NHS

East Lancashire Hospitals

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

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TRUST BOARD PART 1 MEETING

13 SEPTEMBER 2017, 14:00, SEMINAR ROOM 6, ROYAL BLACKBURN HOSPITAL

AGENDA

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

	OPENING MATTERS			
TB/2017/118	**Chairman's Welcome**	Chairman	v	
TB/2017/119	**Open Forum** To consider questions from the public	Chairman	v	
TB/2017/120	**Apologies** To note apologies.	Chairman	v	
TB/2017/121	**Directors Register and Declaration of Interest** To note the directors register of interests and note any new declarations from Directors.	Company Secretary	d✔	Information
TB/2017/122	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 12 July 2017.	Chairman	d✔	Approval
TB/2017/123	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2017/124	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✔	Information
TB/2017/125	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2017/126	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✔	Information
	QUALITY AND SAFETY			
TB/2017/127	**Patient Story** To receive and consider the learning from a patient story.	Director of Nursing	p	Information/ Assurance
TB/2017/128	**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/2017/129	**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/2017/130	**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

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TB/2017/131	**Quality Strategy** To receive and approve the revised Quality Strategy following presentation to the Quality Committee	Medical Director	d✔	Approval/ Assurance
TB/2017/132	**Update of General Medical Council Enhanced Monitoring**	Medical Director	d✔	Information/ Assurance
STRATEGY				
TB/2017/133	**Sustainability and Transformation Plan (STP) Update**	Chief Executive	v	Information
TB/2017/134	**Workforce Race Equality Standard (WRES) Update**	Director of HR and OD	d✔	Information/ Assurance
ACCOUNTABILITY AND PERFORMANCE				
TB/2017/135	**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
TB/2017/136	**NHS Improvement Self Certification**	Company Secretary	v/p	Information/ Assurance
GOVERNANCE				
TB/2017/137	**Doctors' Revalidation Report and Statement** To receive the doctors' revalidation report and sign the statement	Medical Director	d✔	Information
TB/2017/138	**Emergency Preparedness & Resilience Annual Statement** To receive the annual statement and approve it for submission	Director of Operations	d✔	Approval Assurance
TB/2017/139	**Audit Committee Update Report** To note the matters considered by the Committee in discharging its duties (July 2017)	Committee Chair	d✔	Information
TB/2017/140	**Quality Committee Update Report** To note the matters considered by the Committee in discharging its duties (July 2017) and receive the summary of the Annual Infection Control Report following its presentation at the Quality Committee	Committee Chair	d✔	Information
TB/2017/141	**Trust Board Part Two Information Report** To note the matters considered by the Committee in discharging its duties (July 2017)	Chairman	d✔	Information
FOR INFORMATION				
TB/2017/142	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2017/143	**Open Forum** To consider questions from the public.	Chairman	v	

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TB/2017/144	**Board Performance and Reflection**	Chairman	v	
	To consider the performance of the Trust Board, including asking: • Has the Board focussed on the appropriate agenda items? Any item(s) missing or not given enough attention? • Is the Board shaping a healthy culture for the Board and the organisation and holding to account? • Are the Trust's strategies informed by the soft intelligence from local people's needs, trends and comparative information? • Does the Board give enough priority to engagement with stakeholders and opinion formers within and beyond the organisation?			
TB/2017/145	**Date and Time of Next Meeting** Wednesday 13 December 2017, 2.00pm, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.	Chairman	v	

East Lancashire Hospitals
NHS Trust

TRUST BOARD PART 1

Item | **121**

13 September 2017

Purpose Action

Information

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 Directors' Register of Interest is 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

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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 from September 2016. • Chairman of the NHS England Performers Lists Decision making Panel (PDLP).	26.4.2017.
Kevin McGee Chief Executive	Positive Nil Declaration	26.4.2017.
John Bannister Director of Operations	Positive Nil Declaration	25.4.2017.
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	20.4.2017.
Keith Griffiths Director of Sustainability	Positive Nil Declaration	25.4.2017.

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Name and Title	Interest Declared	Date last updated
Martin Hodgson Director of Service Development	Positive Nil Declaration	20.4.2017.
Christine Hughes Director of Communications and Engagement	• Director at CHIC Communications Ltd.	21.4.2017.
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 • 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 who works at Lancashire Care NHS Foundation Trust	28.4.2017.

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Name and Title	Interest Declared	Date last updated
Kevin Moynes Director of Human Resources & Organisational Development	• Governor of Nelson and Colne College • Spouse works for HEE (NW) as Head of Workforce Transformation.	28.07.2017
Christine Pearson Director of Nursing	Positive Nil Declaration	20.4.2017.
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 employee - GP in Dyneley House Surgery, Skipton • Sister is an employee of pharmaceutical company Novartis	19.4.2017.
Richard Slater Non-Executive Director	Positive Nil Declaration	19.4.2017.
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 • Sister is an advanced clinical nurse practitioner with Pennine Acute Hospitals Trust based at the Royal Oldham hospital. • Member of the Law Society	02.05.2017

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Name and Title	Interest Declared	Date last updated
Professor Michael Thomas Associate Non-Executive Director (appointed 1 September 2016)	• Vice-Chancellor of UCLAN	1.9.2016.
Michael Wedgeworth Associate Non-Executive Director (appointed 1 April 2017)	• Honorary Canon of Blackburn Cathedral in 2003 • Assistant Priest at Blackburn Cathedral since 1995 • Member of the Lancashire Health and Well-Being Board since 2011 • Elected Public Governor at Lancashire Care Foundation Trust and Chair of the Patient Experience Group until April 2017 • Chair of Healthwatch Lancashire since 2015 • 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 • Board member of North West Connected Healthy Cities	26.4.2017.
David Wharfe Non-Executive Director	Positive Nil Declaration	19.4.2017.

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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

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East Lancashire Hospitals
NHS Trust

TRUST BOARD PART ONE REPORT

Item   **122**

13 September 2017

Purpose   Action

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

Summary:

The draft minutes of the previous Trust Board meeting held on 12 July 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

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EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 12 JULY 2017

MINUTES

PRESENT

Professor E Fairhurst	Chairman
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
Dr D Riley	Medical Director
Mr R Smyth	Non-Executive Director
Mr D Wharfe	Non-Executive Director
Mr M Wedgeworth	Associate Non-Executive Director (non-voting)
Mr J Wood	Director of Finance

IN ATTENDANCE

Ms S Ahmed	Member of the Public	Observer/Audience
Mrs M Almond		For Item TB/2017/101
Mrs A Bosnjak-Szekeres	Associate Director of Corporate Governance/ Company Secretary	
Mrs C Lees	Member of the Public	Observer/Audience
Mrs E Steele	Member of the Public	For Item TB/2017/101
Miss K Ingham	Company Secretarial Assistant	Minutes
Mr I Johnson		Observer/Audience
Mr G Parr	Shadow Public Governor	Observer/Audience

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APOLOGIES

Mr R Slater	Non-Executive Director
Professor M Thomas	Associate Non-Executive Director

TB/2017/092   CHAIRMAN'S WELCOME

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

TB/2017/093   OPEN FORUM

Mr Parr asked whether the Board had considered the impact of the recent news from the Nursing and Midwifery Council (NMC) regarding the number of nurses leaving the profession being greater than the number of individuals entering nursing. Mrs Pearson confirmed that the Trust had a process in place for any nurses leaving the Trust due to retirement and they are offered the opportunity to return to the Trust on a part-time basis or to join the staff bank. She confirmed that in the Trust there are more nurses commencing employment with the organisation than leaving. Mr Moynes provided an overview of the work being implemented to retain staff, including the use of retention enhancements. He went on to report that the workforce transformation project was commencing and that there would be a range of new roles developed. Mr Hodgson provided an overview of the work being undertaken within the organisation regarding the model ward and also at the Local Delivery Plan (LDP) level regarding the development of community services.

TB/2017/094   APOLOGIES

Apologies were received as recorded above.

TB/2017/095   DECLARATIONS OF INTEREST

No declarations of interests were made.

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

TB/2017/096   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, pending the following amendment:

TB/2017/089: OPEN FORUM: Mr Smyth confirmed that Mrs Ferris had asked a question at the last Board meeting, rather than Ms Ahmed.

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RESOLVED: **The minutes of the meeting held on 3 May 2017 were approved as a true and accurate record pending the aforementioned amendment.**

TB/2017/097 **MATTERS ARISING**

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

TB/2017/098 **ACTION MATRIX**

All items on the action matrix were reported as complete or were to be presented as agenda items or were due to be presented at subsequent meetings. The following updates were provided:

TB/2017/077: Board Assurance Framework – Mr Moynes confirmed that the workforce transformation plans and budget sharing discussions have started within the Divisions and Divisional leads recognised the need to be flexible with budgets and develop non-traditional roles. Mr Moynes confirmed that the developments would influence the work at the Transformation Board level and agreed to bring a workforce transformation update to the Board later in the year. Directors noted that the first workforce transformation group meeting has taken place.

TB/2017/079: Workforce, Race and Equality Standard (WRES) Action Plan Report – Mr Moynes confirmed that a paper has been developed around compassionate leadership which will be discussed at a future Executive Team meeting and will be presented to the Board when appropriate.

TB/2017/080: Appraisal Update Report – Mr Moynes reported that staff have been informed via email that an appraisal window has been implemented and will close in November 2017. He confirmed that pay progression will be stopped for anyone who has not had an appraisal during that period.

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

A workforce transformation update will be presented to the Board.

A report on the compassionate leadership will be presented to the Board after discussion at the Executive Team meeting.

TB/2017/099 **CHAIRMAN'S REPORT**

Professor Fairhurst confirmed the sad news that Canon Duxbury, Shadow Public Governor

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for the Ribble Valley had passed away earlier in the week. She paid tribute to him and his contribution to the Trust over the past four years. The Board's condolences to his family were noted.

Professor Fairhurst reported that she has attended a recent North West Leadership meeting on equality, diversity and inclusion. She confirmed that the Trust was the third highest contributor to the equality, diversity and inclusion programme. This was a tangible way to evidence the regard for the equality and diversity agenda within the organisation.

Directors noted that the second Nursing Assessment Performance Framework, Safe, Personal and Effective Care Panel took place earlier in the month for ward C5 and the Board agreed the recommendation to award a silver ward status to ward C5. Directors extended their congratulations to the ward team and noted their efforts in achieving this accolade.

Professor Fairhurst reported that she had attended an event to celebrate the 30th anniversary of the opening of the Rakehead rehabilitation unit. She went on to report that the Trust and the University of Central Lancashire (UCLan) had hosted an education day which was a well-attended and positive event that highlighted the closer working between the two organisations.

RESOLVED: **Directors received the report provided.**

Directors approved the recommendation to award silver ward status to ward C5.

TB/2017/100 **CHIEF EXECUTIVE'S REPORT**

Mr McGee referred the Directors to the previously circulated report and highlighted a number of items for information. He confirmed that the Trust had received a letter from NHS Improvement (NHSI) offering their support regarding the work being undertaken concerning private finance initiative (PFI) contracts. Directors noted the national guidance that had been published since the general election, including the refresh of the Five Year Forward View, overarching priorities for Trusts regarding emergency department services, access to primary care, cancer services, mental health care, finance and transformational changes at STP level.

Mr McGee provided an overview of the recent education conference hosted with UCLAN. He reported that Professor Ian Cummings, Chief Executive of Health Education England was the keynote speaker and he spoke about workforce pressures, shortages and workforce transformation across the NHS.

Mr McGee gave a summary of the NHS Confederation conference that had taken place in

June 2017. He confirmed that the Care Quality Commission (CQC) had published a document entitled 'Driving Improvement' which featured eight NHS Trusts that had been in special measures and had since been rated as 'good'. Director noted that the Trust was one of the organisations featured in the document. The document can be found here.

Mr McGee highlighted a number of Trust specific developments, including the increase in the types of procedures that the Da Vinci robot undertakes; the celebration of the 5000th birth at Blackburn Birth Centre; the relocation and reopening of the Stepping Stones Children's Service; and the redevelopment of the garden area at Pendle Community Hospital in conjunction with the retailer Marks and Spencer.

Mr McGee reported that since the tragic incident at Grenfell Tower in London on 14 June 2017, all NHS Trusts in the UK have been required to complete various information requests from NHS Improvement (NHSI) regarding the use of external cladding on buildings and fire safety. He confirmed that the Trust had been rated as a low risk following the responses being submitted and reviewed by NHSI. At this time the Trust is not required to take any further action, but the decision has been made to undertake further internal work with the assistance of the local fire service to assess the sites where the Trust cares for inpatients.

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

TB/2017/101 **PATIENT STORY**

Mrs Pearson introduced Mrs Esther Steele to the Directors and confirmed that she had asked to share her experience of services from the perspective of a family member and as an NHS employee. Mrs Steele reported that her mother had been in good health, but had begun to lose weight. Following a visit to her GP she had been referred to the hospital for a gastroscopy, the results of which had shown no abnormalities. Mrs Steele went on to report that her mother had been taken ill in the night and brought into the Royal Blackburn Teaching Hospital's emergency department via ambulance at 2.30am, where she was triaged and assessed. The department was busy and she had been asked to sit in a wheelchair until she could be seen. Her mother was uncomfortable and Mrs Steele felt it was not particularly suitable, given that her mother was wearing her night clothes. Directors noted that Mrs Steele and her mother had been waiting in the department for around five hours when they asked how long it would be before they were seen. Around this time Mrs Steele's mother was moved to a bay in the 'Minors' area of the department, catheterised and a cannula was put in her right hand. This was a problem, as she was right handed and could not do puzzles, which would help to occupy her time. She was eventually moved across to

the 'Majors' side of the department where she remained for the rest of the day. A further three moves occurred before Mrs Steele's mother was moved to a ward area. Unfortunately her hospital entertainment bundle did not move with her and was not enacted until later in the day, following a request from the family. Mrs Steele received a call from the staff on the ward on Monday morning to say that her mother had suffered a cardiac arrest in the early hours of the morning and had passed away. Mrs Steele confirmed that during her mother's time in the hospital and following her death, there were a number of issues that needed to be addressed, including the lack of communication between medical/clinical staff and the family, the length of time it took for her mother to be moved to a ward (15 hours), although Mrs Steele acknowledged that this would not have made a difference to the outcome of the event. Mrs Steele also raised an issue in relation to information governance, where the family had been updated about another patient's condition rather than her mother's.

