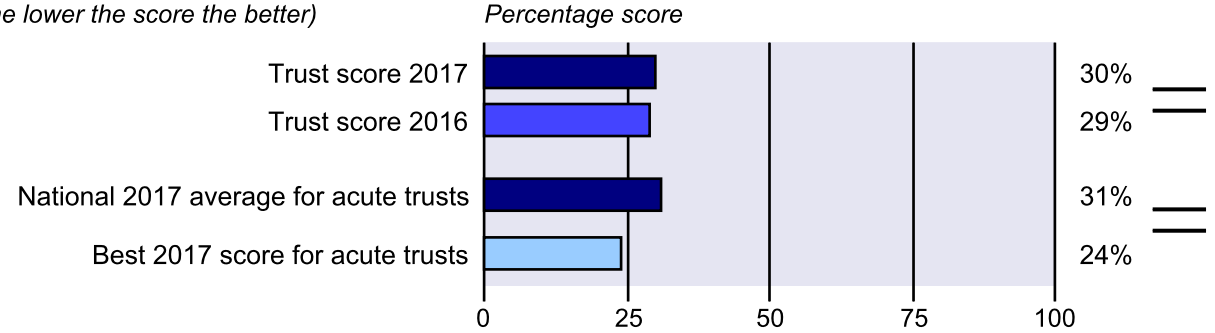
(the higher the score the better)



Errors & incidents

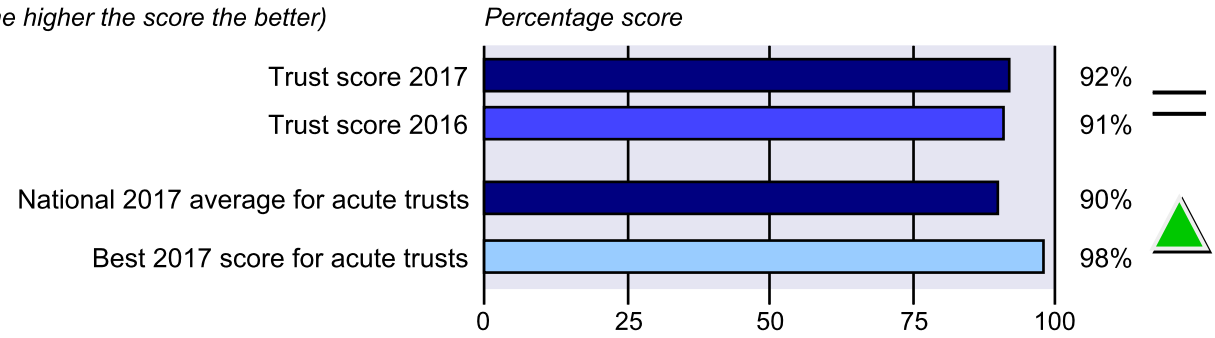
KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



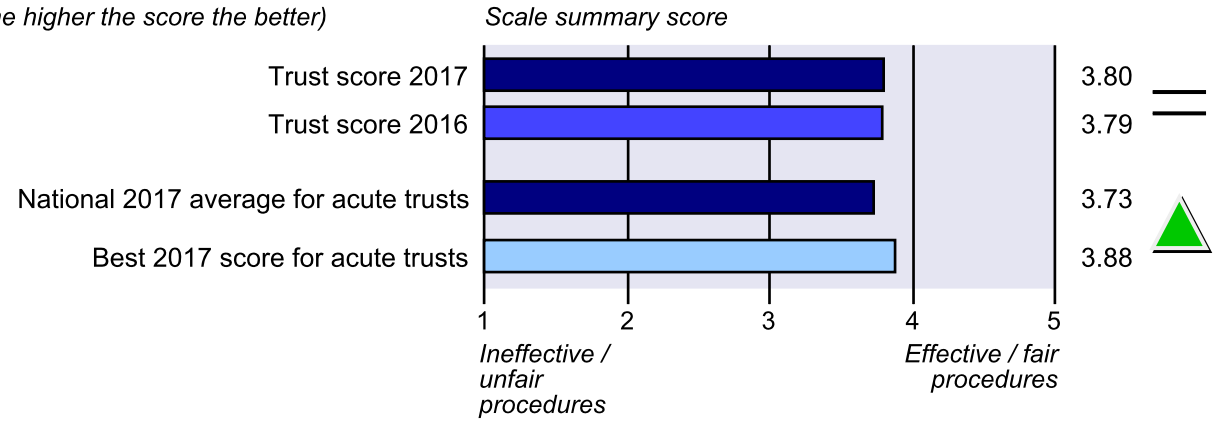
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



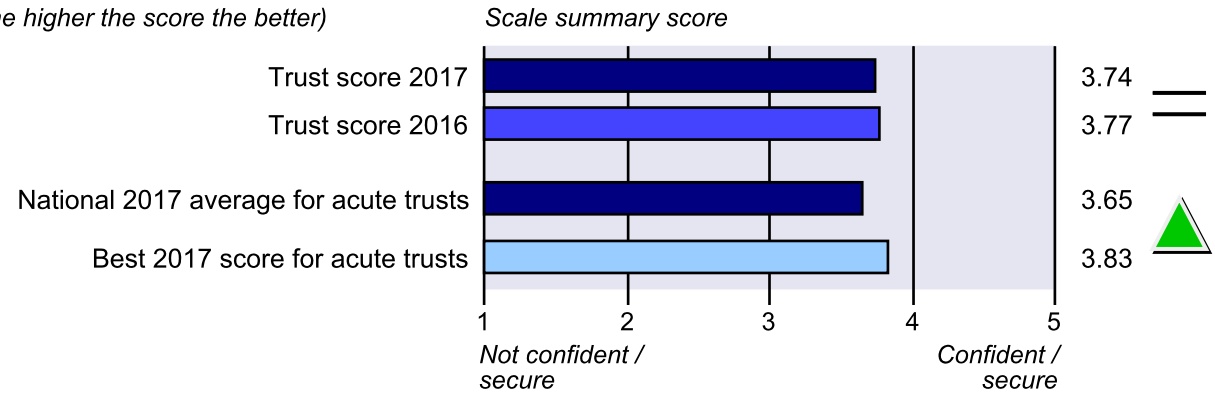
KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice

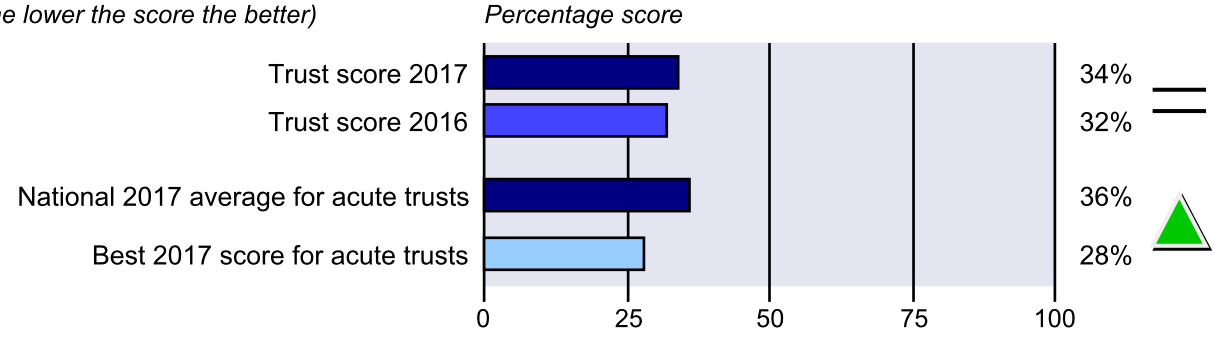
(the higher the score the better)



Health and wellbeing

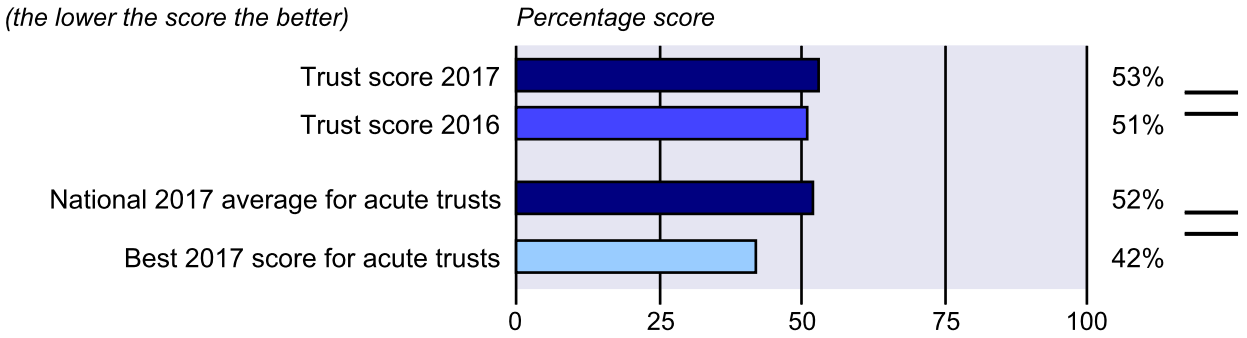
KEY FINDING 17. Percentage of staff feeling unwell due to work related stress in the last 12 months

(the lower the score the better)



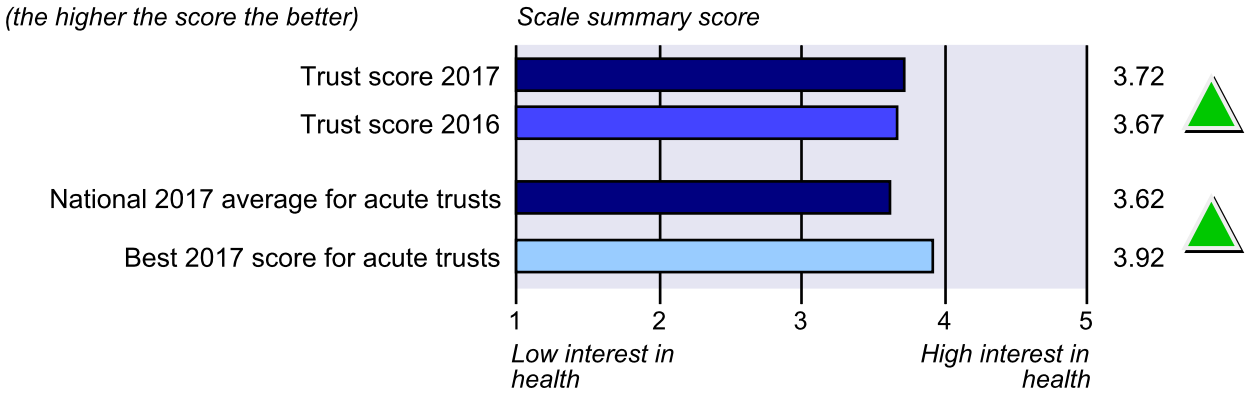
KEY FINDING 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

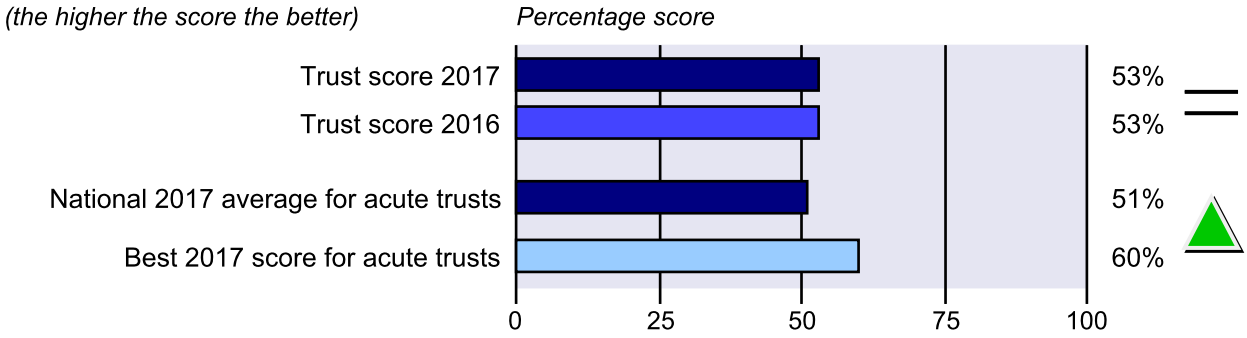
(the higher the score the better)



Working patterns

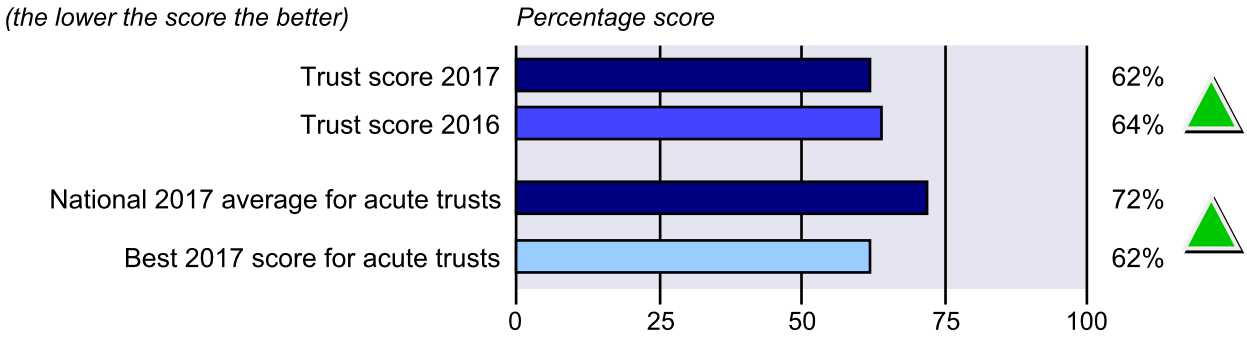
KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns

(the higher the score the better)



KEY FINDING 16. Percentage of staff working extra hours

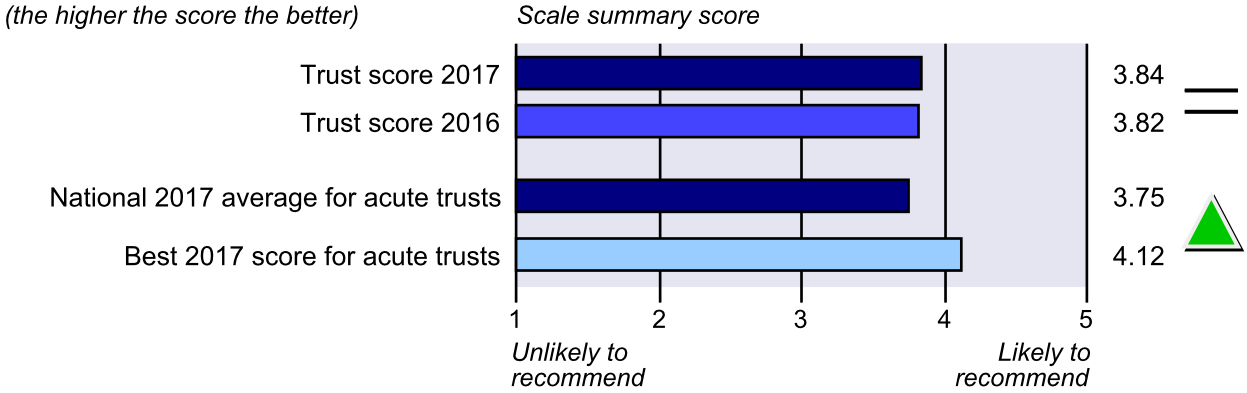
(the lower the score the better)



Job satisfaction

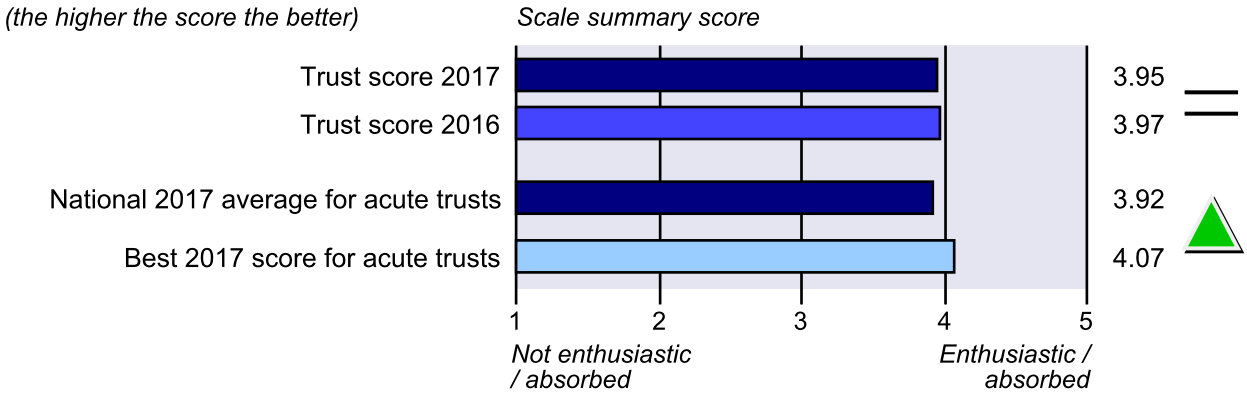
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



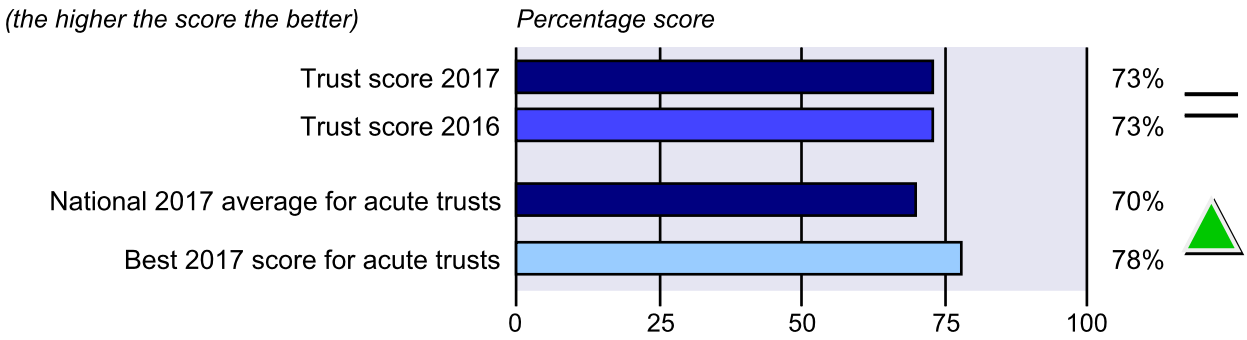
KEY FINDING 4. Staff motivation at work

(the higher the score the better)



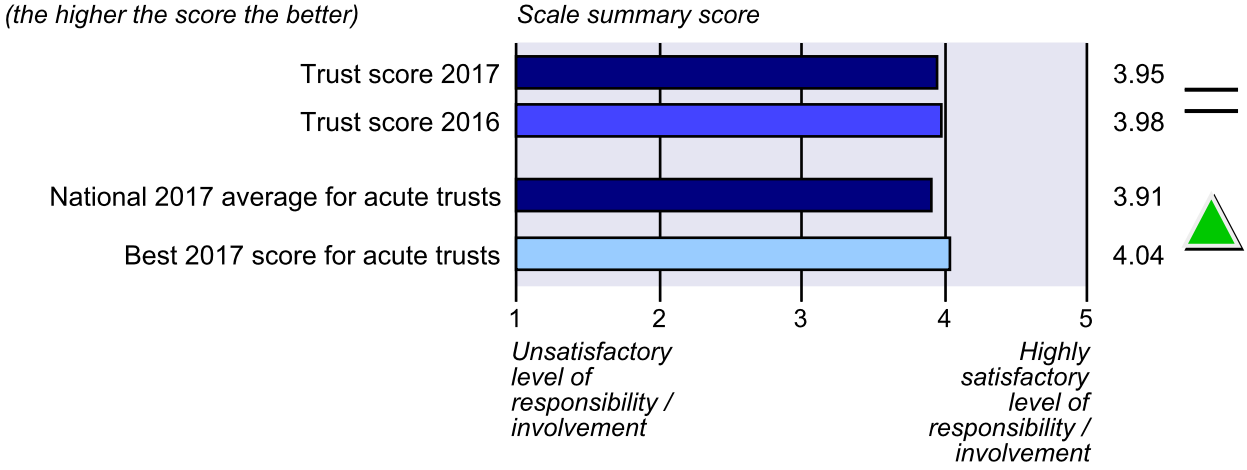
KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)



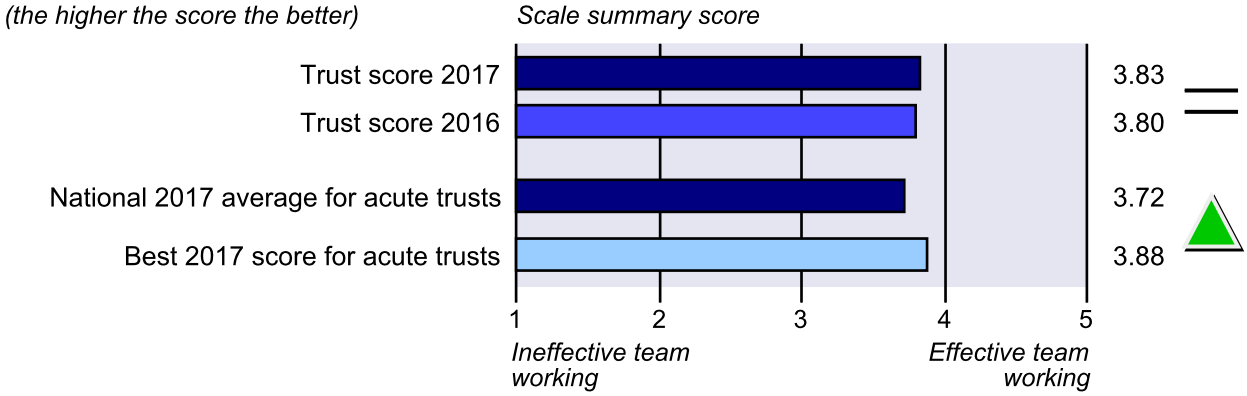
KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

(the higher the score the better)



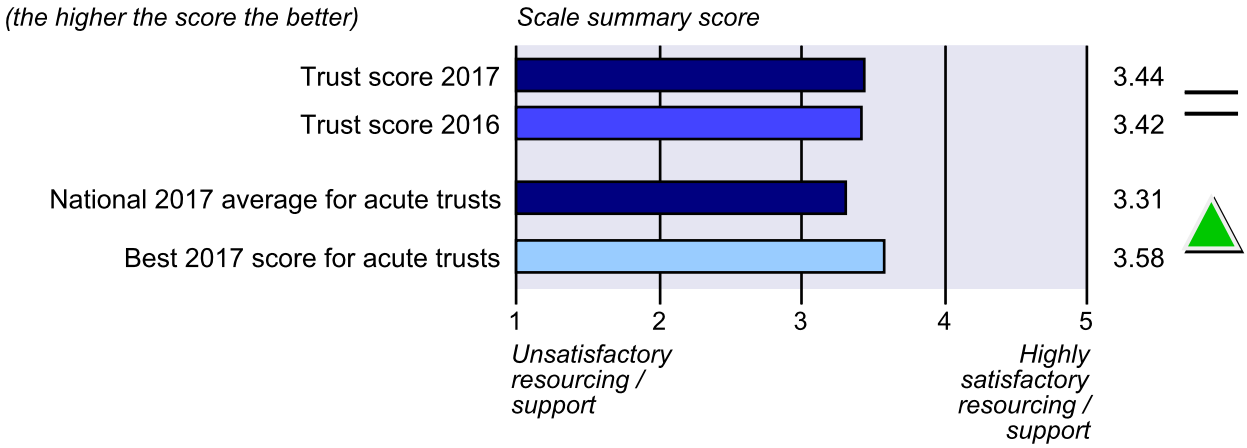
KEY FINDING 9. Effective team working

(the higher the score the better)



KEY FINDING 14. Staff satisfaction with resourcing and support

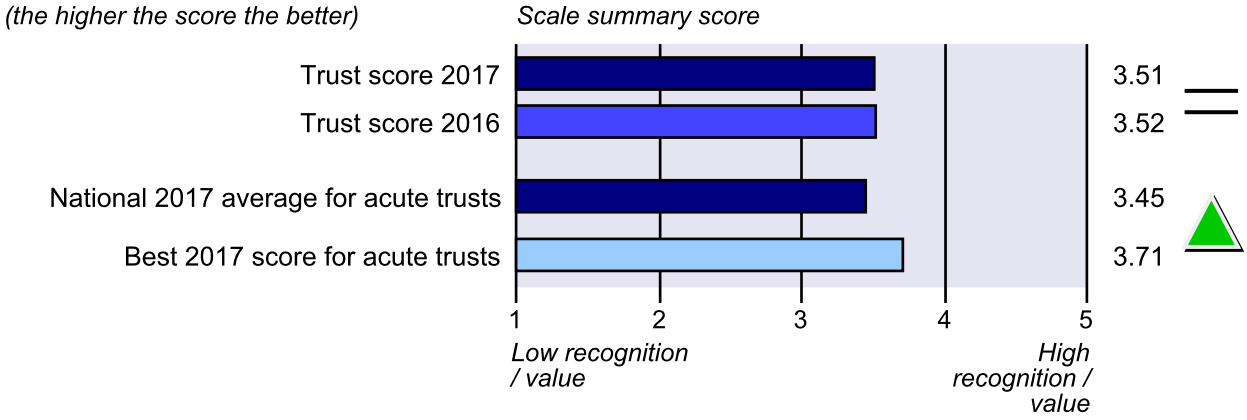
(the higher the score the better)



Managers

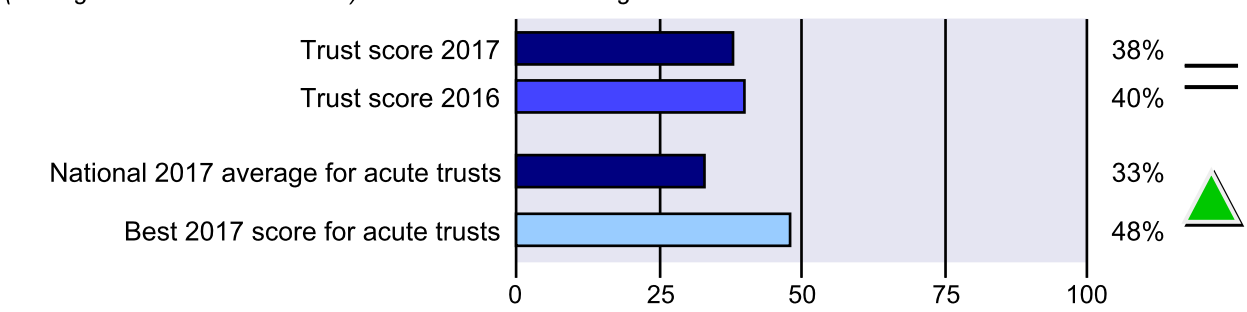
KEY FINDING 5. Recognition and value of staff by managers and the organisation

(the higher the score the better)



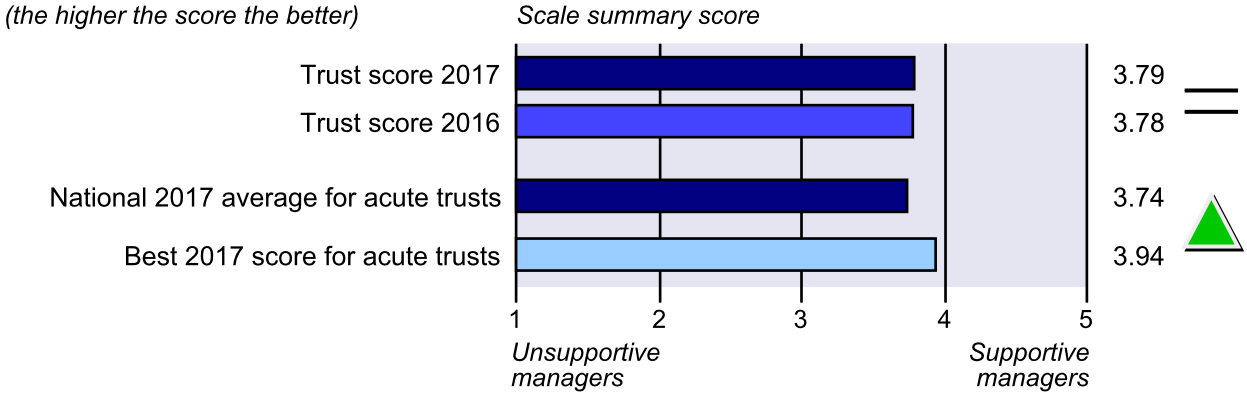
KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



KEY FINDING 10. Support from immediate managers

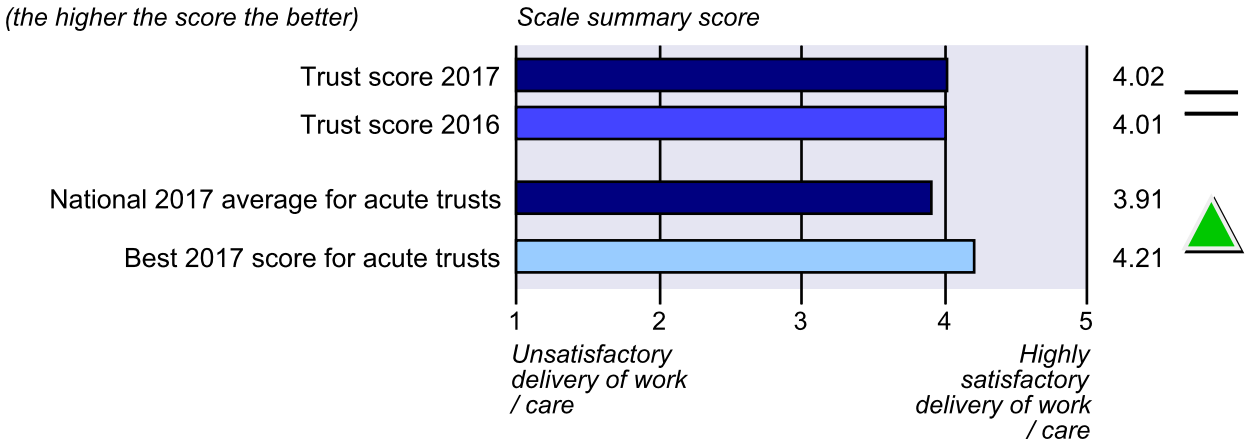
(the higher the score the better)



Patient care & experience

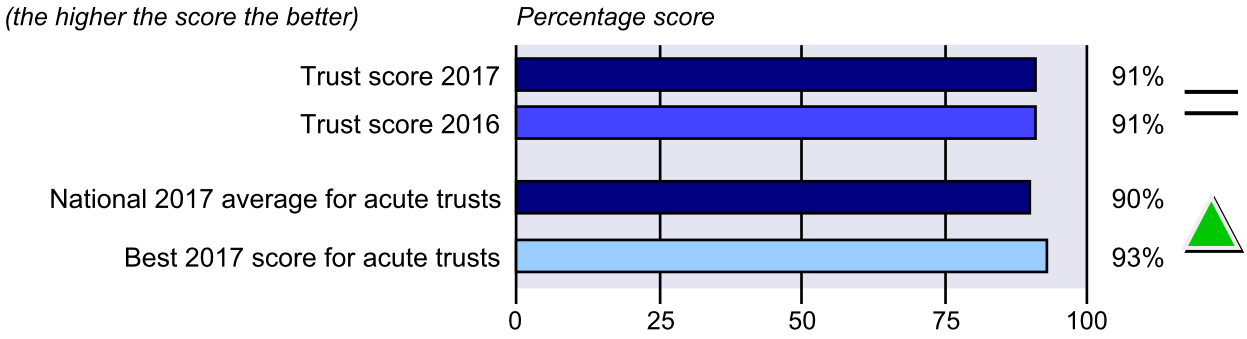
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver

(the higher the score the better)



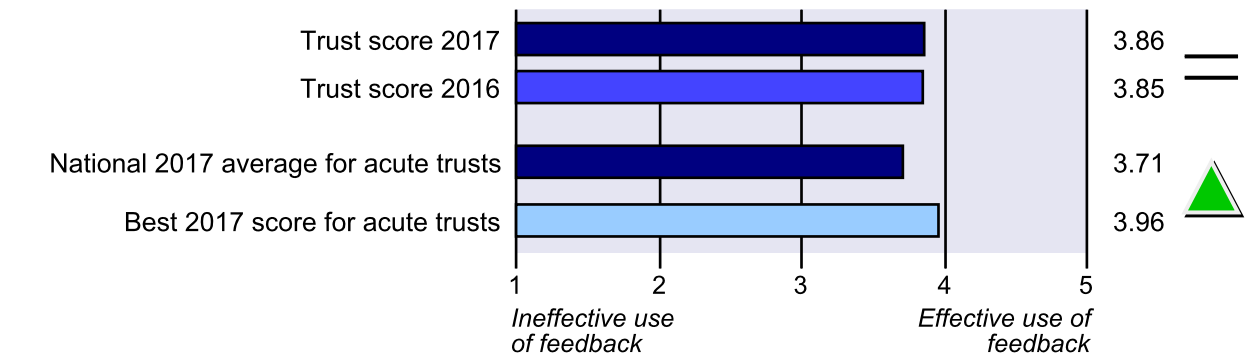
KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



KEY FINDING 32. Effective use of patient / service user feedback

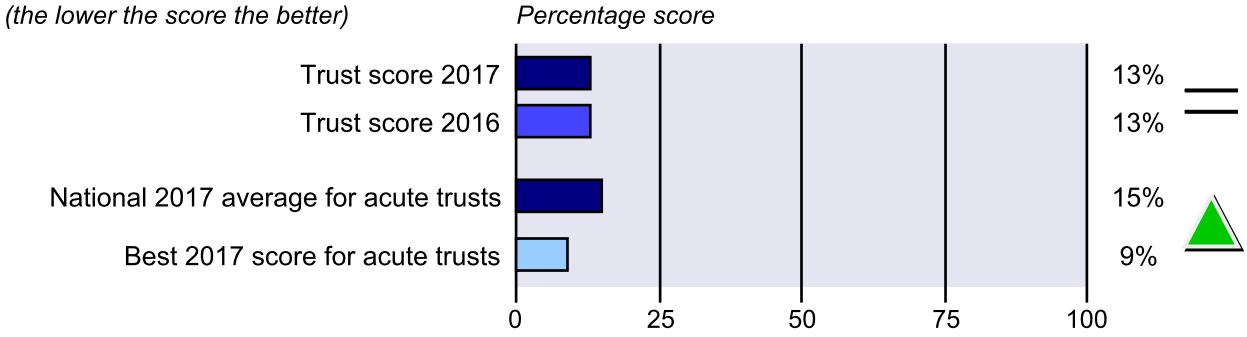
(the higher the score the better)



Violence, harassment & bullying

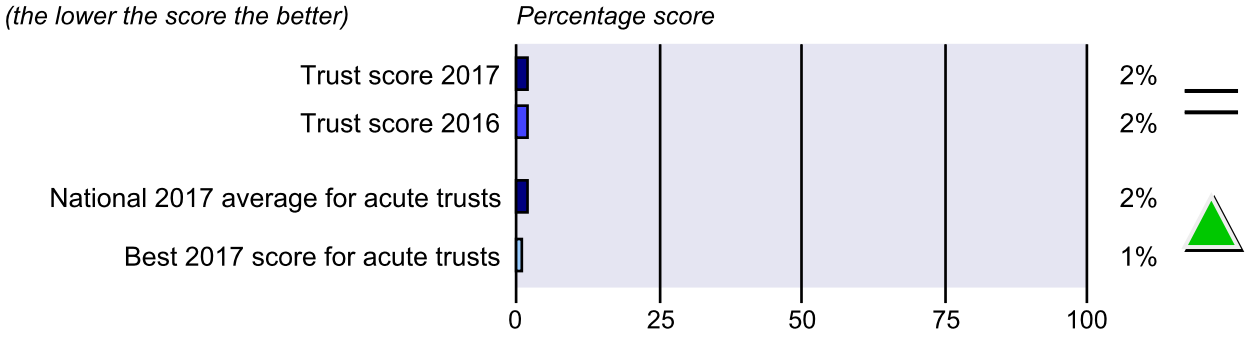
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