Mrs Pearson thanked Mrs Steele for sharing her experience and agreed that some of the points raised were very important. Directors noted that the seemingly little things were the very things that made the biggest difference to a patient, such as inserting a cannula into the non-dominant hand. Mrs Pearson confirmed that these issues would be fed back to the senior nurses via the Nursing and Midwifery Forum. Dr Riley echoed the comments made by Mrs Pearson and confirmed that he had written a letter to Mrs Steele following the death of her mother about the aspect of the clinical care. Mrs Steele stated that the letter had been greatly appreciated and had put her mind at rest regarding many of the issues that she had raised. Dr Riley went on to say that Mrs Steele's experience was not unique especially in relation to the long wait before the transfer to the ward and he stated that this was not good enough and the Trust was not proud of it. He said that these are things that the Trust is continually trying to manage and improve. He confirmed that it was important to recognise that the Trust does not get it right all the time and when things go wrong, we must apologise and learn as much as possible from the event to reduce the likelihood of it happening again.

Mr Wedgeworth stated that it was good practice that the Board heard stories that were not wholly positive, as it provided good learning for the Trust.

In response to Mr Barnes's question, Dr Riley provided an overview of the current handover process and confirmed that the doctor on duty on the ward may not have seen the patient at the point in time that the family was asking for an update.

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

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TB/2017/102   CORPORATE RISK REGISTER

Dr Riley presented the report and provided an overview of the four proposed changes to the Corporate Risk Register. The proposed changes were as follows: risk 6912: f*ailure to meet ICO requirements will lead to ICO interventions and financial penalties* risk score was reduced from 12 to 9; risk 7017: *aggregated risk – failure to meet internal and external activity targets in year will result in loss of autonomy for the Trust* risk score to be reduced from 12 to 9; risk 6828: *aggregated risk – failure to deliver stroke care within national guidance will adversely impact patient care and attract financial penalties* risk score to be reduced from 12 to 9; and risk 1660: *failure to provide refurbished ward areas due to delays in refurbishment programme impacting on regulatory, contractual & national performance target* risk score to be reduced from 15 to 12.

Mr Wharfe suggested that risk 6912 should not be reduced until after the next Audit Committee meeting in September when the management response to the recent internal audit on data breaches would be presented. Mrs Bosnjak-Szekeres assured the Board members that since the Company Secretariat took over the management of the Freedom of Information requests in March 2017, there were no outstanding responses for new requests received after that date. She confirmed that work was still ongoing to manage the backlog of outstanding requests that were passed over to the team in March. Directors noted that the backlog had reduced but around 50 historical cases remained open.

Mr Hodgson reported that the Sentinel Stroke National Audit Programme (SSNAP) had rated the Trust as 'C' at its last audit, which was a significant improvement from the historical rating of 'E'. Professor Fairhurst stated that the Board recognised the work being undertaken within the Trust to reduce the stroke risk rating and that it was vital that stroke patients received the right care in a timely manner.

In response to Mr Barnes's question, Mr Bannister provided an overview of the work being done to reduce risk 1660 and offered to meet with Mr Barnes following the meeting to provide more information if required.

Professor Fairhurst noted that risk 3841: *Failure to meet demand in chemotherapy units due to staffing and accommodation will result in treatment breaches preventing safety and quality being at the heart of everything we do,* remained on the register despite the relocation of the Chemotherapy Unit. Mr Bannister confirmed that the unit on the Royal Blackburn Teaching Hospital site had been relocated, however the unit at the Burnley General Teaching Hospital site was not due to be completely relocated until the end of August 2017, therefore the risk remained on the register for the time being.

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

TB/2017/103 **BOARD ASSURANCE FRAMEWORK**

Dr Riley referred Directors to the previously circulated report and provided an overview of the work carried out over the course of the month to revise and consolidate the original six risks down to five more concise risks. The proposed revised risks were noted to be: 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; risk 2 – recruitment and workforce planning fail to deliver the Trust objectives; risk 3 – 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; risk 4 - the Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework; and risk 5: the Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements.

Dr Riley reported that following the recommendations made in the internal audit findings report by the Mersey Internal Audit Agency, it was proposed that the above risks be monitored at Board Sub-Committee level as follows: risks 1, 3 and 5 to be monitored by the Finance and Performance Committee and the Quality Committee, where each Sub-Committee will discuss the elements of the risks falling within their respective remits; risk 2 to be monitored by the Quality Committee and risk 4 to be monitored by the Finance and Performance Committee.

Mr Smyth confirmed that the methodology used for the revision of the document and the need for the timely implementation of the internal audit briefing report recommendations had been discussed at the last Audit Committee.

In response to Mr Barnes's question, Dr Riley reported that elements of performance that affected both finance and patient safety/quality, such as the four hour standard, would be discussed at both the Quality Committee and the Finance and Performance Committee.

Directors approved the revised Board Assurance Framework and agreed that the Board's Sub-Committees would begin to discuss their assigned BAF risks at their meetings from September 2017 onwards.

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

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Assurance Framework.

Directors agreed that the Board's Sub-Committees would begin to monitor their BAF risks at their meetings from September 2017 onwards. Therefore risks 1, 3 and 5 will be monitored by the Finance and Performance Committee and the Quality Committee, where each Sub-Committee will discuss the elements of the risks falling within their respective remits; risk 2 will be monitored by the Quality Committee and risk 4 will be monitored by the Finance and Performance Committee.

TB/2017/104   **SERIOUS INCIDENTS REQUIRING INVESTIGATION REPORT**

Dr Riley presented the report to the Directors and proposed that future reports of this nature should not include the location where the incident occurred and instead include increased description in order to preserve anonymity. Directors agreed that this was an appropriate course of action for future reports.

Dr Riley provided an overview of the report and highlighted the improvement in performance regarding the completion of duty of candour within the required timeframe. Directors noted the summary provided about the Antenatal and Newborn Screening Programme which had been included within the report, the lessons learnt and progress towards completion of the action plan for improvement. In response to Professor Fairhurst's question, Mrs Pearson confirmed that discussions had already commenced regarding the linking of the screening programme and work regarding the prevention of stillbirths. Directors noted that the Trust was involved in the national neonatal collaborative.

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

TB/2017/105   **Sustainability and Transformation Plan (STP) Update**

Mr McGee reported that the Trust continues to work with colleagues across the STP area and confirmed that following the general election there has been an announcement that there would be eight fast track Accountable Care Systems (ACSs). Directors noted that the Fylde Coast and Blackpool were announced as being one of these. Mr McGee suggested that following the development of the aforementioned ACS, the Lancashire and South Cumbria STP area is likely to move towards an ACS model soon after. The learning from the Fylde Coast and Blackpool work will be shared across the other local delivery plan (LDP) areas within the STP, prior to the development of the STP level ACS.

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In response to Mr Wharfe's question, Mr McGee confirmed that the local and regional Clinical Commissioning Groups (CCGs) are working closely and it is possible that there will be one management team in the future. He went on to suggest that eventually the CCGs across the STP area may merge to take on a strategic commissioning role and day to day commissioning may be devolved to the ACSs.

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

TB/2017/106　　　　　**INTEGRATED PERFORMANCE REPORT**

Mr McGee introduced the report to the Directors and confirmed that the majority of the report related to activity within the month of May 2017.   He highlighted the revised format of the document and confirmed that it followed the NHSI Single Oversight Framework guidance and associated CQC domains.

a)　　　　　**Performance**

Mr Bannister reported that the Referral to Treatment performance continued to be good, with 92.4% of patients seen within the required timeframes. He confirmed that there were 18,970 attendances in the emergency department in May, of which 16,008 were within the required four hours. Overall performance for the month was 84.4% against the 95% target. Directors noted that there were five 12 hour breaches in the month, all of which were patients awaiting mental health assessment/admission.

Mr Bannister reported that performance against the ambulance handover compliance indicator was achieved at 92.2%. 2,316 of the 2,945 patients who were brought into the Trust via ambulance were handed over in less than 30 minutes, with 629 patients being over the 30 minute threshold.

Directors noted that the Trust maintained compliance with all the cancer standards, with the exception of the two week breast symptomatic indicator, that was due to patient choice issues rather than lack of capacity within the department.

There was one patient who had a cancelled operation within the month and was not re-booked within the required 28 days limit. A full root cause analysis is being undertaken to understand the reasons for this.

In response to Mr Barnes's question, Mr Bannister confirmed that the majority of indicators are set by NHSI, with any locally set targets being reviewed on an annual basis and approved by NHSI.

RESOLVED:　　　　　**Directors noted the information provided under the Performance**

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b)   Quality

Dr Riley introduced the quality performance data and confirmed that no further confirmed MRSA infections have been reported in May. There have been four cases of Clostridium Difficile (CDiff) identified since the last meeting, bringing the total number of cases for the year to 6 against a trajectory of 28 for the year. Directors noted that the mortality indicators remained within the expected range.

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

c)   Human Resources

Mr Moynes reported that sickness absence had reduced to 4.1% for May and confirmed that it was likely that this was a seasonal variation rather than an improvement that would be sustained. Directors noted that the current vacancy rate for the Trust as a whole stood at 7%, with a 10% vacancy rate for nursing staff. Mr Moynes confirmed that the current appraisal rate was at 66% for staff on the Agenda for Change pay rates and improvement plans are in place to increase compliance by the end of November 2017.

Directors discussed the vacancy rates for various staff groups and the fluctuations across the Trust. Mr Moynes offered to provide a breakdown of vacancy rates across the various staff groups to Directors if required.

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 challenging in May. There were three areas that fell below the 80% average fill rate for registered nurses/midwifes on day shifts and one area on night duty. This is an improvement in comparison with the previous month. There was one red flag incident reported in the month, relating to the completion of intentional rounding. No harm was identified in the reported case.

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

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e) Finance

Mr Wood presented the finance section and reported that the Trust, in common with all the other providers, had not yet received the Sustainability and Transformation Funds (STF) that were due from the centre (£9,200,000). Directors noted that in the event that the funds are not received by the end of September 2017, the Trust may need to take out a loan to sustain the cash position. Mr Wood provided an update in relation to the newly issued guidelines for the achievement of targets in order to receive STF monies in 2017/18, including the need to achieve the financial control total in order to receive 70% of the STF monies. The remaining 30% would be split equally between the achievement of primary care streaming and the achievement of the four hour standard.

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

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

TB/2017/107 POLICY FOR THE REVIEW OF CLINICAL CARE FOLLOWING THE DEATH OF A PATIENT IN HOSPITAL

Dr Riley presented the proposed policy and confirmed that it had been developed following a requirement from the Secretary of State for Health. He provided an overview of the policy and a summary of the process that would be followed under the new policy. He confirmed that a structured judgemental review will be undertaken as part of the process. Directors noted that training will be provided to an identified group of individuals who will undertake the reviews. This group will be made up of both medical and nursing staff. Dr Riley reported that a new reporting format will be provided to the Board in the future, as a result of the new policy and process.

Miss Malik stated that the policy had been presented to the Quality Committee at its last meeting. The Committee had agreed with the proposed approach and recommended the document to the Board for adoption.

In response to Mr Barnes's question, Dr Riley provided an overview of the current reporting of mortality reviews through the sub-committees to the Board and confirmed that future reporting would come to the Board via the integrated performance report from September 2017. Directors approved the policy for implementation within the Trust.

RESOLVED: **Directors received, discussed and approved the policy for implementation across the Trust.**

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TB/2017/108   ANNUAL AUDIT LETTER

Mr Wood referred the Directors to the previously circulated document and confirmed that it was presented to the Board for information. The document had been shared with the Audit Committee members at the meeting on 26 May 2017. Mr Wood went on to highlight the unqualified opinion from the external auditors regarding the Trust's financial accounts and statements and the arrangements that were in place to determine the value for money statement.

RESOLVED: Directors received the letter and noted its contents.

TB/2017/109   AUDIT COMMITTEE UPDATE REPORT

Mr Smyth presented the update and reported that the Committee had received confirmation that the Trust had met its financial targets for 2016/17. The Committee also received the finalised versions of the Trust's financial accounts and statements, annual report, annual governance statement, going concern report and quality account and approved them for submission to the Regulator. The Committee also received the external auditor's qualified opinion on the Quality Account and requested that the Quality Committee oversee the work being carried out within the Trust regarding the Venus Thromboembolism (VTE) risk assessments and report back to the Audit Committee. Directors noted that Mr Hill, Deputy Medical Director for Clinical Performance and Strategy had attended the meeting which took place on 3 July to provide an update about the work being undertaken in relation to consultant job planning and the newly procured Allocate system. The Committee was pleased to note the progress made in this area.

RESOLVED: Directors received the report and noted its content.

TB/2017/110   FINANCE AND PERFORMANCE COMMITTEE UPDATE REPORT

Mr Wharfe presented the report to the Directors and highlighted the discussions that had taken place at the last meeting of the Committee. He reported that due to the non-receipt of STF monies there had been a significant deterioration in the cash position reported to the Committee. This deterioration may lead to the requirement to take out a loan from the centre, if monies are not received by the end of quarter two (September 2017). He confirmed that the Committee had received, discussed and approved, under its delegated powers, the Lancashire Procurement Cluster business case on behalf of the Trust Board.

RESOLVED: Directors received the report and noted its content.

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TB/2017/111   **QUALITY COMMITTEE UPDATE REPORT**

Miss Malik presented the report and highlighted the presentation of the UNICEF Baby Friendly Initiative Report and confirmed that the outcome of the assessment visit would be communicated to the Trust later in the month.

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

TB/2017/112   **REMUNERATION COMMITTEE INFORMATION REPOT**

The report was presented to the Board for information.

TB/2017/113   **TRUST BOARD PART TWO UPDATE REPORT**

The report was presented to the Board for information.

TB/2017/114   **ANY OTHER BUSINESS**

There were no further items raised.

TB/2017/115   **OPEN FORUM**

There were no comments or questions raised by the members of the audience.

TB/2017/116   **BOARD PERFORMANCE AND REFLECTION**

Professor Fairhurst invited comments and observations about the meeting from the Directors. Mr McGee commented that the discussions at the meeting had linked back to the Trust's strategy, but there had not necessarily been enough consideration of public health matters within the debates. Professor Fairhurst noted that at the last Senior Leaders' Forum there had been a request to include Non-Executive Directors in the Health Improvement Partnerships and this was an area that the Trust could be more proactive in in the future.

Mr Wedgeworth agreed with the previous comments and suggested that the Trust could give more thought to the context in which the Trust currently operates, such as consideration of life expectancy, health inequalities and other public health factors across the LDP and STP area. Directors noted that more attention should be paid to the Trust's community services as discussions at the Board can become unintentionally focused on the services delivered in the hospital.

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

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TB/2017/117   **DATE AND TIME OF NEXT MEETING**

The next Trust Board meeting will take place on Wednesday 13 September 2017, 14:00, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.

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East Lancashire Hospitals
NHS Trust

TRUST BOARD REPORT

	Item	**124**

13 September 2017

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

(124) Action Matrix

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Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

NHS

East Lancashire Hospitals
NHS Trust

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2017/079: Workforce, Race and Equality Standard (WRES) Action Plan Report	A workforce transformation update will be presented to the Board.	Director of HR and OD	November 2017	Agenda Item November 2017
	A report on the compassionate leadership will be presented to the Board after discussion at the Executive Team meeting.	Director of HR and OD	November 2017	Agenda Item November 2017
TB/2017/103: Board Assurance Framework	Risks 1, 3, 4 and 5 will be monitored by the Finance and Performance Committee.	Finance and Performance Committee	Ongoing	Ongoing
	Risks 1, 2, 3 and 5 will be monitored by the Quality Committee.	Quality Committee	Ongoing	Ongoing

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NHS
East Lancashire Hospitals
NHS Trust

TRUST BOARD REPORT

13 September 2017

Item **126**

Purpose Information

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

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

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

Report linkages

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

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Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

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National Updates

1. **On the day briefing: Mental health workforce plan** - Health Education England (HEE) has published *Stepping forward to 2020/21: the mental health workforce plan for England*. The workforce plan is intended to support the delivery of the *Five year forward view for mental health* and will draw on its funding. The plan is mainly concerned with the formal, specialist mental health workforce employed by mental health trusts and other NHS-funded providers.   This briefing summarises the plan, covering: where we are now, where we need to be, what we need to do to get there, actions for trusts as employers, actions for sustainability and transformation partnerships.

2. **NHS England will seek extra funds for cybersecurity –** Matthew Swindells, NHS England's director of operations and information, is interviewed by the HSJ in which he confirms NHS England will seek substantial new capital funding for cybersecurity in the wake of the WannaCry ransomware attack in May. He would not be drawn on how much money was needed, but indicated it was likely to be in the hundreds of millions. Mr Swindells also confirmed NHS England was in talks with Microsoft about a new central licensing agreement covering "core software" to be used across the entire NHS, with a particular focus on cybersecurity. Mr Swindells said trusts that had kept investing in IT infrastructure were unaffected by the attack and there were clearly organisations that had not taken cybersecurity seriously enough.**Scale of care home beds shortage revealed -** A BBC Radio 4 You and Yours investigation has found that up to 3,000 elderly people will not be able to get beds in UK care homes by the end of next year. Its findings suggest that increasing demand from an ageing population could see the shortage grow to more than 70,000 beds in nine years' time. In the past three years, one in 20 UK care home beds has closed, and research suggests not enough are being added to fill the gap.

3. **Top universities to host new academy which will train digital healthcare leaders of the future -** Three of the world's top universities will provide virtual masterclasses in leadership and digital as part of a comprehensive programme to provide NHS staff with the right skills to drive digital innovation. The NHS Digital Academy led by Imperial College London's Institute of Global Health Innovation in partnership with Harvard Medical School and The University of Edinburgh will open for applications in September.

4. **Increased access to mental health services -** The Secretary of State for Health has announced a comprehensive workforce plan, which outlines how the health and

care system will meet the diverse needs of people who access mental health services and promised to increase access to one million extra people by 2021. Stepping forward to 2020/21:The mental health workforce plan for England is the very first time health organisations including Health Education England, NHS England and NHS Improvement have come together to concentrate on mental health services to ensure people have access to better treatment.

5. **National survey shows cancer patients feel increasingly positive about their NHS care -** This year's National Cancer Patient Experience survey has shown the majority of patients with cancer consider their care to be very positive. Patients were asked to rate care between zero (very poor) to 10 (very good) and the survey received an average score of 8.7 from respondents regarding their care.

6. **NHS England launches plan to drive out wasteful and ineffective drug prescriptions -** NHS England has published detailed plans to cut out prescriptions for ineffective, over-priced and low value treatments, potentially saving the NHS more than £190 million a year. A formal public consultation is being launched on new national guidelines which state 18 treatments – including homeopathy and herbal treatments – should generally not be prescribed. Trimming hundreds of millions from the nation's rapidly growing drugs bill will help to create headroom to reinvest all savings in newer and more effective NHS medicines and treatments.

7. **NHS ability to recruit and retain staff as serious as funding concerns** - NHS Digital has published NHS vacancy data which shows that more than 86,000 posts were vacant between January-March 2017. In March 2017 there were 30,613 advertised full-time equivalent vacancies published in England, compared to 26,424 in 2016 and 26,406 in 2015. Nurses and midwives accounted for the highest proportion of shortages, with 11,400 vacant posts in March 2017.

8. **NHS could save £108m by introducing 'at the door' surgical assessments** - NHS trusts could see significant reductions to unnecessary hospital admissions by introducing consultant-led surgical assessments at the front door, a report released has found. Research by the Getting It Right First Time Programme (GIRFT) has found that the implementation of this policy in hospitals could reduce general surgery admissions by 30% a year, leading to an annual cost saving of around £108m. The change would also yield better results by freeing up hospital bed space, which has recently reached crisis levels as trusts across England continue to operate above the recommended capacity. GIRFT also recommended a raft of other changes that could be brought in

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to improve general surgery and create better patient outcomes and reduce the disparity in quality between trusts across the country.

9. **Government warns NHS could face fines for IT meltdowns -** The NHS along with UK airlines and utility firms could all face big fines if IT blunders or cyber-hacks lead to service failures. Ministers have warned that IT meltdowns like that suffered by BA earlier this year, or the WannaCry hack attack on the NHS, could lead to fines "as a last resort" if services fail and bosses are found to have been at fault.

10. **Nearly half of maternity wards turn away expectant mothers last year** More than 40% of maternity wards in England closed their doors to expectant mothers at least once in 2016. The data has been obtained by Labour following FOI requests. They found 42 out of 96 trusts said they had shut maternity wards temporarily on a total of 382 occasions. Some were closed overnight, while other closures lasted more than 24 hours. The most common reasons given were too few staff and not enough beds.

11. **Increase in medical school places -** An extra 500 places for medical school placements have been confirmed for next year and a further 1000 places will be allocated across the country, based on an open bidding process, increasing the number of student doctors by 25%. The Department of Health announced the extra places will also be targeted at under-represented social groups such as lower income students, as well as regions that usually struggle to attract trainee medics. The Government has pledged to ensure the places are allocated to medical schools who will work closely with their local communities to help talented students from disadvantaged backgrounds become doctors. The announcement followed the Government's response to a consultation on expanding undergraduate medical education.

Local Developments

12. **Heroes' huge toy drop off at children's ward** - Superheroes and car enthusiasts stopped by Royal Blackburn Teaching Hospital to drop off a haul of toys for the children's ward on Sunday. Pendle Powerfest, a group run by volunteers, arrived at the hospital in a number of flashy motors to deliver two carts full of gifts and games along with a £500 Amazon voucher. Children on the ward were also invited outside to look at and explore the vehicles. "Seeing our patients faces light up when the Pendle Powerfest team came onto the ward was absolutely fantastic," said Angela Whitworth, Play Specialist at East Lancashire Hospitals NHS Trust.

13. **Art students add a splash of colour to hospital** - Patients and visitors to the Royal Blackburn Teaching Hospital now enjoy artwork created by talented students from Blackburn College. As part of their Level 2 Art & Design studies, the students spent several months creating each piece of artwork which were officially unveiled last week in the General Outpatient department at the hospital.   Blackburn College Art Lecturer, Anna Ashworth, said: "All the pieces selected were based on a theme of 'light' and the students hope that the artwork on display will contribute to a calm relaxing environment in the Outpatients area."

14. **Pendle couple's winter wonderland benefits stroke** patients - Two big-hearted Barrowford residents transformed their front garden into a **winter** wonderland and raised hundreds of pounds to thank NHS staff who helped a close friend recover following a serious illness. Paul and Clare Earnshaw have given their Gisburn Road home a Christmas makeover complete with thousands of decorations, snowmen and reindeer for the past eight years. And when Paul's friend Simon Burrows, 44, suffered an unexpected stroke on Boxing Day 2015, Clare and Paul decided to make their latest Christmas spectacular a charitable one – and raised £720 for East Lancashire Stroke Therapy Team who helped Simon during his rehabilitation.

15. **Top professor casts an eye on local service** - East Lancashire Hospitals NHS Trust showed how it can be a national leader recently when staff welcomed Professor Nick Bosanquet to visit their Ophthalmology/ Integrated Eye Service. Professor Bosanquet, the Emeritus Professor of Health Policy at London's Imperial College, decided to visit the Trust after representatives from the service were invited to a round table event in the House of Commons. Professor Bosanquet said: "When I learnt about the Integrated Eye Service, I was intrigued to find out more. The main aspect of Optometrists being trained and accredited to offer services such as follow-up treatment for cataract operations in the community is extremely innovative and effective.

16. **Working together, education and care closer to home -** We've had two pieces of particularly good news. First, as an example of use working more closely with GPs in the area, we have just combined forces with Roe Lee Surgery in Blackburn and launched a new ultrasound service. This is to offer rapid access to "non-obstetric" ultrasound scans, such as the ones used to rapidly diagnose DVT (deep vein thrombosis) or other vascular problems. Joint working like this brings services closer to patients' homes whilst still being carried under the guidance of hospital staff. Obstetric Scans for pregnant ladies will still be carried out at the hospital. Health

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Education England (HEE) also visited the Trust to interview trainee doctors and senior medical staff, as part of our annual inspection. HEE are the national organisation responsible for approving education, training and overall workforce development for the health sector.

17. **Clitheroe nurses receive 'Bereavement Care Champion' title** - A pair of kind-hearted community nurses from Clitheroe Health Centre have been recognised for the compassionate care they provide for local patients and families. Community Staff Nurses Helen Kirkwood and Karen Counsell have both received the title '**Bereavement Care Champion**' from colleagues at East Lancashire Hospitals NHS Trust as a result of the special care provided when a patient reaches the end of their life. "Bereavement care means providing practical support to families for an event that no one anticipates or can be fully prepared for," said new **Bereavement Care Champion**, Helen Kirkwood.

18. **Emergency staff receives thanks from Abu Hanifah Foundation** - Staff in the Emergency Department at the Royal Blackburn Teaching Hospital were delighted to receive a visit from Children from the Abu Hanifah Foundation (AHF) as part of their project to present all the emergency services with gifts. The children compiled gifts such as a hamper, a framed picture and a special thank you card in appreciation of all their daily efforts to safeguard, protect and preserve life of all members of the local community. The daily dedication, courage and selflessness of the fire, ambulance, police and casualty services has been studied by the children at the foundation, especially in light of the recent Westminster Bridge, Manchester Arena, Finsbury Park and Grenfell Tower tragedies. The children therefore felt compelled and wanted to show their gratitude personally on behalf of all the Blackburn Muslim community.

19. **Andrew inspires pupils' career choice -** East Lancashire Hospitals' Practice Education Facilitator, Andrew Keavey, joined industry experts as part of a special event to inspire pupils to achieve their career goals. Andrew, a qualified children's nurse with 22 years' experience, was invited to Alder Grange School's #ICan event to speak with Year 10 students about the options available for male nursing staff in today's NHS. "It was a pleasure to meet everyone at Alder Grange," said Andrew. "The response from students was really positive and they were amazed to find out that, with over one million employees, the NHS has lots of opportunities for male nursing staff."

20. **Lord Carter visits pioneering procurement cluster –** ELHT was honoured to welcome Lord Carter of Coles to the Royal Blackburn Teaching Hospital on the

Tuesday (18th July). Eminent health reform expert, Lord Carter, visited three Lancashire hospitals in support of his work in reviewing operational productivity and performance in NHS hospitals across England. The Trust is working together with Blackpool Teaching Hospitals NHS Foundation Trust and Lancashire Teaching Hospitals NHS Trust to create a joint procurement service, which allows all three trusts to work more efficiently and more productively.

21. **MP tests out hospital labs for Biomedical Science Day -** East Lancashire Hospitals NHS Trust invited Julie Cooper MP to its Clinical Laboratory Medicine Department last week to highlight the important role that Biomedical Scientists play at Royal Blackburn and Burnley General Teaching Hospitals. Clinical Director for Laboratory Medicine, Dr Kathryn Brownbill, gave Julie a tour that explored the Blood Transfusion, Haematology, Biochemistry, Microbiology and Histopathology departments. All Departments provide a diverse range of techniques to enable clinical decision making, including cancer diagnosis, disease prevention, treatment and monitoring.

22. **Call for more mums to breastfeed** - On the occasion of World Breastfeeding Week (#WBW2017), health professionals from East Lancashire Hospitals NHS Trust and Lancashire Care NHS Foundation Trust are coming together to encourage more breastfeeding in Lancashire. There are many barriers to breastfeeding and what is required is a coordinated approach to ensure that an increasing number of babies are breastfed and that mothers receive support to continue to breastfeed their babies for as long as they want to. The two local NHS Trusts, both members of the Lancashire Infant Feeding Partnership, are promoting high standards of breastfeeding via infant feeding leads, midwives, health visitors and lactation consultants across Lancashire.

23. **IT Crowd receive well deserved Employee of the Month award** - Each month, East Lancashire Hospitals NHS Trust (ELHT) gives a special recognition to an outstanding staff member or team for going that extra mile. July's month's employee of the month is awarded not to an individual, but to a whole team of dependable heroes. The IT department received many nominations for the award which goes to show how appreciative of their work everybody at the Trust is. This is a department that works quietly in the background, a team who keep the cogs turning even when faced with adversity. During the cyber-attack, the Trust's IT department worked tirelessly to keep systems running and to ensure that patients' safety was not

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compromised. They worked together in a coordinated and collaborative manner, managing a massive issue with patience and professionalism.