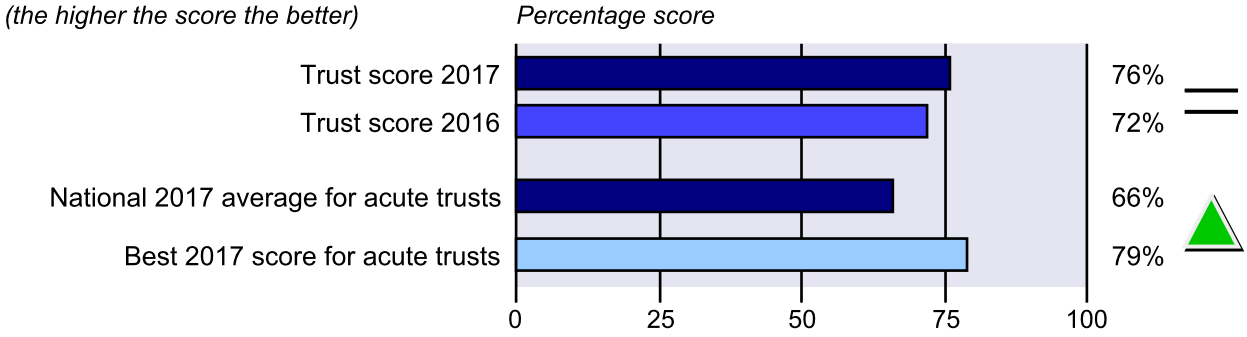
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



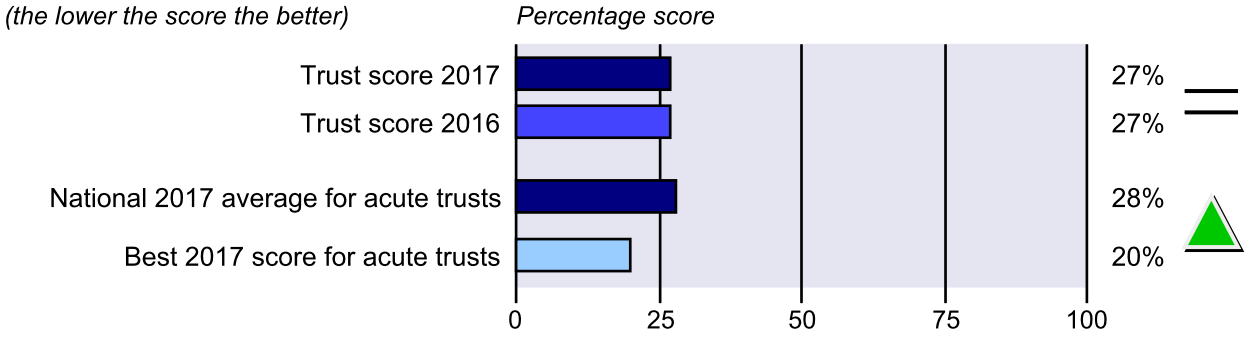
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



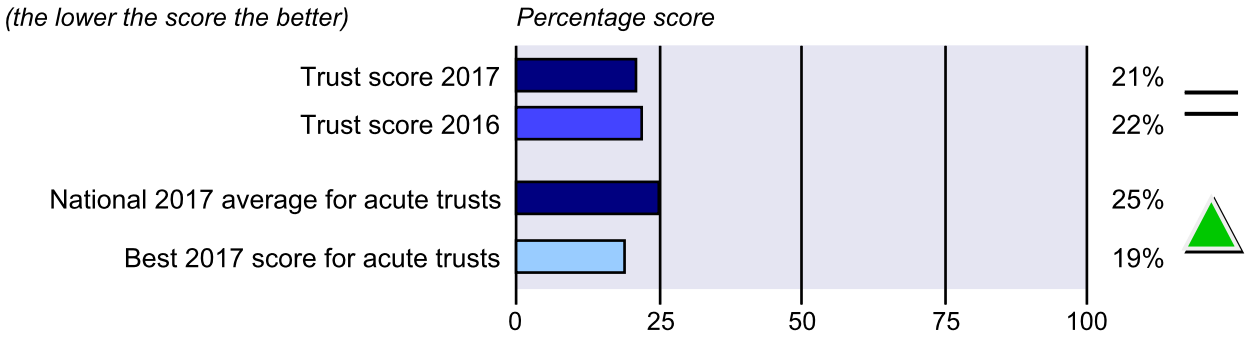
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



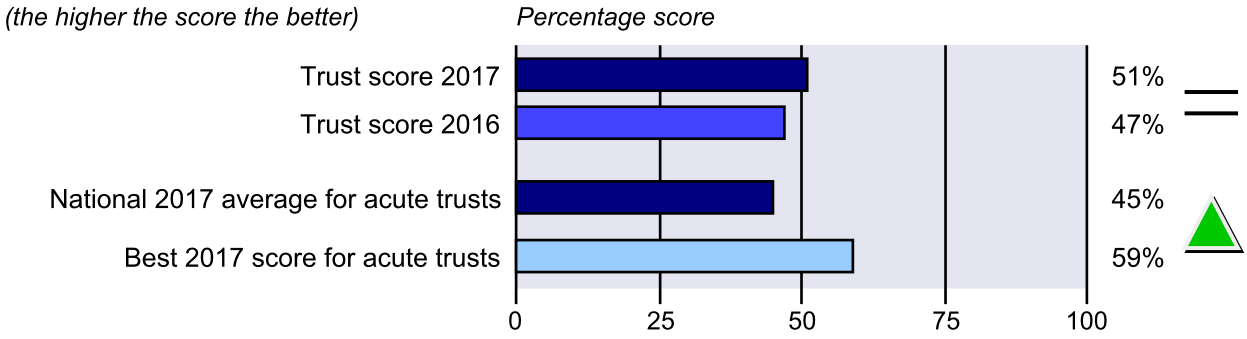
KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



5. Workforce Race Equality Standard (WRES)

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

			Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	26%	27%	26%
		BME	22%	28%	21%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	20%	25%	22%
		BME	24%	27%	20%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	87%	87%	86%
		BME	68%	75%	73%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	5%	7%	6%
		BME	16%	15%	14%

6. Key Findings by work group characteristics

Tables 6.1 to 6.4 show the Key Findings at East Lancashire Hospitals NHS Trust broken down by work group characteristics: occupational groups, locations, and full time/part time staff.

Technical notes:

- As in previous years, there are two types of Key Finding:
    - percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
    - scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5
- For most of the Key Findings presented in tables 6.1 to 6.4, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative result. For these Key Findings, marked with an asterisk and shown in italics, the lower the score the better.
- Care should be taken not to over interpret the findings if scores differ slightly. For example, if for 'KF11. % appraised in the last 12 months' staff in Group A score 45%, and staff in Group B score 40%, it may appear that a higher proportion of staff in Group A have had appraisals than staff in Group B. However, because of small numbers in these sub-groups, it is probably not statistically significant. A more sensible interpretation would be that, on average, similar proportions of staff in Group A and B have had appraisals.
- Please note that, unlike the overall trust scores, data in this section are not weighted.
- Please also note that all percentage scores are shown to the nearest 1%. This means scores of less than 0.5% are displayed as 0%.
- In order to preserve anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

Table 6.1: Key Findings for different occupational groups

	Adult / General Nurses	Mental Health Nurses	Other Registered Nurses	Nursing / Healthcare Assistants	Medical / Dental	Occupational Therapy	Physiotherapy	Radiography	Other Allied Health Professionals	General Management	Other Scientific & Technical	Admin & Clerical	Central Functions / Corporate Services	Maintenance / Ancillary	Public Health / Health Improvement
Appraisals & support for development															
KF11. % appraised in last 12 mths	93	92	92	93	90	100	99	91	95	95	93	90	92	91	85
KF12. Quality of appraisals	3.43	2.83	3.07	3.22	2.92	3.33	3.42	2.76	3.23	3.41	2.87	2.93	3.31	2.65	3.12
KF13. Quality of non-mandatory training, learning or development	4.33	-	4.16	4.15	3.96	4.13	4.19	3.94	4.11	3.99	3.93	3.88	4.02	3.81	-
Equality & diversity															
* *KF20. % experiencing discrimination at work in last 12 mths*	11	21	11	12	20	3	9	14	9	6	11	8	7	10	17
KF21. % believing the organisation provides equal opportunities for career progression / promotion	86	-	88	91	85	96	92	75	87	86	79	87	75	78	-
Errors & incidents															
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	43	21	41	28	51	19	29	28	25	8	42	15	6	24	18
KF29. % reporting errors, near misses or incidents witnessed in last mth	96	-	99	89	95	-	92	92	87	-	96	76	-	78	-
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.92	3.78	3.85	3.86	3.65	3.92	4.03	3.77	3.76	3.88	3.90	3.68	3.82	3.53	-
KF31. Staff confidence and security in reporting unsafe clinical practice	3.93	3.79	3.77	3.75	3.73	3.88	3.90	3.57	3.69	3.91	3.75	3.61	3.74	3.40	3.81
Health and wellbeing															
* *KF17. % feeling unwell due to work related stress in last 12 mths*	35	29	39	38	36	37	35	42	32	36	31	30	25	28	33
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	55	69	60	63	40	47	49	59	53	50	52	54	46	51	50
KF19. Org and mgmt interest in and action on health and wellbeing	3.84	3.46	3.66	3.78	3.56	3.89	4.03	3.35	3.71	3.98	3.69	3.74	3.89	3.39	3.91
Working patterns															
KF15. % satisfied with the opportunities for flexible working patterns	59	64	45	51	44	46	59	37	47	76	43	57	76	38	62
* *KF16. % working extra hours*	72	92	77	53	91	60	70	51	54	83	63	45	62	32	31
Number of respondents	570	14	221	213	161	63	153	99	180	85	252	657	147	191	13

Due to low numbers of respondents, no scores are shown for the following occupational groups: Social Care Staff, Commissioning Staff and Patient Transport Service.

Table 6.1: Key Findings for different occupational groups (cont)

	Adult / General Nurses	Mental Health Nurses	Other Registered Nurses	Nursing / Healthcare Assistants	Medical / Dental	Occupational Therapy	Physiotherapy	Radiography	Other Allied Health Professionals	General Management	Other Scientific & Technical	Admin & Clerical	Central Functions / Corporate Services	Maintenance / Ancillary	Public Health / Health Improvement
Job satisfaction															
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.93	3.81	3.78	3.88	3.86	3.85	3.95	3.64	3.80	4.04	3.76	3.81	3.95	3.68	3.82
KF4. Staff motivation at work	4.14	4.17	4.08	3.96	4.08	3.95	4.08	3.72	3.97	4.04	3.75	3.79	3.77	3.81	3.90
KF7. % able to contribute towards improvements at work	79	79	77	68	74	79	82	59	76	91	73	70	78	49	77
KF8. Staff satisfaction with level of responsibility and involvement	4.15	3.94	4.00	4.00	4.04	3.98	4.09	3.65	3.96	4.08	3.86	3.83	3.84	3.66	3.96
KF9. Effective team working	4.09	4.07	3.93	3.84	3.86	3.96	4.08	3.50	3.92	3.89	3.83	3.62	4.00	3.34	3.18
KF14. Staff satisfaction with resourcing and support	3.53	3.70	3.23	3.55	3.30	3.39	3.44	3.32	3.42	3.50	3.37	3.55	3.51	3.28	3.46
Managers															
KF5. Recognition and value of staff by managers and the organisation	3.63	3.60	3.49	3.56	3.46	3.67	3.77	3.25	3.50	3.79	3.37	3.51	3.65	3.16	3.47
KF6. % reporting good communication between senior management and staff	38	57	36	47	38	41	47	24	34	50	40	32	48	21	42
KF10. Support from immediate managers	3.96	3.88	3.78	3.86	3.70	4.01	4.08	3.51	3.90	3.96	3.65	3.76	3.93	3.29	4.00
Patient care & experience															
KF2. Staff satisfaction with the quality of work and care they are able to deliver	4.05	4.07	3.75	4.34	3.95	3.91	3.99	4.04	4.06	3.94	3.89	4.06	3.96	3.97	-
KF3. % agreeing that their role makes a difference to patients / service users	95	86	96	94	95	97	94	93	92	87	89	82	86	84	100
KF32. Effective use of patient / service user feedback	3.98	-	3.89	3.84	3.77	3.95	4.09	3.66	3.83	4.01	3.55	3.69	3.84	3.67	-
Violence, harassment & bullying															
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	28	38	10	34	11	11	14	16	8	2	3	2	0	5	8
* *KF23. % experiencing physical violence from staff in last 12 mths*	3	0	2	5	2	2	0	5	0	0	2	1	0	2	8
KF24. % reporting most recent experience of violence	82	-	71	82	67	-	44	57	55	-	-	86	-	-	-
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	40	57	39	43	33	19	26	39	18	10	14	21	4	11	31
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	22	29	22	20	24	10	13	22	16	19	17	21	17	22	23
KF27. % reporting most recent experience of harassment, bullying or abuse	56	-	53	60	35	58	53	46	54	39	41	49	38	56	-
Overall staff engagement	4.02	3.91	3.88	3.84	3.94	3.89	4.01	3.59	3.86	4.11	3.75	3.76	3.86	3.60	3.87
Number of respondents	570	14	221	213	161	63	153	99	180	85	252	657	147	191	13

Due to low numbers of respondents, no scores are shown for the following occupational groups: Social Care Staff, Commissioning Staff and Patient Transport Service.

Table 6.2: Key Findings for different locations

	Integrated Care Group	Diagnostics & Clinical Support	Surgical and Anaesthetics Serv	Family Care	Estates & Facilities	Finance & Informatics	HR & OD	Trust Headquarters	Quality & Safety	Clinical Flow L3|Clinical Flow	Research & Development
Appraisals & support for development											
KF11. % appraised in last 12 mths	91	95	90	92	89	94	90	78	88	79	96
KF12. Quality of appraisals	3.24	3.07	3.11	2.97	2.69	3.25	3.23	4.52	3.39	2.64	3.48
KF13. Quality of non-mandatory training, learning or development	4.17	4.02	4.17	4.08	3.83	4.04	4.12	4.35	3.96	3.75	4.24
Equality & diversity											
* *KF20. % experiencing discrimination at work in last 12 mths*	13	10	11	9	8	9	11	8	13	5	8
KF21. % believing the organisation provides equal opportunities for career progression / promotion	88	85	84	91	77	80	72	91	59	69	93
Errors & incidents											
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	36	27	33	33	21	9	9	9	12	33	26
KF29. % reporting errors, near misses or incidents witnessed in last mth	92	90	91	98	83	67	82	-	-	-	-
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.81	3.83	3.81	3.88	3.60	3.78	3.80	4.12	3.77	3.59	3.81
KF31. Staff confidence and security in reporting unsafe clinical practice	3.83	3.74	3.71	3.75	3.44	3.68	3.73	4.23	3.80	3.45	4.00
Health and wellbeing											
* *KF17. % feeling unwell due to work related stress in last 12 mths*	38	33	35	36	28	25	33	19	33	53	25
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	57	51	56	58	49	45	49	32	55	63	50
KF19. Org and mgmt interest in and action on health and wellbeing	3.70	3.73	3.72	3.77	3.40	3.89	3.92	4.50	3.89	3.47	4.04
Working patterns											
KF15. % satisfied with the opportunities for flexible working patterns	50	48	56	58	41	71	67	86	85	50	46
* *KF16. % working extra hours*	69	55	63	71	39	53	54	76	53	76	57
Number of respondents	723	1043	543	314	327	160	143	37	40	20	24

Please note that the locations classification was provided by East Lancashire Hospitals NHS Trust

Table 6.2: Key Findings for different locations (cont)

	Integrated Care Group	Diagnostics & Clinical Support	Surgical and Anaesthetics Serv	Family Care	Estates & Facilities	Finance & Informatics	HR & OD	Trust Headquarters	Quality & Safety	Clinical Flow L3|Clinical Flow	Research & Development
Job satisfaction											
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.82	3.80	3.91	3.83	3.67	3.91	3.93	4.42	3.96	3.68	4.15
KF4. Staff motivation at work	4.02	3.87	4.02	4.04	3.80	3.76	3.77	4.31	3.85	3.92	3.99
KF7. % able to contribute towards improvements at work	74	73	73	80	51	73	78	89	78	75	88
KF8. Staff satisfaction with level of responsibility and involvement	3.95	3.90	4.07	4.06	3.68	3.82	3.85	4.39	3.99	3.70	4.13
KF9. Effective team working	3.89	3.77	3.91	3.92	3.35	3.93	3.88	4.25	3.98	3.53	3.97
KF14. Staff satisfaction with resourcing and support	3.40	3.47	3.54	3.37	3.32	3.52	3.54	3.81	3.59	3.26	3.59
Managers											
KF5. Recognition and value of staff by managers and the organisation	3.53	3.49	3.53	3.59	3.14	3.66	3.68	4.30	3.65	3.18	3.84
KF6. % reporting good communication between senior management and staff	39	38	33	40	21	56	35	67	40	32	50
KF10. Support from immediate managers	3.84	3.77	3.81	3.92	3.28	3.98	3.86	4.43	3.96	3.62	4.03
Patient care & experience											
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.98	4.01	4.14	3.92	3.99	3.97	4.00	4.45	4.10	3.92	4.09
KF3. % agreeing that their role makes a difference to patients / service users	92	90	92	94	83	83	90	93	81	100	92
KF32. Effective use of patient / service user feedback	3.87	3.83	3.84	3.89	3.59	3.83	3.92	4.40	3.84	-	-
Violence, harassment & bullying											
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	27	6	16	7	4	1	4	5	3	37	4
* *KF23. % experiencing physical violence from staff in last 12 mths*	4	1	3	2	2	0	0	0	0	11	0
KF24. % reporting most recent experience of violence	84	55	78	74	-	-	-	-	-	-	-
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	35	23	31	40	11	3	6	5	15	42	8
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	21	16	23	24	23	17	19	20	37	44	38
KF27. % reporting most recent experience of harassment, bullying or abuse	52	49	55	50	57	48	41	-	60	-	-
Overall staff engagement	3.87	3.80	3.93	3.91	3.59	3.81	3.88	4.38	3.94	3.81	4.04
Number of respondents	723	1043	543	314	327	160	143	37	40	20	24

Please note that the locations classification was provided by East Lancashire Hospitals NHS Trust

Table 6.3: Key Findings for different locations Page 1 of 2

	Community Services LV4	Mfop & Complex Needs L4	Therapies & Orthotics L4	Theatres & Day Surgery L4	Clinical Outpatients L4	Obstetrics L4	Environmental Services L4	Radiological Services L4	General Paediatrics L4	Emergency Dept & Urgent Care	Anaesthetics & Critical Care L4	General Surg Services L4
Appraisals & support for development												
KF11. % appraised in last 12 mths	96	90	98	84	95	87	90	91	95	83	99	94
KF12. Quality of appraisals	3.27	3.33	3.45	2.81	2.91	2.74	2.88	2.81	2.84	3.07	3.84	2.87
KF13. Quality of non-mandatory training, learning or development	4.16	4.16	4.19	3.99	3.86	4.02	3.81	3.99	4.05	4.17	4.68	4.01
Equality & diversity												
* *KF20. % experiencing discrimination at work in last 12 mths*	8	18	7	16	11	11	3	13	7	15	8	5
KF21. % believing the organisation provides equal opportunities for career progression / promotion	93	84	92	68	85	97	86	79	80	80	89	84
Errors & incidents												
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	23	46	25	53	16	47	10	25	33	43	34	28
KF29. % reporting errors, near misses or incidents witnessed in last mth	93	100	94	96	74	100	-	90	100	88	97	88
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.84	3.86	3.87	3.77	3.64	3.94	3.69	3.80	3.60	3.68	4.29	3.77
KF31. Staff confidence and security in reporting unsafe clinical practice	3.89	3.94	3.83	3.63	3.64	3.72	3.50	3.64	3.58	3.72	4.21	3.66
Health and wellbeing												
* *KF17. % feeling unwell due to work related stress in last 12 mths*	34	37	39	40	26	35	26	39	53	48	28	38
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	61	57	50	63	49	66	47	54	48	54	43	62
KF19. Org and mgmt interest in and action on health and wellbeing	3.86	3.63	3.94	3.37	3.70	3.57	3.33	3.47	3.58	3.40	4.28	3.70
Working patterns												
KF15. % satisfied with the opportunities for flexible working patterns	48	49	52	38	52	35	28	37	57	31	73	48
* *KF16. % working extra hours*	65	66	61	61	41	80	29	50	68	72	51	63
Number of respondents	227	112	246	93	271	91	105	149	61	52	85	64

Please note that the locations classification was provided by East Lancashire Hospitals NHS Trust

Table 6.3: Key Findings for different locations (cont) Page 1 of 2

	Community Services LV4	Mfop & Complex Needs L4	Therapies & Orthotics L4	Theatres & Day Surgery L4	Clinical Outpatients L4	Obstetrics L4	Environmental Services L4	Radiological Services L4	General Paediatrics L4	Emergency Dept & Urgent Care	Anaesthetics & Critical Care L4	General Surg Services L4
Job satisfaction												
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.87	3.83	3.80	3.76	3.80	3.74	3.73	3.69	3.49	3.53	4.33	3.73
KF4. Staff motivation at work	4.00	4.00	3.98	3.86	3.80	3.97	3.92	3.80	3.96	3.89	4.28	3.92
KF7. % able to contribute towards improvements at work	77	74	82	63	67	71	44	57	80	54	84	71
KF8. Staff satisfaction with level of responsibility and involvement	3.96	3.97	4.00	3.93	3.85	4.03	3.70	3.73	4.03	3.72	4.49	3.98
KF9. Effective team working	3.95	3.96	4.06	3.77	3.46	3.83	3.26	3.57	3.88	3.37	4.40	3.71
KF14. Staff satisfaction with resourcing and support	3.42	3.32	3.40	3.33	3.60	3.04	3.20	3.41	3.20	3.31	4.07	3.41
Managers												
KF5. Recognition and value of staff by managers and the organisation	3.64	3.45	3.65	3.16	3.44	3.40	3.24	3.29	3.35	3.12	4.22	3.26
KF6. % reporting good communication between senior management and staff	43	39	44	14	34	30	22	29	30	17	58	28
KF10. Support from immediate managers	3.96	3.75	4.06	3.41	3.66	3.89	3.16	3.53	3.63	3.36	4.34	3.78
Patient care & experience												
KF2. Staff satisfaction with the quality of work and care they are able to deliver	4.08	3.81	3.84	4.09	4.19	3.54	4.19	4.13	3.93	3.91	4.34	4.00
KF3. % agreeing that their role makes a difference to patients / service users	93	87	91	91	84	92	88	93	98	84	95	90
KF32. Effective use of patient / service user feedback	3.89	3.81	3.92	3.45	3.65	3.87	3.78	3.70	3.76	3.52	4.51	3.61
Violence, harassment & bullying												
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	10	56	13	14	2	11	4	13	7	29	28	14
* *KF23. % experiencing physical violence from staff in last 12 mths*	0	7	0	0	1	1	0	4	3	6	2	3
KF24. % reporting most recent experience of violence	72	86	50	-	-	-	-	56	-	73	83	-
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	27	42	20	15	28	51	8	37	40	44	20	39
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	17	25	16	29	17	30	19	23	19	21	8	17
KF27. % reporting most recent experience of harassment, bullying or abuse	49	60	60	59	51	52	75	46	39	39	58	27
Overall staff engagement	3.90	3.85	3.89	3.78	3.75	3.82	3.64	3.65	3.77	3.64	4.32	3.80
Number of respondents	227	112	246	93	271	91	105	149	61	52	85	64

Please note that the locations classification was provided by East Lancashire Hospitals NHS Trust

Table 6.3: Key Findings for different locations Page 2 of 2

	Orthopaedic Services L4	Pharmacy L4	Acute Medicine	IMPReS L4	Clinical Laboratory Medicine L4	Digestive Diseases	Logistics L4	Cardiology	Head & Neck L4	Neonates L4	Business Support Unit	OTHER
Appraisals & support for development												
KF11. % appraised in last 12 mths	94	90	96	98	93	79	78	95	83	96	80	91
KF12. Quality of appraisals	3.14	2.98	3.36	3.27	2.59	3.20	2.42	3.43	2.71	3.12	2.85	3.15
KF13. Quality of non-mandatory training, learning or development	4.14	3.96	4.28	4.00	3.92	4.25	3.68	4.28	3.79	3.94	3.87	4.09
Equality & diversity												
* *KF20. % experiencing discrimination at work in last 12 mths*	13	11	16	6	12	16	17	12	13	8	12	9
KF21. % believing the organisation provides equal opportunities for career progression / promotion	89	78	89	90	79	89	76	83	84	89	97	80
Errors & incidents												
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	30	47	54	21	36	42	39	35	25	48	31	21
KF29. % reporting errors, near misses or incidents witnessed in last mth	90	98	100	82	97	90	81	94	75	-	67	88
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.81	4.03	3.88	4.01	3.69	3.78	3.40	3.89	3.39	4.00	3.75	3.76
KF31. Staff confidence and security in reporting unsafe clinical practice	3.66	3.81	3.92	3.82	3.65	3.87	3.13	3.78	3.28	4.02	3.58	3.72
Health and wellbeing												
* *KF17. % feeling unwell due to work related stress in last 12 mths*	31	29	33	29	38	37	25	36	41	28	30	33
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	53	50	61	49	55	54	51	52	66	52	35	52
KF19. Org and mgmt interest in and action on health and wellbeing	3.69	3.70	3.80	3.84	3.55	3.72	3.38	3.80	3.59	4.11	3.50	3.78
Working patterns												
KF15. % satisfied with the opportunities for flexible working patterns	47	42	61	58	40	53	28	69	52	56	60	64
* *KF16. % working extra hours*	71	62	75	61	63	79	43	77	63	57	53	59
Number of respondents	72	134	57	127	102	60	54	67	63	25	51	1007

Please note that the locations classification was provided by East Lancashire Hospitals NHS Trust

Table 6.3: Key Findings for different locations (cont) Page 2 of 2

	Orthopaedic Services L4	Pharmacy L4	Acute Medicine	IMPReS L4	Clinical Laboratory Medicine L4	Digestive Diseases	Logistics L4	Cardiology	Head & Neck L4	Neonates L4	Business Support Unit	OTHER
Job satisfaction												
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.87	3.89	3.96	4.01	3.56	3.77	3.36	4.04	3.63	3.94	3.91	3.91
KF4. Staff motivation at work	4.08	3.82	4.07	4.14	3.58	4.08	3.67	4.11	3.90	4.26	3.97	3.92
KF7. % able to contribute towards improvements at work	69	79	68	81	65	76	42	83	63	79	75	75
KF8. Staff satisfaction with level of responsibility and involvement	4.08	3.86	3.94	4.08	3.79	4.03	3.50	4.06	3.94	4.03	4.03	3.93
KF9. Effective team working	3.92	3.99	3.96	3.97	3.60	3.93	3.14	4.08	3.59	4.14	3.71	3.85
KF14. Staff satisfaction with resourcing and support	3.64	3.46	3.54	3.56	3.17	3.33	3.35	3.49	3.25	3.66	3.62	3.49
Managers												
KF5. Recognition and value of staff by managers and the organisation	3.49	3.46	3.49	3.76	3.17	3.59	2.94	3.67	3.45	3.64	3.52	3.57
KF6. % reporting good communication between senior management and staff	35	45	63	40	33	36	13	42	21	60	31	41
KF10. Support from immediate managers	3.85	3.64	3.86	4.00	3.59	3.86	3.19	4.14	3.62	3.82	3.67	3.84
Patient care & experience												
KF2. Staff satisfaction with the quality of work and care they are able to deliver	4.20	3.90	4.08	4.19	3.71	3.92	3.81	4.06	3.97	4.25	4.04	4.05
KF3. % agreeing that their role makes a difference to patients / service users	89	91	95	96	89	95	77	91	83	100	91	90
KF32. Effective use of patient / service user feedback	3.69	3.51	3.83	4.13	3.47	4.13	-	3.96	3.62	3.88	4.07	3.90
Violence, harassment & bullying												
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	24	3	59	2	0	32	10	20	6	0	10	7
* *KF23. % experiencing physical violence from staff in last 12 mths*	7	2	4	0	2	4	6	5	2	0	2	1
KF24. % reporting most recent experience of violence	73	-	93	-	-	82	-	92	-	-	-	80
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	41	18	63	23	7	40	27	34	37	32	24	18
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	33	14	12	11	15	27	28	25	30	20	10	23
KF27. % reporting most recent experience of harassment, bullying or abuse	64	41	67	40	39	67	44	38	52	-	42	52
Overall staff engagement	3.89	3.83	3.94	4.05	3.56	3.87	3.35	4.04	3.74	3.97	3.91	3.88
Number of respondents	72	134	57	127	102	60	54	67	63	25	51	1007

Please note that the locations classification was provided by East Lancashire Hospitals NHS Trust

Table 6.4: Key Findings for different work groups

	Full time / part time[a]	
	Full time	Part time
Appraisals & support for development		
KF11. % appraised in last 12 mths	92	91
KF12. Quality of appraisals	3.13	3.00
KF13. Quality of non-mandatory training, learning or development	4.09	4.01
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	10	10
KF21. % believing the organisation provides equal opportunities for career progression / promotion	84	85
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	30	21
KF29. % reporting errors, near misses or incidents witnessed in last mth	91	89
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.81	3.77
KF31. Staff confidence and security in reporting unsafe clinical practice	3.73	3.71
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	35	26
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	55	46
KF19. Org and mgmt interest in and action on health and wellbeing	3.73	3.70
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	52	57
* *KF16. % working extra hours*	62	45
Number of respondents	2681	611

[a] Full time is defined as staff contracted to work 30 hours or more a week

Table 6.4: Key Findings for different work groups (cont)

	Full time / part time[a]	
	Full time	Part time
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.84	3.81
KF4. Staff motivation at work	3.92	3.96
KF7. % able to contribute towards improvements at work	73	67
KF8. Staff satisfaction with level of responsibility and involvement	3.94	3.91
KF9. Effective team working	3.85	3.67
KF14. Staff satisfaction with resourcing and support	3.45	3.47
Managers		
KF5. Recognition and value of staff by managers and the organisation	3.51	3.52
KF6. % reporting good communication between senior management and staff	38	33
KF10. Support from immediate managers	3.80	3.72
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	4.01	4.06
KF3. % agreeing that their role makes a difference to patients / service users	90	90
KF32. Effective use of patient / service user feedback	3.85	3.86
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	13	6
* *KF23. % experiencing physical violence from staff in last 12 mths*	2	2
KF24. % reporting most recent experience of violence	76	76
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	26	24
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	21	18
KF27. % reporting most recent experience of harassment, bullying or abuse	52	51
Overall staff engagement	3.85	3.81
Number of respondents	2681	611

[a] Full time is defined as staff contracted to work 30 hours or more a week

7. Key Findings by demographic groups

Tables 7.1 and 7.2 show the Key Findings at East Lancashire Hospitals NHS Trust broken down by different demographic groups: age group, gender, disability and ethnic background.

Technical notes:

- As in previous years, there are two types of Key Finding:
    - percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
    - scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5
- For most of the Key Findings presented in tables 7.1 and 7.2, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative result. For these Key Findings, marked with an asterisk and shown in italics, the lower the score the better.
- Care should be taken not to over interpret the findings if scores differ slightly. For example, if for 'KF11. % appraised in the last 12 months' staff in Group A score 45%, and staff in Group B score 40%, it may appear that a higher proportion of staff in Group A have had appraisals than staff in Group B. However, because of small numbers in these sub-groups, it is probably not statistically significant. A more sensible interpretation would be that, on average, similar proportions of staff in Group A and B have had appraisals.
- Please note that, unlike the overall trust scores, data in this section are not weighted.
- Please also note that all percentage scores are shown to the nearest 1%. This means scores of less than 0.5% are displayed as 0%.
- In order to preserve anonymity of individual staff, a score is replaced with a dash if the demographic group in question contributed fewer than 11 responses to that score.

Table 7.1: Key Findings for different age groups

	Age group			
	Age 16-30	Age 31-40	Age 41-50	Age 51+
Appraisals & support for development				
KF11. % appraised in last 12 mths	90	90	93	93
KF12. Quality of appraisals	3.25	3.29	3.13	2.95
KF13. Quality of non-mandatory training, learning or development	4.11	4.15	4.13	4.00
Equality & diversity				
* *KF20. % experiencing discrimination at work in last 12 mths*	10	12	10	9
KF21. % believing the organisation provides equal opportunities for career progression / promotion	82	83	85	85
Errors & incidents				
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	30	28	29	27
KF29. % reporting errors, near misses or incidents witnessed in last mth	91	94	91	91
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.82	3.89	3.82	3.73
KF31. Staff confidence and security in reporting unsafe clinical practice	3.73	3.79	3.76	3.68
Health and wellbeing				
* *KF17. % feeling unwell due to work related stress in last 12 mths*	28	31	35	35
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	50	55	52	53
KF19. Org and mgmt interest in and action on health and wellbeing	3.69	3.80	3.73	3.70
Working patterns				
KF15. % satisfied with the opportunities for flexible working patterns	54	58	56	48
* *KF16. % working extra hours*	58	61	62	57
Number of respondents	439	650	908	1210

Table 7.1: Key Findings for different age groups (cont)

	Age group			
	Age 16-30	Age 31-40	Age 41-50	Age 51+
Job satisfaction				
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.90	3.88	3.85	3.80
KF4. Staff motivation at work	3.78	3.96	3.98	3.95
KF7. % able to contribute towards improvements at work	72	76	74	70
KF8. Staff satisfaction with level of responsibility and involvement	3.85	3.98	3.97	3.93
KF9. Effective team working	3.85	3.90	3.88	3.72
KF14. Staff satisfaction with resourcing and support	3.58	3.50	3.48	3.37
Managers				
KF5. Recognition and value of staff by managers and the organisation	3.41	3.61	3.57	3.47
KF6. % reporting good communication between senior management and staff	38	42	40	33
KF10. Support from immediate managers	3.71	3.89	3.83	3.73
Patient care & experience				
KF2. Staff satisfaction with the quality of work and care they are able to deliver	4.02	4.06	4.04	4.00
KF3. % agreeing that their role makes a difference to patients / service users	91	91	92	89
KF32. Effective use of patient / service user feedback	3.77	3.88	3.92	3.82
Violence, harassment & bullying				
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	15	12	11	11
* *KF23. % experiencing physical violence from staff in last 12 mths*	1	1	2	2
KF24. % reporting most recent experience of violence	70	80	84	72
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	22	23	25	28
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	17	19	20	21
KF27. % reporting most recent experience of harassment, bullying or abuse	41	55	58	50
Overall staff engagement	3.80	3.89	3.89	3.82
Number of respondents	439	650	908	1210

Table 7.2: Key Findings for other demographic groups

	Gender				Disability		Ethnic background	
	Men	Women	Prefer to self-describe	Prefer not to say	Disabled	Not disabled	White	Black and minority ethnic
Appraisals & support for development								
KF11. % appraised in last 12 mths	91	92	100	86	90	92	92	86
KF12. Quality of appraisals	3.16	3.10	3.48	2.51	2.91	3.16	3.08	3.34
KF13. Quality of non-mandatory training, learning or development	4.06	4.09	-	3.96	4.06	4.09	4.08	4.15
Equality & diversity								
* *KF20. % experiencing discrimination at work in last 12 mths*	17	9	-	12	16	9	8	25
KF21. % believing the organisation provides equal opportunities for career progression / promotion	76	87	-	71	78	86	87	68
Errors & incidents								
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	32	27	9	22	33	27	28	30
KF29. % reporting errors, near misses or incidents witnessed in last mth	88	92	-	91	90	91	92	87
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.74	3.82	-	3.61	3.71	3.82	3.80	3.81
KF31. Staff confidence and security in reporting unsafe clinical practice	3.68	3.75	-	3.35	3.58	3.77	3.74	3.67
Health and wellbeing								
* *KF17. % feeling unwell due to work related stress in last 12 mths*	32	34	27	50	47	30	34	33
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	45	54	45	69	70	49	54	46
KF19. Org and mgmt interest in and action on health and wellbeing	3.69	3.74	3.59	3.28	3.69	3.74	3.74	3.67
Working patterns								
KF15. % satisfied with the opportunities for flexible working patterns	53	54	73	33	45	55	53	51
* *KF16. % working extra hours*	64	58	-	66	60	59	60	57
Number of respondents	567	2589	11	59	585	2615	2866	377

Table 7.2: Key Findings for other demographic groups (cont)

	Gender				Disability		Ethnic background	
	Men	Women	Prefer to self-describe	Prefer not to say	Disabled	Not disabled	White	Black and minority ethnic
Job satisfaction								
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.82	3.85	3.58	3.48	3.75	3.86	3.83	3.89
KF4. Staff motivation at work	3.92	3.95	3.73	3.57	3.84	3.95	3.91	4.11
KF7. % able to contribute towards improvements at work	71	73	64	50	65	74	73	72
KF8. Staff satisfaction with level of responsibility and involvement	3.88	3.96	3.89	3.51	3.80	3.97	3.94	3.92
KF9. Effective team working	3.80	3.83	3.61	3.59	3.72	3.85	3.82	3.84
KF14. Staff satisfaction with resourcing and support	3.44	3.46	3.57	3.12	3.32	3.49	3.44	3.57
Managers								
KF5. Recognition and value of staff by managers and the organisation	3.42	3.55	3.79	2.90	3.38	3.54	3.52	3.51
KF6. % reporting good communication between senior management and staff	40	37	55	19	32	39	37	40
KF10. Support from immediate managers	3.71	3.81	3.79	3.36	3.71	3.81	3.80	3.69
Patient care & experience								
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.99	4.04	-	3.50	3.94	4.04	4.01	4.17
KF3. % agreeing that their role makes a difference to patients / service users	91	91	-	81	88	91	90	90
KF32. Effective use of patient / service user feedback	3.79	3.87	-	3.53	3.72	3.88	3.86	3.84
Violence, harassment & bullying								
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	11	12	18	5	14	11	12	12
* *KF23. % experiencing physical violence from staff in last 12 mths*	2	2	0	2	3	2	2	2
KF24. % reporting most recent experience of violence	64	78	-	-	76	75	76	77
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	22	26	55	25	33	24	26	22
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	19	20	45	33	31	18	20	24
KF27. % reporting most recent experience of harassment, bullying or abuse	42	54	-	39	57	51	52	52
Overall staff engagement	3.83	3.86	3.62	3.45	3.73	3.87	3.84	3.92
Number of respondents	567	2589	11	59	585	2615	2866	377

8. Work and demographic profile of the survey respondents

The occupational group of the staff survey respondents is shown in table 8.1, other work characteristics are shown in table 8.2, and demographic characteristics are shown in table 8.3.