24. **High scores for Trust in PLACE Assessment** - Excellent marks for standards such as food, cleanliness, environment condition and disability have been awarded to East Lancashire Hospitals NHS Trust in the Patient-Led Assessment of the Care Environment (PLACE) report. The Trust's organisational **food rating rose to 81.94%**; a significant boost on the previous year's score of 77.74%. The increase is due to commitments towards ELHT's food and drinks strategy, which has improved the nutritional value of food served at hospital sites. The PLACE rating also saw large increases for **disability domain (87.15%)** and **dementia friendly domain (84.95%)**, both of which scored well above the national averages. This is along with the overall assessments for **cleanliness and condition, appearance and maintenance**, which remain high over 90% (95.46% and 92.69% respectively).

25. **New children's outpatients opens at Burnley General Teaching Hospital** - The new children's outpatients department at Burnley General Teaching Hospital opened its doors this week following a move to improved facilities as part of an ongoing £18 million redevelopment of the hospital. Located on Level 1 in Area 6 (Wilson Hey), the new children's outpatients department offers nine consultation rooms, two treatment rooms, two weighing rooms and two waiting areas.

26. **Red2Green at ELHT –** Multi-professional teams including nurses, doctors, therapists, pharmacists together with Senior Managers and healthcare experts at ELHT are working together to improve patient experience and reduce the length of time people spend in hospital. The concept of 'Red2Green' (or red-versus-green day) approach**,** is the brainchild of NHS Improvement Senior Clinical Improvement Adviser, Dr Ian Sturgess and is based on a simple method used to reduce unnecessary waiting for patients. "Each day a patient spends in hospital should contribute towards their recovery and discharge. Days where no recovery enhancing treatment is given is classed as a 'red day', whereas days that add value and progresses a patient closer to discharge are 'green days'.   "The concept is complemented with work to end 'PJ paralysis', an additional national campaign the trust has embraced which focuses on encouraging patients to be more mobile by changing out of their pyjamas into day-time clothes.

27. **All systems go for new chemotherapy and breast care units** - Work on the new £550,000 chemotherapy and breast care facilities to improve and increase treatment has started at Burnley General Teaching Hospital. The new facilities, both located in

Area 3 next to the existing breast screening service, will dramatically improve the experience for both chemotherapy and breast care patients. The new chemotherapy unit was partially paid for by £100,000 in public donations following a 12-month fundraising campaign by Rosemere Cancer Foundation. The new chemotherapy and breast care units at Burnley General Teaching Hospital will build on the Trust's excellent reputation for cancer treatment, as well as speeding up diagnosis and reducing the number of hospital visits' patients need to make.

28. **Ward C8 have applied for SILVER Ward status** – Following three consecutive Green outcomes of the Nursing Assessment and Performance Framework (N.A.P.F.) assessments the ward applied for SILVER ward status in August 2017. The ward provided a portfolio of evidence and delivered a presentation to the S.P.E.C. (Safe, Personal, and Effective Care) panel to demonstrate how they have achieved consistently high quality care. The staff also described how they will maintain these standards and will showcase this to the rest of the organisation. The panel agreed that the ward should be recommended for this prestigious award following the review. This will be the fourth ward to gain SILVER status if approved. **Approval is therefore required from the Trust Board to award this area SILVER for delivering Safe, Personal and Effective Care at all times.**

29. **(i) Use of the Trust Seal** - The Trust Seal was applied on 30 August 2017 to the Supplementary Agreement No.15 relating to the Replacement Car Park Contractor between ELHT and Consort Healthcare (Blackburn) Limited and to the Service Providers Collateral Agreement relating to the provision of car parking management services at the Royal Blackburn Teaching Hospital between Empark UK Limited , ELHT and Consort Healthcare (Blackburn) Limited. The Director of Finance and the Medical Director were the signatories.

    (ii) The Single Oversight Framework (SOF) was initially introduced in 2016/17 by NHS Improvement and it brought together the systems previously deployed by the Trust Development Authority (TDA) and Monitor, to help identify where NHS provider organisations may require support and assistance. NHS improvement have made a series of proposed changes and consultation is underway on these changes. The full documents can be found at https://improvement.nhs.uk/documents/1538/Draft Single Oversight Framework 2017-18_FINAL_2.pdf

30. **Health Fayre and Annual General Meeting - 20 September** - Everyone's invited to Blackburn Cathedral on Wednesday 20 September as East Lancashire Hospitals NHS Trust celebrates its Health Fayre and Annual General Meeting. The free event

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starts at 1.30pm and will feature something for everyone, including health checks and advice, information stalls about local health services, charity cake and craft stalls, entertainment, Tai Chi and much more besides.   It's a chance for everyone to find out more about the wealth of hospital and community services on their doorstep, meet NHS staff from a range of professions, find out about local NHS careers - or get free health check-ups.

Summary and Overview of Board Papers

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

Summary of Chief Executive's Meetings for July 2017

03/07/16	Team Brief – AVH
03/07/17	Team Brief – CCH
05/07/17	NHS NWLA Board Meeting – Manchester
05/07/17	Meeting with the GGI – Manchester
05/07/17	BwD CCG Governing Body – Blackburn
11/05/17	Bishop of Burnley - RBH
12/07/16	Trust Board – RBH
13/07/17	Star Awards – RBH
14/07/17	Meeting with GGI – RBH
18/07/17	Professor Rudd/SSNAP Team Visit – RBH
18/07/17	Lord Carter Visit – RBH
19/07/17	System Teleconference - RBH
19/07/17	Meeting with the EU Federation – Oswaldtwistle Mills Business Centrre
20/07/17	Action on A&E Meeting – Liverpool
24/07/17	ELTH/CCG Meeting – RBH
24/07/17	Elective Centre Visit – BGH
25/07/17	Programme Directors Interviews – RBH
25/07/17	Meeting with Project Co – RBH
26/07/17	GGI Meeting - RBH
26/07/17	Together a Healthier Future Programme Executive Team – Blackburn
26/07/17	System Leaders Forum – Blackburn
27/07/17	Quarterly Review Meeting with NHSI – RBH

Summary of Chief Executive's Meetings for August 2017

21/08/17	ELHT/ELCCG Meeting – RBH
21/08/17	Deloitte North Healthcare Dinner with Jim Mackey – Leeds
22/08/17	Meeting with NLAG CEO - Lincolnshire
23/08/17	System Teleconference - RBH
23/08/17	Meeting with Graham Burgess and Harry Catherall RE ACO- RBH
24/08/17	Secretary of State for Health DoH – London
25/08/17	System Teleconference - RBH
30/08/17	GGI Coaching Session – RBH
30/08/17	Meeting with NHSI – Manchester
31/08/17	NHSI Monday Surge Workshop - Blackburn

Summary of Chief Executive's Meetings for September 2017

01/09/17	Lancashire Chief Executive Meeting – Preston
04/09/17	Meeting with Anne Gibbs NHSI – Preston
05/09/17	System Teleconference – RBH
05/09/17	Russ McLean - RBH
06/09/17	System Teleconference – RBH
06/09/17	NHS NWLA Board Meeting – Manchester
06/09/17	BwD AGM - Blackburn
06/09/17	UCLan/ELHT Partnership Meeting – Preston
07/09/17	Meeting with Steven Barnard – Nelson
07/09/17	A&E Delivery Board – Nelson
07/09/17	KPMG Meeting – RBH
08/09/17	System Teleconference – RBH
08/09/17	Accountable Care System Meeting – Blackburn
11/09/17	Health and Care Innovation EXPO - Manchester
12/09/17	Health and Care Innovation EXPO – Manchester
13/09/17	System Teleconference - RBH
13/09/17	Trust Board – RBH
14/09/17	Action on A&E - Haydock
14/09/17	ELHT and UCLan Strategic Board – RBH
15/09/17	System Teleconference - RBH
15/09/17	CQC Executive Reviewer Induction – Birmingham
18/09/17	A&E Preparation for Winter Meeting - London

19/09/17	AEDB Planning Meeting – RBH
20/09/17	System Teleconference – RBH
20/09/17	ELHT AGM - Blackburn
21/09/17	ELHT Improvement Workshop – RBH
22/09/17	System Teleconference – RBH
25/09/17	System Teleconference – RBH
25/09/17	Visit to NWAS HQ – Preston
27/09/17	System Teleconference – RBH
27/09/17	NW Neonatal Operational Delivery Board – Liverpool
28/09/17	Lancashire & South Cumbria UEC Winter Workshop - Lancaster
28/09/17	Meeting with Andrew Horsfall and Dean of Blackburn – RBH
28/09/17	Board Development Session – Blackburn
29/09/17	Board Development Session – Blackburn
29/09/17	Team Brief - BGTH

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NHS
East Lancashire Hospitals
NHS Trust

TRUST BOARD REPORT	**Item**	**128**

13 September 2017	**Purpose** Action

Title	Corporate Risk Register
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 in accordance with the Trust's Risk Management Strategy and Policy. 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, discuss and approve the proposed changes to the Corporate Risk Register and note the assurances provided in relation to the ongoing monitoring of the Corporate Risk Register in line with our Risk Management Strategy and Policy.

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

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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

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Introduction

1.   The Risk Assurance Meeting has delegated responsibility for verifying and monitoring the Corporate Risk Register on a monthly basis. The Head of Legal Services has met with each Risk Owner and / or Risk Handler to monitor any changes to the risks, the risk management action plans and controls and assurances during August to prepare this report.

2.   There are a number of risk assessments in development which indicate the uncontrolled risks would score above 15. The Head of Legal Services and Associate Director of Quality and Safety have provisionally reviewed these risks to determine whether any of these risks need to be escalated to the Corporate Risk Register at this stage. As this is not the case, support will be given to the risk owners and risk handlers through the monthly Risk Assurance Meeting to assess the risks in the context of organisational wide Corporate Risk Register, verify risk scores and challenge mitigation plans, and identified controls and assurances. Any proposed changes to the Corporate Risk Register will be presented to internal Quality and Safety meetings during September so that an updated Corporate Risk Register can be presented to the next Trust Board meeting.

Corporate Risk Register

3.   The current Corporate Risk Register is attached at Appendix 1. Members are asked to note:

Risk 1810 –   Failure to meet service needs due to lack of Trust capacity impacts adversely on patient care (formerly Failure to meet service needs at times of increased attendance in ED/UCC/MAU impacts adversely on patient care)

- The change to the title of risk and definition of the hazard is to reflect capacity issues across the organisation. The change to the risk handler to Mr Tony McDonald. Addition to ongoing actions.

Risk 3841 -   Failure to meet demand within the chemotherapy units will result in treatment breaches preventing safety & quality being at the heart of everything we do

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- Due to the completion of actions to strengthen controls and mitigate the risk (The opening of the Oncology Unit on the Royal Blackburn Teaching Hospital site, and the recruitment and appointment of staff to vacancies to the establishment) the risk has been re-evaluated and currently is assessed as scoring 12. Consequently the risk has been de-escalated / removed from Corporate Risk Register to Surgery and Anaethetics divisional risk register and oversight at their divisional management board.

Risk 7067 – Failure to provide timely Mental Health treatment impacts adversely on patient care & safety and quality

- Updated controls and assurances

Conclusion

The Board is requested to receive and review the report and approve changes proposed to the Corporate Risk Register.

Frances Murphy, Head of Legal Services, August 2017

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Appendix 1 Corporate Risk Register

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:	
What is the Hazard:	• *Lack of 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 • Bed meetings on a regular basis daily • Ongoing recruitment • Ongoing discussion with commissioners for health economy solutions • ED/UCC/AMU will take stable	Where are the gaps in control:	Trust has no control over the number of attendees accessing ED/UCC services		

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Appendix 1 Corporate Risk Register

	assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley • ED/UCC/AMU will take stable assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley		
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
Notes: Mitigating actions are deployed on a daily basis at an operational level to reduce the risk to patient care. Risk last reviewed on 18th August 2017. Next review date 18th September 2017

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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 (ICG), 4488 (ICG), 5702 (ICG),5703 (ICG), 6487 (ICG), 6637 (ICG), 6930 (ICG)
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.

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Appendix 1 Corporate Risk Register

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 (ICG), 4640 (SAS), 4708 (DCS), 5789 (ICG), 6487 (ICG), 6637 (ICG), 6930 (ICG)
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	• Daily staffing teleconference with Director of Nursing	What are the gaps in			

Appendix 1 Corporate Risk Register

are in place:	• 6 monthly formal audit of staffing needs to acuity of 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	assurance:	
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	Update by 30 September 2017	
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. Risk last reviewed on 21st August 2017. Next review date 18th September 2017			

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Appendix 1 Corporate Risk Register

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: 4 Consequence: 4 Total: 16	Target Rating:	Likelihood: 4 Consequence: 3 Total: 12
Risk Handler:	Allen Graves	Risk Owner:	Michelle Brown	Linked to Risks:	1487 (DCS), 1489 (DCS), 4118 (FC), 6115 (FC), 6229 (ICG), 6230 (ICG), 6487 (ICG), 6509 (FC), 6868 (FC)
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	Where are the gaps in control:	Individual acting outside control environment in place		

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Appendix 1 Corporate Risk Register

	• Daily review of cash balances • Finance department standard operating procedures and segregation of duties		
What assurances are in place:	• Variety of financial monitoring reports produced to support planning and performance • Monthly budget variance undertaken and reported widely • External audit reports on financial systems and their operation • Monthly budget variance undertaken by Directorate and reported at Divisional Meeting • Monthly budget variance report produced and considered by corporate and Trust Board meetings • internal audit reports on financial system and their operation	What are the gaps in assurance:	
Actions to be carried out	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. Risk last reviewed on 18th August 2017. Next review date 18th September 2017			

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Appendix 1 Corporate Risk Register

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: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 2 Consequence:3 Total: 6
Risk Handler:	Jill Wild	Risk Owner:	John Bannister	Linked to Risks:	4423 (FC), 2161 (FC) 6095 (ICG)
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:	• Impact on 4 hour and 12 hour standards 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*	Where are the gaps in control:	• Unplanned demand • ELCAS only commissioned to provide weekday service • Limited appropriately trained agency staff available		

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Appendix 1 Corporate Risk Register

	• *Twice weekly review of performance at Executive Team teleconference* • *Discussion and review at four times daily clinical flow meeting*		
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*	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. Risk last reviewed on 18th August 2017. Next review date 18th September 2017

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East Lancashire Hospitals
NHS Trust

TRUST BOARD REPORT

13 September 2017

Item 129

Purpose Approval

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

Summary:

The Executive Directors have reviewed the risks monitored on the BAF and updated the controls, assurances and actions in relation to each risk where appropriate. Following the decision of the Board to delegate the review and deep-dive of the risks to its sub-Committees, the Quality Committee reviewed risks 1, 2, 3, and 5. The Finance Committee will be reviewing risks 1, 2, 4 and 5. The format of the BAF has been revised slightly and it how includes for each risk the consequences of the risk materialising. There are no proposed changes to the risk scores.

Recommendation:

The Trust Board is asked to note the changes and approve the Board Assurance Framework.

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

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The Executive Directors have updated the BAF risks and the following changes have been made since the document was last presented to the Board. The Quality Committee also carried out the deep dive of risks 1, 2, 3 and 5.

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).   New key controls include:

    a) The Trust has agreed the transformation schemes for 2017/18:

        i.   Emergency Care System

        ii.   Productivity and Efficiency

        iii. Support Services, Efficiency and Cost

        iv.   Discharge and recovery (with Pennine Lancashire LDP)

    b) Emergency Care Programme Board meets regularly and reports are submitted to the A&E Delivery Board.

2.   New updates include:

    a) Transformation plans developed further using new software (PM3) to drive delivery.

    b) Service Improvement training is being developed that will be delivered by the OD team. Timeline for completion of the revision by the end of November 2017.

    c) Overarching business case made up of the component business cases in the process of being completed. The In Hospital Business Case is being finalised for submission and will be presented to the System Leaders Forum in September.

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

3.   The **risk score remains** 12 (likelihood 3 x consequence 4). Updates/actions include:

    a) 36 band 5 and 6 nurse appointments have been made following a social media campaign with start dates over the next 18 months.

    b) Piloting parallel recruitment process regarding unconscious bias in line with the WRES plan.

    c) Purchase of a Global Medical Careers Jobs Board in order to provide greater reach globally.

Risk 3: 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

4. The **risk score remains** 16 (likelihood 4 x consequence 4). Key controls include:

    a) Number of senior clinicians involved with STP work groups.

    b) System Leaders Forum and STP Finance Group

5. Potential Sources of Assurance include:

    a) ELHT Chief Executive chairing the STP Providers' Forum.

    b) Appointment of STP Provider Network Programme Director.

6. Gaps in control include:

    a) STP System Management model is still in development; need to evolve new governance processes.

7. Actions/Updates include:

    a) Component Business Cases submitted on 25 August 2017.

    b) The Executives reviewed the In Hospital Business Case before submission and they are shaping and influencing the Business Case. The case will be presented to the System Leaders Forum at the end of September 2017.

    c) Publishing the overarching business case and public consultation at Pennine Lancashire level planned in October 2017.

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

8. The **risk score remains** 16 (likelihood 4 x consequence 4).   A new potential source of assurance has been included relating to the financial objectives being included in individual appraisals and action taken when personal objectives are not delivered.

9. Gaps in control have been updated to include weaknesses in appraisals and accountability framework.

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

10. The **risk score remains** 16 (likelihood 4 x consequence 4). The section on key controls has been updated to include:

Safe | Personal | Effective

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a) Implementation of the internal four hour recovery team with weekly meetings in place with key stakeholders across divisions. Introduction of a cross system A & E Delivery Board Sub-Group meeting on a weekly basis.

b) Weekly Medical Staffing Review.

11. potential sources of assurance has been updated to reflect the increased number of wards that have been given Silver Ward status and the number of ward areas that have been identified as being ready to present their portfolio to the panel for accreditation.

12. Gaps in control have been updated to include:

a) External environment, high demand and difficulties with discharges impacting on our ability to deliver services and affecting patient experience.

b) Medical Staffing gaps due to vacancies/inability to secure locum staff means that on occasions that some slots/rotas are not filled. There is still a high number of nursing and midwifery vacancies (261 – of those 100 in pipeline to start during September 2017).

13. The actions/updates section of this risk have been updated as follows:

a) Work on the Emergency Care Pathway and Model Wards continues. Implementation of Red to Green Days, criteria led discharge to be implemented by the end of December 2017. Discharge to assess and ambulatory emergency care to be extended to support 50 patients per week by the end of September 2017.

b) Four hour target at 90% to be achieved by end of September 2017.

c) Nursing Assessment and Performance Framework assessments are continuing. Two Silver Accreditation of a ward approved by the Trust Board with a third pending.

d) A fourth ward area is to be presented to the accreditation panel in September 2017.

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary, 30 August 2017.

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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) Divisional Transformation Boards report into the Transformation Board that reports into the Finance & Performance Committee. Membership of the Pennine Lancashire Senior Leaders Forum and Care Professionals Board. Transformation/business plans linked to the clinical strategy, high level workforce and estate interdependencies identified. Two year operational plan linking to the transformational plan agreed and submitted to the regulator. 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 Internal Audit significant assurance on transformation reported to the Audit 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 Economic modelling and forecasting linking with new clinical models. 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 Hosting the STP Programme Director for the 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 Organistaonal Programme has been agreed.	15	10	12	3x4	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	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.	Using the Transformation Board meetings and our membership on Pennine Lancashire to influence delivery of transformation. Resources allocated for the delivery of the transformation programme. PMO infrastructure significantly increased and support to build capacity at Divisional level is ongoing. Plans developed further using new software (PM3) to drive delivery. Plans for the service redesign to be driven by the clinical leadership. Update - methodology presented to the Transformation Board and accepted for inclusion into the Pennine Lancashire Transformation Plan. Management of this issue is still ongoing. Service Improvement training is being developed will be delivered by the OD team. Timeline for completion of the revision by the end of November 2017. PMO primary focus on emergency pathway currently as it is identified as an increased risk and is highlighted to the Finance and Performance Committee. Clinical engagement progressed at both Pennine Lancashire and Healthier Lancashire level and the Care Professionals Board is maturing. Overarching business case made up of the component business cases in the process of being completed. The In Hospital Business Case is being finalised for submission and will be presented to the System Leaders Forum in September.

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	Potential Sources of Assurance	Initial Risk Score	Risk Tolerance Score	Current Risk Score	Likelihood x Consequence	Annual Risk Score 2017/18				Gaps in Control	Gaps in Assurance	Actions Planned / Update
What controls/systems, we have in place to assist in securing delivery of our objective.	*Where we can gain evidence that our controls/systems on which we are place reliance, are effective*					Q1	Q2	Q3	Q4	*Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	*Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	*Dates, notes on slippage or controls/assurance failing.*
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.

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. | Performance measures, time limited focus groups with action plans, board and committee reports, regulatory and inspection agencies, stakeholders, internal audit.

National staff survey response rate increased in 2016/17 with a good survey outcome. The Trust is third in the country in relation to performance against key indicators. Employee sponsor group monitoring the staff survey action plan

WRES action plan with timelines in place. Regular reporting to the Board on progress. Work with the Fanshawe Report. | 16 | 10 | 12 | 3x4 | 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. | 36 band 5 and 6 nurse appointments have been made following a social media campaign with start dates over the next 18 months.

The Trusts recruitment and retention plan continues to be in place. We continue to embed to the 'Retire and Return' approach.

WRES progress update report presented to the Trust Board in May 2017. Piloting parallel recruitment process re. unconscious bias

The Workforce Transformation Strategy approach has been agreed at the Quality Committee in March 2017. The 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. This approach will direct the Pennine Lancashire approach to workforce transformation.

Workforce Transformation Team in place.

First cohort of Associate Nurses pilot started in Trust.

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 |

Strategic Risk: Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) will not be sufficient to support the delivery of sustainable, safe and effective care through clinical pathways

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.

Key Controls	Potential Sources of Assurance	Initial Risk Score	Risk Tolerance Score	Current Risk Score	Likelihood x Consequence	Annual Risk Score 2017/18				Gaps in Control	Gaps in Assurance	Actions Planned / Update
What controls/systems, we have in place to assist in securing delivery of our objective.	*Where we can gain evidence that our controls/systems on which we place reliance, are effective*					Q1	Q2	Q3	Q4	*Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	*Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	*Dates, notes on slippage or controls/assurance failing.*
Senior Leaders' Forum meets to discuss strategy. Engagement by senior leaders in wider transformation programmes. Regular Board updates and decisions on key actions. Strengthen links between internal transformation and external change processes.	Verbal and written updates, where appropriate Board approvals will be established and permissions will be provided by the Board to let Executives to progress the generations of ideas and options with external stakeholders.	16	12	16	4x4	16	16			System leaders agreed a process to develop the governance system for an ACS across Pennine Lancashire; however this is still in the early phase.	Set/prescribed timeline for consultation with public but uncertainty about the detail of the consultation.	Regular updates provided to Board and the Audit Committee.
Care Professional Group of Pennine Lancashire reporting to the Transformation Steering Group. Care Professionals Group at STP level also formed.	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).									STP System Management model is still in development, need to evolve new governance processes.	Lack of unified approach in relation to procurement by Commissioners. Priorities of CCGs to be aligned with priorities for pathway redesign (e.g. stroke).	Pennine Lancashire project solution design phase completed and case for change published

New Programme Lead for Pennine Lancashire LDP appointed. 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. Second component business case prepared and consultation planned for end of August. |
At Pennine Lancashire level health improvement priorities agreed (HIMPs). HIMPs reporting to the Care Professionals Board.	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.											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
Number of senior clinicians involved with STP work groups.												
System Leaders Forum.	STP governance oversight forms part of the Audit Committee standing agenda for 2017/18.											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.
STP Finance Group.	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.

Appointment of STP Provider Network Programme Director. | | | | | | | | | | | Component Business Cases submission date was 25 August 2017. The Executives reviewed the In Hospital Business Case before submission and shaping and influencing the Business Case. Presentation to the System Leaders Forum at the end of September 2017.

Publishing the overarching business case and public consultation at Pennine Lancashire level in October 2017. |

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. Financial recovery plan in place and is being implemented through the Transformation Board. Monitoring through the Transformation Board, Finance and Performance Committee and Trust Executives.	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 recovery plan approved by Trust Board March 2017. Governance through PMO to be monitored by Finance and Performance Committee. Financial objectives are included in individual appraisals. Action taken when personal objectives are not delivered.	16	12	16	4x4	16	16			Additional workforce controls to remain in place. policies and procedures may require amendments where they are no longer fit for purpose. Controls around transformation schemes and SRCP to be monitored by the PMO and the Finance Department with Division to be held to account via the PMO. Gaps in control regarding funding for A&E and STF Funding - recovery plan underway. Weaknesses in appraisals and accountability framework.	Utilise the internal audit programme to test for assurance on core controls, SRCP and transformation plans.	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.

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 place reliance, 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 performances 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.	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.	15	9	16	4x4	16	16			External environment, high demand and difficulties with discharges impacting on our ability to deliver services and affecting patient experience.	Risks around some of the national trajectories identified. Recovery plans are being implemented.	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.
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.	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.									Medical 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 nursing and midwifery vacancies (261 - 100 in pipeline to start during September 2017).	Continued non-elective activity is placing pressure on the elective care and the RTT target. Funding to resource Nursing Assessment Performance Framework yet to be agreed.	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.
Nursing Assessment Performance Framework received significant assurance from internal audit.	Trust rated 'Good' by CQC.									Lack of control over community capacity.	Assessments under the Framework to go through the Patient Safety & Risk Assurance Committee before presentation to the Quality Committee.	Board receives regular SRCP and transformation updates.
System wide approach as part of the new A&E Delivery Board.	ED performance improvement action plan aligned with the NHSI Rapid Improvement Collaborative									Complaints are a potential source of action by the CQC.		Work on the Emergency Care Pathway and Model Wards continues. Implementation of red to green days and criteria led discharge to be implemented by the end of December 2017. Discharge to assess and ambulatory emergency care to be extended to support 50 patients per week by the end of September 2017. Work ongoing with NHSI and AQUA.
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 and 4 hour performance.	Cancer, RTT and 4 hour standard improvement plans underway and having an impact through enhanced operational meetings.									Wider system analysis of capacity in primary care and care sector needed. Risk of not being able to deliver 7 day services.		Four hour target at 90% to be achieved by end of September 20017.
Implementation of the internal four hour recovery team, weekly meeting in place with key stakeholders across divisions. Introduction of a cross system A & E Delivery Board Sub-Group meeting on a weekly basis.	Silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments continues. Two Silver Accreditation of a ward approved by the Trust Board with a third pending.											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.
Weekly Medical Staffing Review.	Increased number of assessments under the framework planned all inpatient wards completed in ICG and SAS. Work due 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.											Nursing Assessment and Performance Framework assessments are continuing. Two Silver Accreditation of a ward approved by the Trust Board with a third pending. A fourth ward area is to be presented to the Panel in September 2017.