Table 8.1: Occupational group of respondents

Occupational group	Number questionnaires returned	Percentage of survey respondents
Allied Health Professionals		
Occupational Therapy	63	2%
Physiotherapy	153	5%
Radiography	99	3%
Clinical Psychology	5	0%
Psychotherapy	4	0%
Arts Therapy	2	0%
Other qualified Allied Health Professionals	103	3%
Support to Allied Health Professionals	66	2%
Scientific and Technical / Healthcare Scientists		
Pharmacy	122	4%
Other qualified Scientific and Technical / Healthcare Scientists	89	3%
Support to Scientific and Technical / Healthcare Scientists	41	1%
Medical and Dental		
Medical / Dental - Consultant	105	3%
Medical / Dental - In Training	28	1%
Medical / Dental - Other	28	1%
Operational ambulance staff		
Paramedic	2	0%
Patient Transport Service	1	0%
Nurses, Midwives and Nursing Assistants		
Registered Nurses - Adult / General	570	18%
Registered Nurses - Mental Health	14	0%
Registered Nurses - Learning Disabilities	2	0%
Registered Nurses - Children	48	2%
Midwives	72	2%
Health Visitors	2	0%
Registered Nurses - District / Community	75	2%
Other Registered Nurses	22	1%
Nursing auxiliary / Nursing assistant / Healthcare assistant	213	7%
Social Care Staff		
Approved social workers / Social workers / Residential social workers	2	0%
Social care managers	1	0%

Occupational group	Number questionnaires returned	Percentage of survey respondents
Other groups		
Public Health / Health Improvement	13	0%
Commissioning managers / support staff	7	0%
Admin and Clerical	657	21%
Central Functions / Corporate Services	147	5%
Maintenance / Ancillary	191	6%
General Management	85	3%
Other	84	3%
Did not specify	259	

Sums of percentages may add up to more than 100% due to rounding, and do not include 'did not specify' responses

Table 8.2: Work characteristics of respondents

	Number questionnaires returned	Percentage of survey respondents
Full time / part time		
Full time	2681	81%
Part time	611	19%
Did not specify	83	
Length of time in organisation		
Less than a year	229	7%
Between 1 to 2 years	356	11%
Between 3 to 5 years	441	14%
Between 6 to 10 years	560	18%
Between 11 to 15 years	421	13%
Over 15 years	1126	36%
Did not specify	242	

Sums of percentages may add up to more than 100% due to rounding, and do not include 'did not specify' responses

Table 8.3: Demographic characteristics of respondents

	Number questionnaires returned	Percentage of survey respondents
Age group		
Between 16 and 30	439	14%
Between 31 and 40	650	20%
Between 41 and 50	908	28%
51 and over	1210	38%
Did not specify	168	
Gender		
Male	567	18%
Female	2589	80%
Prefer to self-describe	11	0%
Prefer not to say	59	2%
Did not specify	149	
Ethnic background		
White	2866	88%
Black and minority ethnic	377	12%
Did not specify	132	
Disability		
Disabled	585	18%
Not disabled	2615	82%
Did not specify	175	

Sums of percentages may add up to more than 100% due to rounding, and do not include 'did not specify' responses

Appendix 1

Key Findings for East Lancashire Hospitals NHS Trust benchmarked against other acute trusts

Technical notes:

- The first column in table A1 shows the trust's scores for each of the Key Findings. The same data are displayed in section 3 and 4 of this report.
- The second column in table A1 shows the 95% confidence intervals around the trust's scores for each of the Key Findings.
- The third column in table A1 shows the average (median) score for each of the Key Findings for acute trusts. The same data are displayed in section 3 and 4 of this report.
- The fourth and fifth columns in table A1 show the thresholds for the lowest and highest 20% for each of the Key Findings for acute trusts. The data are used to describe comparisons with other trusts as displayed in section 3 and 4 of this report.
- The sixth column in table A1 shows the lowest score attained for each of the Key Findings by an acute trust.
- The seventh column in table A1 shows the highest score attained for each of the Key Findings by an acute trust.
- For most of the Key Findings presented in table A1, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative score. For these Key Findings, marked with an asterisk and shown in italics, the lower the score the better.
- Please note that the data presented in table A1 are rounded to the nearest whole number for percentage scores and to two decimal places for scale summary scores.

Table A1: Key Findings for East Lancashire Hospitals NHS Trust benchmarked against other acute trusts

	Your trust		National scores for acute trusts				
	Trust score	95% Confidence Interval	Median score	Threshold for lowest 20%	Threshold for highest 20%	Lowest score attained	Highest score attained
Response rate	43	-	44	39	50	29	73
Appraisals & support for development							
KF11. % appraised in last 12 mths	92	[91, 93]	86	81	91	65	96
KF12. Quality of appraisals	3.11	[3.06, 3.16]	3.11	3.01	3.20	2.83	3.52
KF13. Quality of non-mandatory training, learning or development	4.09	[4.06, 4.12]	4.05	4.01	4.10	3.90	4.22
Equality & diversity							
* *KF20. % experiencing discrimination at work in last 12 mths*	11	[10, 12]	12	10	14	8	25
KF21. % believing the organisation provides equal opportunities for career progression / promotion	84	[83, 86]	85	82	88	69	94
Errors & incidents							
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	30	[28, 32]	31	28	33	24	42
KF29. % reporting errors, near misses or incidents witnessed in last mth	92	[90, 94]	90	89	91	86	98
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.80	[3.78, 3.83]	3.73	3.64	3.79	3.46	3.88
KF31. Staff confidence and security in reporting unsafe clinical practice	3.74	[3.71, 3.77]	3.65	3.58	3.71	3.43	3.83
Health and wellbeing							
* *KF17. % feeling unwell due to work related stress in last 12 mths*	34	[32, 36]	36	34	40	28	46
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	53	[51, 54]	52	49	55	42	59
KF19. Org and mgmt interest in and action on health and wellbeing	3.72	[3.69, 3.76]	3.62	3.51	3.71	3.34	3.92
Working patterns							
KF15. % satisfied with the opportunities for flexible working patterns	53	[51, 55]	51	47	54	40	60
* *KF16. % working extra hours*	62	[60, 64]	72	69	74	62	78

Table A1: Key Findings for East Lancashire Hospitals NHS Trust benchmarked against other acute trusts (cont)

	Your trust		National scores for acute trusts				
	Trust score	95% Confidence Interval	Median score	Threshold for lowest 20%	Threshold for highest 20%	Lowest score attained	Highest score attained
Job satisfaction							
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.84	[3.81, 3.87]	3.75	3.58	3.94	3.34	4.12
KF4. Staff motivation at work	3.95	[3.92, 3.97]	3.92	3.87	3.96	3.76	4.07
KF7. % able to contribute towards improvements at work	73	[71, 74]	70	67	72	59	78
KF8. Staff satisfaction with level of responsibility and involvement	3.95	[3.93, 3.97]	3.91	3.86	3.96	3.76	4.04
KF9. Effective team working	3.83	[3.81, 3.86]	3.72	3.67	3.80	3.59	3.88
KF14. Staff satisfaction with resourcing and support	3.44	[3.42, 3.47]	3.31	3.23	3.40	3.12	3.58
Managers							
KF5. Recognition and value of staff by managers and the organisation	3.51	[3.48, 3.54]	3.45	3.36	3.53	3.21	3.71
KF6. % reporting good communication between senior management and staff	38	[36, 39]	33	28	38	20	48
KF10. Support from immediate managers	3.79	[3.75, 3.82]	3.74	3.67	3.81	3.55	3.94
Patient care & experience							
KF2. Staff satisfaction with the quality of work and care they are able to deliver	4.02	[3.98, 4.05]	3.91	3.82	3.99	3.69	4.21
KF3. % agreeing that their role makes a difference to patients / service users	91	[90, 92]	90	89	91	86	93
KF32. Effective use of patient / service user feedback	3.86	[3.82, 3.89]	3.71	3.62	3.78	3.41	3.96
Violence, harassment & bullying							
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	13	[11, 14]	15	13	17	9	22
* *KF23. % experiencing physical violence from staff in last 12 mths*	2	[1, 3]	2	2	3	1	5
KF24. % reporting most recent experience of violence	76	[72, 81]	66	63	72	55	79
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	27	[25, 28]	28	25	30	20	36
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	21	[19, 22]	25	22	28	19	38
KF27. % reporting most recent experience of harassment, bullying or abuse	51	[48, 54]	45	42	47	36	59

Appendix 2

Changes to the Key Findings since the 2015 and 2016 staff surveys

Technical notes:

- For most of the Key Findings presented in tables A2.1 and A2.2, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative result. For these Key Findings, marked with an asterisk and shown in italics, the lower the score the better.

- It is likely that we would see some small change simply due to sample differences between the two years. The final column of the tables shows whether the change in your trust is statistically significant or not. If a change is not significant, then there is no evidence of a real change in the trust score.

- Please note that the trust scores and change scores presented in tables A2.1 and A2.2 are rounded to the nearest whole number for percentage scores and to two decimal places for scale summary scores.

- All percentage scores are shown to the nearest 1%. This means scores of less than 0.5% are displayed as 0%.

- In certain cases a dash (-) appears in Table A2.2. This is either because the Key Finding was not calculated in previous years, or there have been changes in how the Key Finding has been calculated this year.

To enable comparison between years, scores from 2016 and 2015 have been re-calculated and re-weighted using the 2017 formulae, so may appear slightly different from figures in previous feedback reports. More details about these changes can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

Table A2.1: Changes in the Key Findings for East Lancashire Hospitals NHS Trust since 2016 survey

	East Lancashire Hospitals NHS Trust			
	2017 score	**2016 score**	**Change**	**Statistically significant?**
Response rate	43	48	-4	N/A
Appraisals & support for development				
KF11. % appraised in last 12 mths	92	77	15	Yes
KF12. Quality of appraisals	3.11	3.18	-0.07	Yes
KF13. Quality of non-mandatory training, learning or development	4.09	4.05	0.03	No
Equality & diversity				
* *KF20. % experiencing discrimination at work in last 12 mths*	11	10	1	No
KF21. % believing the organisation provides equal opportunities for career progression / promotion	84	85	-1	No
Errors & incidents				
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	30	29	1	No
KF29. % reporting errors, near misses or incidents witnessed in last mth	92	91	1	No
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.80	3.79	0.01	No
KF31. Staff confidence and security in reporting unsafe clinical practice	3.74	3.77	-0.03	No
Health and wellbeing				
* *KF17. % feeling unwell due to work related stress in last 12 mths*	34	32	2	No
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	53	51	2	No
KF19. Org and mgmt interest in and action on health and wellbeing	3.72	3.67	0.06	Yes
Working patterns				
KF15. % satisfied with the opportunities for flexible working patterns	53	53	0	No
* *KF16. % working extra hours*	62	64	-2	Yes

Table A2.1: Changes in the Key Findings for East Lancashire Hospitals NHS Trust since 2016 survey (cont)

	East Lancashire Hospitals NHS Trust			
	2017 score	**2016 score**	**Change**	**Statistically significant?**
Job satisfaction				
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.84	3.82	0.02	No
KF4. Staff motivation at work	3.95	3.97	-0.02	No
KF7. % able to contribute towards improvements at work	73	73	-1	No
KF8. Staff satisfaction with level of responsibility and involvement	3.95	3.98	-0.03	No
KF9. Effective team working	3.83	3.80	0.03	No
KF14. Staff satisfaction with resourcing and support	3.44	3.42	0.02	No
Managers				
KF5. Recognition and value of staff by managers and the organisation	3.51	3.52	-0.01	No
KF6. % reporting good communication between senior management and staff	38	40	-2	No
KF10. Support from immediate managers	3.79	3.78	0.00	No
Patient care & experience				
KF2. Staff satisfaction with the quality of work and care they are able to deliver	4.02	4.01	0.00	No
KF3. % agreeing that their role makes a difference to patients / service users	91	91	0	No
KF32. Effective use of patient / service user feedback	3.86	3.85	0.00	No
Violence, harassment & bullying				
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	13	13	0	No
* *KF23. % experiencing physical violence from staff in last 12 mths*	2	2	0	No
KF24. % reporting most recent experience of violence	76	72	4	No
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	27	27	0	No
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	21	22	-1	No
KF27. % reporting most recent experience of harassment, bullying or abuse	51	47	4	No

Table A2.2: Changes in the Key Findings for East Lancashire Hospitals NHS Trust since 2015 survey

	East Lancashire Hospitals NHS Trust			
	2017 score	**2015 score**	**Change**	**Statistically significant?**
Response rate	43	39	4	-
Appraisals & support for development				
KF11. % appraised in last 12 mths	92	82	10	Yes
KF12. Quality of appraisals	3.11	3.12	-0.01	No
KF13. Quality of non-mandatory training, learning or development	4.09	3.99	0.09	Yes
Equality & diversity				
* *KF20. % experiencing discrimination at work in last 12 mths*	11	9	1	No
KF21. % believing the organisation provides equal opportunities for career progression / promotion	84	84	0	No
Errors & incidents				
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	30	29	1	No
KF29. % reporting errors, near misses or incidents witnessed in last mth	92	93	-1	No
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.80	3.77	0.04	No
KF31. Staff confidence and security in reporting unsafe clinical practice	3.74	3.74	0.01	No
Health and wellbeing				
* *KF17. % feeling unwell due to work related stress in last 12 mths*	34	35	-1	No
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	53	53	0	No
KF19. Org and mgmt interest in and action on health and wellbeing	3.72	3.63	0.09	Yes
Working patterns				
KF15. % satisfied with the opportunities for flexible working patterns	53	54	-1	No
* *KF16. % working extra hours*	62	67	-5	Yes

Table A2.2: Changes in the Key Findings for East Lancashire Hospitals NHS Trust since 2015 survey (cont)

	East Lancashire Hospitals NHS Trust			
	2017 score	**2015 score**	**Change**	**Statistically significant?**
Job satisfaction				
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.84	3.80	0.04	No
KF4. Staff motivation at work	3.95	3.99	-0.04	Yes
KF7. % able to contribute towards improvements at work	73	72	0	No
KF8. Staff satisfaction with level of responsibility and involvement	3.95	3.94	0.01	No
KF9. Effective team working	3.83	3.84	0.00	No
KF14. Staff satisfaction with resourcing and support	3.44	3.38	0.06	Yes
Managers				
KF5. Recognition and value of staff by managers and the organisation	3.51	3.48	0.03	No
KF6. % reporting good communication between senior management and staff	38	39	-1	No
KF10. Support from immediate managers	3.79	3.74	0.05	Yes
Patient care & experience				
KF2. Staff satisfaction with the quality of work and care they are able to deliver	4.02	3.99	0.03	No
KF3. % agreeing that their role makes a difference to patients / service users	91	91	0	No
KF32. Effective use of patient / service user feedback	3.86	3.89	-0.03	No
Violence, harassment & bullying				
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	13	12	0	No
* *KF23. % experiencing physical violence from staff in last 12 mths*	2	2	0	No
KF24. % reporting most recent experience of violence	76	72	4	No
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	27	26	1	No
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	21	23	-3	Yes
KF27. % reporting most recent experience of harassment, bullying or abuse	51	46	5	Yes

Appendix 3

Data tables: 2017 Key Findings and the responses to all survey questions

For each of the 32 Key Findings (Table A3.1) and each individual survey question in the core version of the questionnaire (Table A3.2), this appendix presents your trust's 2017 survey response, the average (median) 2017 response for acute trusts, and your trust's 2016 survey response (where applicable).

In Table A3.1, the question numbers used to calculate the 32 Key Findings are also listed in the first column.

In Table A3.2, the responses to the survey questions are presented in the order that they appear within the core version of the 2017 questionnaire.

Technical notes:

- In certain cases a dash (-) appears in Tables A3.1 or A3.2. This is in order to preserve anonymity of individual staff, where there were fewer than 11 responses to a survey question or Key Finding.

- Please note that the figures reported in tables A3.1 and A3.2 are un-weighted, and, as a consequence there may be some slight differences between these figures and the figures reported in sections 3 and 4 and Appendix 2 of this report, which are weighted according to the occupational group profile of a typical acute trust.

- The question data within this section excludes any non-specific responses ('Don't know'/'Can't remember').

- More details about the calculation of Key Findings and the weighting of data can be found in the document ***Making sense of your staff survey data***, which can be downloaded from: www.nhsstaffsurveys.com

Table A3.1: Key Findings for East Lancashire Hospitals NHS Trust benchmarked against other acute trusts

	Question number(s)	Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
Appraisals & support for development				
KF11. % appraised in last 12 mths	Q20a	92	86	76
KF12. Quality of appraisals	Q20b-d	3.10	3.10	3.18
KF13. Quality of non-mandatory training, learning or development	Q18b-d	4.08	4.05	4.04
Equality & diversity				
* *KF20. % experiencing discrimination at work in last 12 mths*	Q17a-b	10	12	9
KF21. % believing the organisation provides equal opportunities for career progression / promotion	Q16	84	85	85
Errors & incidents				
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	Q11a-b	28	30	26
KF29. % reporting errors, near misses or incidents witnessed in last mth	Q11c	91	90	90
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	Q12a-d	3.80	3.73	3.79
KF31. Staff confidence and security in reporting unsafe clinical practice	Q13b-c	3.73	3.65	3.76
Health and wellbeing				
* *KF17. % feeling unwell due to work related stress in last 12 mths*	Q9c	34	36	32
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	Q9d-g	53	52	50
KF19. Org and mgmt interest in and action on health and wellbeing	Q7f, 9a	3.72	3.62	3.67
Working patterns				
KF15. % satisfied with the opportunities for flexible working patterns	Q5h	53	51	53
* *KF16. % working extra hours*	Q10b-c	59	71	62

Table A3.1: Key Findings for East Lancashire Hospitals NHS Trust benchmarked against other acute trusts (cont)

	Question number(s)	Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
Job satisfaction				
KF1. Staff recommendation of the organisation as a place to work or receive treatment	Q21a, 21c-d	3.83	3.76	3.82
KF4. Staff motivation at work	Q2a-c	3.93	3.92	3.95
KF7. % able to contribute towards improvements at work	Q4a-b, 4d	72	70	72
KF8. Staff satisfaction with level of responsibility and involvement	Q3a-b, 4c, 5d-e	3.93	3.90	3.96
KF9. Effective team working	Q4h-j	3.81	3.71	3.78
KF14. Staff satisfaction with resourcing and support	Q4e-g, 5c	3.45	3.31	3.43
Managers				
KF5. Recognition and value of staff by managers and the organisation	Q5a, 5f, 7g	3.51	3.44	3.51
KF6. % reporting good communication between senior management and staff	Q8a-d	37	33	39
KF10. Support from immediate managers	Q5b, 7a-e	3.78	3.74	3.77
Patient care & experience				
KF2. Staff satisfaction with the quality of work and care they are able to deliver	Q3c, 6a, 6c	4.02	3.92	4.03
KF3. % agreeing that their role makes a difference to patients / service users	Q6b	90	90	91
KF32. Effective use of patient / service user feedback	Q21b, 22b-c	3.85	3.71	3.86
Violence, harassment & bullying				
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	Q14a	12	14	12
* *KF23. % experiencing physical violence from staff in last 12 mths*	Q14b-c	2	2	2
KF24. % reporting most recent experience of violence	Q14d	76	67	71
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	Q15a	26	27	26
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	Q15b-c	20	25	22
KF27. % reporting most recent experience of harassment, bullying or abuse	Q15d	52	45	48

Table A3.2: Survey questions benchmarked against other acute trusts

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
	Contact with patients			
Q1	% saying they have face-to-face contact with patients / service users as part of their job	81	83	83
	Staff motivation at work			
	% saying often or always to the following statements:			
Q2a	"I look forward to going to work"	58	58	59
Q2b	"I am enthusiastic about my job"	74	74	75
Q2c	"Time passes quickly when I am working"	79	77	79
	Job design			
	% agreeing / strongly agreeing with the following statements:			
Q3a	"I always know what my work responsibilities are"	88	88	89
Q3b	"I am trusted to do my job"	92	92	93
Q3c	"I am able to do my job to a standard I am personally pleased with"	83	80	84
	Opportunities to develop potential at work			
	% agreeing / strongly agreeing with the following statements:			
Q4a	"There are frequent opportunities for me to show initiative in my role"	73	73	75
Q4b	"I am able to make suggestions to improve the work of my team / department"	78	74	77
Q4c	"I am involved in deciding on changes introduced that affect my work area / team / department"	56	53	56
Q4d	"I am able to make improvements happen in my area of work"	60	56	59
Q4e	"I am able to meet all the conflicting demands on my time at work"	52	46	50
Q4f	"I have adequate materials, supplies and equipment to do my work"	61	54	62
Q4g	"There are enough staff at this organisation for me to do my job properly"	38	31	36
Q4h	"The team I work in has a set of shared objectives"	74	72	73
Q4i	"The team I work in often meets to discuss the team's effectiveness"	65	58	65
Q4j	"Team members have to communicate closely with each other to achieve the team's objectives"	79	78	80
	Staff job satisfaction			
	% satisfied or very satisfied with the following aspects of their job:			
Q5a	"The recognition I get for good work"	54	52	54
Q5b	"The support I get from my immediate manager"	69	67	68
Q5c	"The support I get from my work colleagues"	83	81	82
Q5d	"The amount of responsibility I am given"	74	74	76
Q5e	"The opportunities I have to use my skills"	72	71	75
Q5f	"The extent to which my organisation values my work"	47	43	48
Q5g	"My level of pay"	36	30	43
Q5h	"The opportunities for flexible working patterns"	53	51	53
	Contribution to patient care			
	% agreeing / strongly agreeing with the following statements:			
Q6a	"I am satisfied with the quality of care I give to patients / service users"	84	81	85
Q6b	"I feel that my role makes a difference to patients / service users"	90	90	91
Q6c	"I am able to deliver the patient care I aspire to"	72	67	73

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
	Your managers			
	% agreeing / strongly agreeing with the following statements:			
Q7a	"My immediate manager encourages those who work for her/him to work as a team"	75	74	75
Q7b	"My immediate manager can be counted on to help me with a difficult task at work"	72	71	72
Q7c	"My immediate manager gives me clear feedback on my work"	62	61	61
Q7d	"My immediate manager asks for my opinion before making decisions that affect my work"	56	55	56
Q7e	"My immediate manager is supportive in a personal crisis"	77	74	75
Q7f	"My immediate manager takes a positive interest in my health and well-being"	69	67	67
Q7g	"My immediate manager values my work"	71	71	71
Q8a	"I know who the senior managers are here"	86	83	85
Q8b	"Communication between senior management and staff is effective"	45	40	47
Q8c	"Senior managers here try to involve staff in important decisions"	37	34	38
Q8d	"Senior managers act on staff feedback"	37	32	37
	Health and well-being			
Q9a	% saying their organisation definitely takes positive action on health and well-being	38	32	35
Q9b	% saying they have have experienced musculoskeletal problems (MSK) in the last 12 months as a result of work activities	25	26	24
Q9c	% saying they have have felt unwell in the last 12 months as a result of work related stress	34	36	32
Q9d	% saying in the last three months they had gone to work despite not feeling well enough to perform their duties	57	56	55
	If attended work despite not feeling well enough (YES to Q9d), % saying they...			
Q9e	...had felt pressure from their manager to come to work	25	27	24
Q9f	...had felt pressure from their colleagues to come to work	19	21	18
Q9g	...had put themselves under pressure to come to work	92	92	92
	Working hours			
Q10a	% working part time (up to 29 hours a week)	19	20	18
Q10b	% working additional PAID hours	28	35	29
Q10c	% working additional UNPAID hours	47	57	48
	Witnessing and reporting errors, near misses and incidents			
Q11a	% witnessing errors, near misses or incidents in the last month that could have hurt staff	16	17	15
Q11b	% witnessing errors, near misses or incidents in the last month that could have hurt patients / service users	24	26	22
Q11c	If they witnessed an error, near miss or incident that could have hurt staff or patients / service users (YES to Q11a or YES to Q11b), % saying the last time this happened, either they or a colleague had reported it	95	95	94

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
	Fairness and effectiveness of procedures for reporting errors, near misses or incidents			
	% agreeing / strongly agreeing with the following statements:			
Q12a	"My organisation treats staff who are involved in an error, near miss or incident fairly"	57	55	58
Q12b	"My organisation encourages us to report errors, near misses or incidents"	90	88	89
Q12c	"When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again"	72	69	72
Q12d	"We are given feedback about changes made in response to reported errors, near misses and incidents"	60	56	59
	Raising concerns about unsafe clinical practice			
Q13a	% saying if they were concerned about unsafe clinical practice they would know how to report it	95	95	95
	% agreeing / strongly agreeing with the following statements:			
Q13b	"I would feel secure raising concerns about unsafe clinical practice"	71	69	73
Q13c	"I am confident that the organisation would address my concern"	62	57	63
	Experiencing and reporting physical violence at work			
	% experiencing physical violence at work from patients / service users, their relatives or other members of the public in last 12 months...			
Q14a	Never	88	86	88
Q14a	1 to 2 times	8	9	7
Q14a	3 to 5 times	2	3	3
Q14a	6 to 10 times	1	1	1
Q14a	More than 10 times	1	1	1
	% experiencing physical violence at work from managers in last 12 months...			
Q14b	Never	99	99	99
Q14b	1 to 2 times	0	0	0
Q14b	3 to 5 times	0	0	0
Q14b	6 to 10 times	0	0	0
Q14b	More than 10 times	0	0	0
	% experiencing physical violence at work from other colleagues in last 12 months...			
Q14c	Never	98	98	98
Q14c	1 to 2 times	1	1	1
Q14c	3 to 5 times	1	0	0
Q14c	6 to 10 times	0	0	0
Q14c	More than 10 times	0	0	0
Q14d	(If YES to Q14a, Q14b or Q14c) % saying the last time they experienced an incident of physical violence, either they or a colleague had reported it	76	67	71
	Experiencing and reporting harassment, bullying and abuse at work			
	% experiencing harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public in last 12 months...			
Q15a	Never	74	73	74
Q15a	1 to 2 times	16	17	16
Q15a	3 to 5 times	5	6	5
Q15a	6 to 10 times	2	2	2
Q15a	More than 10 times	3	3	2

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
	% experiencing harassment, bullying or abuse at work from managers in last 12 months...			
Q15b	Never	90	87	89
Q15b	1 to 2 times	7	9	7
Q15b	3 to 5 times	2	2	2
Q15b	6 to 10 times	1	1	1
Q15b	More than 10 times	1	1	1
	% experiencing harassment, bullying or abuse at work from other colleagues in last 12 months...			
Q15c	Never	84	81	84
Q15c	1 to 2 times	11	13	12
Q15c	3 to 5 times	3	3	3
Q15c	6 to 10 times	1	1	1
Q15c	More than 10 times	1	1	1
Q15d	(If YES to Q15a, Q15b or Q15c) % saying the last time they experienced an incident of harassment, bullying or abuse, either they or a colleague had reported it	52	45	49
	Equal opportunities			
Q16	% saying the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	84	85	85
	Discrimination			
Q17a	% saying they had experienced discrimination from patients / service users, their relatives or other members of the public in the last 12 months	5	6	5
Q17b	% saying they had experienced discrimination from their manager / team leader or other colleagues in the last 12 months	6	8	7
	% saying they had experienced discrimination on the grounds of:			
Q17c	Ethnic background	41	40	33
Q17c	Gender	23	19	20
Q17c	Religion	13	4	9
Q17c	Sexual orientation	4	4	5
Q17c	Disability	9	8	10
Q17c	Age	17	18	21
Q17c	Other reason(s)	30	33	34
	Job-relevant training, learning and development			
Q18a	% having received non-mandatory training, learning or development in the last 12 months	73	71	77
	% who had received training, learning and development in the last 12 months (YES to Q18a) agreeing / strongly agreeing with the following statements:			
Q18b	"It has helped me to do my job more effectively"	85	84	83
Q18c	"It has helped me stay up-to-date with professional requirements"	88	87	88
Q18d	"It has helped me to deliver a better patient / service user experience"	82	82	83
Q19	% who had received mandatory training in the last 12 months	98	97	98
	Appraisals			
Q20a	% saying they had received an appraisal or performance development review in the last 12 months	92	86	76

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
	If (YES to Q20a) had received an appraisal or performance development review in the last 12 months:			
Q20b	% saying their appraisal or development review definitely helped them to improve how they do their job	22	22	23
Q20c	% saying their appraisal or development review definitely helped them agree clear objectives for their work	33	34	34
Q20d	% saying their appraisal or development review definitely made them feel their work was valued by the organisation	29	30	29
Q20e	% saying the values of their organisation were definitely discussed as part of the appraisal	40	33	31
Q20f	% saying their appraisal or development review had identified training, learning or development needs	65	64	70
	If (YES to Q20a) had received an appraisal or performance development review AND (YES to Q20f) training, learning or development needs identified as part of their appraisal or development review:			
Q20g	% saying their manager definitely supported them to receive training, learning or development	58	51	59
	Your organisation			
	% agreeing / strongly agreeing with the following statements:			
Q21a	"Care of patients / service users is my organisation's top priority"	80	76	80
Q21b	"My organisation acts on concerns raised by patients / service users"	77	73	78
Q21c	"I would recommend my organisation as a place to work"	66	61	65
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	72	71	70
	Patient / service user experience measures			
	% saying 'Yes'			
Q22a	"Is patient / service user experience feedback collected within your directorate / department?"	92	89	91
	If patient / service user feedback collected (YES to Q22a), % agreeing or strongly agreeing with the following statements:			
Q22b	"I receive regular updates on patient / service user experience feedback in my directorate / department"	70	62	70
Q22c	"Feedback from patients / service users is used to make informed decisions within my directorate / department"	64	58	64
	BACKGROUND DETAILS			
	Gender			
Q23a	Male	18	20	19
Q23a	Female	80	77	81
Q23a	Prefer to self-describe	0	0	0
Q23a	Prefer not to say	2	2	0
	Age group			
Q23b	Between 16 and 30	14	16	13
Q23b	Between 31 and 40	20	21	18
Q23b	Between 41 and 50	28	27	28
Q23b	51 and over	38	34	40
	Ethnic background			
Q24	White	88	88	89
Q24	Mixed	1	1	1
Q24	Asian / Asian British	9	7	8
Q24	Black / Black British	1	2	0
Q24	Chinese	0	0	0
Q24	Other	1	1	1

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
	Sexuality			
Q25	Heterosexual (straight)	93	91	93
Q25	Gay Man	1	1	1
Q25	Gay Woman (lesbian)	1	1	1
Q25	Bisexual	0	1	0
Q25	Other	0	0	0
Q25	Preferred not to say	5	7	5
	Religion			
Q26	No religion	25	34	24
Q26	Christian	61	53	63
Q26	Buddhist	0	1	0
Q26	Hindu	1	2	1
Q26	Jewish	0	0	0
Q26	Muslim	7	2	6
Q26	Sikh	0	0	0
Q26	Other	1	2	1
Q26	Preferred not to say	5	6	4
	Disability			
Q27a	% saying they have a long-standing illness, health problem or disability	18	17	17
Q27b	If long-standing disability (YES to Q27a and if adjustments felt necessary), % saying their employer has made adequate adjustment(s) to enable them to carry out their work	81	74	74
	Length of time at the organisation (or its predecessors)			
Q28	Less than 1 year	7	9	7
Q28	1 to 2 years	11	14	10
Q28	3 to 5 years	14	17	15
Q28	6 to 10 years	18	17	19
Q28	11 to 15 years	13	14	16
Q28	More than 15 years	36	28	34
	Occupational group			
Q29	Registered Nurses and Midwives	26	28	25
Q29	Nursing or Healthcare Assistants	7	8	6
Q29	Medical and Dental	5	9	6
Q29	Allied Health Professionals	16	12	17
Q29	Scientific and Technical / Healthcare Scientists	8	8	6
Q29	Social Care staff	0	0	0
Q29	Emergency Care Practitioner	0	0	0
Q29	Paramedic	0	0	0
Q29	Emergency Care Assistant	0	0	0
Q29	Ambulance Technician	0	0	0
Q29	Ambulance Control Staff	0	0	0
Q29	Patient Transport Service	0	0	0
Q29	Public Health / Health Improvement	0	0	0
Q29	Commissioning staff	0	0	0
Q29	Admin and Clerical	21	17	20
Q29	Central Functions / Corporate Services	5	5	5
Q29	Maintenance / Ancillary	6	6	10
Q29	General Management	3	3	3
Q29	Other	3	3	2

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
	Team working			
Q30a	% working in a team	95	95	94
	(If YES to Q30a): Number of core members in their team			
Q30b	2-5	19	22	21
Q30b	6-9	18	20	17
Q30b	10-15	18	18	20
Q30b	More than 15	45	38	42

Appendix 4

Other NHS staff survey 2017 documentation

This report is one of several ways in which we present the results of the 2017 national NHS staff survey:

1) A separate summary report of the main 2017 survey results for East Lancashire Hospitals NHS Trust can be downloaded from: www.nhsstaffsurveys.com. The summary report is a shorter version of this feedback report, which may be useful for wider circulation within the trust.