East Lancashire Hospitals
NHS Trust

TRUST BOARD REPORT

13 September 2017

Item	**130**
Purpose	Information
	Action
	Monitoring

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 July and August 2017

This report also provides a summary themed analysis of Radiation Incidents

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

Report linkages

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

Safe | Personal | Effective

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Impact

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

Previously considered by: N/A

Safe | **Personal** | **Effective**

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Introduction

This paper provides the Board with:

- Part 1:

An overview of all Serious Incidents Requiring Investigation (SIRIs) with Duty of Candour that have been reported during July and August 2017

- Part 2:

An overview of all Serious Incidents Requiring Investigation (SIRIs) with Duty of Candour that have been reported during July and August 2017

- Part 3:

Trends, themes and analysis of radiation incidents

Part 1: Overview of SIRIS Reported

STEIS SIRIs reported in July and August 2017

There have been 7 serious incidents requiring investigation which have been reported through Strategic Executive Information System (STEIS). Each incident has had a rapid review undertaken which has been copied 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.

	eIR1	Division	Description	Duty of candour served	Rapid Review done?	Next steps
1	1128538	FC	Intrapartum baby death	Yes	Yes	RCA to be presented at Sept Panel
2	1128828	ICG	Missed diagnosis of a stroke	Yes	Yes	RCA to be presented at Sept Panel
3	1129838	ICG	Patient fall resulting in fracture neck of femur	Yes	Yes	RCA to be presented to October Panel

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	eIR1	Division	Description	Duty of candour served	Rapid Review done?	Next steps
4	1129371	ICG	Patient fall resulting in fracture neck of femur	Yes	Yes	RCA to be presented to October Panel
5	1130217 1128256 1127961 1128000 1128261 1130200 (Cluster)	ICG	12 hour mental health breaches (no harm)	Yes	Yes	Cluster review to be presented to October Panel
6	1129806	ICG	Patient fall resulting in fracture neck of femur	Yes	Yes	RCA to be presented to October Panel
7	1129342	SAS	Theatre never event	Yes	Yes	RCA to be presented at Sept Panel

Part 2: Non STEIS SIRIs reported in July and August 2017

There were 17 non-STEIS incidents deemed to be serious incidents requiring investigation. A rapid review has been undertaken for the majority of the incidents reported below and a full root cause analysis investigation once completed will be presented to each divisional SIRG panel.

	eIR1	Division	Decision for RCA to SIRG (Month)	Description	Duty of candour	Rapid Review done?	Next steps
1	1118072	ICG	July	Un-witnessed fall on ward	No N/A	Yes	RCA to DSIRG September
2	1126726	SAS	July	Bleeding issue	Yes	Yes	RCA to DSIRG September
3	1128046	SAS	July	Delayed diagnosis	No N/A	Yes	RCA to DSIRG September
4	1128030	SAS	July	Unplanned re-	No N/A	Yes	RCA to

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	eIR1	Division	Decision for RCA to SIRG (Month)	Description	Duty of candour	Rapid Review done?	Next steps
				admission soon after discharge			DSIRG October
5	1128491	FC	July	Unexpected deterioration	Yes	Yes	RCA to SIRG September
6	1128174	DCS	July	Histology error	Yes	Yes	RCA to SIRG October
7	1129014	SAS	July	Unexpected deterioration	Yes	No	RCA to DSIRG October
8	1129085	ICG	July	Un-witnessed fall leading to harm	Yes	Yes	RCA to DSIRG October
9	1130312	ICG	Aug	Inadequate response to treatment leading to hospital admission	No – N/A	No	RCA to DSIRG October
10	1128419	FC	July	Unexpected deterioration	No N/A	Yes	RCA to SIRG Oct
11	1127354	SAS	Aug	Patient discharged home following accident, delaying communicating MR result	No N/A	Yes	RCA to DSIRG Nov
12	1130135	FC	Aug	Unexpected transfer to NICU	No N/A	Yes	Concise RR to SIRG Sept
13	1130814	FC	Aug	Unexpected transfer to NICU	No N/A	Yes	Concise RR to SIRG Sept

	eIR1	Division	Decision for RCA to SIRG (Month)	Description	Duty of candour	Rapid Review done?	Next steps
14	1131009	FC	Aug	Unexpected transfer to NICU	No N/A	Yes	Concise RR to SIRG Sept
15	1131127	SAS	Aug	Complications following metal on metal hip surgery	No N/A	No – Straight to RCA	RCA to DSIRG Nov
16	1131341	FC	Aug	Expected neonatal death	No N/A	Yes	RCA to SIRG Nov

Duty of candour has been delivered to all of the above STEIS and non-STEIS if applicable within the 10 days of the incident occurring. Where it states No - N/A this is due to a low harm incident.

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

Part 3– Radiation Incidents

Introduction -

The Trust manages radiation incidents in accordance with the Ionizing Radiation Medical Exposure Regulations (IR(ME) R 2000, the Trust's C128 V1 Ionising Radiation Safety Policy and C003 V4.4 Incident Management Policy. All radiation incidents are reported through Datix and follow the Trust's investigation process.

The CQC has set out some additional reporting requirements:

- Exposures "much greater than intended" (MGTI), occurring otherwise than as a result of equipment failure, must be reported to CQC
- Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) incident must be

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reported to CQC as soon as practicable after preliminary investigation has confirmed that the exposure was MGTI or that a decision has been made that a voluntary notification is worthwhile.

- Notifications should be made within two weeks of the exposure taking place.

Radiation Incidents generally fall into 3 categories:

- **Technical repeats / Equipment failures** -

Technical repeats and equipment failures are not reportable to the Care Quality Commission (CQC) though would be reported to our Radiation Protection Advisor, HSE and the MHRA if severe. Such incidents would include mechanical and software errors or failures in the image processing equipment during acquisition or process of an x-ray image. All equipment is covered by a comprehensive maintenance contract to reduce the likeliness of such errors but while relatively few and far between, they are possible

- **Non reportable (Human Factors)**

These incidents are related to errors made by the referrer, practitioner or operator but which do not in a resultant dose to the patient which is much greater than intended. This may include such situations as requesting or irradiation of wrong body part.

- **Reportable (Human Factors)**

These incidents relate to errors made by the referrer, practitioner or operator but which do lead to an unintended dose to the patient which is much greater than intended. This may include such situations as referring the wrong patient for the test, requesting or irradiation of wrong body part.

The Trust's Radiation Protection Advisor (IRS) determines whether or not incidents are reportable to the CQC based on multiplication factors and perceived long term risk to the patient.

There were 21 incidents reported over a period of 15 months. This represents 0.005% of the total examinations completed in the Radiology department during the same period.

Radiation Incidents Jan 2016 - March 2017
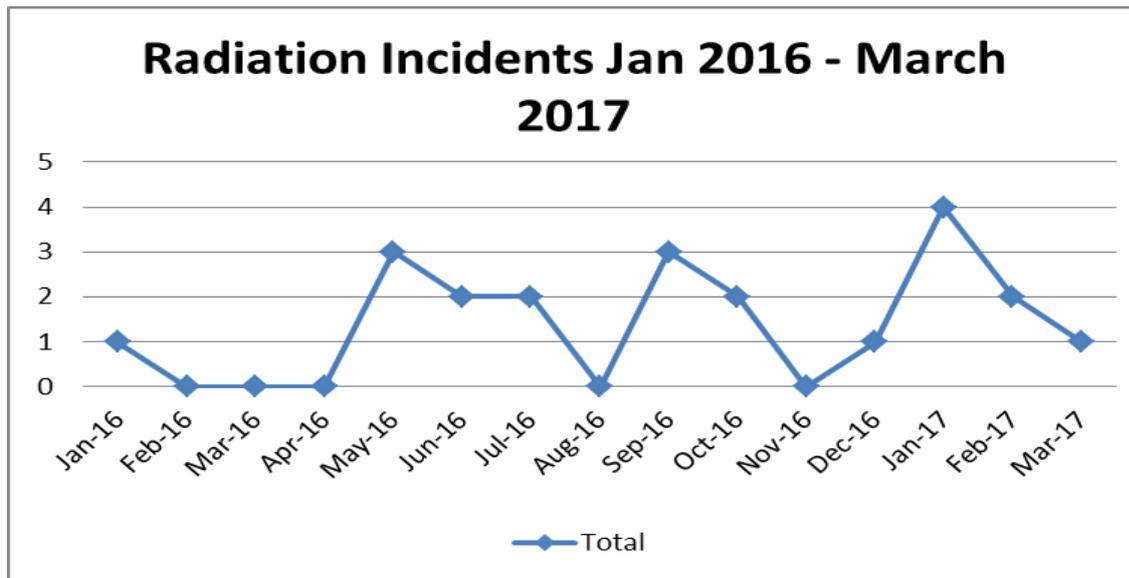
Further analysis and breakdown of the data for January 2016 to March 2017 confirmed the incidents to be of low harm and

- 8 incidents were due to technical repeats caused by equipment malfunction.
- 5 incidents were due to referral errors i.e. incorrect patient referred for examination or incorrect part requested.
- 8 incidents were due to administrative or procedural errors or omissions in the Radiology Department i.e. wrong part scanned, patient identification procedure not followed correctly

Conclusion

After thorough investigation and identifying common service and care delivery trends the below actions were implemented to mitigate the risk of future incidents:

- Referrers must adopt a procedure to ensure that the correct patient or body part is selected on the ICE desktop system prior to submitting a request. There is a 'double check' system on ICE which asks the referrer to confirm that they are submitting the request for the correct patient.
- The Radiology 'PAUSE & CHECK' system has been modified to ensure that the correct protocol is selected in CT prior to commencing the scanogram.
- The Radiology patient identification process has been re-issued to remind staff about the need to request information from patients rather than asking them to confirm the information that is offered.

- Radiographers are reminded to check with the referring clinician at the time of the examination if there is any doubt or question about the details in the request.

- A process for the management of radiation incidents has been developed and disseminated to staff (see attached)

The Trust is able to demonstrate that there is a clear and robust mechanism to identify, report and investigate radiation incidents and ensure compliance with the CQC requirements. Feedback from incidents is provided by way of team meetings and 1-1 to staff within the department to support learning and development and also to raise awareness of human factors.

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Procedure for Management of Radiation Incidents

This is the local procedure to be observed by all staff in any cases where an incorrect, unintended or greater than intended exposure to Ionizing Radiation is encountered.

Staff Member

Ensure immediately that the required examination/s has / have been completed for the patient and that subsequent management is not delayed

Complete an IR1 Immediately detailing all aspects of the incident including exposure factors and dose.

Forward IR1 to Line Manager and highlight this with them in person ASAP. IR1 reference must be forwarded to Radiology Directorate Manager.

If incident occurs outside normal working hours and is related to equipment malfunction report to Senior Radiographer on duty and consider using alternative equipment.

Investigating Manager

Ensure all details of the incident are documented and that a root cause analysis is undertaken to include identification of any training requirements or immediate engineer interventions required.

Complete Radiation Incident Report form and forward to Radiation Protection Advisor for advice. Inform patient of error and offer apology and explanation.

Upload Root Cause Analysis to DATIX IR1 file and submit to trust SIRG panel for approval via Directorate and Divisional Governance forums.

ADVICE RECIEVED FROM RADIATION PROTECTION ADVISOR

Senior Radiology Manager

Reportable to Care Quality Commission. Complete online reporting form.

Forward copy of reporting form to Head of Patient Safety, Associate Director of Quality and Patient Safety and Executive Medical Director

Finalise feedback to CQC further to approval of RCA at SIRG Panel.

Record correspondence with CQC on DATIX

Non CQC -Reportable Incident

Ensure patient is Informed in writing of error in accordance with Duty of Candour obligation.

File copy of Incident dose report and letter in patient records and on DATIX

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TRUST BOARD REPORT

13 September 2017

Item 131

Purpose Information

Title	Quality Strategy
Author	Mr D Dixon, Head of Clinical Effectiveness
Executive sponsor	Mr D Tansley, Associate Director of Quality & Safety

Summary: This paper provides the Board with the updated Quality Strategy 2017-19. Our Quality Strategy describes how the Trust will enhance the safety and effectiveness of care, whilst continuing to improve patient experience over the next three years.

Recommendation: The Board is asked to receive the paper, note its contents and approve the document.

Report linkages

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

Safe | Personal | Effective

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:

Quality Strategy

2017-19

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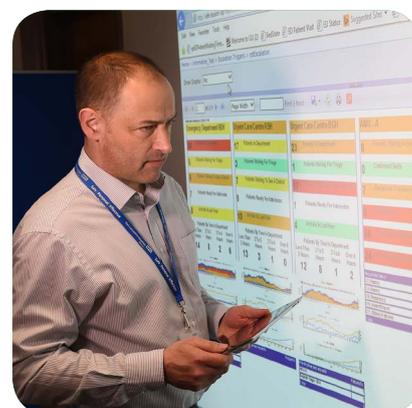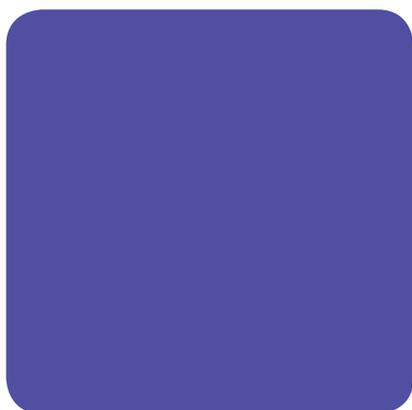
1. Introduction

Quality underpins the vision of East Lancashire Hospitals NHS Trust (ELHT) which is to be "widely recognised for providing safe, personal and effective care". Our Quality Strategy describes how the Trust will enhance the safety and effectiveness of care, whilst continuing to improve patient experience over the next three years.

This document follows on from ELHT's Quality Strategy 2014-17. The overarching principles of the desire to improve quality remain unchanged from the previous strategy. However, this document is a reflection of the advances the Trust has made in improving the quality of care for patients and developing robust governance structures.

For the duration of this strategy, we aim to focus our quality improvement efforts on initiatives that will:

- Reduce harm and mortality

- Improve patient experience, engagement and involvement

- Ensure the care our patients receive is reliable and evidence-based.

This document reiterates our commitment to delivering high standards of safe, personal and effective care to patients, as well as promoting a culture which embraces continuous improvement, safety, candour, and compassion in everything we do.

2. Our Vision and Values

Our Strategic Framework provides a comprehensive overview of the Trust's overall vision. We are committed to ensuring that quality drives everything we do. It is at the core of our vision statement, and underpins our organisational values, objectives, operating principles and improvement priorities.

Our key commitment is to the delivery of the best possible healthcare services to the local population while ensuring future viability by continually improving the productivity and efficiency of services. This strategy supports achievement of the Strategic Framework.

2

👁 Our Vision:

To be widely recognised for providing safe, personal and effective care

🤝 Our Objectives:

Put safety and quality at the heart of everything we do

Invest in and develop our workforce

Work with key stakeholders to develop effective partnerships

Encourage innovation and pathway reform, and deliver best practice

Become a successful foundation trust

👍 Our Values:

• Put patients first • Respect the individual • Act with integrity

• Serve the community • Promote positive change

🏅 Our Operating Principles:

Quality is our organising principle.
We strive to improve quality and increase value.

Clinical leadership influences all our thinking

Everything is delivered by and through our clinical divisions

Support departments support patient care

We deliver what we say we will deliver

Compliance with standards and targets is a must.
This helps secure our independence and influence.

We understand the world we live in, deal with its difficulties and celebrate our successes.

📊 Our Improvement Priorities:

Reducing mortality

Avoiding unnecessary admissions

Enhancing communications and engagement

Delivering reliable care

Timeliness of care

3. Quality At The Heart Of Everything We Do

Quality of care is a central organising principle for the NHS across the three dimensions of patient safety, patient experience and clinical effectiveness. Our approach to quality aligns with this definition as we strive to provide safe, personal and effective care for the people of East Lancashire and Blackburn with Darwen.

It is our continuous aim to deliver high quality, high value care and contribute to a health gain for our community. As such we have organised our quality strategy around providing "Safe, Personal, Effective" care.

- **Providing safe care** means taking action to reduce avoidable harm and prevent errors to patients whilst they are in our care

- **Providing care that is personal** means ensuring the services we provide are person-centred and that people are treated as individuals with dignity, in privacy and with compassion at the right time and in the right place for them

- **Providing effective care** means providing care based upon the best evidence that produces the best outcomes for patients. It means fostering a culture of constant improvement by evaluating the quality and effectiveness of services on a routine basis.

The objectives in this strategy ensures we focus on making improvements in areas that have the greatest benefit, and we sustain improvements that have already been attained.

It is our steadfast belief that being successful in these priority areas will result in improved outcomes for our patients and a better working environment for our staff.

Each year, through our Quality Accounts, we will report our performance and progress in each of these domains and will identify further improvement priorities.

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4. Safe Care

We are committed to providing safe, high quality services and harm-free care. We strive to ensure that our patients are cared for in surroundings which are safe and clean, delivered by caring and competent staff. When patient safety incidents do occur, we are committed to managing them in an open and transparent manner, in accordance with the Duty of Candour, and ensuring we learn and continuously improve care as a result.

Quality Aim: Reduce harm, prevent errors and deliver consistently safe care.

What are we trying to accomplish?

- To sustain a safe hospital without avoidable deaths and reducing preventable harm to patients and staff

- Maintain mortality rates within the expected range of the Summary Hospital-level Mortality Indicator (SHMI).
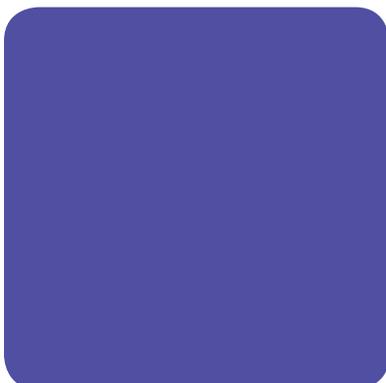
4.1 Harm Free Care

The Trust co-ordinates a comprehensive rolling programme of quality improvement initiatives which strive to reduce avoidable harm. Our priorities are:

Priorities	Quality Aim	How will achievements be measured?	How will achievements be monitored?
Discharge	Implement a Trust-wide approach to support safe discharge to continuing care	Metrics and dashboards through the Improvement Collaborative	Patient Safety & Risk Assurance Committee
Safe Transfers of Care	Implement a Trust-wide approach to improve staff and patient handover between care areas and organisations	Metrics and dashboards through the Improvement Collaborative	Patient Safety & Risk Assurance Committee
Deteriorating Patients	Implement a Trust-wide approach to improve the recognition of and response to the deteriorating patient	Deteriorating Patient scorecard; Sepsis care bundle; Acute Kidney Injury (AKI) care bundle; Audits	Deteriorating Patient Steering Group; Patient Safety & Risk Assurance Committee
Falls	Spread the 'Let's Eliminate Avoidable Falls' (LEAF) change package to every ward across the Trust	Ward-level run charts; performance dashboards	Patient Safety & Risk Assurance Committee
Pressure Ulcers	Spread the Pressure Ulcer Change Package across the Trust	Ward-level run charts; performance dashboards	Patient Safety & Risk Assurance Committee

6

4.2 Safety Culture

A positive safety culture has been found to be a common characteristic of high reliability organisations, where a lack of complacency and a constant concern about safety is built into the organisational fabric (The Health Foundation, 2013). It is our ambition to be an organisation that is recognised for having an excellent safety culture by:

- Embedding learning from the existing safety culture work in theatres

- Undertaking safety culture surveys in other identified areas (Neo-natal Intensive Care Unit; Estates and Facilities)

- Supporting improvements based on the safety culture survey outputs

- Promoting the 'Prompt to Protect' campaign to develop an open reporting culture for infection control and safety issues.

4.3 Incident Reporting and Investigations

The delivery of high quality healthcare requires the identification, management and minimisation of events or activities which could result in unnecessary risks to patients, staff, visitors or members of the public. To do this, we will:

- Develop the capabilities of our incident reporting system, Datix, to ensure we provide a robust, stable risk management system for use across the Trust

- Adopt and endorse the 'Speak Out Safely' campaign to support staff when raising concerns

- Encourage staff to report incidents, take responsibility for actions to minimise risks and fully apply their Duty of Candour

- Embed 'Human Factors' to examine why incidents occurred.

4.4 Incident Reporting and Investigations

To assure that the quality of care provided is evidence-based and appropriate to the needs of the patient, we have adopted the Nursing Assessment Performance Framework (NAPF) which has been designed around the Chief Inspector of Hospitals 5 Key Lines of Enquiry – safe, effective, caring, responsive and well-led. We aim to:

- Extend the NAPF assessment to all wards and specialties

- Support and enable all wards to achieve SPEC (Safe, Personal, Effective Care) status whereby they maintain 'good' for 24 months (3 assessments).

4.5 How Will We Monitor Progress?

The Trust reports progress through the Patient Safety and Risk Assurance Committee. PSRAC examines the detail of and provide assurance on the effectiveness of incident management, risk, divisional governance, and harm free care.

8

5. Personal Care

It is our ambition to ensure that our patients, their families and carers receive an experience that not only meets but exceeds their expectations. We are committed to capturing feedback and continually learning in order that we drive continuous improvements.

Quality Aim: Deliver patient-centred care.

What are we trying to accomplish?

- Use individual patient feedback to enhance the delivery of safe, personal and effective care for all patients

- Continually improve the experience of patients, families and carers from their first contact with the Trust through to their safe discharge from our care.

5.1 Patient Experience

Treating our patients with compassion, kindness, dignity and respect has a positive effect on recovery and clinical outcomes. To improve patient experience in our hospitals, we will:

- Implement our Patient / Carer & Family Experience Strategy

- Listen to our patients, their families and carers, and respond to their feedback

- Use Experience Based co-design in responding to patient feedback to introduce and sustain improvements across the Trust in relation to discharge

- Implement 'Hello, my name is…' in all introductory interactions

- Continue to deliver patient stories at Trust Board.

5.2 Patient, Public and Staff Involvement

Involvement in proposals for change will develop people's sense of ownership in their local healthcare services. To do this, we aim to:

• Actively involve patients, carers and staff in all relavant quality improvements including the Patient / Carer Information and Involvement Project

• Ensure actions from the 'You Said - We Did' feedback are displayed and shared widely across the Trust.

5.3 Carer Identification and Support

We are making a commitment to do more to help identify, support and recognise the vital role of carers by:

• Implementing our Patient / Carer & Family Experience Strategy

• Working closely with local carer groups to ensure there is a continual dialogue regarding the care provided

• Raising awareness of the carer role and the right to individual carer assessments

• Supporting John's Campaign for carers of those with dementia.

5.4 Complaints

We are committed to delivering high quality care but recognise there are occasions when a complaint will be made. To support patients and their families, the Trust will:

• Improve the response times for formal and informal complaints and concerns

• Intervene at an early stage to address concerns prior to escalation into a formal complaint

• Maintain appropriate and clear communication with families throughout the complaint process

• Promote the ways in which patients are able to raise concerns.

5.5 How Will We Monitor Progress?

The Trust reports progress through the Patient Experience Group. PEG examines the effectiveness of divisional and corporate arrangements to monitor and improve patient experience.

6. Effective Care

Consistent delivery of high-quality care leads to better outcomes for patients. It is our ambition to deliver care that is effective, reliable and based upon the best evidence available.

> **Quality Aim:** Deliver consistently effective and reliable care.
>
> **What are we trying to accomplish?**
>
> - Increase the proportion of patients who receive evidence-based care
>
> - Reduce variations in the quality of care.

6.1 Clinical Effectiveness

We work to ensure that the care delivered to patients is both effective and based upon the best evidence available. To do this, we will:

- Develop and embed a series of care bundles and pathways in high-priority areas such as Acute Kidney Injury, Alcohol Related Liver Disease, Chronic Obstructive Pulmonary Disease, Community Acquired Pneumonia and Sepsis

- Ensure systems are in place to provide clinical areas with timely data on care bundle measurement in order to facilitate improvements

- Participate in the relevant national audits to provide assurance of effective care delivery

- Use the findings from the relevant national audits to support the continued improvement of quality outcomes by sharing learning and good practice across the organisation

- Utilise Clinical Audit expertise to provide the evidence-base and measurement function which drives quality improvement initiatives.

6.2 Best Practice Guidance

The continuous development of evidence-based practice is important as it ensures we are delivering consistent and reliable care for our patients:

- Standardise practice across Divisions in line with best practice guidance to ensure the reliability of care

- Ensure the relevant NICE (National Institute for Health and Care Excellence), NCE (National Confidential Enquiries) and specialist national guidance are regularly assessed and implemented to deliver interventions based upon the best possible evidence

- Develop and maintain a system of 'Decision Support' so the Trust has a centralised repository for clinical standards, policies, guidelines and procedures

- Participate in the GIRFT (Getting It Right First Time) programme, in line with national guidance.

6.3 How Will We Monitor Progress?

The Trust reports progress through the Clinical Effectiveness Committee. CEC is engine room for ensuring there are appropriate arrangements to provide assurance of effective care delivery and improvement across the organisation.

7. Key Enablers for Delivering the Quality Strategy

7.1 Governance

Safety and quality are monitored through our corporate governance structure, reporting to the Board via the Quality Committee. The Quality Committee is informed by the following committees:

- Patient Safety and Risk Assurance Committee (PSRAC)

- Patient Experience Group (PEG)

- Clinical Effectiveness Committee (CEC).

Reporting in Divisions replicates this corporate structure to ensure consistent reporting from 'floor to Board' and, through this structure, they are held to account on their plans to achieve the objectives outlined in this strategy.

Governance Structure
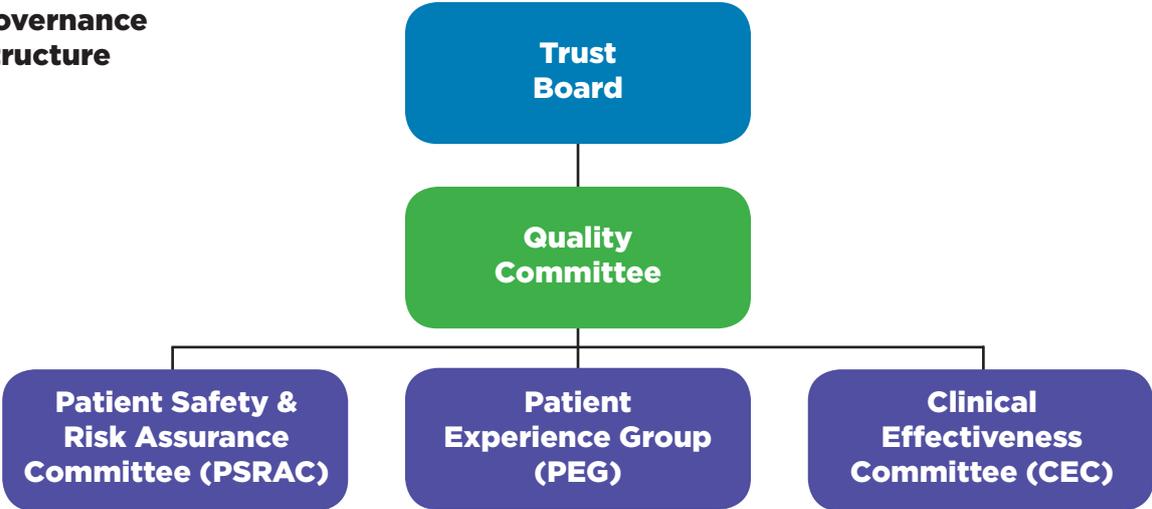
7.2 Building Quality Improvement Capability

Berwick (2013) championed the need for the NHS to have "a considered, resourced and driven agenda of capability building in order to generate the capacity for continuous improvement." A key enabler that will determine the success of this strategy is the creation and sustainment of a culture that enables continuous quality improvement to thrive.

The ELHT Quality Improvement Framework aims to build the capability for delivering this strategy by developing improvement skills in staff at all levels of the organisation.

Quality Improvement Framework

Innovator
Expert resource that promotes the development of a QI culture

Practitioner
Expert resource that promotes the development of a QI culture

Lead
Staff leading a QI project should have a deeper understanding of improvement theory to enable them to plan, test and implement improvements across teams and systems

Participant
Staff participating in a QI project should have a foundation level knowledge of the principles that underpin quality improvement

Awareness
All staff working within ELHT should have a basic awareness of quality improvement methodologies

The purpose of the QI Framework is to:

- Develop improvement capability by equipping staff with the skills to deliver continuous quality improvement

- Educate staff on the use of quality improvement methodologies through educational programmes, coaching support and networking opportunities

- Utilise the expertise of regional improvement specialists such as the Advancing Quality Alliance (AQuA), Haelo and the Academic Health Science Networks (AHSNs)

- Support staff to effectively improve care using ELHT's '7 Steps to Safe, Personal, Effective Care' improvement methodology, which is based on the Institute for Healthcare Improvement's (IHI) Model for Improvement

- Establish a robust framework to enable the Quality Improvement team to co-ordinate Trust-wide improvement efforts

- Recognise, reward, celebrate and share the successes of those who are actively engaged in quality improvement activity

- Show visible commitment to encouraging a culture of continuous quality improvement throughout ELHT.

This approach seeks to support the organisation in both meeting today's pressures and creating sustainable improvements for future Safe, Personal & Effective care.

14

7.3 Pastoral Care

The Francis Report (2010) highlighted the need for organisations to create and maintain the right culture to deliver high-quality care that is responsive to patients' needs and preferences. It emphasised that organisations must recognise the physical and mental challenges of health care jobs, and staff should be given the right support and opportunity to discuss their experiences.