2) A national briefing document, describing the national Key Findings from the 2017 survey and making comparisons with previous years, will be available from www.nhsstaffsurveys.com in March 2018.

3) The document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com. This includes details about the calculation of Key Findings and the data weighting method used.

4) A series of detailed spreadsheets will be made available after publication via www.nhsstaffsurveys.com. In these detailed spreadsheets you will be able to find:
    - responses of staff in your trust to every core survey question
    - responses in every trust in England
    - the average responses for each major trust type (e.g. all acute trusts, all ambulance trusts)
    - the average responses for each major occupational and demographic group within the major trust types

Appendix 3: Workforce Race Equality Standard (WRES) 4 indicators from 2017 staff survey results

KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	2017 White	2017 BME	2016 White	2016 BME
	26% →	22% →	26%	21%
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	**2017 White**	**2017 BME**	2016 White	2016 BME
	20% ↑	24% ↓	22%	20%
KF21. Percentage believing that the Trust provides equal opportunities for career progression or promotion	**2017 White**	**2017 BME**	2016 White	2016 BME
	87% ↑	68% ↓	86%	73%
Q17B. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	**2017 White**	**2017 BME**	2016 White	2016 BME
	5% ↑	16% ↓	6%	14%

Appendix 4: NHS Staff Survey overall engagement score benchmarking data- North West

Overall Engagement score			Local Acute Trust	Rank
2016	2017	Trend		
3.96	3.95	↓	St Helens And Knowsley Hospitals NHS Trust	1
3.95	3.95	-	Wrightington, Wigan and Leigh NHS Foundation Trust	2
3.95	3.89	↓	Tameside Hospital NHS Foundation Trust	3
3.88	3.86	↓	Bolton NHS Foundation Trust	4
3.86	3.86	-	East Lancashire Hospitals NHS Trust	4
3.90	3.85	↓	Mid Cheshire Hospitals NHS Foundation Trust	5
3.80	3.85	↑	Airedale NHS Foundation Trust	6
3.86	3.83	↓	East Cheshire	7
3.81	3.83	↑	Blackpool Teaching Hospitals	8
3.79	3.79	-	University Hospital of South Manchester Foundation Trust	9
3.78	3.79	↑	University Hospitals of Morecambe Bay Foundation Trust	10
3.84	3.78	↓	Central Manchester University Hospitals	11
3.80	3.78	↓	Salford Royal	12
3.80	3.78	↓	Lancashire Teaching Hospitals NHS Foundation Trust	13
3.80	3.75	↓	Calderdale and Huddersfield NHS Foundation Trust	14
3.78	3.75	↓	Wirral University Teaching Hospital NHS Foundation Trust	15
3.77	3.75	↓	Countess of Chester Hospital NHS Foundation Trust	16
3.77	3.74	↓	Royal Liverpool & Broadgreen University Hospitals Trust	17
3.73	3.74	↑	Warrington and Halton Hospitals NHS Foundation Trust	18
3.75	3.73	↓	Stockport	19
3.70	3.72	↑	Aintree University Hospital NHS Foundation Trust	20
3.64	3.71	↑	Pennine Acute Hospitals NHS Trust	21
3.81	3.63	↓	Lancashire Care NHS Foundation Trust	22
3.66	3.63	↓	Southport and Ormskirk Hospital	23
3.60	3.62	↑	North Cumbria University Hospitals NHS Trust	24

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 15

14 March 2018

Purpose Monitoring

Title	Integrated Performance Report for the period **April 2017 to January 2018**
Author	Mr M Johnson, Associate Director of Performance and Informatics
Executive sponsor	Mr J Bannister, Executive Director of Operations

Summary:

This paper presents the corporate performance data at January 2018

Report linkages

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

	effective care through clinical pathways
	The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework
	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

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

Previously considered by: Not applicable

Board of Directors, Update

Corporate Report

Executive Overview Summary

One never event reported during January, relating to a diagnostic incident. A total of eleven incidents were reported to StEIS during the period.

Two clostridium difficile infections were detected during January, bringing the total to 28 against the Trust target of 28. No further MRSA infections.

Nurse and midwifery staffing remained challenging in January with 10 areas below the 80% average fill rate during the period.

Patient experience scores are above threshold and the complaints rate is still low. HSMR remains 'better than expected'

The number of ambulance handovers over 30 minutes reduced during January, however the HAS compliance indicator continues to be below threshold, although has improved slightly on last month. The 4 hour target performance remains below the 95% threshold, however the proportion of delayed discharges has remained just above threshold. There was 1 physical breaches of the 12 hour trolley wait standard in January and 4 mental health breaches.

Operational pressures around elective care pathways continued in January with elective pacing in place and pressures on beds due to emergency patients. There was a high number of operations cancelled on day, and there were five breaches of the 28 day standard in January.

Despite the pressures, the Referral to Treatment (RTT) target improved to 92.3% above the 92% standard. There were no breaches of the 52wk standard at the end of January.

All cancer targets were met during December and for quarter 3.

Sickness rates are still above threshold, however are lower than last year in the period.

The vacancy rate increased further in January to 8.2%

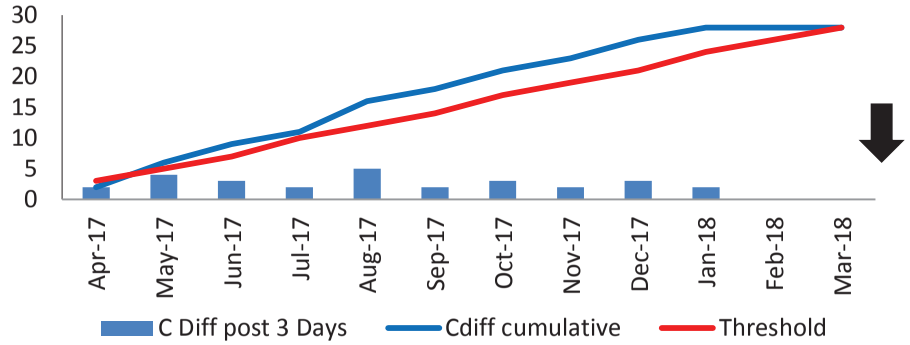
The Trust continues to report that we remain on target to achieve our 2017-18 control total, only after excluding the STF allocation. As a result, an overall Finance and Use of Resources metric score of 3 is forecast.

Introduction

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

SAFE

C Difficile

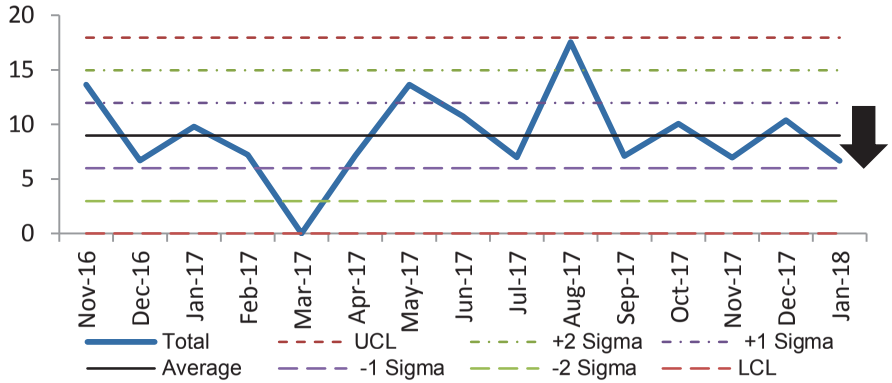


There were no MRSA infections reported in January. Year to date there have been two cases attributed to ELHT.

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

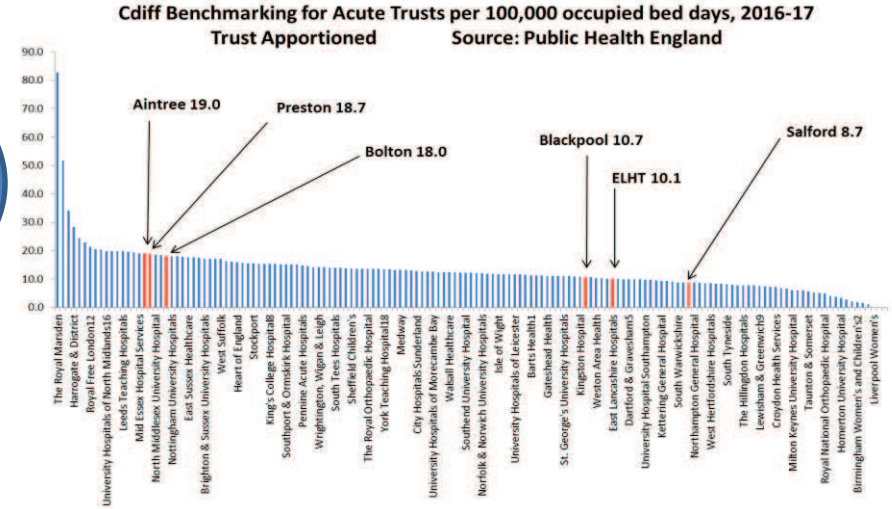
The year to date cumulative figure is 28 against the trust target of 28. The detailed infection control report will be reviewed through the Quality Committee.

C Difficile per 100,000 occupied bed days



The rate of infection per 100,000 bed days was below the average in January at 6.7

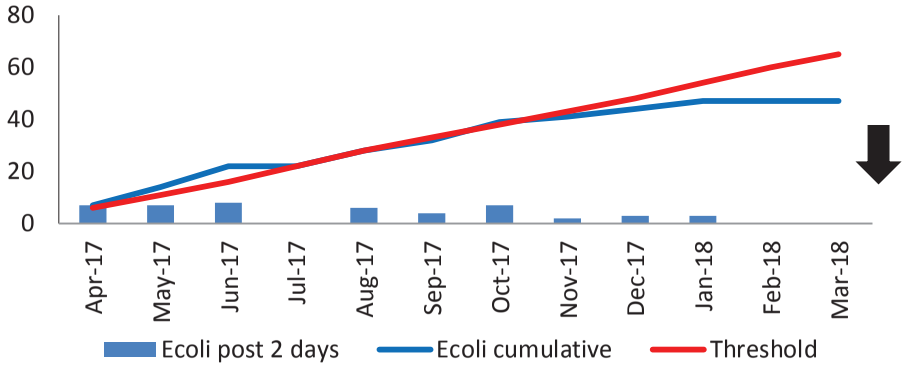
C Difficile benchmarking



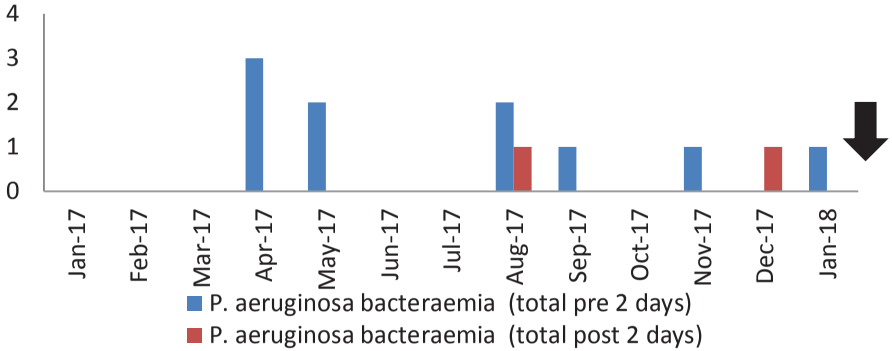
ELHT ranked 51st out of 153 trusts in 2016-17 with 10.1 clostridium infections per 100,000 bed days. The best performing trust had 0 and the worst performer had 83 infections per 100,000 bed days.

SAFE

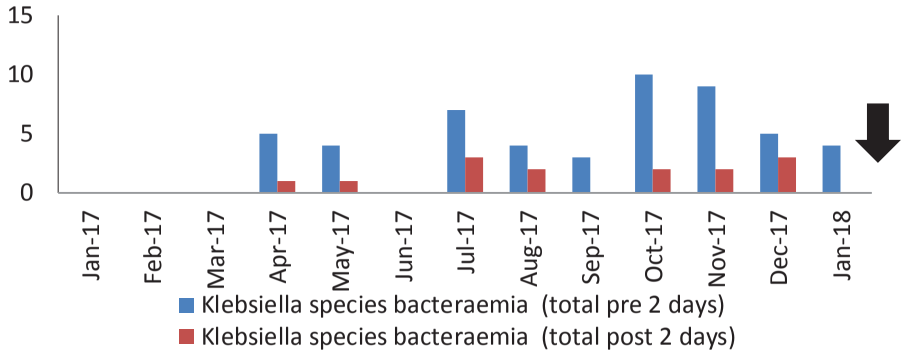
E. Coli



P.aeruginosa



Klebsiella



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

One of the first priorities is reducing E.coli BSI which account for 55% of all BSI nationally. The 2017/18 the aim is to achieve a 10% reduction.

In 2016/17 there were 420 E. coli bacteraemia; 72 were post 2 days of admission. This year we should have no more than 65 E. coli bacteraemia.

There were three E.coli bacteraemia detected in January, which brings the year to date figure to 47, which is under the threshold.

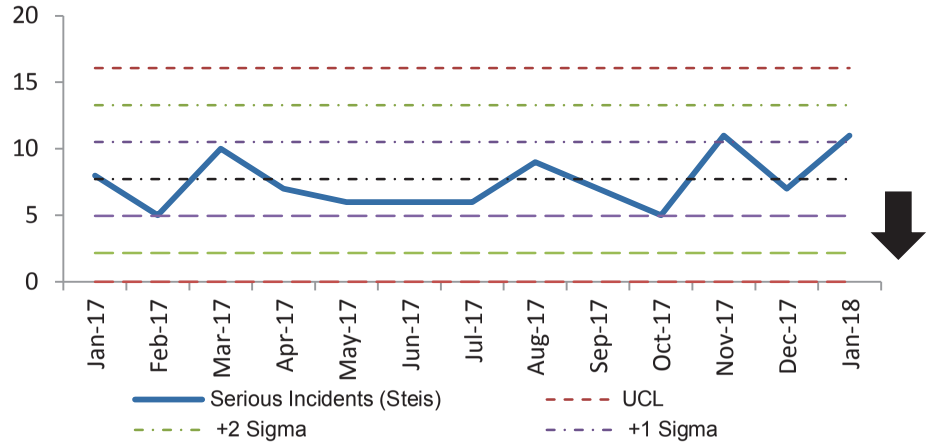
From April 2017, NHS Trusts must report cases of bloodstream infections due to *Klebsiella species* and *Pseudomonas aeruginosa* to Public Health England.

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

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

SAFE

Serious Incidents

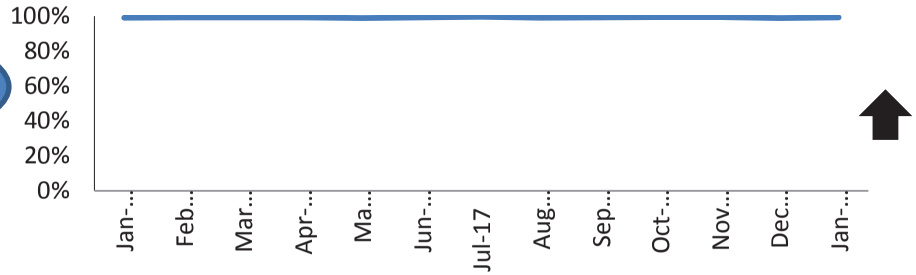


There was one never event reported in January, relating to a diagnostic incident.

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

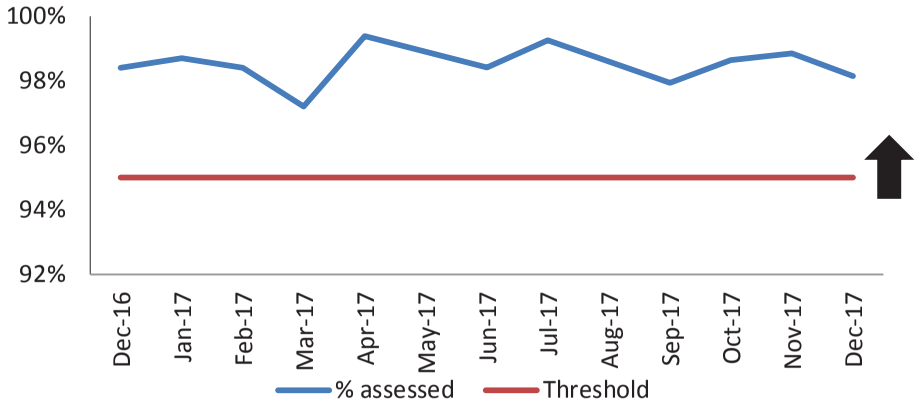
StEIS Category	No. Incidents in January
Diagnostic Incident	1
Slips Trips and Falls	1
Pressure Ulcer	5
Medication Error	1
Treatment Delay	1
Maternity/ Obstetrics - baby only	1
Pending Review	1

% Harm Free



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

VTE assessment

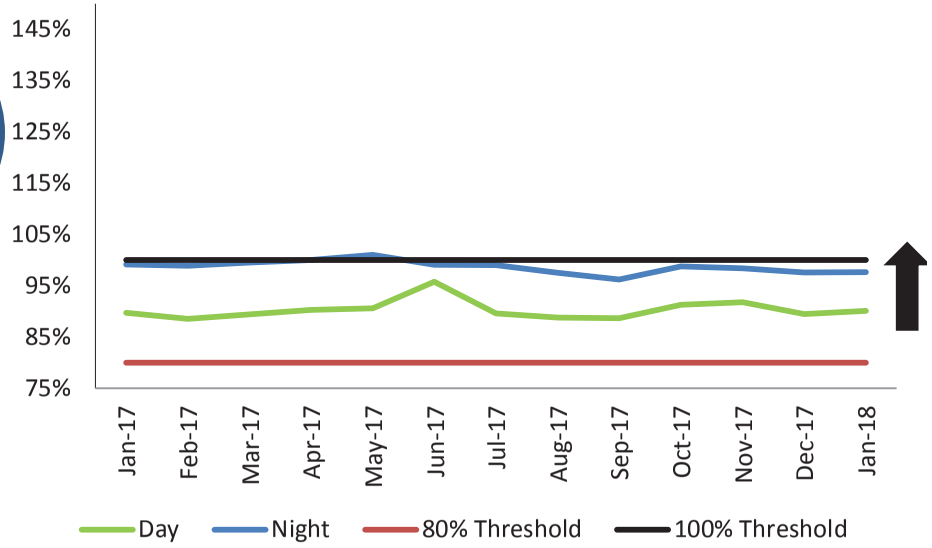


The Trust remains consistent with the percentage of patients with harm free care at 99.3% for January using the National safety thermometer tool.

For January we are reporting the current position as one grade 2 hospital aquired, nine grade 2 community acquired, two grade 3 hospital aquired and 1 grade 4 hospital aquired pressure ulcers. All pending investigation.

SAFE

Registered Nurses/ Midwives



Nursing and midwifery staffing in January 2018 remained extremely challenging. 10 areas fell below an 80% average fill rate for registered nurses on day shifts, which was however a slight improvement on December 17. Within the family care division 1 area fell below the 80% average fill rate for registered midwives on night duty.

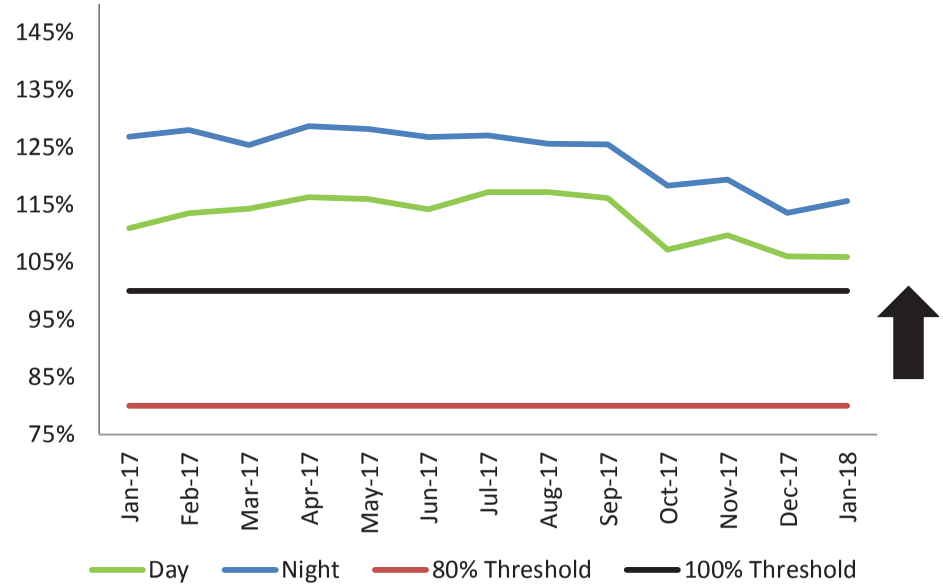
The causative factors remain as in previous months, compounded by escalation areas being opened, vacancies and sickness. There are other issues emerging in that registered nurse allocation on arrival shifts have been difficult to fill as agency staff it would appear are accepting shifts and then either cancelling at last minute or not attending. At this juncture anecdote suggests that some nurses belong to more than one agency and if they get a better offer in respect of hourly rate they change to that shift. The agencies have also been holding out for increasing hourly rates of pay. The Director of Nursing has written to NHS Improvement expressing her concerns

Of the 10 areas below the 80% for registered nurses on day shifts, 8 were due to co-ordinator unavailability which is in addition to agreed staffing levels, leaving 2 areas of concern.

Daylight shifts:

- B2
- B18

Care Staff



Night Shifts Registered Midwives

- Blackburn Birth Centre

The situation remains as in previous months and Blackburn Birth Centre is still experiencing difficulty staffing to the planned requirements on night duty due to sickness and maternity leave. To maintain safety and mitigate the risk, the numbers of women at any one time in labour are reduced in line with the safe staffing when required.
It should be noted that actual and planned staffing does not denote acuity, dependency, the amount of women in labour or bed occupancy. The divisions consistently risk assess 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 /midvives (%)	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
Jan-18	90.10%	105.90%	97.60%	115.70%	27991	8.84	10	0	1	1

2 red flag incidents were reported for the month of January. C2 ward reported, unable to reliably carry out intentional rounding on night duty, due to staff being moved to support another area, no harms have been identified as a consequence. The second red flag refers to less than 2 registered nurses present on ward C10, which was incorrect.

Actions taken:

- Extra allocation on arrival shifts continue to be booked.
- Safe staffing conference at 10 am followed up with meetings through out the day where required to ensure safe staffing, with contingencies agreed for weekends and out of hours.
- Extra health care assistant shifts are utilised to support registered nurse gaps if required
- On going active recruitment/open days
- The staffing templates will change over the coming months to reflect the roll out of the 12 hour shift pattern, some differences may be noticed in respect of actual and planned hours as a consequence

Family Care November - January 2018

Maternity

Month	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Staffed to full Establishment	01:28.8	01:29.2	01:31	01:30.2	01:30	01:29	01:29.9	01:28.8	01:29.9	01:28.7	01:30.0	01:29
Excluding mat leave and vacancies	01:30.3	01:30.4	01:32.1	01:30.7	01:31	01:30	01:30.6		01:31.1	01:30.1	01:31.1	01:30.2
With gaps filled through ELHT Midwife staff bank	01:29.4	01:29.3	01:31.2	01:29.3	01:30	01:28	01:29.3		01:29.8	01:29.2	01:30.1	01:28.3
	Bank Usage 6.165 WTE	Bank usage 8.225 WTE	Bank usage 5.66 Per WTE	Bank usage 9.60 WTE	Bank usage 6.8 WTE	Bank usage 8.22 WTE	Bank usage 9.11 WTE		Bank usage 9.10 WTE		Bank usage 6.43 WTE	Bank usage 10.04 WTE

The midwife/birth ratios calculated using the Birth Rate Plus Tool from the 1st October 2017 to the 31st March 2018 is 1:28
The staffing figures do not reflect how many women were in labour or acuity of areas.

Staffing Red flag Events

On reviewing Datix, 12 incidents were reported overall as Red Flag events in January.
All of the 12 incidents reported occurred within Maternity Services.
These were reported under the following categories:

- 2 missed breaks
- 1 staff shortage – medical
- 9 staff shortage – midwives

On further review none of the incidents were red flag events, plans had been implemented and put in place through the escalation process to ensure patient safety and plans were reviewed on a regular basis with the relevant staff and senior teams where applicable. **No harm** was identified.

Maternity currently have 4 wte vacancies within midwifery. The gaps are currently filled using ELHT midwives on the bank. Where the midwife staffing levels are not at the minimum levels, staff are rotated dependant on acuity and services diverted to other areas of maternity to maintain safety. Blackburn Birth Centre at times are staffed with 2 midwives and this is sometimes planned to support LWNC or vacancies. However the activity is reduced to mitigate this. There is a continuous process in place for recruitment and future dates are planned. Acuity is assessed twice daily with a multi-professional team in the safety huddles on Central Birth Suite, the huddles reviews the whole picture across maternity services at ELHT and staff are moved accordingly to ensure safe staffing.

NICU

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

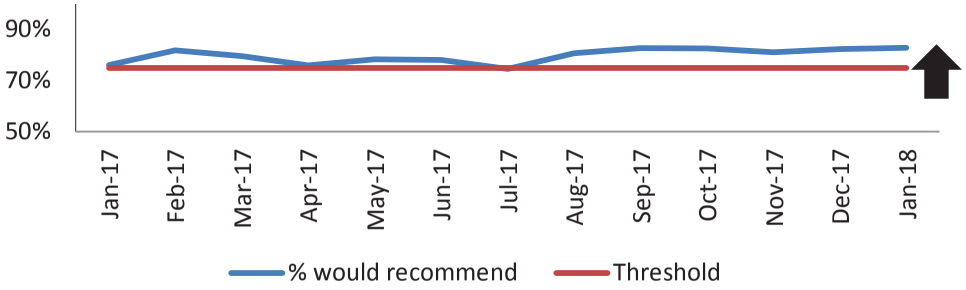
Paediatrics

Paediatrics has seen increased acuity due to tier 4 patients requiring 1:1 or more trained in restraint. Activity and acuity are closely monitored and recorded 3 times throughout the day on safe staffing.

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

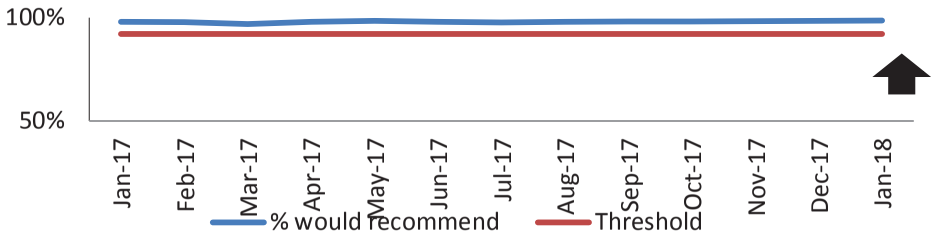
CARING

Friends & Family A&E



These metrics reflect national measurement methodology, which measures the proportion of patients that would recommend the Trust to friends and family. The latest Trust development authority thresholds have been included where available.

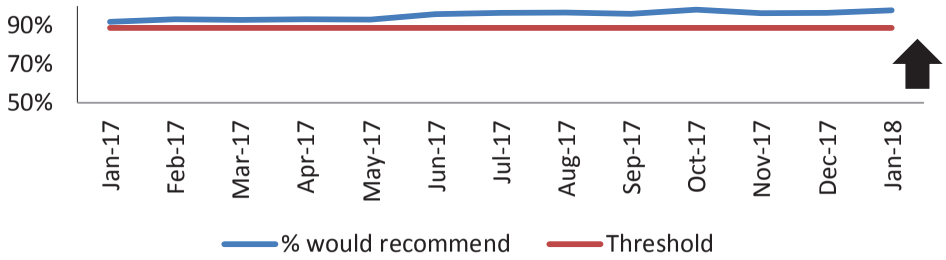
Friends & Family Inpatient



The number that would recommend A&E to friends and family has increased in January to 82.8% with a response rate of 20.1%

The proportion that would recommend inpatient services has improved to 98.6% in January. The response rate was 48.6%

Friends & Family Community

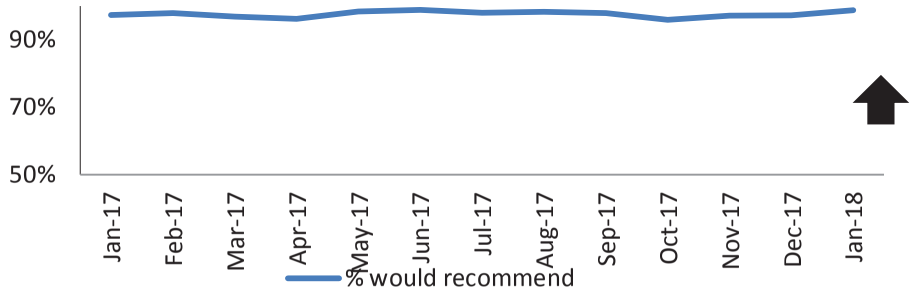


Community services would be recommended by 97.7% in January.

Maternity services would be recommended by 98.8% in January.

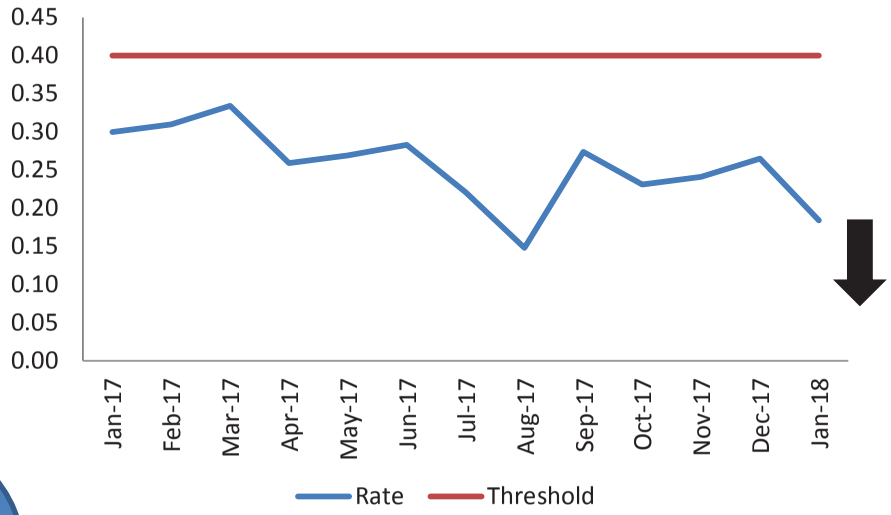
Volunteer support is now available for inputting responses and matrons are alerted to areas with low response rates.

Friends & Family Maternity



CARING

Complaints per 1000 contacts



The Trust opened 22 new formal complaints in January. The number of complaints closed in January was 27.

ELHT is targeted to achieve a threshold of at or less than 0.4 formal complaints per 1,000 patient contacts – made up of inpatient, outpatient and community contacts. The Trust on average has approximately 115,000 patient contacts per calendar month and reports its performance against this benchmark.

For January the number of complaints received is shown as 0.18 Per 1,000 patient contacts.

Patient Experience

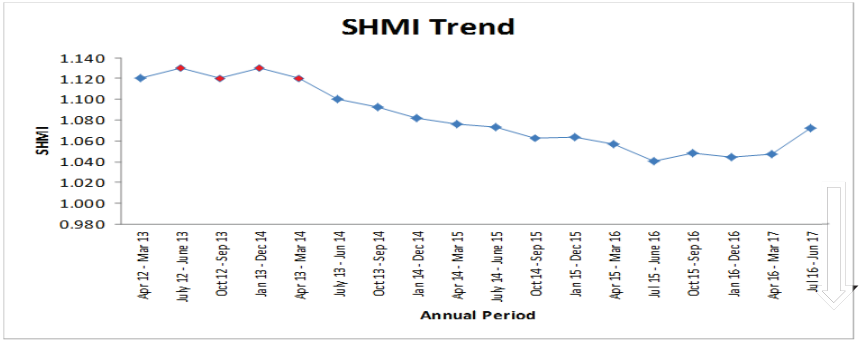
January 2018 Totals	Overall		Dignity	Information	Involvement	Quality
	No.	%	%	%	%	%
Trust	2141	97%	99%	96%	98%	97%
Integrated Care Group - Acute	644	97%	99%	99%	99%	96%
Integrated Care Group - Community	387	98%	100%	93%	99%	99%
Surgery	376	97%	99%	96%	99%	98%
Family care	533	97%	98%	96%	97%	98%
Diagnostic and Clinical	191	93%	95%	92%	93%	91%

The tables below demonstrate divisional performance from the range of patient experience surveys for November and December 2017. The threshold is a positive score of 90% or above for each of the 4 competencies.

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

EFFECTIVE

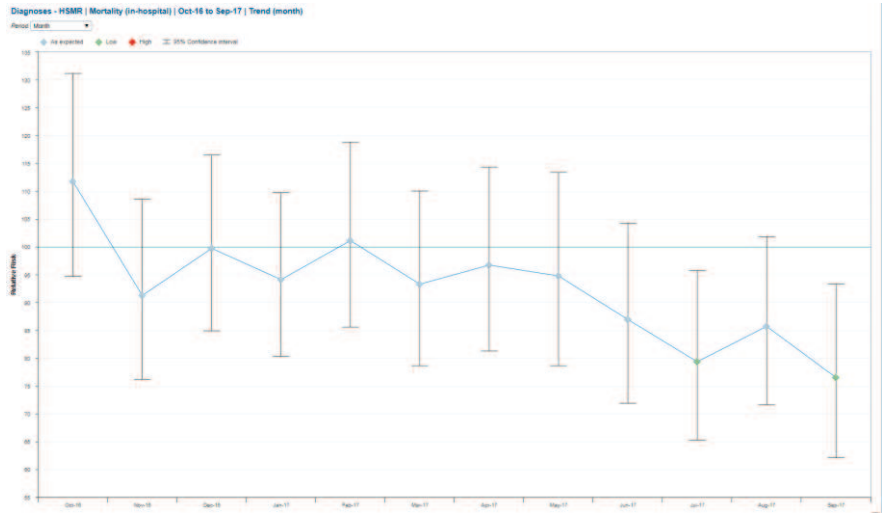
SHMI Published Trend



Dr Foster Indicative HSMR rolling 12

	DFI Rebased on latest month October 16 – September 17 (Risk model July 17)
TOTAL	92.8 (CI 88.3 – 97.5)
Weekday	92.0 (CI 86.9 – 97.4)
Weekend	95.0 (CI 86.2 – 104.7)
Deaths in Low Risk Diagnosis Groups	81.6 (CI 49.2 – 127.5)

Dr. Foster Indicative HSMR monthly Trend



The latest Trust SHMI value as reported by the Health and Social Care Information Centre and Care Quality Commission has deteriorated slightly to 1.07 and is still within expected levels, as published in September 2017.

The latest indicative 12 month rolling HSMR (October 16 – September 17) is reported as 'significantly better than expected' at 92.8 against the monthly rebased risk model.

The weekday HSMR is also 'significantly better than expected'

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

There are currently nine 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.

Four learning disability deaths are currently being reviewed through the Learning Disability Mortality Review Panel with an update expected next month.

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 scoes allocated. Any death allocated a SJR score of 1 or 2 will have a stage 2 SJR completed.

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

	Month of Death				
Stage 1	pre Oct 17	Oct-17	Nov-17	Dec-17	Jan-18
Deaths requiring SJR (Stage 1)	33	51	61	47	65
Allocated for review	30	48	21	0	0
SJR Complete	22	23	2	0	0
1 - Very Poor Care					
2 - Poor Care	3	4	1		
3 - Adequate Care	7	6	1		
4 - Good Care	10	9			
5 - Excellent Care	2	4			
Stage 2					
Deaths requiring SJR (Stage 2)	3	4	1		
Allocated for review	2	4	1		
SJR-2 Complete	1	1			
1 - Very Poor Care					
2 - Poor Care					
3 - Adequate Care	1	1			
4 - Good Care					
5 - Excellent Care					

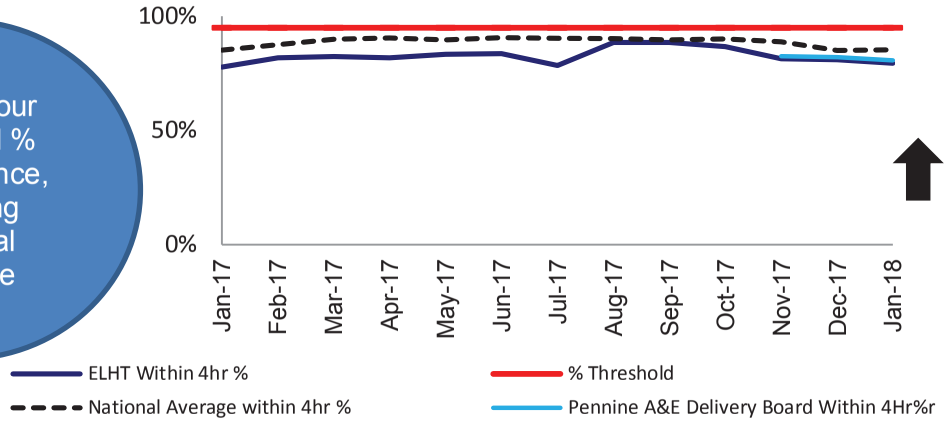
Commissioning for Quality and Innovation

EFFECTIVE

CQUIN Scheme		Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Q1	Q2	Q3	Q4
national	**NHS STAFF HEALTH & WELLBEING** - Flu Vaccine Uptake	**75%**									**77.6%**						77.6%	
national	**SEPSIS PART A- IDENTIFICATION**- screening in **emergency department** - Adult	**90.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%	100.0%		
national	- screening in **emergency department** - child	**90.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%	100.0%		
national	- screening in an **inpatient** setting - adult	**90.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%	100.0%		
national	- screening in an **inpatient** setting -child	**90.0%**	n/a	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%	100.0%		
national	**SEPSIS PART A- IDENTIFICATION**- TOTAL %	**90.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**							**100%**	**100%**		
national	**SEPSIS PART B - ANTIBIOTIC ADMINISTRATION** - **Emergency Department - adult** - number eligible	**90.0%**	26	28	26	16	28	19							80	63		
national	- antiobiotic administration - adult %	**90.0%**	80.8%	92.9%	80.8%	75.0%	89.3%	84.2%							85.0%	84.1%		
national	- antiobiotic administration - **Emergency Department - child** - number eligible	**90.0%**	1	1	1	2	1	1							3	4		
national	- antiobiotic administration child %	**90.0%**	100%	100%	100%	0%	100%	100%							100%	50%		
national	- antiobiotic administration - **Emergency Department** TOTAL %	**90.0%**	81.5%	93.1%	81.5%	66.7%	89.7%	85.0%							85.5%	82%		
national	**SEPSIS PART B - ANTIBIOTIC ADMINISTRATION - Inpatient - adult** - number eligible	**90.0%**	15	20	19	10	37	9							54	56		
national	- antiobiotic administration - adult %	**90.0%**	100.0%	100.0%	94.7%	100.0%	91.9%	100.0%							98.1%	94.6%		
national	- antiobiotic administration - **Inpatient - child** - number eligible	**90.0%**	0	2	1	0	0	0							3	0		
national	- antiobiotic administration child %	**90.0%**	n/a	100%	100%	0.00%	n/a	n/a							100%	0%		
national	- antiobiotic administration TOTAL %	**90.0%**	100.0%	100.0%	95.0%	90.90%	91.90%	100.00%							98.3%	93%		
national	**SEPSIS PART B - ANTIBIOTIC ADMINISTRATION - TOTAL Number Eligible**		42	51	47	29	66	29							140	124		
national	**SEPSIS PART B - ANTIBIOTIC ADMINISTRATION - TOTAL %**	**90.0%**	**88.1%**	**96.1%**	**87.2%**	**75.9%**	**90.9%**	**89.7%**							**90.7%**	**87.1%**		
national	**SEPSIS PART C - ANTIBIOTIC REVIEW -** % Prescriptions Reviewed within 72 Hrs	**Q1 25% Q2 50% Q3 75% Q4 90%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**							**100%**	**100%**		
national	**REDUCTION IN ANTIBIOTIC CONSUMPTION- PART D**- Total antiobiotic consumption per 1000 admissions	**4944.0**		**4782.2**			**4,896.4**								4,782	4,896		
national	-Antibiotic % Reduction on 2016 baseline	**-2.0%**		**-5.2%**			**-2.9%**								-5.2%	-3.0%		
national	- Total consumption of carbapenem per 1000 admissions	**32.8**		**35.8**			**40.6**								36	41		
national	-Carbapenam % Reduction on 2016 baseline	**-1.0%**		**7.8%**			**22.3%**								7.80%	22.30%		
national	- Total consumption of piperacillin per 1000 admissions	**109.8**		**81.4**			**64.9**								81	65		
national	- Piperacillin % Reduction on 2016 baseline	**-1.0%**		**-26.6%**			**-41.5%**								-26.6%	-41.5%		
Spec Comms	**MEDICINES OPTIMISATION -** Trigger 1 - Faster adoption of prioritised best value medicines as they become available	**90.0%**																

RESPONSIVE

A&E 4 hour standard % performance, including National average

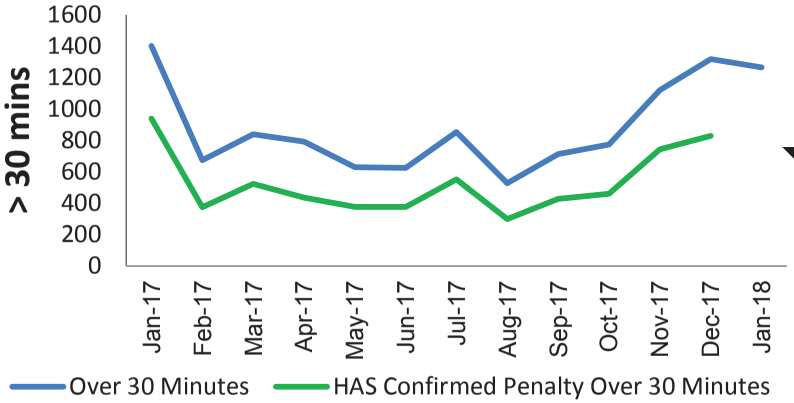


Overall performance against the ELHT Accident and Emergency four hour standard deteriorated in January to 79.5%, below the 95% threshold. The performance against the Pennine A&E Delivery Board four hour standard has also deteriorated to 80.7% in January.

The number of attendances during January was 18,511 and of these 14,933 were treated and left the department within 4 hours. (Pennine A&E Delivery Board)

The national performance was 85.3% in January with 5 out of 137 reporting trusts with type 1 departments achieved the 95% standard.

Handovers

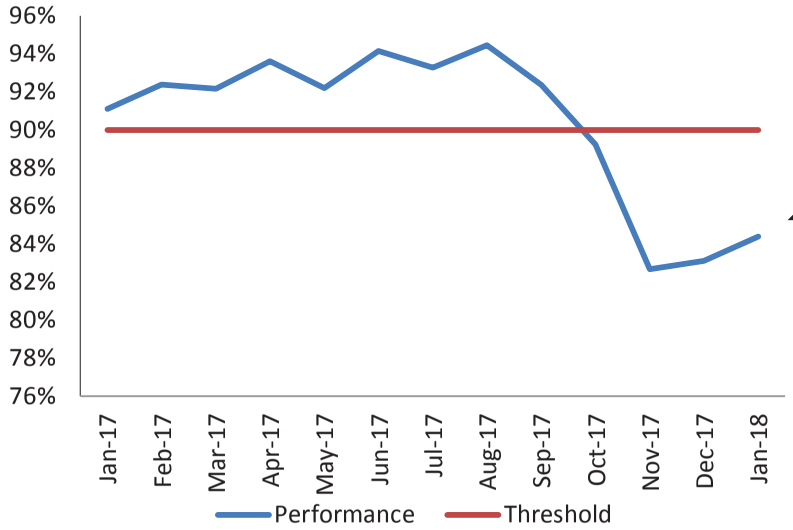


There were 5 reported breaches of the 12 hour trolley wait standard from decision to admit during January. Four were mental health breaches and one was a physical breach. Rapid review timelines are completed in accordance with the NHS England Framework and a root cause analysis will be undertaken.

The number of handovers over 30 minutes decreased to 1267 for January compared with 1319 for December. During January, 937 handovers were within 15 minutes of arrival and a further 1016 were 15-30 minutes.

The validated NWAS penalty figures are reported as at December as;- 463 missing timestamps, 599 handover breaches (30-60 mins) and 230 handover breaches (>60 mins).

HAS Compliance

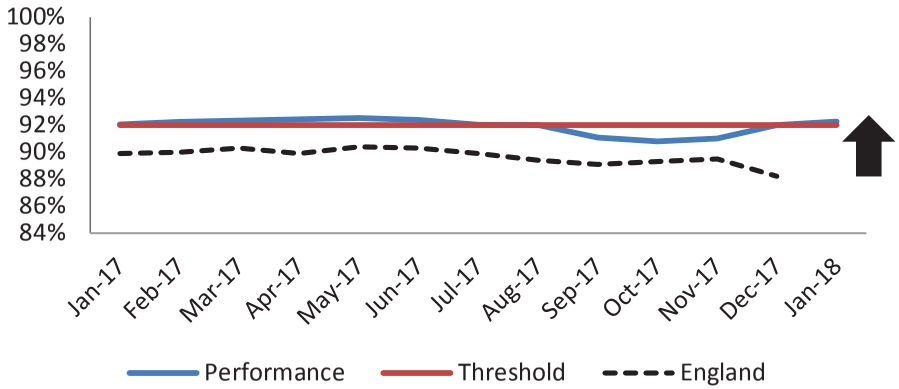


The ambulance handover compliance indicator measures the compliance with PIN entry on completion of patient handover. This was not achieved at 84.4% in January, which is below the 90% threshold.

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

RESPONSIVE

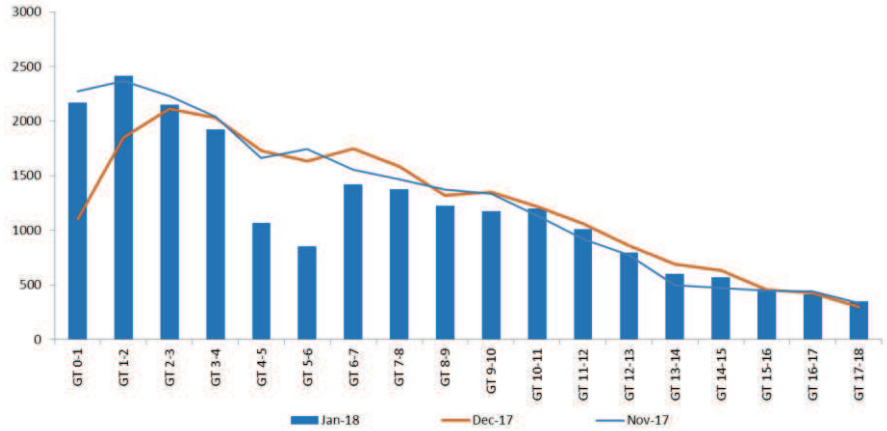
RTT Ongoing



The 18 week referral to treatment (RTT) % ongoing position was achieved in January with 92.3% patients, waiting less than 18 weeks to start treatment at month end, which was an improvement on the December position of 92.0%

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

RTT Ongoing 0-18 Weeks



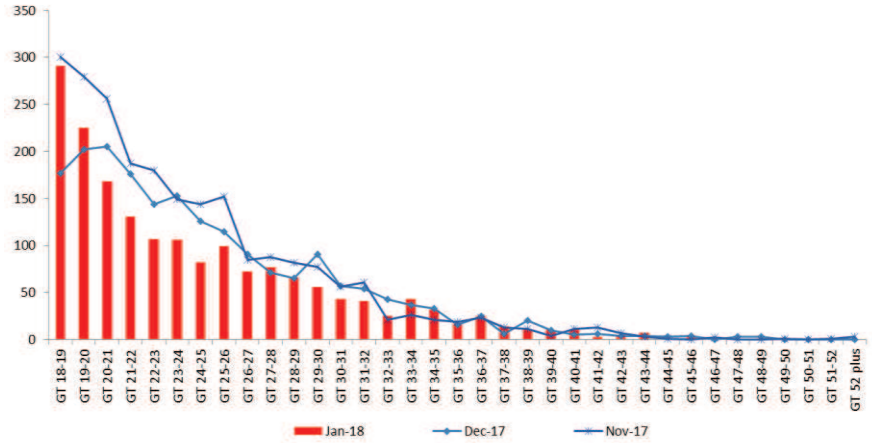
The total number of on-going pathways has reduced again in January to 22,968 from 24,031 in December.

There has been a further reduction in patients waiting over 18 weeks at the end of January to 1775 from 1920 in December.

The median wait has reduced to 6.8 weeks in January from 7.1 weeks in December.

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

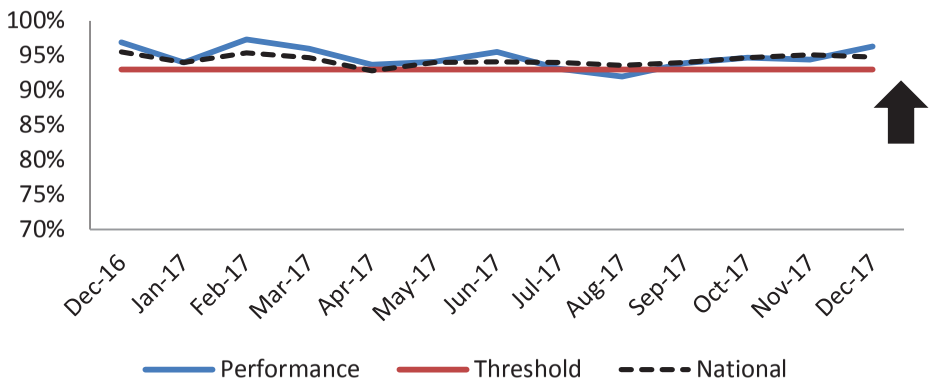
RTT Over 18 weeks



The latest published figures from NHS England show deterioration of the ongoing standard nationally (reported 1 month behind), with 88.2% of patients waiting less than 18 weeks to start treatment in December, compared with 89.5% in November.

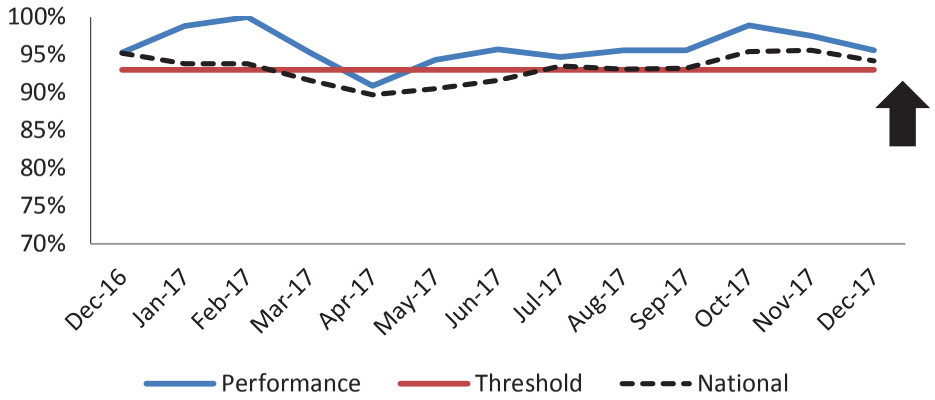
RESPONSIVE

Cancer 2 Week



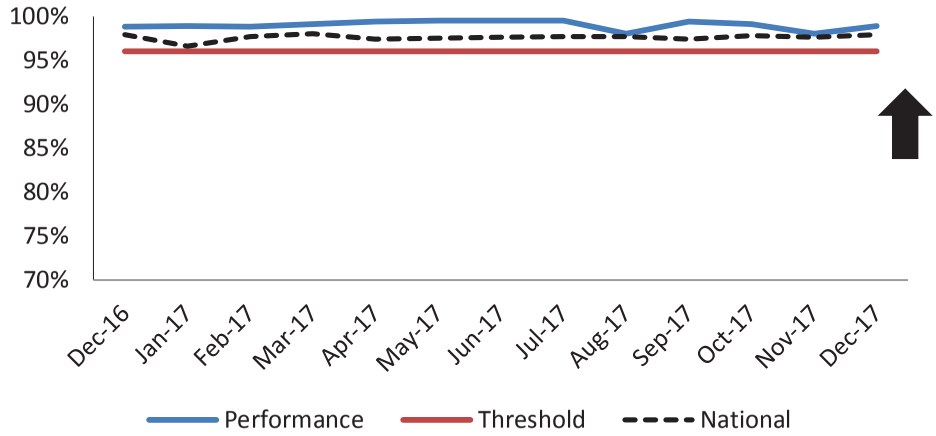
The cancer 2 week wait for GP referrals standard was achieved in December at 96.3% and quarter 3 was achieved at 95.1%

Cancer 2 Week - breast



The 2 week breast symptomatic standard was achieved in December at 95.6% and quarter 3 at 97.4%

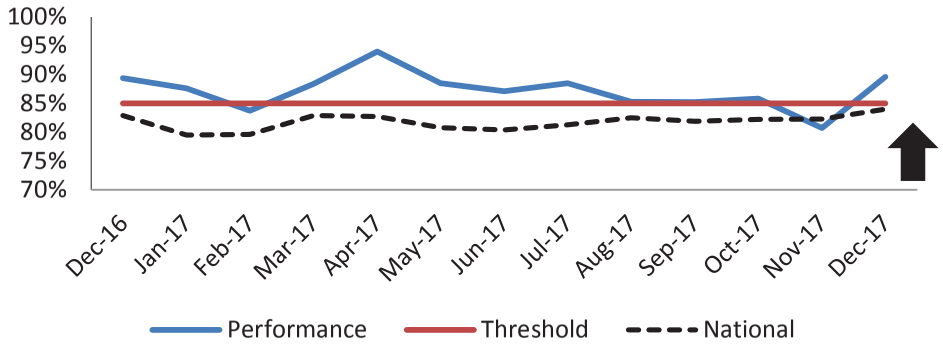
Cancer 31 day



The 31 day target was achieved in December at 98.9% and quarter 3 at 98.7%

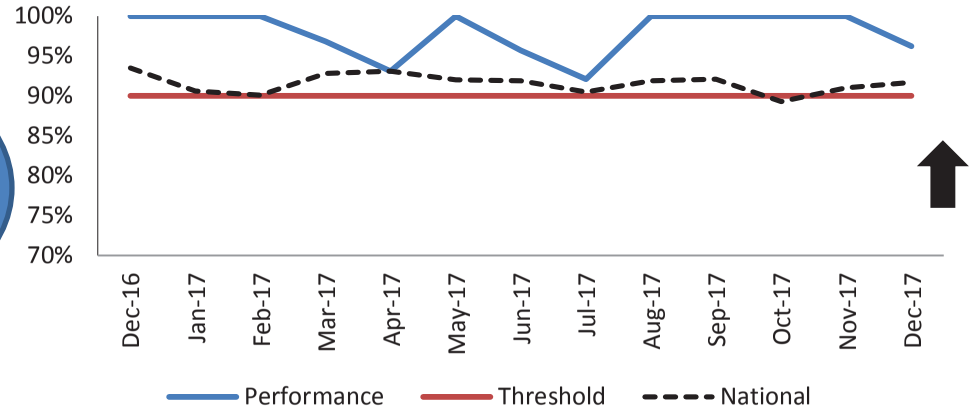
RESPONSIVE

62 Day Cancer



62 day performance was achieved in December at 89.6% and in quarter 3 at 85.2%

62 Day Screening



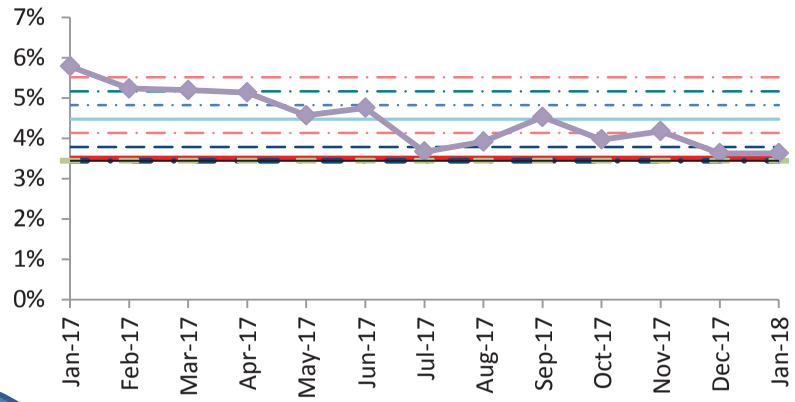
The 62 day screening standard continued to be achieved in December at 96.2% and also in quarter 3 at 98.9%

Cancer Patients Treated > Day 104

There was 1 patient treated after day 104 in December and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the Consultants involved in the pathway as required.

RESPONSIVE

Delayed Discharges per 1000 bed days

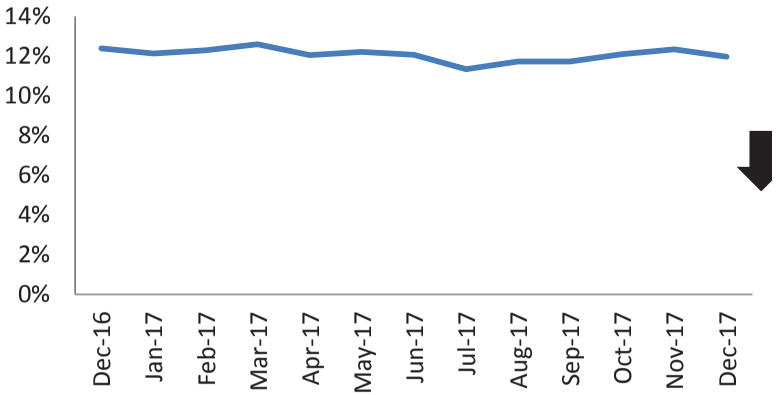


The proportion of delays reported against the delayed transfers of care standard has been maintained at 3.6% which remains just above the threshold of 3.5%.

This equates to an average of 30 beds lost per day in January. The top three reasons for the bed days lost due to delayed discharge are; 'Awaiting completion of assessment' (38%) 'Patient or Family Choice' (31%) Awaiting public funding' (9%). The failure of this target is multi-factorial, linked to complex discharge processes involving ELHT and partners.

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

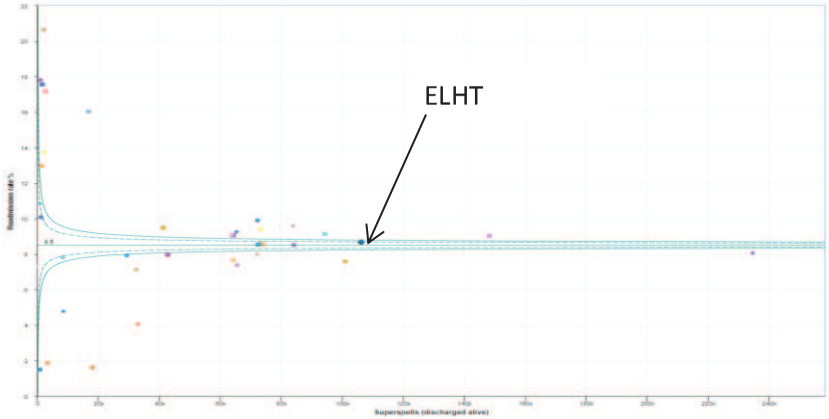
Emergency Readmissions



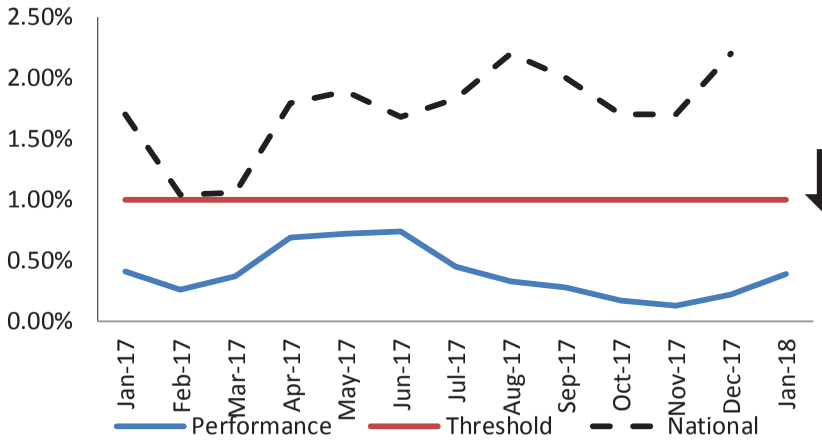
The emergency readmission rate has reduced to 11.2% in December 2017 compared to 12.4% in December 2016.

Dr Foster benchmarking shows ELHT have slightly higher rate than the North West average, but are not an outlier.

Readmissions within 30 days vs North West - Dr Foster
September 2016 - August 2017



Diagnostic Waits



In January 0.4% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is within the 1% threshold.

RESPONSIVE

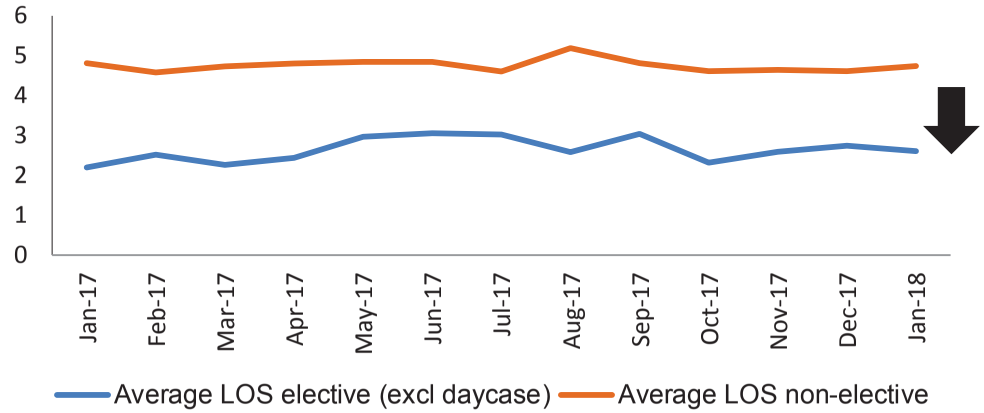
Average Length of Stay Benchmarking

Dr Foster Benchmarking October 16 - September 17

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	60,701	10,080	50,621	3.3	2.7	-0.7
Emergency	52,719	52,719	0	4.9	5.0	0.1
Maternity/ Birth	13,916	13,916	0	2.2	2.5	0.4
Transfer	192	192	0	10.1	27.0	16.9

Dr Foster benchmarking shows the Trust length of stay to be below the expected when compared to national case mix adjusted, for elective, however slightly higher than expected for non-elective.

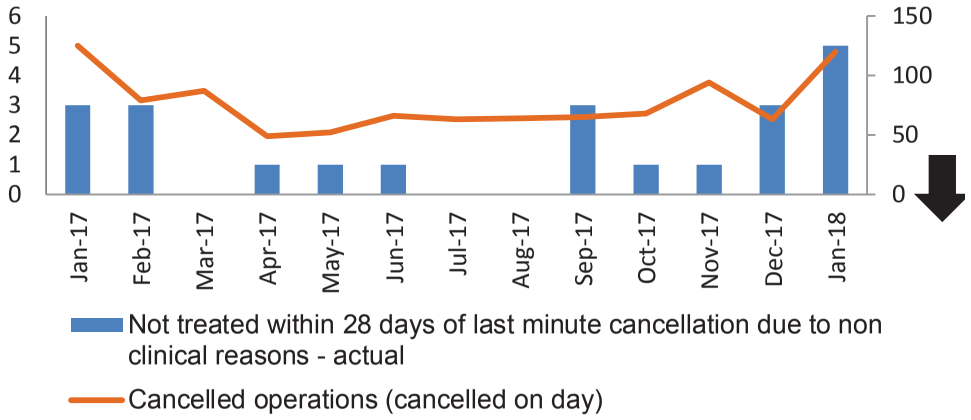
Average Length of Stay



The Trust non elective average length of stay increased slightly to 4.7 days in January, compared to 4.6 in December.

The elective length of stay (excluding day case) has reduced from 2.7 days in December to 2.6 in January.

Operations cancelled on day - 28 day standard

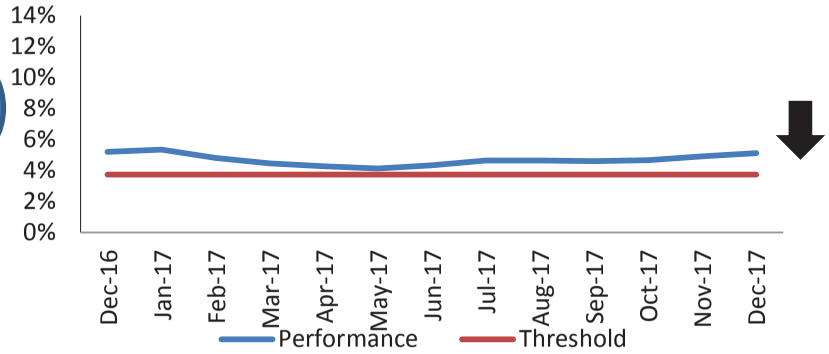


There were 120 operations cancelled on the day of operation in January. There were five 'on the day' cancelled operations not rebooked within 28 days in January.

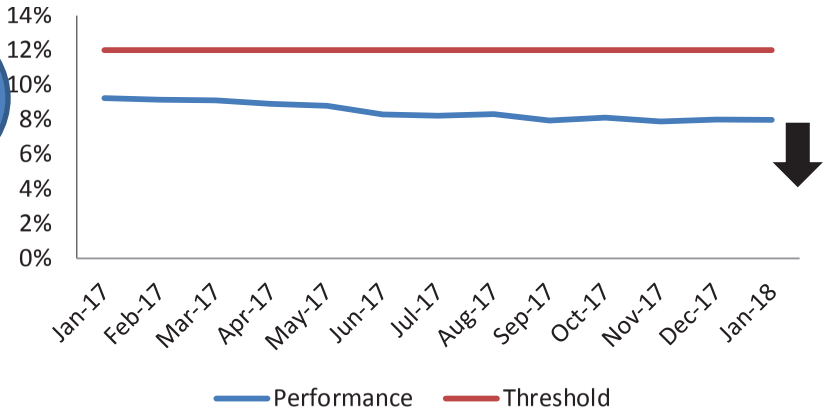
Patients that had procedures cancelled on the day are monitored regularly to ensure dates are offered within the 28 days. Risks are escalated to senior managers and escalated at the weekly operations meeting.

WELL LED

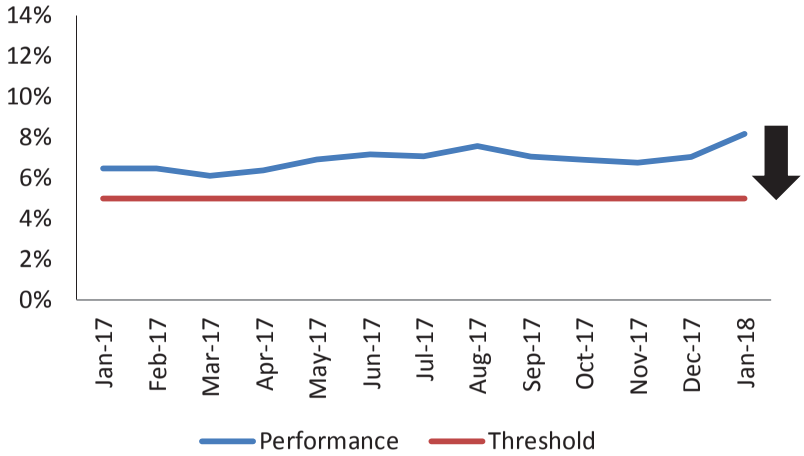
Sickness



Turnover Rate



Vacancy Rate



The sickness absence rate increased from 4.91% in November 2017 to 5.12% in December. This is lower than December 2016 (5.21%). The Trust target is 3.75%, which is recognised as a challenging target to achieve.

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

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

Overall the Trust is now employing 7220 FTE staff in total. This is a net increase of 13 FTE from the previous month. The number of nurses in post at January 2018 stood at 2305 FTE which is the same as last month and a net increase of 257 FTE since 1st April 2013.

As at 31st January 2018 there are a further 86 external nurses in the recruitment pipeline.

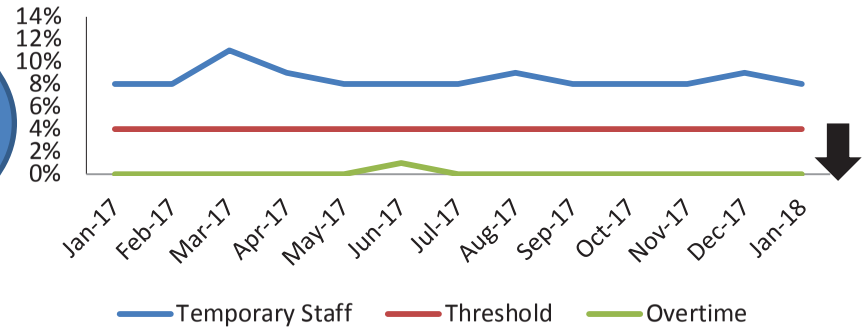
The vacancy rate for nurses now stands at 9.3% (237 FTE)

As of January 2018 there are 30 FTE Medical posts vacant of which 3 posts have been offered and awaiting pre-employment checks or confirmation of start dates to be agreed. Of the remaining posts, 27 are currently out to advert, 6 are in the shortlisting /interview stage and 21 are due to be advertised.

The vacancy rates for doctors now stands at 5.06%

WELL LED

Temporary costs and overtime as % total pay bill

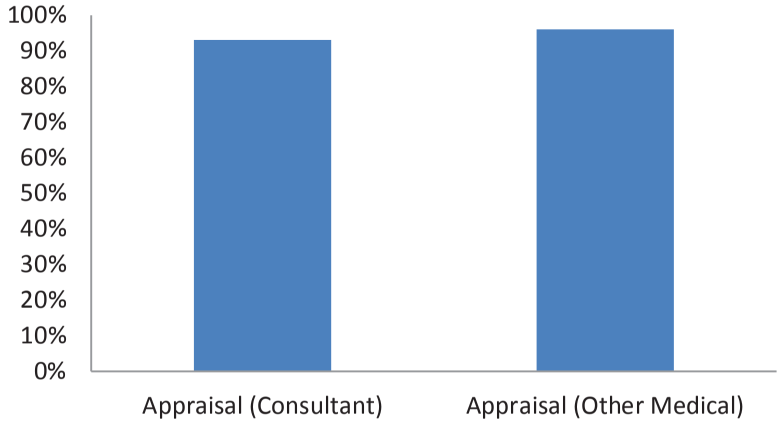


In 2016/17 East Lancashire Hospitals NHS Trust spent £27.5m on temporary staffing. This represented 9% of the overall pay bill. (8% 2015/16; 9% 2014/15; 8% 2013/4; 5.5% 2012/13).
For the year ending 2016/17 the Trust spent £27,555,803 (£15,030,431 agency; £12,525,372 bank).

In January 2018 the Trust spent £2,509,675 on bank and agency. This was more than in January 2017 (£2,127,294) and more than in December 2017 (£2,225,849).

Total expenditure to date for 2017/18 is £22,482,030

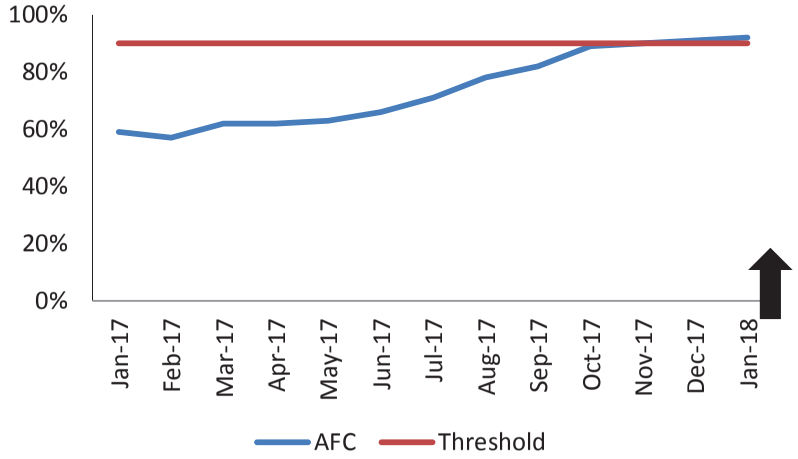
Appraisals, Consultant & Other Medical



The appraisal rates for consultants and career grade doctors are reported cumulative year to date, April – January 2018 and reflect the number of reviews completed that were due in this period.

The consultant appraisal rate has decreased on last month to 93%. The other medical staff appraisal rate has increased to 96%, above the 90% threshold.

Appraisals AFC



The AFC appraisal rates continue to be reported as a rolling 12 month figure and have increased in January to 92% from 91% in December.

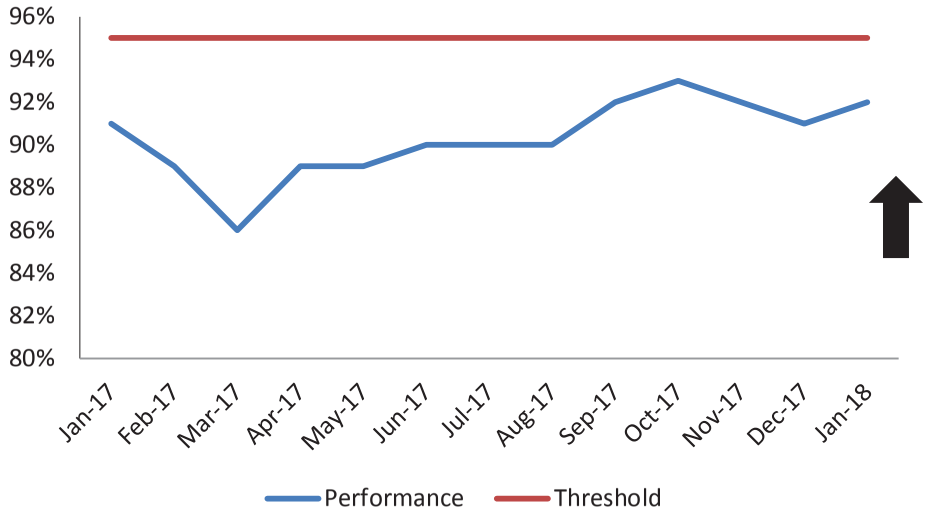
There has been a range of Trust wide actions to support compliance which are on-going. These actions are monitored through the Finance & Performance Committee.

WELL LED

Job Plans

Information Governance Toolkit

Core Skills Training % Compliance



	Target	Compliance at end January
Basic Life Support	90%	91%
Conflict Resolution Training Level 1	90%	96%
Equality, Diversity and Human Rights	90%	96%
Fire Safety	90%	88%
Health, Safety and Welfare Level 1	90%	97%
Infection Prevention	90%	96%
Information Governance	95%	92%
Prevent Healthwrap	90%	94%
Safeguarding Adults	90%	96%
Safeguarding Children	90%	95%
Safer Handling Theory	90%	96%

The job plan compliance for 2017/18 is at 100% in January.

2018/19 Job plans have been issued with a deadline of 30th June 2018 for signoff. Currently all job plans are in discussion with clinical leads, clinical directors and Divisional Director teams. To date 2% of all job plans for 2018/19 have been completed and forwarded for 2nd level sign off. Team job planning meetings have been scheduled between December 2017 and February 2018, with actual job plan meetings to be scheduled in March, April, May 2018.

Information governance toolkit compliance has improved in January to 92%, however is still below below the 95% threshold.

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

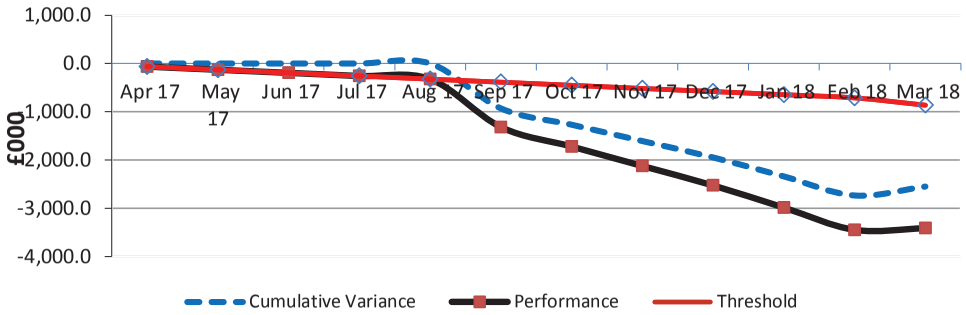
Two of the eleven areas are currently below target for training compliance.

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.

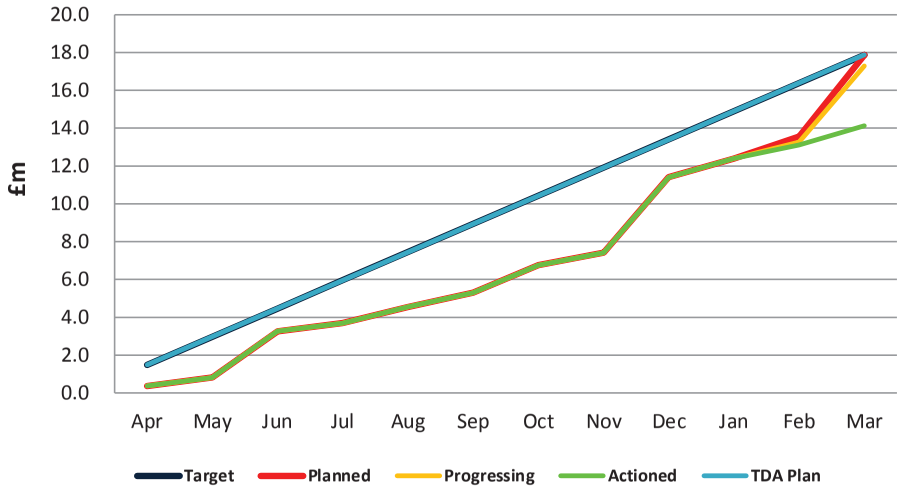
Finance & Use of Resource metrics

Area	Metric	Actual YTD Performance	Actual YTD Score	Forecast outturn Performance	Forecast outturn Score
Financial sustainability	Capital service capacity	1.3	3	1.3	3
	Liquidity (days)	(9.6)	3	(12.1)	3
Financial efficiency	I&E margin	(0.7%)	3	(0.7%)	3
Financial control	Distance from financial plan	(0.5%)	2	(0.5%)	2
	Agency spend	19.0%	2	19.0%	2
Total			3		3

Break Even Duty



Efficiency Savings



The Trust has a planned outturn position for 2017-18 of a deficit of £0.863m. This figure includes our notified non-recurrent STF allocation of £11.272m. Our control total for the year is a deficit of £12.135m, excluding the STF allocation. This is the figure that NHSI will monitor us against via the Single Oversight Framework.

The Trust's current performance against target for four-hour A&E waits means that the Trust is £2.3m behind plan for the STF allocation. This remains a risk for the Trust for the final quarter.

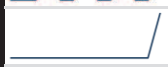
As a result, the Trust is now reporting that we remain on target to achieve our control total, only after excluding the STF allocation.

As a result of the deterioration in the financial performance of the Trust, which has also affected liquidity, the overall Finance and Use of Resources metric score for the year to date is 3, which is also the forecast position for 2017-18.

The Trust has fully identified the SRCP schemes for 2017-18 at £17.9m, although only 38% of savings will be achieved recurrently. £14.1m of SRCP schemes have been achieved to date. The position is reported in further detail in the Sustaining Safe, Personal and Effective Transformation paper.

APPENDIX 1

Safe

		Threshold 17/18	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Monthly Sparkline
M64	CDIFF	28	3	2	0	2	4	3	2	5	2	3	2	3	2	
M64.1	Cdiff Cumulative from April	28	30	32	32	2	6	9	11	16	18	21	23	26	28	
M65	MRSA	0	0	0	0	0	1	0	0	0	0	0	1	0	0	
M124	E-Coli (post 2 days)	65	7	7	5	7	7	8	0	6	4	7	2	3	3	
M154	P. aeruginosa bacteraemia (total pre 2 days)					3	2	1	0	2	1	0	1	0	1	
M155	P. aeruginosa bacteraemia (total post 2 days)					0	0	0	0	1	0	0	0	1	0	
M156	Klebsiella species bacteraemia (total pre 2 days)					5	4	6	7	4	3	10	9	5	4	
M157	Klebsiella species bacteraemia (total post 2 days)					1	1	0	3	2	0	2	2	3	0	
M66	Never Event Incidence	0	0	0	0	2	0	0	1	0	0	2	0	0	1	
M67	Medication errors causing serious harm (Steis reported date)	0	0	0	0	0	0	0	0	0	0	0	0	0	1	
C28	Percentage of Harm Free Care	92%	99.1%	99.3%	99.3%	99.2%	99.0%	98.7%	99.7%	99.1%	98.8%	99.5%	99.4%	99.0%	99.3%	
M68	Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	98.7%	98.4%	97.2%	99.4%	99.2%	98.4%	99.3%	99.2%	97.9%	98.6%	98.9%	98.1%		
M69	Serious Incidents (Steis)		8	5	10	7	6	7	6	9	6	5	11	7	11	
M70	CAS Alerts - non compliance	0	0	0	0	0	0	0	0	0	2	0	3	2	2	
M146	Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80%	90%	89%	89%	90%	91%	96%	90%	89%	89%	91%	92%	90%	90%	
M147	Safer Staffing -Day-Average fill rate - care staff (%)	80%	111%	114%	114%	116%	116%	114%	117%	117%	116%	107%	110%	106%	106%	
M148	Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80%	99%	99%	100%	100%	101%	99%	99%	98%	96%	99%	98%	98%	98%	

M149	Safer Staffing -Night-Average fill rate - care staff (%)	80%	127%	128%	125%	129%	128%	127%	127%	126%	126%	118%	119%	114%	116%	
M150	Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80%	0	7	11	6	6	3	2	5	6	4	4	5	12	10	
M151	Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80%	0	0	1	3	1	1	1	0	0	1	1	0	1	0	
M152	Safer Staffing - Day -Average fill rate - care staff- number of wards <80%	0	4	1	1	1	1	0	1	1	0	1	1	1	1	
M153	Safer Staffing - Night -Average fill rate - care staff- number of wards <80%	0	1	1	1	1	1	1	1	1	1	1	1	1	1	

Caring

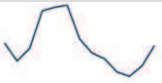
		Threshold 17/18	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Monthly Sparkline
C38	Inpatient Friends and Family - % who would recommend	92.07%	98.1%	97.9%	97.0%	98.0%	98.4%	98.0%	97.7%	97.9%	98.2%	98.2%	98.3%	98.5%	98.6%	
C31	NHS England Inpatients response rate from Friends and Family Test		53.2%	47.4%	47.0%	49.4%	48.2%	43.1%	49.5%	48.3%	51.2%	49.8%	47.7%	51.6%	48.6%	
C40	Maternity Friends and Family - % who would recommend	91.86%	97.4%	97.9%	96.9%	96.2%	98.4%	98.9%	98.0%	98.3%	98.0%	96.0%	97.2%	97.2%	98.8%	
C42	A&E Friends and Family - % who would recommend	74.90%	76.0%	81.8%	79.6%	75.9%	78.3%	78.1%	74.6%	80.6%	82.7%	82.5%	81.1%	82.3%	82.8%	
C32	NHS England A&E response rate from Friends and Family Test		21.3%	21.2%	22.1%	20.9%	20.0%	16.8%	18.6%	17.4%	15.8%	20.3%	19.5%	20.3%	20.1%	
C44	Community Friends and Family - % who would recommend	88.62%	91.9%	93.1%	92.8%	93.1%	92.9%	95.8%	96.5%	96.6%	95.9%	98.1%	96.3%	96.4%	97.7%	
C15	Complaints – rate per 1000 contacts	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.1	0.3	0.2	0.2	0.3	0.2	
M52	Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Effective

		Threshold 17/18	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Monthly Sparkline
M73	Deaths in Low Risk Categories - relative risk	Outlier	75.9	65.0	67.3	81.4	85.2	90.4	83.9	85.0	81.6					
M74	Hospital Standardised Mortality Ratio - Weekday (DFI Indicative)	Outlier	94.7	95.6	94.9	94.0	94.6	95.5	94.9	93.3	92.0					
M75	Hospital Standardised Mortality Ratio - Weekend (DFI Indicative)	Outlier	97.8	98.1	96.7	96.6	97.7	97.2	95.9	96.2	95.0					
M54	Hospital Standardised Mortality Ratio (DFI Indicative)	Outlier	95.5	96.2	95.3	94.7	95.4	95.9	95.2	94.1	92.8					
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Outlier			1.05			1.07								
M159	Stillbirths	<5	3	3	1	1	2	3	4	2	2	2	5	4	3	
M160	Stillbirths - Improvements in care that impacted on the outcome								1							
M89	CQUIN schemes at risk	0			3			0								

Responsive

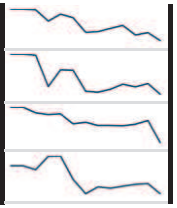
		Threshold 17/18	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Monthly Sparkline
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95%	77.8%	81.9%	82.4%	81.8%	83.3%	83.6%	78.5%	88.6%	88.6%	86.7%	81.3%	81.0%	79.5%	
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95%	78.8%	82.8%	83.4%	82.7%	84.4%	84.7%	80.0%	89.2%	89.2%	87.5%	82.5%	82.1%	80.7%	
M62	12 hour trolley waits in A&E	0	16	7	5	1	5	13	7	7	1	2	4	4	5	
M81	HAS Compliance	90%	91.12%	92.39%	92.17%	93.62%	92.20%	94.16%	93.28%	94.46%	92.37%	89.24%	82.68%	83.12%	84.40%	
M82	Handovers > 30 mins ALL	0	1402	674	840	793	629	626	854	528	714	775	1122	1319	1267	
M82.6	Handovers > 30 mins ALL (NWAS Confirmed Penalty)	0	940	376	524	436	377	378	552	299	428	461	745	829		
C1	RTT admitted: percentage within 18 weeks	N/A	71.3%	70.7%	69.8%	68.4%	71.5%	71.4%	70.9%	68.6%	69.5%	64.8%	65.3%	79.0%	72.2%	
C3	RTT non- admitted pathways: percentage within 18 weeks	N/A	91.3%	92.5%	92.0%	91.9%	94.3%	92.2%	91.8%	94.6%	90.8%	89.4%	89.0%	90.0%	90.7%	
C4	RTT waiting times Incomplete pathways	92%	92.0%	92.2%	92.3%	92.4%	92.5%	92.4%	92.0%	92.0%	91.1%	90.8%	91.0%	92.0%	92.3%	

C37.1	RTT 52 Weeks (Ongoing)	0	3	2	1	1	0	1	2	0	0	1	3	3	0	
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1%	0.4%	0.3%	0.4%	0.7%	0.7%	0.7%	0.5%	0.3%	0.3%	0.2%	0.1%	0.2%	0.4%	
C18	Cancer - Treatment within 62 days of referral from GP	85%	87.6%	83.7%	88.4%	94.0%	88.5%	87.1%	88.5%	85.3%	85.2%	85.8%	80.7%	89.6%		
C19	Cancer - Treatment within 62 days of referral from screening	90%	100.0%	100.0%	96.8%	93.1%	100.0%	95.7%	92.1%	100.0%	100.0%	100.0%	100.0%	96.2%		
C20	Cancer - Treatment within 31 days of decision to treat	96%	98.9%	98.8%	99.1%	99.4%	99.5%	99.5%	99.5%	98.0%	99.4%	99.1%	98.0%	98.9%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98%	100.0%	100.0%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94%	95.9%	100.0%	95.3%	95.7%	100.0%	95.5%	97.9%	92.9%	97.9%	97.6%	100.0%	95.0%		
C24	Cancer - seen within 14 days of urgent GP referral	93%	94.0%	97.3%	96.0%	93.7%	94.1%	95.5%	93.1%	92.0%	93.9%	94.7%	94.4%	96.3%		
C25	Cancer - breast symptoms seen within 14 days of GP referral	93%	98.8%	100.0%	95.3%	90.9%	94.3%	95.7%	94.7%	95.6%	95.6%	98.9%	97.5%	95.6%		
C36	Cancer 62 Day Consultant Upgrade	85%	93.6%	89.3%	94.4%	93.3%	94.2%	96.8%	91.2%	90.0%	86.4%	93.2%	88.9%	88.5%		
C25.1	Cancer - Patients treated > day 104		2	5	2	1	3	1	6	3	4	2	8	1		
M9	Urgent operations cancelled for 2nd time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	3	3	0	1	1	1	0	0	3	1	1	3	5	
M138	Cancelled operations (cancelled on day)	0	125	79	87	49	52	66	63	64	65	68	94	63	120	
M55	Proportion of delayed discharges attributable to the NHS	3.5%	5.8%	5.2%	5.2%	5.1%	4.6%	4.8%	3.7%	3.9%	4.5%	4.0%	4.2%	3.6%	3.6%	
C16	Emergency re-admissions within 30 days		12.1%	12.3%	12.6%	12.1%	12.2%	12.1%	11.4%	11.7%	11.7%	12.1%	12.4%	12.0%	12.2%	
M90	Average LOS elective (excl daycase)		2.2	2.5	2.3	2.4	3.0	3.1	3.0	2.6	3.0	2.3	2.6	2.7	2.6	
M91	Average LOS non-elective		4.8	4.6	4.7	4.8	4.8	4.8	4.6	5.2	4.8	4.6	4.6	4.6	4.7	

Well led

		Threshold 17/18	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Monthly Sparkline
M77	Trust turnover rate	12%	9.2%	9.1%	9.1%	8.9%	8.8%	8.3%	8.2%	8.3%	8.0%	8.1%	7.9%	8.0%	8.0%	
M78	Trust level total sickness rate	3.75%	5.4%	4.8%	4.5%	4.3%	4.1%	4.3%	4.7%	4.7%	4.6%	4.7%	4.9%	5.1%		
M79	Total Trust vacancy rate	5%	6.5%	6.5%	6.1%	6.4%	6.9%	7.2%	7.1%	7.6%	7.1%	6.9%	6.8%	7.0%	8.2%	
M80.3	Appraisal (AFC)	90%	59.0%	57.0%	62.0%	62.0%	63.0%	66.0%	71.0%	78.0%	82.0%	89.0%	90.0%	91.0%	92.0%	
M80.3	Appraisal (Consultant)	90%	92.0%	96.0%	99.0%	80.0%	81.0%	86.0%	87.0%	90.0%	88.0%	93.0%	94.0%	95.0%	93.0%	
M80.4	Appraisal (Other Medical)	90%	94.0%	99.0%	99.0%	67.0%	100.0%	90.0%	97.0%	91.0%	94.0%	95.0%	95.0%	95.0%	96.0%	
M80.2	Safeguarding Children	90%	90.0%	90.0%	88.0%	89.0%	90.0%	90.0%	93.0%	94.0%	95.0%	95.0%	95.0%	95.0%	95.0%	
M80.2	Information Governance Toolkit Compliance	95%	91.0%	89.0%	86.0%	89.0%	89.0%	90.0%	90.0%	90.0%	92.0%	93.0%	92.0%	91.0%	92.0%	
F8	Temporary costs as % of total paybill	4%	8%	8%	11%	9%	8%	8%	8%	9%	8%	8%	8%	9%	8%	
F9	Overtime as % of total paybill	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	
F1	Cumulative Retained Deficit for breakeven duty (£M)	(0.8)	(3.0)	(1.5)	1.5	(0.1)	(0.1)	(0.2)	(0.3)	(0.3)	(1.3)	(1.7)	(2.1)	(2.5)	(3.0)	
F2	SRCP Achieved % (green schemes only)	100.0%	99%	101%	101%	18%	28%	32%	34%	40%	46%	53%	54%	77%	79%	
F3	Liquidity days	>(14.0)	(7.1)	(6.1)	(6.3)	(5.2)	(5.0)	(5.5)	(6.2)	(6.7)	(7.5)	(7.8)	(8.8)	(9.2)	(9.6)	
F4	Capital spend v plan	85%	67%	77%	85%	42%	38%	32%	41%	46%	55%	57%	68%	77%	88%	
F16	Finance & Use of Resources (UoR) metric - overall	3	3	2	2	2	2	2	2	2	3	3	3	3	3	
F17	Finance and UoR metric - liquidity	3	3	2	2	3	3	3	3	3	3	3	3	3	3	
F18	Finance and UoR metric - capital service capacity	3	3	3	3	2	2	2	2	2	3	3	3	3	3	
F19	Finance and UoR metric - I&E margin	3	3	3	2	3	3	3	3	3	3	3	3	3	3	
F20	Finance and UoR metric - distance from financial plan	1	1	1	1	2	1	1	1	1	2	2	2	2	2	
F21	Finance and UoR metric - agency spend	2	3	3	3	1	2	2	2	2	2	2	2	2	2	

F12 BPPC Non NHS No of Invoices	95%	96.8%	96.8%	96.7%	96.2%	96.5%	96.3%	95.7%	95.7%	95.8%	96.0%	95.5%	95.7%	95.3%
F13 BPPC Non NHS Value of Invoices	95%	96.8%	96.8%	96.7%	95.3%	96.1%	96.0%	95.1%	95.0%	95.2%	95.4%	95.3%	95.4%	94.9%
F14 BPPC NHS No of Invoices	95%	96.2%	96.2%	95.8%	95.7%	95.7%	95.1%	95.2%	95.0%	95.0%	95.0%	95.1%	95.3%	94.0%
F15 BPPC NHS Value of Invoices	95%	98.7%	98.7%	98.6%	99.1%	99.1%	98.2%	97.6%	97.9%	97.9%	97.9%	98.0%	98.0%	97.7%



East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 16

14 March 2018

Purpose Information Assurance

Title	Finance and Performance Committee Update Report
Author	Miss K Ingham, Company Secretarial Assistant
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 the 27 November 2017 and 29 January 2018.

The Board is asked to note the content of the report and approve the revised terms of reference for the Committee.

Report linkages

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

Impact

Legal	No	Financial	No

Equality	No	Confidentiality	No

Previously Considered by: NA

Finance and Performance Committee Update Report

At the meeting of the Finance and Performance Committee held on 27 November 2017 members considered the following matters:

1. The Committee received the Integrated Performance Report, including an overview of the current financial position for the months of October 2017. Members noted the Trust performance against the four hour standard in the month was 87.5%. Members received an overview of the work that was taking place to improve performance. Members noted that there had been two instances of 12 hour trolley waits, and it was confirmed that the patients were awaiting assessments for mental health beds/mental health bed availability. Members noted that as of 1 December 2017 there would be a new mental health assessment unit which would support the further improvement against the 4 hour standard.
2. Members noted that the performance against the ambulance handover indicator had deteriorated in the period with the number of handovers taking in excess of 30 minutes increasing. An improvement plan for referral to treatment standards has been implemented however due to operational pressures across the emergency care pathway the standard was not met during the month of October.
3. The Committee discussed the impact that the non-achievement of STF monies and a need to utilise funds to improve the service would have on the ability to meet the Trust's financial control total.
4. Members also discussed the access to the Better Care Fund and noted that central Lancashire was currently under significant pressure to reduce delayed transfers of care, with the Pennine Lancashire footprint being viewed as performing adequately against this indicator, therefore the majority of investment from Lancashire County Council would be targeted at the central Lancashire area first.
5. The Committee received the Finance Report and noted that there had been deterioration in the divisional expenditure. Members discussed the financial; risks and agreed to escalate the matter to the Trust Board together with the recommendation that the risk score for the Board Assurance Framework (BAF) for the financial risk (Risk 4) be increased to 20 due to the increase in the likelihood score from 4 to 5.
6. The Committee members shared their concerns around the fact that the complete finance report was not presented to the Trust Board and the potential issues that this may cause. It was agreed that the issue would be raised with the Trust Chairman

and pending agreement the report in its entirety be included on the future Board session agendas.

7. Members discussed the ways that the Divisions are held accountable for their financial performance. The Non-Executive members of the Committee suggested that a financial recovery plan be developed for the remainder of the financial year which would also cover the second phase of the SRCP delivery for 2018/19.
8. Members of the Committee received the Sustaining Safe, Personal and Effective Care 2017/18 update report and noted that that a short and medium term plan was being developed to bring the plan back in line for delivery by the end of the period. Members discussed the Productivity and Efficiency programme and it was noted that delivery against this particular programme was crucial to the delivery of the overall programme.
9. Members noted that there had been a change in leadership within the PMO, with Mr Challender moving across to the Pennine Lancashire PMO and Mrs Brown taking over the responsibility for the Trust's PMO function. The overall responsibility for the PMO and delivery of SRCP schemes had also moved under the remit of finance.
10. The Committee received a presentation about the financial planning for 2018/`9 that provided an overview of the national positon in relation the planning framework that had been issued in autumn 2016. Members noted the update on the progress towards the achievement of the financial control total for the current year and the plans for the achievement of a financial balance by the end of 2018/19. The Committee noted the overview of the of the ways that efficiencies will be delivered, including an administration review, implementation of a managed print solution, review and rationalisation of back office functions, review of translation services, cost reductions relating to agency usage, review and elimination of unfunded posts, appropriate use of the apprenticeship levy.
11. The Committee received a presentation on the Lancashire Procurement Cluster (LPC); an overview of the next steps and a breakdown of the newly implemented balanced scorecard. The presentation highlighted the vision for the LPC; the work being undertaken to create the new organisation, including the development of four core work streams (procurement; systems and p2p; logistics and supply chain; and supplier relationship management/contract management); the new senior management team structure and an update on recruitment to vacant posts; and progress against the implementation plan. In addition to these items, members noted

that the Trust's procurement team were positively engaged in the process and the achievement of level 1 Accreditation for the Department of Health's Standards of Procurement with work beginning towards achievement of level 2.

12. Members received a presentation on the Estates Strategy that highlighted the key drivers for the change including the sustainable development plan, the capital investment plan, travel plans and accommodation strategy.
13. The Committee received an update report on tenders and the report on the EPR selection. The Committee also received the minutes of the Contract and Data Quality Board for information.

At the meeting of the Finance and Performance Committee held on 29 January 2018 members considered the following matters:

1. The Committee received the Integrated Performance Report, including an overview of the current financial position to the end of December 2017. The members noted the improvement in the RTT and cancer performance since the last meeting and that both performance indicators had been met. Members also noted the focused piece of work being undertaken with NWAS to identify and reduce the issues leading to the increases in ambulance handover times.
2. Members discussed the impact of the loss of elective activity over the recent months due to winter pressures and noted that the impact had been minimised by moving as much elective surgery to the Burnley site as possible. Members received an overview of the work that was taking place to manage the flow through the hospital.
3. Members received the finance report and noted that the Trust was performing in line with the planned year end position and that the financial movement in the month had been favourable to the Trust. The Committee were informed that the STF monies would be received in the quarter following the one in which the monies were earned and this was affecting the cash position amongst other factors. Members noted that the overall theme of the finance report was positive, but agreed that the size of the challenge in the coming year was not to be underestimated.
4. The Committee received a presentation on Sustaining Safe, Personal and Effective Care and Mrs Brown provided a presentation regarding the work that had been undertaken from the beginning of the month to re-base the Trust PMP, including an audit carried out by MIAA which is expected to receive limited assurance.

5. The members were provided with an overview of the revised SRCP and transformation schemes and the way in which they were now being managed. The Committee also received a summary of the additional schemes that had been included in the transformation plans, including managed print and paperless/online payslips, which are projected to release recurrent savings of around £400,000.
6. Members noted the revision of the financial assurance body that would report into the Committee and would replace the old style Transformation Board/SRCP report. Members also received an update in relation to the PMP working across the Pennine Lancashire LDP area and the overview of the findings from the work relating to community hospitals and moving care into a domiciliary setting, which will have a positive benefit on reducing the length of stay.
7. The Committee reviewed the elements of the Board Assurance Framework (BAF) that were specific to the remit of the Committee and received a report on the 2018/19 Financial Planning Assumptions. Members noted that the Trust remained on track to achieve the financial year end control total for 2017/18, however there would be an underlying deficit position carried into 2018/19.
8. The Committee received an update report on tenders and the report on the reference cost submission. The Committee also received the minutes of the Contract and Data Quality Board for information.

Kea Ingham, Company Secretarial Assistant, 6 March 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 17

14 March 2018

Purpose Information Assurance

Title	Audit Committee Update Report
Author	Miss K Ingham, Company Secretarial Assistant
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 4 December 2017 and 5 March 2018.

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Audit Committee Update

At the meeting of the Audit Committee held on 4 December 2017 members considered the following matters:

1. The internal audit reports listed below were presented to the Committee:
   a) Salary Overpayments (limited assurance)
   b) E-Rostering and Emergency Department Staffing (significant assurance)
   c) Cyber Security Baseline Technical Controls Assessment (no assurance rating required)
2. The Committee received an update from Dr Littley, Associate Medical Director in relation to the work that was taking place to improve clinical coding across the Trust. Members discussed the need for plain language to be used in notes in order for coders to accurately code episodes of care and the positive impact that electronic patient records would have on the ability to code activity. The Committee offered their support to Dr Littley and the Clinical Coding Team if needed.
3. The Committee received the Anti-fraud Service Progress Report and noted the progress being made in relation to the referrals and investigations that were currently underway and the two cases that had been closed since the last meeting. Members noted that NHS Protect had now become the NHS Counter Fraud Authority. The Committee recognised the work that anti-fraud services were undertaking in reviewing a number of Trust policies particularly those relating to sickness absence, annual leave and study leave. They also noted the weaknesses identified in the policies and the associated recommendations that had been made.
4. The Committee received the Information Commissioners Office Audit Report Executive Summary regarding information governance issues at the Trust. The Committee noted that there had been a number of recommendations made with one being classed as urgent, 24 classed as high priority and a total of 63 medium and low priority recommendations. Committee members noted the reporting and monitoring of the associated action plan would be through the Information Governance Steering Group (IGSG) and into the Committee by regular reporting and receiving the minutes of the IGSG.
5. The Committee received the IGSG minutes for information; an update in relation to the development of the Lancashire Procurement Cluster; and the external audit progress report.

At the meeting of the Audit Committee held on 5 March 2018 members considered the following matters:

1. The internal audit reports listed below were presented to the Committee:
   a) Project Management Office (PMO) including Transformation Schemes (limited assurance)
   b) Bank and Agency Staff Review (limited assurance)
   c) Holding Lists(significant assurance)
   d) Bedboard Management (significant assurance)
   e) IT Service Continuity & IT Asset Management Detailed Follow-up Review (no assurance rating required)
2. The Committee received the management response updates in relation to the following areas:
   a) Project Management Office (PMO) including Transformation Schemes
      i. It was noted that the PMO would revise its governance processes in order to provide improved assurance regarding progress of schemes and this would be reported to the Board via the Finance and Performance Committee.
   b) IMT Asset Management and Cyber Security
      i. Members noted that the actions being undertaken to address the recommendations in the cyber security audit report were continuing, but that they were not progressing at the anticipated pace. The Committee also noted that an overarching IMT improvement plan had been developed to draw together all the recommendations and associated actions from a series of reports.
3. The Committee received an update in relation to the actions being implemented following the Information Commissioners Office (ICO) audit that took place in October 2017. Members requested that progress towards completion of actions be updated to the Committee on a regular basis through the IGSG meeting minutes. The Committee members also requested that a clear indication of timescales for completion of actions be provided. Members stressed the importance of ensuring that the Trust was not exposed to unacceptable levels of risk in relation to the completion of actions and that all actions must be completed by the time of the ICO follow up visit, which is expected in mid-summer 2018.
4. The Committee received the Anti-fraud Service Progress Report and noted the progress being made in relation to the referrals and investigations that were currently underway.

5. Members of the Committee received a presentation concerning the new system that was being developed to manage declarations of interest.

6. The Committee received, discussed and approved for recommendation to the Trust Board (pending minor amendments/refinements) the Standing Orders. The Committee also agreed to recommend, with the exception of one section relating to VSM pay approvals, the Standing Financial Instructions (SFI's) to the Trust Board for approval. It was agreed that more detail about the Trust VSM pay arrangements outside the Executive Director roles is required to inform the discussion by the Audit Committee regarding the aforementioned issue, prior to the section being revised in the SFI's and presented to the Board for approval.

7. The Committee received and approved the proposed internal audit and Anti-Fraud work plans for 2018/19; agreed the process for delivery of the Head of Internal Audit Opinion; received and approved in principle the draft going concern statement and internal controls statement. In addition the Committee also received and approved the revised accounting policies, Standards of Conduct Policy and Anti-Bribery Policy and considered the draft Annual Governance Statement. The Committee also received the minutes of the IGSG meeting that was held in January 2018.

Kea Ingham, Company Secretarial Assistant, 6 March 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 18a

14 March 2018

Purpose Approval

Title	Annual Review of the Standing Financial Instructions
Author	Mrs A Bosnjak-Szekeres, Associate Director of Corporate Governance

Summary: The Finance Team and the Associate Director of Corporate Governance/Company Secretary have undertaken the review of the standing financial instructions (SFI's). The revised document was presented to the Audit Committee on the 5 March 2018. The Audit Committee agreed to recommend the revised document to the Trust Board for ratification bar the one item highlighted in green (section 9.1.4), that the Committee agreed to explore and review further before making a recommendation to the Board on these items.

There are a number of references within the document that have not yet been completed and are identified by XX, these will be completed prior to final publication. A final check of formatting will also be carried out prior to publication.

Recommendation: The Board is asked to ratify the revised document (apart from the section highlighted in green) on the recommendation of the Audit Committee.

Report linkages

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

positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Previously considered by: NA

East Lancashire Hospitals NHS Trust

TRUST WIDE DOCUMENT

DOCUMENT TITLE:	**STANDING FINANCIAL INSTRUCTIONS**
DOCUMENT NUMBER:	**ELHT/F15 Version 13**

DOCUMENT PURPOSE:	Identify the reservation and delegation of powers and standing financial instructions for the Trust.
TARGET AUDIENCE:	All Trust Personnel
DISTRIBUTION:	All Trust policy manuals and intranet
AUTHOR(S):	Associate Director of Corporate Governance/Company Secretary
EXECUTIVE DIRECTOR RESPONSIBLE:	Director of Finance

DOCUMENT REPLACES	Version 12
POLICY COUNCIL:	N/A
AUTHORISED BY:	Trust Board
NEXT REVIEW DATE:	December 2017

STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1 General

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

1.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

1.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.5 The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.2 Responsibilities and delegation

1.2.1 The Trust Board

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

1.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Matters Reserved to the Board' document. All other powers have been delegated to such other committees as the Trust has established or individuals as indicated in the scheme of delegation or these Standing Financial Instructions.

1.2.3 **The Chief Executive and Director of Finance**

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.4 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

1.2.5 **The Director of Finance**

The Director of Finance is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.2.6 **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.2.7 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.2.8 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.

2. AUDIT

2.1 Audit Committee

2.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Board;

(f) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

(g) Review and approve corporate policies on behalf of the Board

2.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health. (To the Director of Finance in the first instance.)

2.1.3 It is the responsibility of the Director of Finance to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

2.2 Director of Finance

2.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit

standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(e) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;

(ii) major internal financial control weaknesses discovered;

(iii) progress on the implementation of internal audit recommendations;

(iv) progress against plan over the previous year;

(v) strategic audit plan covering the coming three years;

(vi) a detailed plan for the coming year.

2.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;

(ii) waste, extravagance, inefficient administration;

(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.3.3 The Director of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

2.3.4 The Chief Internal Auditor shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least annually.

2.4 External Audit

The External Auditor is appointed by the Trust Board on the recommendation of the Auditor Panel and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Financial Reporting Council if the issue cannot be resolved.

2.5 Fraud and Corruption

2.5.1 In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud and corruption.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

2.5.3 The Local Counter Fraud Specialist shall report to the Trust Director of Finance and shall work with staff in the Counter Fraud and Security Management Services (CFSMS) and the Regional Counter Fraud and Security Management Services

2.5.4 in accordance with the Department of Health Fraud and Corruption Manual.

2.5.5 The Local Counter Fraud Specialist will provide a written report quarterly to the Audit Committee, on counter fraud work within the Trust.

2.6 Security Management

2.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

2.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

2.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed LSMS.

3. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board an Annual Business Plan (ABP) which takes into account financial targets and forecast limits of available resources. The ABP will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in activity, delivery of services or resources required to achieve the plan.

3.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Local Delivery Plan;

(b) accord with activity and workforce plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

3.1.3 The Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

3.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

3.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;

(c) individual and group responsibilities;

(d) authority to exercise virement;

(e) achievement of planned levels of service;

(f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

3.3 Budgetary Control and Reporting

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) Balance sheet position showing movement from previous month and movement year

to date

(ii) movements in working capital;

(iii) Movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

(vii) service line reporting information

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, activity and workforce budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the ABP and a balanced budget.

3.4 Capital Expenditure

The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI XX).

3.5 Monitoring Returns

The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and International Financial Reporting Standards where applicable;

(b) prepare and submit annual financial reports to the Department of Health certified in accordance with current guidelines;

(c) submit financial returns to the Department of Health for each financial year in accordance with the timetable prescribed by the Department of Health.

4.2 The Trust's annual accounts must be audited by an auditor appointed by the Trust Board on the recommendation of the Auditor Panel The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

4.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Group Accounting Manual.

5. BANK AND GBS ACCOUNTS

5.1 General

5.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued from time to time by the Department of Health. In line with 'Cash Management in the NHS' Trusts should minimize the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

5.1.2 The Board shall approve the banking arrangements.

5.2 Bank and GBS Accounts

5.2.1 The Director of Finance is responsible for:

(a) bank accounts and GBS accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts

to be overdrawn.

(e) monitoring compliance with DH guidance on the level of cleared funds.

5.3 Banking Procedures

5.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Tendering and Review

5.4.1 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

5.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall follow the Department of Health's advice in the "Costing" Manual in setting prices for NHS service agreements.

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health/

NHS Improvement or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical standards in the NHS and the provisions of the Bribery Act 2010 shall be followed.

6.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt Recovery

6.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving

the Trust from responsibility for any loss.

7. TENDERING AND CONTRACTING PROCEDURE

The Trust's policy is to seek to maximise value for money in the procurement of goods and services whilst ensuring that operational requirements are fulfilled and statutory obligations met.

7.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with the Standing Orders and the Standing Financial Instructions (except where the Suspension of Standing Orders is applied).

7.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

7.3 Reverse eAuctions

The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. For further guidance on Reverse eAuctions refer to www.ogc.gov.uk

7.4 Capital Investment Manual, NHSI and Department of Health and Social Care capital investment guidance

The Trust shall comply as far as is practicable with the requirements of Capital regime, investment and property business case approval guidance for NHS providers issued by NHS Improvement and the Department of Health and Social Care, "Capital Investment Manual" and Estate Code in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance "The Procurement and Management of Consultants within the NHS".

7.5 Formal Competitive Tendering

Trust Officers will as a matter of course seek to use NHS or other Public Body Contracts. In cases where they are not available or are inappropriate for use the following rules by value apply. All values are for the total procurement value over the life of the goods/services.

Both quotations and tenders are formal requests from the Trust to potential suppliers to provide prices/costs against a defined procurement.

Tenders representing a value greater that the OJEU level and more complicated procurements will comprise a range of standard documentation as advised by the Department of Health and Government.

In cases where the Trust, by prior agreement, uses another Public Body to undertake procurement then the Statutory Framework of that Body will apply to the procurement – the Trust having agreed and documented this in advance.

In cases where the Trust, by prior agreement, undertakes procurement on behalf of another Public Body the Trust's Statutory Framework will apply – all parties having agreed and documented this in advance.

7.5.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

7.5.2 Health Care Services

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 16.

7.5.3 Exceptions and instances where formal tendering need not be applied

It should be noted that European Procurement Law applies at all times and cannot

be waivered. Trust Procurement will advise budget holders as to how compliance can be achieved.

7.5.4 Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed **£35,000**;

(b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No. 16.13.

7.5.5 Formal tendering procedures **may be waived** in the following circumstances:

(d) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(e) where the requirement is covered by an existing contract;

(f) where a government agreement is in place and have been approved by the Board;

(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(i) where specialist expertise is required and is available from only one source;

(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

7.5.6 The Director of Finance will ensure that any fees paid are reasonable and within

commonly accepted rates for the costing of such work.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure. All proposed waivers will be requested by means of the Trust approved formal Waiver Form and in line with the Trust's Scheme of Delegation.

Trust Procurement will consider all requests to waive tendering and quotation requirements as set out in these Standing Orders and Standing Financial Instructions based upon both the information presented and appropriate research. Approval will be granted or declined in the first instance by Trust Procurement and the form will then be submitted to the Director of Finance. If either party declines the waiver request the Trust Procurement Officer will brief and advise the commissioning officer of the reason.

Where it is decided that competitive tendering is not applicable andshould be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee on an annual basis

7.5.7 **Fair and Adequate Competition**

Where the exceptions set out in SFI Nos. XX apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

7.5.8 **List of Approved Firms**

The Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. W here in the opinion of the Director of Finance it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive (see SFI XX list of Approved Firms).

7.5.9 **Building and Engineering Construction Works**

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with EU Regulations, Procure21+ / Procure22 and Private Finance Initiatives) without Department of Health approval.

7.5.10 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

7.6 Contracting/Tendering Procedure

Trust Procurement will support budget holders in sourcing and identifying potential suppliers. Sources of potential suppliers will include but not be limited to:

- Via posting on the Government website and per the Public Procurement Regulations 2015 contracts finder
- NHS or other Public Body Contractors
- Respondents to Notices placed in the Official Journal of the European Union
- Respondents to Notices placed in appropriate Journals
- Those advised by Trust Officers based upon their operational and technical knowledge

A pre-selection process will usually be undertaken including, where appropriate, indicative costing methodologies.

In the case of hard copy paper tenders, a list of the suppliers invited to submit a tender will be provided for the Director of Finance's office and include the tender reference and the closing date and time for receipt of tenders.

Tender documents will be issued according to one of three methods:

(1) Electronically via the Trust Tender Management (TM) system.

This involves giving Tenderers electronic access to Tender Documents and their return electronically. The Trust may also elect to utilise the Electronic Auction option as part of this method which involves facilitating an online reverse auction where against an agreed range of products/ services tenderers submit prices within a timescale with an expectation that suppliers submitting the lowest prices will achieve the highest score for the pricing elements of the Tender. The trust may also invite non price Tender submissions in addition to the Electronic Auction.

Electronic Auctions will be operated in accordance with the protocols of the TM System provider and the Trust Procurement/E-Commerce Department.

(2) Electronically from an approved Trust Officer email address.

This involves the electronic dissemination of the Tender Documents to the Director of Finance's office and includes the tender reference and the closing date and time for receipt of tenders.

(3) By paper hard copy.

This involves the posting of paper hard copy Tender Documents and the return of the paper hard copy. All invitations to tender shall state the date and time as being the latest time for receipt of tenders. All invitations to tender shall state that no paper hard copy tender will be accepted unless:

(a) submitted in a plain sealed package or envelope bearing a pre- printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with EU regulations, Procure21+/Procure22 and Private Finance Initiatives; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

7.7 Receipt and safe custody of paper hard copy and tenders issued electronically from an approved Trust Officer's email address

The Chief Executive or his nominated representative will be responsible for the

receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

7.8 Opening tenders and Register of tenders

Tenders issued electronically via the TM System should be submitted and opened in accordance with the TM System protocols. These protocols having been agreed with the system provider and having been approved by the Trust's Internal Audit System prior to implementation. The Tenders will remain within the TM System under a password controlled and time locked secure electronic environment.

Tenders issued electronically from an approved Trust Officer email address must be returned addressed to the Director of Finance or delegated officer and submitted in accordance with the notified tender deadline.

7.9 Tenders issued by paper hard copy should be opened:

(a) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive and not from the originating department.

(b) A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

(c) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(d) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(e) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The Trust's Company Secretary will count as a Director for the purposes of opening

tenders.

(f) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(g) A register shall be maintained by the Chief Executive, or a person authorised by him, to show for each set of competitive tender invitations dispatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender. Each entry to this register shall be signed by those present.
- A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(h) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

7.10 Admissibility

If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive or Director of Finance.

(ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.11 Late Tenders

Tenders received after the due time and date, but prior to the opening of the other tenders may be considered only if the Chief Executive or his nominated officer decides that there exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

(iv) The TM System will require the Trust's authorised Officers to approve the opening of Tenders received past the Tender Return date – until this is agreed they will be stored securely online

7.12 Acceptance of formal tenders (See overlap with SFI No. XX)

The Tender Document will normally state that the awarded is to be based on the most economically advantageous bid. This will normally include full life cycle costs.

In cases where the EU Thresholds apply, the Award Criteria must be included in either the Notice in the Official Journal of the European Union or in the Tender.

Contract Award criteria are agreed by Trust Officers as part of the procurement process. In projects of significant value/risk this will include budget holders, finance staff and procurement officers along with any other appropriate Trust Officers.

(i) The procurement process must allow sufficient time for pre- offer (tender) engagement with potential suppliers including the application of indicative pricing methodologies. These will be conducted in accordance with Department of Health / Government Guidance. Post tender negotiation /pre contract negotiation is not permitted within the OJEU tendering process. In exceptional cases at the discretion of Trust Procurement it may be undertaken for below OJEU threshold tendering exercises. Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender. These clarifications will be conducted in accordance with Department of Health/ Office of Government Commerce Guidance.

(ii) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy,

the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these factors and their weighting in the award process must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

All tenders should be treated as confidential and should be retained for inspection.

All tender awards need to be posted on the contracts finder website as per the Public Procurements Regulations 2015.

7.13 Tender reports to the Trust Board

Reports to the Trust Board will be made on an exceptional circumstance basis only.

7.14 List of approved firms

(a) **Responsibility for maintaining list**

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

(b) **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate

maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) **Financial Standing and Technical Competence of Contractors**

The Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

7.15 Exceptions to using approved contractors

If in the opinion of the Chief Executive and the Director of Finance or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

7.16 Quotations: Competitive and non-competitive

7.16.1 General Position on quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £15,000 but not exceed £35,000.

7.16.2 Competitive Quotations

7.16.2.1 Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

7.16.2.2 Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Quotations will usually comprise a single document.

Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

7.16.2.3 All quotations should be treated as confidential and should be retained for inspection.

7.16.2.4 The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

7.16.3 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

7.16.3.1 the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

7.16.3.2 the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

7.16.3.3 miscellaneous services, supplies and disposals;

7.16.3.4 where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (i) and (ii) of this SFI) apply.

7.16.4 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

7.17 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

Designated budget holders	up to	£25,000
Divisional General Managers & Other Directors	up to	£75,000
Executive Directors	up to	£250,000
Director of Finance	up to	£500,000
Deputy Chief Executive	up to	£500,000
Chief Executive	up to	£1,000,000
Trust Board	over	£1,000,000

These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

7.18 Instances where formal competitive tendering or competitive quotation is not required

Refer to section XX

(a) The Trust shall use the NHS Logistics for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use the NHS Supply Chain - where tenders or quotations are not required, because expenditure is below £15,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

7.19 Private Finance for capital procurement (see overlap with SFI No. XX)

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.20 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, Estate Code, Capital regime, investment and property business case approval guidance for NHS providers and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

7.21 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.22 Disposals (See overlap with SFI No. XX)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £5,000 this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

7.23 In-house Services

7.23.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

7.23.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £ 500,000, a Non-Executive member of the Board should be a member of the evaluation team.

7.23.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

7.23.4 The evaluation team shall make recommendations to the Board.

7.23.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

7.24 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No.XX)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust charitable funds and private resources.

8. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES

8.1 **Service Level Agreements (SLAs)**

The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within the Annual Business Plan (ABP) and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

8.2 **Involving Partners and jointly managing risk**

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion

responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 **Reports to Board on SLAs**

The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

9 TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

9.1 **Remuneration Committee**

9.1.1 In accordance with Standing Orders the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

9.1.2 The Committee will:

9.1.2.1 agree the appropriate remuneration and terms of service for the Chief Executive and Executive Directors including:

9.1.2.1.1 all aspects of salary (including any performance-related elements/bonuses);

9.1.2.1.2 provisions for other benefits, including pensions and cars;

9.1.2.1.3 arrangements for termination of employment and other contractual terms;

9.1.2.2 Advise the Board of the remuneration and terms of service of the Executive Directors to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

9.1.2.3 monitor the performance of individual Executive Directors via the annual appraisal report of the Chief Executive for the Non-Executive Directors and the Chairman's appraisal report for the Chief Executive.

9.1.2.4 Advise on and oversee appropriate contractual arrangements for such staff

including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

9.1.2.5 Carry out duties under the Trust's Fit and Proper Person Test Policy;

9.1.2.6 The Remuneration Committee and Non-Executive Directors will be involved in the recruitment of Executive Directors through focus groups that form part of the selection process.

9.1.3 The Committee shall report in writing to the Board. The Board shall remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Remuneration Committee meetings should record such decisions.

9.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

9.1.5 The Trust will pay allowances to the Chairman and Non-Executive Directors (including Associate Non-Executive Directors) of the Board in accordance with instructions issued by the Secretary of State for Health.

9.2 **Funded Establishment**

9.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

9.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive.

9.3 **Staff Appointments**

9.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

9.3.1.1 unless authorised to do so by the Chief Executive;

9.3.1.2 Within the limit of their approved budget and funded establishment.

9.3.2 The Board will approve procedures presented by the Chief Executive for the

determination of commencing pay rates, condition of service, etc, for employees.

9.4 **Processing Payroll**

9.4.1 The Director of Finance is responsible for:

9.4.1.1 specifying timetables for submission of properly authorised time records and other notifications;

9.4.1.2 the final determination of pay and allowances;

9.4.1.3 making payment on agreed dates;

9.4.1.4 agreeing method of payment.

9.4.2 The Director of Finance will issue instructions regarding:

9.4.2.1 verification and documentation of data;

9.4.2.2 the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

9.4.2.3 maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

9.4.2.4 security and confidentiality of payroll information;

9.4.2.5 checks to be applied to completed payroll before and after payment;

9.4.2.6 authority to release payroll data under the provisions of the Data Protection Act;

9.4.2.7 methods of payment available to various categories of employee and officers;

9.4.2.8 procedures for payment by cheque, bank credit, or cash to employees and officers;

(a) procedures for the recall of cheques and bank credits;

(b) pay advances and their recovery;

(c) maintenance of regular and independent reconciliation of pay control accounts;

(d) separation of duties of preparing records and handling cash;

(e) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

9.4.3 Appropriately nominated managers have delegated responsibility for:

9.4.3.1 submitting time records, and other notifications in accordance with agreed timetables;

9.4.3.2 completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance;

9.4.3.3 submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or

retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

9.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 **Contracts of Employment**

The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

10 NON-PAY EXPENDITURE

10.1 **Delegation of Authority**

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

10.1.2 The Chief Executive will set out:

10.1.2.1 the list of managers who are authorised to place requisitions for the supply of goods and services;

10.1.2.2 the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 **Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. XX)**

10.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. W here this advice is not acceptable to the requisitioner,

the Director of Finance (and/or the Chief Executive) shall be consulted.

10.2.2 **System of Payment and Payment Verification**

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.2.3 **The Director of Finance will:**

10.2.3.1 advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

10.2.3.2 prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

10.2.3.3 be responsible for the prompt payment of all properly authorised accounts and claims;

10.2.3.4 be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

10.2.3.4.1 A list of Board employees (including specimens of their signatures) authorised to certify invoices.

10.2.3.4.2 Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;

- the account is in order for payment.

10.2.3.4.3 A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

10.2.3.4.4 Instructions to employees regarding the handling and payment of accounts within the Finance Department.

10.2.3.5 be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 19.2.4 below.

10.2.4 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. In such instances:

10.2.4.1 Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 3.5%).

10.2.4.2 The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

10.2.4.3 The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

10.2.4.4 The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.2.5 **Official orders**

Official Orders must:

(a) be in a form approved by the Director of Finance;

(b) state the Trust's terms and conditions of trade;

(c) only be issued to, and used by, those duly authorised by the Chief Executive.

10.2.6 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits

specified by the Director of Finance and that:

10.2.6.1 all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

10.2.6.2 contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

10.2.6.3 where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

10.2.6.4 no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

10.2.6.4.1 isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

10.2.6.4.2 conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Orders and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff") and the Bribery Act 2010;

10.2.6.5 no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

10.2.6.6 all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

10.2.6.7 verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

10.2.6.8 orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

10.2.6.9 goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

10.2.6.10 changes to the list of employees and officers authorised to certify invoices are notified to the Director of Finance;

10.2.6.11 purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

10.2.6.12 petty cash records are maintained in a form as determined by the Director of Finance.

10.2.6.13 All attempts to bribe or otherwise induce members of staff to procure products or services from a particular supplier are reported immediately to the Director of Finance

10.2.7 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within EU regulations, Procure21+/Procure22, Private Finance Initiative and Estate Code. The technical audit of these contracts shall be the responsibility of the relevant Director.

11 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. XX)

11.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act **shall** comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

12 EXTERNAL BORROWING

12.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance is also responsible for reporting periodically to the Board concerning the level of PDC held and all loans and overdrafts.

12.1.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Director of Finance.

12.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

12.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the Department of Health.

12.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

12.1.6 All long-term borrowing must be consistent with the plans outlined in the current LDP and be approved by the Trust Board.

12.2 **INVESTMENTS**

12.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

12.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

12.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

13 FINANCIAL FRAMEWORK

The Director of Finance should ensure that members of the Board are aware of the Financial Framework. This document contains directions which the Trust must follow. It also contains directions to Strategic Health Authorities regarding resource and capital allocation and funding to Trust's. The Director of Finance should also ensure that the direction and guidance in the framework is followed by the Trust.

14 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

14.1 Capital Investment

14.1.1 The Chief Executive:

14.1.1.1 shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

14.1.1.2 is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

14.1.1.3 shall ensure that the capital investment is not undertaken without confirmation of commissioner(s) support and the availability of resources to finance all revenue consequences, including capital charges.

14.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

14.1.2.1 that a business case (in line with Capital regime, investment and property business case approval guidance for NHS providers) is produced setting out:

14.1.2.1.1 an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

14.1.2.1.2 the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

14.1.2.2 that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

14.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the Estate Code.

14.1.4 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HMRC guidance.

14.1.5 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

14.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

14.1.6.1 specific authority to commit expenditure;

14.1.6.2 authority to proceed to tender (see overlap with SFI No. XX);

14.1.6.3 approval to accept a successful tender (see overlap with SFI No. XX).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with Estate Code guidance and the Trust's Standing Orders.

14.1.7 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes.

14.2 Private Finance

14.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

14.2.1.1 The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

14.2.1.2 Where the sum involved exceeds delegated limits, the business case must be

referred to the Department of Health or in line with any current guidelines.

14.2.1.3 The proposal must be specifically agreed by the Board.

14.3 Asset Registers

14.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

14.3.2 Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the *Capital Accounting Manual* as issued by the Department of Health.

14.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

14.3.3.1 properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

14.3.3.2 stores, requisitions and wages records for own materials and labour including appropriate overheads;

14.3.3.3 lease agreements in respect of assets held under a finance lease and capitalised.

14.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

14.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

14.3.6 Each asset is to be appropriately valued in accordance with agreed accounting policies

14.3.7 The value of each asset shall be depreciated using methods and rates as specified in the *Capital Accounting Manual* issued by the Department of Health.

14.3.8 The Director of Finance of the Trust shall calculate and pay capital charges as specified by the Department of Health.

14.4 Security of Assets

14.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

14.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable

instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

14.4.2.1 recording managerial responsibility for each asset;

14.4.2.2 identification of additions and disposals;

14.4.2.3 identification of all repairs and maintenance expenses;

14.4.2.4 physical security of assets;

14.4.2.5 periodic verification of the existence of, condition of, and title to, assets recorded;

14.4.2.6 identification and reporting of all costs associated with the retention of an asset;

14.4.2.7 reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

14.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

14.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

14.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

14.4.6 Where practical, assets should be marked as Trust property.

15 STORES AND RECEIPT OF GOODS

15.1 General position

15.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

15.1.2 kept to a minimum;

15.1.3 subjected to annual stock take;

15.1.4 valued at the lower of cost and net realisable value.

15.2 Control of Stores, Stocktaking, condemnations and disposal

15.2.1 Subject to the responsibility of the Director of Finance for the systems of control,

overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

15.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

15.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

15.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

15.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

15.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 24 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

15.3 Goods supplied by NHS Logistics

For goods supplied via the NHS Logistics central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.

16 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

16.1 Disposals and Condemnations

16.1.1 **Procedures**

The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

16.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

16.1.3 All unserviceable articles shall be:

16.1.3.1 condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

16.1.3.2 recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

16.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

16.2 **Losses and Special Payments**

16.2.1 **Procedures**

The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

16.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant LCFS and CFSMS regional team in accordance with Secretary of State for Health's Directions.

The Director of Finance must notify the Counter Fraud and Security Management Services (CFSMS) and the External Auditor of all frauds.

16.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

16.2.3.1 the Audit Committee,

16.2.3.2 the External Auditor

16.2.3.3 in the event of theft or arson, the police.

16.2.4 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16.2.5 For any loss, the Director of Finance should consider whether any insurance claim can be made.

16.2.6 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.7 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

16.2.8 All losses and special payments must be reported to the Audit Committee on an annual basis

17 INFORMATION TECHNOLOGY

17.1 Responsibilities and duties of the Director of Finance

17.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

17.1.1.1 devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

17.1.1.2 ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

17.1.1.3 ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

17.1.1.4 ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

17.1.2 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

17.1.3 The Associate Director of Corporate Governance/Company Secretary shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner.

17.2 **Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application**

17.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance:

17.2.1.1 details of the outline design of the system;

17.2.1.2 in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

17.3 **Contracts for Computer Services with other health bodies or outside agencies**

The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

17.4 **Risk Assessment**

The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

17.5 **Requirements for Computer Systems which have an impact on corporate financial systems**

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

18 PATIENTS' PROPERTY

18.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

18.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; ***(notices are subject to sensitivity guidance)***
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

18.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

18.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

18.5 In all cases where property of a deceased patient is of a total value in excess of

£5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

18.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

18.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19 FUNDS HELD ON TRUST

19.1 Corporate Trustee

(1) Standing Order No. 2.7 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SFI 4.8.3 that defines the need for compliance with Charities Commission latest guidance and best practice. For further information in relation to the requirements in relation to Charitable Funds please see the Standing Orders and Standing Financial Instructions for Charitable Funds.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

19.2 Accountability to Charity Commission and Secretary of State for Health

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds

held on trust and to the Secretary of State for all funds held on trust.

19.3 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

19.4 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 16.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

20 ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF CONDUCT (see overlap with Standing Orders)

The Director of Finance and Associate Director of Corporate Governance/Company Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and the NHS England Managing Conflicts of Interest guidance published in June 2017 (https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf) and is also deemed to be an integral part of the Standing Orders and the Standing Financial Instructions.

21 RETENTION OF RECORDS

21.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

21.2 The records held in archives shall be capable of retrieval by authorised persons.

21.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

22 RISK MANAGEMENT AND INSURANCE

22.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

i. a process for identifying and quantifying risks and potential liabilities;
ii. engendering among all levels of staff a positive attitude towards the control of risk;
iii. management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
iv. contingency plans to offset the impact of adverse events;
v. audit arrangements including; Internal Audit, clinical audit, health and safety review;
vi. a clear indication of which risks shall be insured;
vii. arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement on the effectiveness of Internal Control (SIC) within the Annual Report and Accounts as required by current Department of Health guidance.

22.2 Insurance: Risk Pooling Schemes administered by NHSLA

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

22.3 Insurance arrangements with commercial insurers

30.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(2) where the Trust is involved with a consortium in a **Private Finance Initiative**

contract and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

22.4 Arrangements to be followed by the Board in agreeing Insurance cover

22.4.1 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

22.4.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

22.4.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions, which may have a far-reaching effect, must be reported to the Chief Executive. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior officers as appropriate. All items concerning Finance must be carried out with Standing Financial Instructions and Standing Orders.

	Delegated Matter	Authority Delegated To
1	Management of Budgets Responsibility of keeping expenditure within budgets At individual budget level (pay and non-pay) At service level For all other areas	Budget holder Divisional General Manager Director of Finance or Appropriate Delegated Manager
2	Maintenance/ Operation of Bank Accounts	Director of Finance
3	Non - Pay Revenue and Capital Expenditure/Requisitioning/ Ordering / Payment of Goods and Services Budgets are spent consistent with their purpose Non-Pay Expenditure for which no specific budget has been set up	Divisional General Manager or Departmental Manager

	Delegated Matter	Authority Delegated To
b)	and which is not subject to funding under delegated powers of virement Orders exceeding 12 month period All contracts for goods and Services and subsequent variations to contracts	Chief Executive, Director of Finance or Service Manager Director of Finance and Divisional General Manager Divisional General Manager or Director of Finance
4 a) b)	Capital Schemes Selection of Architects, Quantity Surveyors, Consultant Engineer and other professional advisors within EU Regulations Financial monitoring and reporting on all capital scheme expenditure	Director of Finance

	Delegated Matter	Authority Delegated To
5	Quotation, Tendering and Contract Procedures	Head of Procurement or delegated officer
	Obtaining quotations for goods/ services up to £15,000	Head of Procurement or delegated officer Head
a)	Obtaining 3 written quotations for goods/ services from £15,000 to £35,000	of Procurement or delegated officer
		Head of Procurement or Director of Finance or
b)	Obtaining competitive tenders for expenditure over £35,000	Chief Executive
	Waiving of Quotations and Tenders subject to SFI's	Board Director and Senior Manager for paper
	Opening tenders and quotations	tenders and Director of Finance/delegated officers
c)		for electronic tenders
d)		

6 a) b)	Setting of Fees and Charges Private Patients, Overseas Visitors, Income Generation & other patient related services Price of NHS Service Agreements. Charges for all NHS Service Agreements, be they block, cost per case, cost and volume or spare capacity	 Director of Finance or Nominated Deputy Director of Finance or Nominated Deputy
7 a)	Engagement of staff not on the Establishment Engagement of Trust solicitors Booking of Bank or Agency Staff • Medical Locums • Nursing	Chief Executive/ Director of Finance/ Deputy Chief Executive/ Associate Director of Safety & Quality Divisional General Manager or Nominated
8	Expenditure on Charitable and Endowment Funds Up to £3,000 per request Over £3,000 per request Over £20,000	Departmental Manager/ Directorate Nurse Director of Finance or Executive Director
9 a) b) c) d)	Agreements/ Licenses Preparation and signature of all tenancy agreements/ licences for staff subject to Trust policy on accommodation for staff Extension to existing leases Letting of premises to outside organisations Approval of rent based on professional assessment	 Facilities Manager Director of Finance/ Facilities Manager Director of Finance/ Chief Executive Director of Finance
10 a)	Condemning and Disposals Items obsolete, obsolescent,	

	irreparable or cannot be repaired cost effectively	Supplies Manager Budget Holder
i)	With current/ estimated purchase less than £50	Service Manager – Radiology Service Manager – Radiology
ii)	With current purchase new price greater than £50	Director of Estates
iii)	Disposal of x-ray films (subject to estimated income of less than £1,000 per sale)	Director of Estates and Director of Finance
iv)	Disposal of x-ray films (subject to estimated income exceeding £1,000 per sale)	
v)	Disposal of mechanical and engineering plant (subject to estimated income of less than £3,000 per sale)	

11	Losses, Write Off and Compensation	
a)	Losses and cash due to theft, fraud, overpayment and others up to £50,000	Chief Executive or Director of Finance
b)	Fruitless payments (including abandoned capital schemes) up to £250,000	Chief Executive or Director of Finance
c)	Bad debts and claims abandoned, private patients, overseas visitors and others up to £50,000	Chief Executive or Director of Finance
d)	Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson) or other up to £50,000	Chief Executive or Director of Finance
e)	Compensation payments made under legal obligation	Chief Executive or Director of Finance or Deputy Chief Executive
f)	Extra contractual payments to contractors up to £50,000	Chief Executive or Director of Finance
g)	Ex-gratia payments to patients and staff for loss of personal effects • Less than £500 • Between £500 and £10,000 • £10,000 to £50,000	Budget Holder / Associate Director of Safety & Quality
h)	For clinical negligence up to £1,000,000(negotiatedsettlements)	Associate Director Safety & Quality
	For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £1,000,000 including plaintiff's costs	/ Deputy Chief Executive Chief Executive / Director of Finance/ Deputy ChiefExecutive
i)	Other, except cases of maladministration where there was no financial loss by claimant £50,000	Chief Executive / Director of Finance/ Deputy Chief Executive
	Write off NHS Debtors	Chief Executive / Director of Finance/ Deputy Chief Executive
	Write off non NHS Debtors	

12 a) i) ii) b)	Reporting of Incidents to the Police Where a criminal offence is suspected Criminal offence of a violent nature Other Where fraud is involved	Executive/ Director of Finance/ Divisional Manager Director of Finance
13	Receiving Hospitality Applies to both individual and collective hospitality receipt items, in excess of £~~25~~50.00 per item received	Declaration required in the Trust's Register
14	Implementation of Internal and External Audit Recommendations	Director of Finance
15	Maintenance & Update on Trust Financial Procedures	Director of Finance
16	Investment of Funds including Charitable and Endowment Funds	Director of Finance

17	**Personnel and Pay**	
	Authority to full funded post on the establishment with permanent staff	Divisional General Manager Director of Finance
	Authority to appoint staff to post not on the formal establishment The granting of additional increments to staff within budget	Director of Finance or Divisional General Manager Chief Executive or Director of Finance
	All requests for upgrading or regarding shall be dealt with in accordance with Trust procedures Establishments	
	Additional staff to the agreed establishment with specifically allocated Finance	Director of Finance Director of Finance
	Additional staff to the agreed establishment without specifically allocated finance	Budget Holder
	Pay	
	Authority to complete standing data forms effecting pay, new starters, variations and leavers Authority to complete and authorise positive reporting forms Authority to authorise overtime Authority to authorise travel and subsistence expenses	Budget Holder Budget Holder Budget Holder
	Leave	Line/ Departmental
	Approval of annual leave	Manager Line/
	Annual leave – approval of carry forward up to a maximum of 5 days or as defined in the initial conditions of service	Departmental Manager Director of HRand
	Annual leave approval of carry over in excess of 5 days but less then 10 days	Organisational Development
	Annual leave approval to carry forward 10 days or more	
	Compassionate leave up to 5 days Special leave arrangements	

	Study leave • Study leave outside the UK • Medical staff study leave (UK) • All other study leave (UK) Removal expenses, excess rent and house purchases Authorisation of payment of removal expenses incurred by officers taking up new appointments providing consideration was promised at interview. Grievance Procedure All grievance cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Head of HR must be sought when the grievance reaches the level of Service Manager Authorised car and mobile phone users Requests for new posts to be authorised as car users Request for new posts to be authorised as mobile telephone users Renewal of Fixed Term contract Staff Retirement Policy Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances Redundancy Ill Health Retirement Decision to pursue retirement on the	Chief Executive or Director of Finance Divisional General Manager Divisional General Manager Divisional General Manager Divisional General Manager Divisional General Manger Divisional General Manager Divisional General Manager Divisional General Manager Chief Executive Chief Executive and Medical Director Divisional General Manager Director of Finance Director of HR and Organisational Development Director of Finance/ Nominated Officer Director of Finance / Nominated Officer

18	Authorisation of New Drugs £25,000 Estimated total yearly cost above £25,000	Deputy Chief Executive/ Divisional General Manager Drugs Committee & Chief Executive/ Director of Finance
19	Authorisation of Sponsorship Deals	Chief Executive/ Medical Director and Director of
20	Authorisation of Research Projects	Chief Executive / Medical Director and Chairman of Research Committee
21	Authorisation of Clinical Trials	Research & Development Committee, Chief Executive and Medical Director
22	Insurance Policies and Risk Manager	Chief Executive, Director of Finance and Deputy Chief Executive
23	Patients and Relatives Complaints Overall responsibility for ensuring that all complaints are dealt with effectively Responsibility for ensuring complaints relating to a directorate area are investigated thoroughly Medico-legal complaints – coordination of their manager	Deputy Chief Executive and Associate Director of Safety & Quality Divisional General Manager and Associate Director of Safety & Quality Associate Director of Safety & Quality
24	Review Trust compliance with the Access to Records Act	Director of Finance or Nominated Officer
25	Review of the Trust's compliance with the Code of Practice for Handling Confidential Information in the Contracting Environment and	Director of Finance or Nominated Officer
26	The keeping of a Register of Interests	Associate Director of Corporate Goveranance/Company Secretary

27	Attestation of Sealings in accordance with Standing Orders	Chief Executive/ Director of Finance/Associate Director of Corporate Governance/Company Secretary
28	The keeping of a Register of Sealings	Associate Director of Corporate Governance/Company Secretary
29	The keeping of the Hospitality Register	Associate Director of Corporate Governance/Company Secretary
30	Retention of Records	Chief Executive

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
Director Of Finance	Approval of all financial procedures.
Director Of Finance	Advice on interpretation or application of SFIs.
All Members Of The Board And Employees	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
Chief Executive	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
Chief Executive & Director Of Finance	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
Chief Executive	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
Director Of Finance	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and staff; e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
All Members Of The Board And Employees	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Chief Executive	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
Audit Committee	Provide independent and objective view on internal control and probity.
Auditor Panel	Provide advice and recommendation on the appointment of the External Auditor.
Board	Appoint External Auditor
Chair Of Audit Committee	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
Director Of Finance	Ensure an adequate internal audit service, for which he/she is accountable, is provided
Director Of Finance	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
Director Of Internal Audit	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
Audit Committee	Ensure cost-effective External Audit.
Chief Executive & Director Of Finance	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
Chief Executive	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Chief Executive	Compile and submit to the Board an Annual Business Plan (ABP) which takes into account financial targets and forecast limits of available resources. The ABP will contain: • a statement of the significant assumptions on which the plan is based;
Director Of Finance	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
Director Of Finance	Ensure adequate training is delivered on an ongoing basis to budget holders.
Chief Executive	Delegate budget to budget holders.
Chief Executive & Budget Holders	Must not exceed the budgetary total or virement limits set by the Board.
Director Of Finance	Devise and maintain systems of budgetary control.
Budget Holders	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board;
Chief Executive	Identify and implement cost improvements and income generation activities in line with the Annual Business Plan.
Chief Executive	Submit monitoring returns
Director Of Finance	Preparation of annual accounts and reports.
Director Of Finance	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. Board approves arrangements.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Director Of Finance	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
All Employees	Duty to inform DoF of money due from transactions which they initiate/deal with.
Chief Executive	Tendering and contract procedure.
Chief Executive	Waive formal tendering procedures.
Chief Executive	Report waivers of tendering procedures to the Audit Committee.
Director Of Finance	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.
Chief Executive	Responsible for the receipt, endorsement and safe custody of tenders received.
Chief Executive	Shall maintain a register to show each set of competitive tender invitations despatched.
Chief Executive And Director Of Finance	Where one tender is received will assess for value for money and fair price.
Chief Executive	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
Chief Executive	Will appoint a manager to maintain a list of approved firms.
Chief Executive	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Chief Executive	The Chief Executive or his nominated officer should evaluate the quotation and select the quote whichgives the best value for money.
Chief Executive Or Director Of Finance	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
Chief Executive	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
Board	All PFI proposals must be agreed by the Board.
Chief Executive	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
Chief Executive	The Chief Executive shall nominate officers with delegated authority to enter into contracts ofemployment, regarding staff, agency staff or temporary staff service contracts.
Chief Executive	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
Chief Executive	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
Chief Executive	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
Chiefexecutive	As the Accountable Officer, ensure that regular reports are provided to the Board by the DoFdetailing actual and forecast income from the SLA
Board	Establish a Remuneration Committee

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Remuneration Committee	Agree the remuneration and terms of service of the CE, and Executive Directors to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; NHS Improvement and evaluate the performance of Executive Directors
Remuneration Committee	Report in writing to the Board ~~the bases about remuneration and terms of service of directors.~~ its decisions
Board	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of servicefor those employees and officers not covered by the Remuneration Committee.
Chief Executive	Approval of variation to funded establishment of any department.
Chief Executive	Staff, including agency staff, appointments and re-grading.
Director Of Finance	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances;
Nominated Managers*	Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time.
Director Of Finance	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms andconditions, adequate internal controls and audit review procedures and that suitable arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.
Nominated Manager*	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Chief Executive	Determine, and set out, level of delegation of **non-pay expenditure** to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system forauthorisation above that level. **TRUST SCHEMES**
Chief Executive	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
Requisitioner*	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
Director Of Finance	Shall be responsible for the prompt payment of accounts and claims.
Director Of Finance	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; c) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; d) Be responsible for the prompt payment of all properly authorised accounts and claims; e) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; f) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; g) Instructions to employees regarding the handling and payment of accounts within the Finance Department; b) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Appropriate Executive Director	Make a written case to support the need for a prepayment.
Director Of Finance	Approve proposed prepayment arrangements.
Budget Holder	Ensure that all items due under a prepayment contract are received (and immediately inform DoF if problems are encountered).
Chief Executive	Authorise who may use and be issued with official orders.
Managers And Officers	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
Chief Executive Director Of Finance	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within EU regulations, Procure21+ / Procure22 (P21+ / P22), Private Finance Initiatives and Estate Code. The technical audit of these contracts shall be the responsibility of the relevant Director.
Director Of Finance	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
Director Of Finance	The DoF will advise the Board on the Trust's ability to pay dividend on Public Dividend Capital (PDC) and report, periodically, concerning the PDC debt and all loans and overdrafts.
Board	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the CE and DoF.)
Director Of Finance	Prepare detailed procedural instructions concerning applications for loans and overdrafts.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Chief Executive Or Director Of Finance	Be on an authorising panel comprising one other member for short term borrowing approval.
Director Of Finance	Will advise the Board on investments and report, periodically, on performance of same.
Director Of Finance	Prepare detailed procedural instructions on the operation of investments held.
Director Of Finance	Ensure that Board members are aware of the Financial Framework and ensure compliance
Chief Executive	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.
Director Of Finance	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
Chief Executive	Issue procedures for management of contracts involving stage payments.
Director Of Finance	Assess the requirement for the operation of the construction industry taxation deduction scheme.
Director Of Finance	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Chief Executive	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
Director Of Finance	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
Director Of Finance	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
Board	Proposal to use PFI must be specifically agreed by the Board.
Chief Executive	Maintenance of asset registers (on advice from DoF).
Director Of Finance	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
Director Of Finance	Calculate and pay capital charges in accordance with Department of Health requirements.
Chief Executive	Overall responsibility for fixed assets.
Director Of Finance	Approval of fixed asset control procedures.
Board, Executive Members And All Senior Staff	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Chief Executive	Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
Director Of Finance	Responsible for systems of control over stores and receipt of goods.
Designated Pharmaceutical Officer	Responsible for controls of pharmaceutical stocks
Designated Estates Officer	Responsible for control of stocks of fuel oil and coal.
Nominated Officers*	Security arrangements and custody of keys
Director Of Finance	Set out procedures and systems to regulate the stores.
Director Of Finance	Agree stocktaking arrangements.
Director Of Finance	Approve alternative arrangements where a complete system of stores control is not justified.
Director Of Finance	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
Nominated Officers*	Operate system for slow moving and obsolete stock, and report to DoF evidence of significant overstocking.
Chief Executive	Identify persons authorised to requisition and accept goods from NHS Supplies stores.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Director Of Finance	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
Director Of Finance	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
All Staff	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and DoF.
Director Of Finance	Where a criminal offence is suspected, DoF must inform the police if theft or arson is involved. In cases of fraud and corruption DoF must inform the relevant LCFS and CFSMS Regional Team in line with SoS directions.
Director Of Finance	Notify CFSMS and External Audit of all frauds.
Director Of Finance	Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
Board	Approve write off of losses (within limits delegated by DH).
Director Of Finance	Consider whether any insurance claim can be made.
Director Of Finance	Maintain losses and special payments register.
Director Of Finance	Responsible for accuracy and security of computerised financial data.
Director Of Finance	Satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. W here this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Associate Director Of Corporate Governance/Company Secretary	Shall publish and maintain a Freedom of Information Scheme.
Relevant Officers	Send proposals for general computer systems to DoF
Director Of Finance	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review.
Director Of Finance	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
Director Of Finance	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, andthat a management rail exists; c) DoF and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
Chief Executive	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

Director Of Finance	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
Departmental Managers	Inform staff of their responsibilities and duties for the administration of the property of patients.
Director Of Finance	Ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
Director Of Finance	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
Chief Executive	Retention of document procedures in accordance with NHS Code of Practice for Records Management
Chief Executive	Risk management programme.
Board	Approve and monitor risk management programme.
Board	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
Director Of Finance	Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.
Director Of Finance	Ensure documented procedures cover management of claims and payments below the deductible.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 18b

14 March 2018

Purpose Action

Title	Standing Financial Instructions and Standing Orders
Author	Mrs A Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary

Summary: The Associate Director of Corporate Governance/Company Secretary has undertaken the review of the standing orders. The Audit Committee received the revised document at its meeting held on the 5 March 2018. The revised document is presented to the Board for ratification.

Recommendation: The Audit Committee agreed to recommend the revised document to the Board for approval. The Board is asked to ratify the document.

Report linkages

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

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Previously considered by: NA

East Lancashire Hospitals NHS Trust TRUST WIDE DOCUMENT	
Delete as appropriate	**Policy**
DOCUMENT TITLE:	**Standing Orders**
DOCUMENT NUMBER:	**ELHT/F24 Version 1**
DOCUMENT REPLACES Which Version	**ELHT/F15 Version 12.1**
LEAD EXECUTIVE DIRECTOR DGM	**Chief Executive**
AUTHOR(S):Note should not include names	**Associate Director of Corporate Governance/Company Secretary**

TARGET AUDIENCE:	**All Trust Personnel**
DOCUMENT PURPOSE:	**Identify the standing orders for the Trust.**
To be read in conjunction with (identify which internal documents)	Standing Financial Instructions

SUPPORTING REFERENCES	

CONSULTATION		
	Committee/Group	**Date**
Consultation	**Audit Committee**	5 March 2018
Approval by:	**Trust Board**	14 March 2018
Ratification date at Policy Council:	**N/A, to be sent for publication following Board approval**	
NEXT REVIEW DATE:	**March 2019**	

Contents

STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

(1) The East Lancashire Hospitals NHS Trust (the Trust) is a statutory body which came into existence on 1st April 2003 under The East Lancashire Hospitals NHS Trust (Establishment) Order 2002 No. 2073 (the Establishment Order) as amended by the East Lancashire Hospitals National Health Service Trust (Establishment) and the Blackburn, Hyndburn and Ribble Valley Health Care National Health Service Trust and Burnley Health Care National Health Service Trust (Dissolution) Amendment Order 2011 No 2223.

(2) The principal place of business of the Trust is The Royal Blackburn Hospital, Haslingden Road, Blackburn.

(3) NHS Trusts are governed by Act of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995 and the Health Act 1999 and subsequent amendments.

(4) As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

(5) The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

(6) The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) setting out the responsibilities of individuals.

(7) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

(1) In addition to the statutory requirements the Secretary of State through the Department of Health issues further directions and guidance.

(2) The Code of Accountability requires that Boards, inter alia, draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of Audit and Remuneration Committees with formally agreed terms of reference. The Codes of Conduct prescribe

various requirements concerning possible conflicts of interest of Board members.

(3) The Code of Practice on Openness in the NHS and the provisions of the Freedom of Information Act 2000 set out the requirements for public access to information on the NHS.

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. Standing Orders 4 and 5 set out the detail of these arrangements. Delegated powers are covered in the Schedule of Matters reserved for the Board and Scheme of Delegation.

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

In accordance with the National Health Service Trusts (Membership and Procedure) Regulations 1990 and the Trust's Establishment Order as amended by The East Lancashire Hospitals National Health Service Trust (Establishment) and the Blackburn, Hyndburn and Ribble Valley Health Care National Health Service Trust and Burnley Health Care National Health Service Trust (Dissolution) Amendment Order 2011 No 2223 and

The East Lancashire Hospitals National Health Service Trust
(Establishment) and the Blackburn, Hyndburn and Ribble Valley
Health Care National Health Service Trust and Burnley Health
Care National Health Service Trust (Dissolution) (Amendment)

Order 2017 no.61 made on 26 January 2017, that came into force on10 February 2017 the composition of the Board shall be:

(1) The Chairman of the Trust (Appointed by NHS Improvement);

(2) 7 Non- Executive Directors (appointed by the Trust NHS Improvement);

(3) 5 Executive Directors including:

- Chief Executive;
- Director of Finance;
- Medical Director
- Director of Nursing
- Director of Service Development

The Trust shall have no more than 13 and no less than 8 voting members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

(4) Other Executive Directors (e.g. Operations, Human Resources and Organisational Development, Sustainability, Communications and Engagement) will also form part of the

Board membership but shall have no voting rights.

(5) NHS Improvement or the Trust Board can appoint Associate Members, who shall be Non-Executive Directors that will form part of the Board membership but shall have no voting rights.

2.2 Appointment of Chairman and Members of the Trust Board

Paragraph 4 of Schedule 5A to the 1977 Act, as inserted by the Health Act 1999, provides that the Chairman is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Chairman and members are set out in the National Health Service Trusts (Membership and Procedure) Regulations 1990 as amended.

2.3 Terms of Office of the Chairman and Members

The regulations setting out the period of tenure of office of the Chairman and members and for the termination or suspension of office of the Chairman and members are contained in Sections 7 to 9 of the National Health Service Trusts (Membership and Procedure) Regulations 1990 as amended.

2.4 Appointment and Powers of the Deputy Chair(s)

(1) Subject to Standing Order 2.4 (2) below, the Chairman and members of the Trust Board may appoint one or two of their numbers, who is/are a Non-Executive member(s), to be Deputy Chair(s), for such period, not exceeding the remainder of their term as a member of the Trust, as they may specify on appointing them.

(2) Any member so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chairman. The Chairman and members may thereupon appoint another member as Deputy Chair(s) in accordance with the provisions of Standing Order 2.4(1).

(3) Where the Chairman of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Deputy Chair(s) shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Deputy Chair(s).

2.5 Role of Board Members

The Board will function as a corporate decision-making body, Executive and Non- Executive Members will be full and equal members (provided they have full voting rights). Their role as members of the Trust Board will be to consider the key strategic issues facing the Trust in

carrying out its statutory and other functions.

(1) Executive Members

Executive Members shall exercise their authority within the terms of these Standing Orders and the Standing Financial Instructions and the Scheme of Delegation.

(2) Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

(3) Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4) Non-Executive Members

The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(5) Chairman

The Chairman shall be responsible for the operation of the Board and chair all Board meetings when present. The Chairman must comply with the terms of appointment and with these Standing Orders.

The Chairman shall liaise with NHS Improvement over the appointment of Non- Executive Directors and once appointed, shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments and their performance.

The Chairman shall work with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.6 Corporate role of the Board

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as Corporate Trustee.

(3) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 3.

(4) The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

2.8.1 Schedule of Matters reserved for the Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved for the Board' that forms part of the Standing Financial Instructions and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.7 Calling meetings

(1) Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Company Secretary to the Board will publish the dates, times and locations of the meeting of the Board in advance.

(2) The Chairman of the Trust may call a meeting of the Board at any time.

(3) One third or more members of the Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

(4) In case of emergencies or the need to conduct urgent business, the Company Secretary shall give to all members as much notice as is considered reasonable by the Chairman or the Deputy Chair(s) of the Trust, of the date, time and place of the meeting by whatever means of communication is considered appropriate by the Chairman or the Deputy Chair(s) of the Trust.

(5) In the event of an emergency or the need to conduct urgent business the Chairman, Deputy Chair(s) or Company Secretary may, in calling the meeting, authorise the meeting to be held in private as a Part 2 meeting of the Trust Board, if the nature of the business to be conducted is commercially sensitive or would otherwise not be in the public interest to disclose at that time. The fact that such a meeting has been held shall be reported to the next Board meeting.

2.8 Notice of Meetings and the Business to be transacted

(1) Save in the case of emergencies or the need to conduct urgent business, before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three clear days before the meeting. Want of service of such a notice on any member shall not affect the validity of a meeting.

(2) In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.

(3) No business shall be transacted at the meeting other than that specified on the

agenda, or emergency motions allowed under the Standing Orders

(4) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 15 calendar days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 calendar days before a meeting may be included on the agenda at the discretion of the Chairman.

2.9 Agenda and Supporting Papers

The Agenda will be sent to members 7 days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in exceptional circumstances

2.10 Notices of Motion

A director desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chairman and Company Secretary, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

2.11 Withdrawal of Motions or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

2.12 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the director who gives it and also the signature of 4 other directors. When any such motion has been disposed of by the Trust, it shall not be competent for any director other than the Chairman to propose a motion to the same effect within 6 months; however the Chairman may do so if he/she considers it appropriate.

2.13 Motions

The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

2.14 Chairman of meeting

(1) At any meeting of the Trust Board the Chairman, if present, shall preside. If the Chairman is

absent from the meeting, the Deputy Chair(s) (if the Board has appointed one), if present, shall preside.

(2) If the Chairman and the Deputy Chair(s) are absent, such member (who is not also an Executive Member of the Trust) as the members present shall choose shall preside.

2.15 Chairman's ruling

The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders, at the meeting, shall be final.

2.16 Quorum

(1) No business shall be transacted at a meeting unless at least one-third of the whole number (rounded up) of the Chairman and voting members (including at least one member who is also an Executive Member of the Trust and one member who is not) is present.

(2) An Officer in attendance for an Executive Director (Officer Member) but without formal acting up status may not count towards the quorum.

(3) If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next item of business.

2.17 Voting

(1) Save as provided in Standing Orders 2.18 - Suspension of Standing Orders and 2 .19 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (i.e. the Chairman of the meeting) shall have a second, and casting vote.

(2) At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

(3) If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

(4) If a member so requests, their vote shall be recorded by name.

(5) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of thevote.

(6) A deputy who has been formally appointed to act up for an Officer Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Officer Member.

(7) A deputy attending the Trust Board meeting to represent an Executive Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member. An Officer's status when attending a meeting shall be recorded in the minutes.

2.18 Suspension of Standing Orders

(1) Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 2.16), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the voting members of the Board are present (including at least one member who is an Executive Member of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes. No formal business may be transacted while the Standing Orders are suspended.

2.19 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- upon a notice of motion under these Standing Orders
- no fewer than half of the Trust's total Non-Executive Directors in post vote in favour of the amendment; and
- at least two thirds of the voting Board members are present at the meeting where the variation or amendment is being discussed, and
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

2.20 Record of Attendance

The names of the Chairman and Directors/members present at the meeting shall be recorded.

2.21 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

No discussion shall take place upon the minutes except upon their accuracy or where the

Chairman considers discussion appropriate.

2.22 Admission of public and the press

(1) Meetings of the Board of Directors will be open to members of the public. At any meeting of the Board of Directors open to members of the public the Chairman may exclude any member of the public if they are interfering with or preventing the proper conduct of the meeting. Members of the public may be excluded from a meeting of the Board of Directors on the grounds that publicity of the matters being reviewed would be prejudicial to public interest, by reason of the confidential nature of business.

(2) Nothing in these Standing Orders shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

3. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

3.1 Appointment of Committees

Subject to such directions as may be given by the Secretary of State for Health, the Trust Board may appoint committees of the Trust; or together with one or more health organisations appoint joint committees.

The Trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

3.2 Applicability of Standing Orders to Committees

The Standing Orders of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. (There is no requirement to hold meetings of committees established by the Trust in public.)

3.3 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such

terms of reference shall have effect as if incorporated into the Standing Orders.

3.4 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

3.5 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

3.6 Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

3.7 Committees established by the Trust Board

The committees, sub-committees, and joint-committees established by the Board are:

a) Audit Committee and Auditor Panel
b) Remuneration Committee
c) Trust Charitable Funds Committee
d) Finance and Performance Committee
e) Quality Committee

The Board approves the terms of reference for these committees and they are reviewed on an annual basis.

3.8 Other Committees

The Board may also establish such other committees as required to discharge the Trust's responsibilities.

4. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

4.1 Delegation of Functions to Committees, Officers or other bodies

Subject to such directions as may be given by the Secretary of State, the Board may make

arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4 , or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

4.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.8) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two Non- Executive members. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

4.3 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub- committees, or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

4.4 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance to provide information and advise the Board in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

Schedule of Matters Reserved to the Trust and Scheme of Delegation

The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the

Board" and "Scheme of Delegation" shall have effect as if incorporated in these Standing Orders.

4.5 Duty to report non-compliance with Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of t h e Trust Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Company Secretary as soon as possible.

5. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

5.1 Declaration of Interests

5.2 Requirements for Declaring Interests and applicability to Board Members

The NHS Code of Accountability and the Trust's Standard of Conduct policy requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

5.3 Interests which are relevant and material

Interests which should be regarded as "relevant and material" are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

d) A position of Authority in a charity or voluntary organisation in the field of health and social care;

e) Any connection with a voluntary or other organisation contracting for NHS services;

f) Research funding/grants that may be received by an individual or their department;

g) Interests in pooled funds that are under separate management.

Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Company Secretary as soon as practicable.

5.4 Advice on Interests

If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Trust or with the Trust's Company Secretary.

Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

5.5 Recording of Interests in Trust Board minutes

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes.

Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting.

5.6 Publication of declared interests in Annual Report

Board members' declarations of interest are entered into the Directors' Register of Interests and published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

5.7 Register of Interests

The Company Secretary will ensure that a Directors' Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by executive and non- executive Trust Board members.

These details will be kept up to date by means of a regular review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

The Register will be available to the public and the Company Secretary will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

5.8 Exclusion of Chairman and Members in proceedings on account of pecuniary interest

5.9 Definition of terms used in interpreting 'Pecuniary' interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing

Order:

a) "Spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

b) "Contract" shall include any proposed contract or other course of dealing.

c) "Pecuniary interest "

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:

a) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

b) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:

a) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or

b) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or

c) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Orders.

5.10 Exclusion in proceedings of the Trust Board

Subject to the following provisions of this Standing Order, if the Chairman or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed. (See SO 5.11 on the 'Waiver' which has been approved by the Secretary of State for Health).

The Trust Board may exclude the Chairman or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

5.11 Waiver of Standing Orders made by the Secretary of State for Health

(1) Power of the Secretary of State to make waivers

Under regulation 11(2) of the NHS (Membership and Procedure) Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a chairman or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

(2) Definition of 'Chairman' for the purpose of interpreting this waiver

The "relevant chairman" is –

(a) at a meeting of the Trust, the Chairman of that Trust;

(b) at a meeting of a Committee –

(i) in a case where the member in question is the Chairman of that Committee, the Chairman of the Trust;

(ii) in the case of any other member, the Chairman of that Committee.

(3) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest. It will apply to:

(i) A member of the East Lancashire Hospitals NHS Trust ("the Trust"), who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of:

(a) services under the National Health Service Act 1977; or

(b) services in connection with a pilot scheme under the National Health Service Act 1997;

for the benefit of persons for whom the Trust is responsible.

(ii) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:

(a) arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(b) has been declared by the relevant chairman as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:

(i) are members of the same profession as the member in question,

(ii) are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(4) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant chairman must consult the Chief Executive before making a declaration in relation to the member in question

(2) (b) above, except where that member is the Chief Executive;

(c) in the case of a meeting of the Trust:

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may not vote on any question with respect to it.

(d) in the case of a meeting of the Committee:

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may vote on any question with respect to it; but

(iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

5.12 Standards of Conduct

The Trust has adopted the Standards of Conduct which are applicable to all staff and those acting on behalf of the Trust.

5.13 Standards of Conduct, Trust Policy and National Guidance

All Trust staff and members of must comply with the Trust's Standards of Conduct and procedures on receipt of hospitality and gifts and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff', the provisions of the Bribery Act 2010 and the NHS England guidelines on declarations of interest issued on 1 June 2017.

(1) Interest of Officers in Contracts

i) Any officer or employee of the Trust who comes to know that the Trust has entered into

or proposes to enter into a contract in which he/she or any person connected with him/her has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Trust's Company Secretary as soon as practicable.

ii) An Officer should also declare to the Trust Company Secretary any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

(2) Canvassing of and Recommendations by Members in Relation to Appointments

i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

(3) Relatives of Members or Officers

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

ii) The Chairman and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

iii) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chairman and members in proceedings on account of pecuniary interest' shall apply.

5.14 Fit and Proper Person Declaration

(1) In addition to being of good character, persons appointed to the post of Executive or Non-Executive Director must:

- Have the qualifications, competence, skills and experience necessary to undertake the role
- Be able by reason of their health to properly perform the role's intrinsic tasks after any reasonable adjustment
- Not be prohibited from holding the position under any other legislation
- "not have been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity"

(S)He must not be:

- an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
- a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
- a person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
- a person included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

5.15 Declarations

The Board requires Executive and Non-Executive Directors to declare on appointment and thereafter on an annual basis that they remain a Fit and Proper Person to be employed as a Director. If Board members have any doubt about the declaration, this should be discussed with the Chairman of the Trust or with the Trust's Company Secretary.

Failure to comply with this requirement or failure to meet the necessary elements of the Fit and Proper Person test will be addressed under the Trust's HR Policies and Procedures for Executive Directors and will be reported to NHS Improvement..

6. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

6.1 Custody of Seal

The common seal of the Trust shall be kept by the Company Secretary in a secure place.

6.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed by the Company Secretary in the presence of two Executive Directors duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

6.3 Register of Sealing

The Company Secretary shall keep a register in which he/she shall enter a record of the sealing of every document.

6.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

7. MISCELLANEOUS (see overlap with SFIs)

7.1 Joint Finance Arrangements

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

See overlap with Standing Financial Instruction.

Scheme of Reservation andDelegation

The Board	Decision Reserved To The Board
The Board	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
The Board	**Regulations and Control** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session 5. Approve a scheme of delegation of powers from the Board to committees. 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 9. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 10. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 11. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.

The Board	Decision Reserved To The Board
	13. Receive report on the use of the seal. 14. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Company Secretary's attention 15. Appoint the External Auditors
The Board	**Appointments/ Dismissal** 1. Appoint the Deputy Chair(s) of the Board. 2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 3. Appoint, discipline and dismiss Executive Directors 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
The Board	**Strategy, Plans and Budgets** 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 3. Approve, or delegate approval to one of its sub-committees, the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment with the value of £1 million and above 5. Approve budgets. 6. Approve annually Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1 million 10. Approve proposals in individual cases for the write off of losses or making of special payments above the limits

The Board	Decision Reserved To The Board
	of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board. 11. Approve individual non-clinical compensation payments. 12. Approve proposals for action on non- clinical litigation against or on behalf of the Trust.
The Board	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts/delegate it to the Audit Committee
The Board	**Monitoring** 1. Receive of such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board. 3. Receive reports from Director of Finance on financial performance against budget and Trust Annual Business Plan.

Scheme of Delegation Derived From the Accountable Officer Memorandum

Delegated To	Duties Delegated
Chief Executive	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
Chief Executive and Director of Finance	Ensure the accounts of the Trust are prepared under principles and in a format directed by the SofS. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
Chief Executive	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.
Chief Executive	*Ensure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of corporate governance including ensuringmanagers:* "have a clear view of their objectives and the means to assess achievements in relation to those objectives be assigned well defined responsibilities for making best use of resources have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
Chairman	Implement requirements of corporate governance.
Chief Executive	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the External Auditors and the National Audit Office (NAO).
Director of Finance	Operational responsibility for effective and sound financial management and information. Approve the opening of bank accounts.

Delegated To	Duties Delegated
Chief Executive	Primary duty to see that Director of Finance discharges this function.
Chief Executive	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
Chief Executive and Director of Finance	Chief Executive, supported by Director of Finance, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
Chief Executive	If CE considers the Board or Chairman is doing something that might infringe probity or regularity, he should set this out in writing to the Chairman and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary HNS Improvement and Department of Health.
Chief Executive	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Board. If the outcome is that they are overruled it is normally sufficient to ensure that their advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform NHS Improvement and the Department of Health. In such cases, the Chief Executive should as a member of the Board vote against the course of action rather than merely abstain from voting.

Scheme of Delegation Derived From the Codes of Conduct and Ac c o u n t a b i l i t y

Delegated To	Authorities/Duties Delegated
The Board	Approve procedure for declaration of hospitality and sponsorship/delegate approval to the Audit Committee.
The Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Standards of Conduct, and other ethical concerns.
All Board members	Subscribe to Standards of Conduct.
The Board	Board members share corporate responsibility for all decisions of the Board.
Chairman and Non-Executive/Officer Members	Chairmanand non-executive members are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of those responsibilities.
The Board	The Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.

Delegated To	Authorities/Duties Delegated
The Board	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these, 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; 4. establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.
Chairman	It is the Chairman's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of

Delegated To	Authorities/Duties Delegated
	the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board and other Board sub-committees; 7. advise the Secretary of State on the performance of Non-Executive Board members.
Chief Executive	The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
Non-Executive Directors	Non-Executive Directors are appointed by NHS Improvement to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
Chairman and Directors	Declaration of conflicts of interest
The Board	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

Scheme of Delegation from Model Standing Orders

Delegated to	Authorities/Duties Delegated
Chairman	Final authority in interpretation of Standing Orders (SOs).
The Board	Appointment of Deputy Chair(s)
Chairman	Call meetings
Chairman	Chair all Board meetings and associated responsibilities
Chairman	Give final ruling in questions of order, relevancy and regularity of meetings
Chairman	Having a second or casting vote
The Board	Suspension of Standing Orders
The Board	Variation or amendment of Standing Orders
The Board	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Delegation of powers includes approval of corporate policies on behalf of the Board)
Chairman and Chief Executive	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members
Chief Executive	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion
All Staff	Disclosure of non-compliance with Standing Orders to the Company Secretary as soon as possible
The Board	Declare relevant and material interests
Company Secretary	Maintain Register(s) of Interests
All Staff	Comply with national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff”
All Staff	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
Company Secretary	Keep seal in safe place and maintain a register of sealing

Delegated to	Authorities/Duties Delegated
Chief Executive/ Executive Director	Approve and sign all documents which will be necessary in legal proceedings

East Lancashire Hospitals NHS Trust

TRUST BOARD **Item 19**

14 March 2018 **Purpose** Information Assurance

Title	Quality Committee Summary Report
Author	Miss K Ingham, Company Secretarial Assistant
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 29 November 2017 and 24 January 2018.

Recommendation: The Board are asked to note the report.

Report linkages

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

Impact

Legal	No	Financial	No

Equality	No	Confidentiality	No

Previously Considered by: NA

Quality Committee Update

At the meeting of the Quality Committee held on 29 November 2017 members considered the following matters:

1. The Committee received the Serious Investigations Requiring Investigation (SIRI) report and spent some time discussing the outcome of the Never Event Summit that took place in October 2017. Members noted that the individual action plans from each event had been combined and in addition to addressing the actions, the plan included the work that was being undertaken to address the cultural issues within the teams affected. Members noted the immediate changes that were implemented following each never event and the internal process that is undertaken when a never event occurs. Members noted that whilst improvements had been made, there was further work to do to meet the required standards. It was agreed that reporting on this matter would be undertaken to the Committee on a quarterly basis.
2. The Committee also received the Nursing Assessment and Performance Framework Quarterly Report; Winter Planning Report; Quality Dashboard Exception Report, Board Assurance Framework Review, Corporate Risk Register; and Summary Reports from the following Sub-Committee Meetings:
   a) Patient Safety and Risk Assurance Committee (September 2017)
   b) Infection Prevention and Control Committee (September 2017)
   c) Health and Safety Committee (October 2017)
   d) Internal Safeguarding Board (November 2017)
   e) Patient Experience Committee (October 2017)
   f) Clinical Effectiveness Committee (October 2017)

At the last meeting of the Quality Committee held on 24 January 2017, members considered the following matters:

1. The Committee received the Corporate Mortality Report and members noted the work that takes place to review patient deaths and adopt possible learning. Members briefly discussed the fact that the Trust appeared to be an outlier in relation to deaths associated with Tuberculosis (TB) and it was noted that this was due to the small numbers of patients recorded as having succumbed to TB at a national level, therefore even relatively small numbers of cases are likely to show the Trust as an outlier.

2. The Committee received the Quarterly Report on Safe Working Hours for Doctors and Dentists in Training and noted the work that was being carried out in relation to encouraging accurate reporting of breaches and exceptions by junior doctors.
3. The Committee members received an update regarding CQC compliance, including the performance against addressing the recommendations from the last CQC inspection and well led review.
4. The Committee also received the Serious Incidents Requiring Improvement (SIRI) Report; Quality Dashboard Exception Report, Board Assurance Framework Review, Corporate Risk Register; proposed committee workplan; and Summary Reports from the following Sub-Committee Meetings:
   a) Infection Prevention and Control Committee (December 2017)
   b) Health and Safety Committee (December 2017)
   c) Clinical Effectiveness Committee (December2017)

Kea Ingham, Company Secretarial Assistant, 6 March 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 20

14 March 2018

Purpose Information
Assurance

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

Summary: The report sets out the matters discussed and decisions made at the Trust Charitable Funds Committee meetings held on 4 December 2017 and 5 February 2018.

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

(20) Trust Charitable Funds Committee Update Report

Trust Charitable Funds Committee Update

At the meeting of the Trust Charitable Funds Committee held on Monday 4 December 2017 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.

1. The Committee received a verbal update on the development of the charity and roll out of the strategy including the preparatory work that was being undertaken across a number of departments to set up appropriate and robust governance structures; work to promote payroll giving and the development of submissions for grants. Committee members noted that much of the planned events would coincide with the 70th anniversary of the NHS. It was agreed that a formal written report from the Fundraising Manager would be prepared for each Committee meeting.
2. The Committee received a report relating to the request to use funds for provision of the long service award for staff. Members noted that the associated costs were higher than in previous years due to the awards covering a three year period and that only staff who had achieved 25 years' service with the Trust were eligible for the award. Members discussed the appropriateness of funding such awards from the charity it was agreed that the income from the staff contributions, such as through the staff gym subscriptions would be used for this purpose and would be recorded separately in the accounts.
3. The Committee also received the draft annual accounts and report for consideration and recommendation to the Corporate Trustee for approval. Members noted that the accounts had been subject to an independent examination by the Trust's external auditors. The Committee also noted the changes to the rules for the accounts in relation to declarations of interest and related party transactions and the need to make any declarations of interest from Committee members in relation to the charity explicit in the annual report of the Charity rather than rely on the Directors Register of Interests that is completed in relation to the Trust Board members. The draft accounts and annual report were recommended to the Corporate Trustee for formal approval. The Corporate Trustee approved the annual accounts and annual report for submission to the Charity Commission at its meeting on 13 December 2017.
4. Members of the Committee received the proposed charity deed and agreed it for recommendation to the Corporate Trustee for approval and adoption. The Corporate Trustee approved the proposed charity deed at its meeting on 13 December 2017.

5. The Committee received a report relating to the proposed changes to the procedure for handling donations. Members approved the proposed revisions to the procedure pending the approval of the costs of procuring the specified ELHT&me pods. It was agreed that the remainder of the policies relating to the charity would be reviewed and presented to the next meeting for approval.
6. The Committee also received the investment report, fund performance and utilisation report, previous minutes of the Staff Lottery Committee and its terms of reference for information.

At the meeting of the Trust Charitable Funds Committee held on Monday 5 February 2018 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.

1. The Committee received a proposal to use a designated portion of the charitable fund (the Behr Legacy) for the development of a collection of historical artefacts relating to the medicine and science in the Burnley area. Members noted that the request was in line with the conditions of the legacy. The Committee members were agreeable in principle but requested further information relating to the costs, location, estates issues and style of the exhibition/collection. It was agreed that a detailed plan would be provided to the members prior to the next meeting to enable a further discussion and resolution to the request.
2. The Committee received an update report from the Fundraising Manager regarding planned activity for the coming year. Members noted that there was a formal launch of a £1,000,000 appeal planned for late February which the Committee Chair and Director of Communications and Engagement would be involved in.
3. The Committee received a report on the review of the policies associated with the charity and discussed the need to enable donations for specific items/areas without the need to set up several individual accounts within the one charity. It was agreed that a form of words would be decided upon and included in the policy to enable team/item specific giving. Pending other amendments discussed at the meeting it was agreed that the policy and associated standard operating procedures were approved.
4. The Committee received an update in relation to the licencing agreement in place for the Staff Lottery. It was confirmed that the staff lottery was a separate entity to the Trust Charitable Fund and therefore there was a need for ELHT&me to apply for a

separate lottery licence. Members briefly discussed the reporting and placement of the staff lottery within the Trust and charity. Members suggested that the lottery may be better suited to report through the staff engagement team rather than through ELHT&me. It was agreed that this issue would be discussed outside the meeting and a proposal paper would be brought to the next meeting for discussion.

5. The Committee also received the investment report, fund performance and utilisation report and dormant funds update report.

Kea Ingham, Company Secretarial Assistant, 6 March 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 21

14 March 2018

Purpose Information Assurance

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

Summary: The list of matters discussed at the Remuneration Committee held on 14 January and 14 February 2018 are presented for Board members' information.

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

Remuneration Committee Information Report

1. At the meeting of the Remuneration Committee held on 14 January 2018 members considered the following matter:
   a) Executive Remuneration

2. At the meeting of the Remuneration Committee held on 14 February 2018 members considered the following matter:
   b) Executive Remuneration

Kea Ingham, Company Secretarial Assistant, 6 March 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 22

14 March 2018

Purpose Information

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

Summary: The report details the agenda items discussed in Part 2 of the Board meetings held on 13 December 2017.

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Trust Board Part Two Information Report

1. At the meeting of the Trust Board on 13 December 2017, the following matters were discussed in private:
   a) Overseas Trade Update
   b) Round Table Discussion: Sustainability and Transformation Plan Board Arrangements and Update
   c) Round Table Discussion: Progress with Local Delivery Plan and Accountable Care System
   d) Round Table Discussion: EPR Selection Update
   e) Round Table Discussion: Practical steps towards ACS
   f) Sustaining Safe, Personal and Effective Care 2017/18 Update Report
   g) Tenders Update
   h) Update on Registered and Non-Registered Professional Judgment Review of Nursing establishments, 2017/18
   i) External Audit Service Procurement: Recommendation of the Auditor Panel
   j) Serious Untoward Incident Report
   k) 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, Company Secretarial Assistant, 6 March 2018