To support our staff, we will:

- Encourage an open culture where staff report incidents and take responsibility for taking action to minimise risks

- Fully apply Duty of Candour, as per national guidance

- Encourage openness and transparency

- Support learning from incidents and sharing lessons learnt

- Conduct Root Cause Analysis (RCA) investigations using a human factors approach.
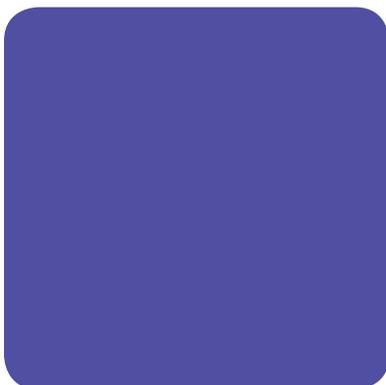
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TRUST BOARD REPORT	**Item**	**132**
13 September 2017	**Purpose**	Information
		Assurance

Title	Update of General Medical Council Enhanced Monitoring
Author	Dr I Stanley, Deputy Medical Director
Executive sponsor	Dr D Riley, Medical Director

Summary: A summary of events leading to the imposition of enhanced monitoring of postgraduate medical education and the outcome of the most recent visit leading to removal of enhanced monitoring

Recommendation: Directors are requested to receive and 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

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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

Introduction

1. In October 2011, Health Education North West (HENW) found that doctors in foundation, core and higher specialty training in medicine and GP posts at East Lancashire Hospitals NHS Trust (ELHT) were working without sufficient supervision. There were also problems with handover processes. HENW contacted the General Medical Council (GMC) in July 2012 to ask for support to address these issues and to request the removal of approval for the GP training posts at Pendle Community Hospital. As a result these posts were withdrawn and alternative staffing measures were put in place.

2. Postgraduate education at ELHT was placed under enhanced monitoring by the GMC. This occurs when medical schools, deaneries and local education and training boards are concerned about the training of medical students or doctors. Initially they need to work with Trusts and health boards to make improvements.

3. If the situation does not improve, the GMC becomes involved and through the process of enhanced monitoring they work with all the organisations involved to improve the quality of training.

For Information

4. In November 2012, the GMC joined HENW on a visit to the Trust and, in April 2013, HENW and the Royal College of General Practitioners further reviewed the GP posts in medicine. HENW revisited in October 2013 and, although they found improvement, concerns remained across the division of medicine. In early 2014 HENW became concerned about the Trust's progress in sustaining these improvements.

5. There were some changes made to the senior management of postgraduate medical education and the Trust Education Board was formed with the development of a clear action plan. At the same time Dr Shirley Remington became the Associate Dean to support the improvement work.

6. The GMC and HENW visited again in February 2015. Three concerns were raised for immediate action by the Trust which were acted upon and some improvement was noted.

7. The next scheduled visit by the GMC and HENW was in May 2016. Whilst considerable improvements were noted some concerns remained

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in medicine and a further targeted visit to medicine alone was scheduled for May 2017. This visit actually occurred in July 2017 due to GMC and HENW staff availability.

8.   At this visit the improvements noted previously had been found to be sustained and whilst concerns still remained in some areas the visiting team were confident that the educational governance systems in place were addressing these.

9.   As a result the Trust were contacted by the GMC on August 24th 2017 to confirm that following a recommendation from HENW the GMC had agreed that East Lancashire Hospitals NHS Trust had satisfactorily and sustainably resolved concerns in connection with general (internal) medicine at Royal Blackburn Teaching Hospital and would no longer be subject to the enhanced monitoring process. The GMC thanked the Trust for its efforts in achieving this.

Conclusion

10.   The Board is asked to note this achievement and to recognise the work of the postgraduate medical education team which has been led by Dr Malcolm Littley. Dr Littley stepped down from the role of Director of Medical Education in June 2017 and this achievement is a fitting reward for his commitment to medical education and leadership of the team.

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East Lancashire Hospitals
NHS Trust

TRUST BOARD REPORT

13 September 2017

Item	**134**

Purpose Information

Monitoring

Title	Workforce Race Equality Standard (WRES)
Author	Mr N Makda, Equality & Diversity Manager
Executive sponsor	Mr K Moynes, Director of HR & OD

Summary:

The workforce Race Equality Standard (WRES) action plan has now been updated to include objectives and timescales as requested by the Trust board.

This report also provides the Board with an update on the implementation of the Workforce Race Equality Standard (WRES) Action Plan for 2017/18

Recommendation: It is recommended that members of the board note the updated action plan and progress made against the 2017/18 action plan.

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

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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	Yes	Confidentiality	No

Previously considered by: Trust Board in May 2017

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Workforce Race Equality Standard (WRES) Action Plan Report

1. As per requirement of item TB/2017/079 suitable objectives and timeframes have now been included in the workforce race equality standard (WRES) action plan (refer to Appendix 1 & 2)

2. Appendix 1 details work undertaken during the period 1st April – 31st March 2017 and provide a summary of the implications of the data that has been analysed and any additional background including action taken to date.

3. Appendix 2 outlines proposed actions to be undertaken over the coming year 1st April 2017 – 21st March 2018

Summary of the Trust's progress against the WRES action plan 2017 / 2018

4. The Workforce Race Equality Standard (WRES) working group continue to monitor and implement the WRES action plan.

5. The Trust is working with Diversity by Design who delivered an introductory session with the Trust Board (i) presenting the feedback from the staff survey which identified key issues and (ii) discussing the value of diversity and (iii) developing possible solutions

6. Diversity by Design has developed a comprehensive outline proposal following the Board session.

7. The recruitment & selection policy and process is being reviewed to ensure our recruitment practices are transparent and inclusive. We are in the process to pilot a change in recruitment in a selected number of teams/ levels of staff

8. Detailed recruitment monitoring has enabled to review our hiring processes at each stage of the recruitment process. By doing so we are able to identify issues candidates might have, from different ethnic backgrounds in the recruitment process. This is now enabling to investigate why this might be and address any issues identified.

9. Robust and detailed data gathering has allowed understanding of specific challenges and patterns within the workforce and we are now able to proactively address these.

10. Two 'Big Conversation' events have been arranged for 5th and 6th October 2017 for Black, Minority and Ethnic (BME) staff where we will listen to BME staff from across the Trust, to give their account of what it is like to work at East Lancashire Hospitals NHS Trust. We will also provide feedback on the WRES work undertaken during the last 12 months.

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11. Ongoing active promotion of Leadership Development Programmes offered by the NHS Leadership Academy and internal leadership courses to BME staff.

12. The Bullying & Harassment Task and Finish Group continue to review practices and policies to encourage positive employee relations and to prevent bullying, harassment and any form of unacceptable behaviour between employees. One proposal is to integrate the bullying and grievance policies into one by way of introducing a 'Resolution Policy' that encourages early resolution and offers a collaborative system of dispute resolution which balances the rights of the parties with their interests and needs; it brings the core principles of mediation to the forefront of dispute resolution and encourages constructive resolution at every stage of a dispute.

13. Quarter 1 monitoring of staff in post data against relevant Census data suggests the BME make up of staff have remained broadly the same at 15%

14. The Trust is working in partnership with the Job Centre to promote job opportunities within the Black Minority ethnic communities.

15. Unconscious bias awareness training is now rolled out to all staff

Recommendation:

16. The Board is asked to note the updated action plan and note the progress against the WRES Action Plan.

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NHS
East Lancashire Hospitals
NHS Trust

Appendix 1 – Workforce Race Equality Indicators 1st April – 31st March 2017

For each of these four workforce indicators, the Standard compares the metrics for White and BME staff.

	Indicator	Data for reporting year (2017)	Data for previous year (2016)	Narrative – the implications of the data and any additional background explanatory narrative	Tracking Progress	Target What success would look like
1	*Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.*	Detailed information refer to appendix 2	Detailed information refer to appendix 2	The staff makeup of the Trust (15%) is still not reflective of the local population (20%). BME representation at 8a and above either no change/deterioration in figure in the last 12 months. For non-clinical staff, BME staff were clearly over-represented at Band 6 and not represented at all among very senior management. For clinical staff, BME staff were clearly over-represented at Band 5 and not represented at all above Band 8C. Among medical staff, there was a clear over-representation of BME staff at the non-consultant career grades	Amber ↕	Increase the numbers of staff from BME groups across all Agenda for Change Bands 1-9 and Very Senior Managers to 20%

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	Indicator	Data for reporting year (2017)	Data for previous year (2016)	Narrative – the implications of the data and any additional background explanatory narrative	Tracking Progress	Target What success would look like
2.	*Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts.*	3.08 times greater	2.38 times greater	Of all indicators, the greatest of concern. BME staff continue to be less likely than White staff to be shortlisted/appointed to roles at the Trust. The relative likelihood of white staff being appointed from shortlisting compared to BME staff is 3.05 times greater	Red →	Decrease the Workforce Race Equality Standard score for indicator Two to 0.50 or below
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*	2015-2017 1.78 times more likely	2014-2016 1.40 times more likely	A slight increase from the previous *2 years of* the relative likelihood of BME staff entering the formal disciplinary process compared to white staff is 1.78 times greater (2014-2016 was 1.4 times greater)	Red →	Decrease the WRES score for indicator Three to 0.30 or below
4	Relative likelihood of White staff accessing non-mandatory training and CPD as compared to BME staff	2017 1.19 times more likely	2016 1.08 times more likely	BME staff continue to be less likely than White staff to be funded for training. Relative likelihood of white staff being funded for training 1.19 times greater compared to the previous year 1.08 times greater.	Red →	Decrease the WRES score for indicator Four to 0.50 or below

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For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for White and BME staff

	Indicator	Data for reporting year (2017)		Data for previous year (2016)		Narrative – the implications of the data and any additional background explanatory narrative	Tracking Progress	Target What success would look like
5	**KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**	White 2016 26%	BME 2016 21%	White 2015 25%	BME 2015 21%	Fairly static between the two years but is still higher than the Trust would expect. Although BME staff still report high levels of harassment, bullying or abuse from patients the percentage was higher for White Staff in figures in the last 12 months.	Amber ↕	The aspirational target for all staff would be 0% however a realistic target would be: A year on year reduction from previous year BME percentage is equal to or less than White percentage
6	**KF 19 [26]. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**	White 22%	BME 20%	White 23%	BME 25%	Slight reduction in the likelihood of BME staff experiencing harassment, bullying or abuse from staff in last 12 months (20% for BME and 22% for white staff) compared to previous year 25% for BME and 23% for white staff. Small variance between White & BME Staff.	Amber ↕	The aspirational target for all staff would be 0% however a realistic target would be: A year on year reduction from previous year BME percentage is equal to or less than White percentage

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#	Indicator	Data for reporting year (2017)		Data for previous year (2016)		Narrative – the implications of the data and any additional background explanatory narrative	Tracking Progress	Target What success would look like
		White	BME	White	BME			
7	**KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion**	White 86%	BME 73%	White 85%	BME 71%	This has improved for both from the previous year for both BME (73%) and White staff (86%) "Believing that the Trust provides equal opportunities for career progression or promotion". Last year 71% for BME and 85% white staff.	Green	A year on year increase from previous year BAME percentage is equal to or more than White percentage
8	**Q17b. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleague**	White 6%	BME 14%	White 6%	BME 14%	This has remained fairly static, no change/ deterioration in figure in the last 12 months for both BME (14%) & White (6%) staff to personally experience discrimination at work from Manager/team leader or other colleagues.	Amber	A year on year reduction from previous year BAME percentage is equal to or less than White percentage

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Boards representation indicator: For this indicator, compare the difference for White and BME staff

		White 2017	BME 2017	White 2016	BME 2016			
9	*Percentage difference between the organisations Board Executive voting membership and its overall workforce.* *Note: Only Executive voting members of the Board should be included when considering this indicator.*	94%	6%	0%	0%	At 31 March 2017, the Board voting membership included 1 Non-Executive Director from a BME Background 9.0%, compared to 91% White Board members. This is a difference of 6% as 15% BME workforce Breakdown of Board Members; 9 Executive Directors with 5 voting members 6 Non-Executive Directors with voting membership 2 Associate Non-Executive Directors (without voting membership)	Green ←	Increase Board BME voting membership to 20%

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East Lancashire Hospitals
NHS Trust

Appendix 2 – Workforce Race Equality Action Plan 2017

	Indicator	Action planned	Responsible for action	Completion Date
1	**Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.**	• Deep dive by collecting and analysing staff data to identify where the specific blocks to talent are in the Trust and then Pilot an area where there is an under-representation, by review of HR/OD policies, processes, utilise positive action to recruit diversity. • Make Managing Difference/ Unconscious Bias training mandatory for all recruiting managers via inclusion in recruitment training accompanied with change in the process. • Increase representation of BME staff by 2% in all areas where there is under-representation • Develop partnership working with CCG's, Local council, Job Centre, NHS Trusts on shared initiatives i.e. WRES	WRES Working Group/ with support from Diversity by Design	March 2018

2	**Relative likelihood of staff being appointed from shortlisting across all posts.**	• Critically examine recruitment processes by piloting an area of under-representation including;
		Rejecting non-diverse shortlists;
		  o Change in process, challenging and sifting out selection bias; (needs to be <u>designed out</u>)
		  o Drafting job specification & PS in a more inclusive way; (focus on a combination of excellence – e.g level of skill etc. – and then crucially on the personal attributes (identity, background, experiences) the person brings – e.g the difference they bring.
		  o Skills mix creating opportunities for different skills, backgrounds and attributes, not just the chosen few
		  o Re-design recruitment materials to specify Trusts desired values and behaviours
			WRES Group with support from Diversity by Design	March 2018

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	Indicator	Action planned	Responsible for action	Completion Date
		• Recruitment panel members must have completed Unconscious Bias training accompanied with a change in process of shortlisting and interviewing • Spot checks / audits of vacancies, analysis by banding	Employment Services/ Equality and Diversity Manager	Ongoing
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	• Dealing with difference training to build confidence in managers in resolving disputes/incidents/problems so that they feel able to deal with BME colleagues in the same way as white colleagues • Unconscious bias training for disciplinary/appeal panels • The development of Diversity Ambassadors who review Disciplinaries	Equality & Diversity Manager	February 2018
4	Relative likelihood of staff accessing non-mandatory training and CPD.	• Identify reasons/rationale why BME staff are refused funding for non-mandatory training and CPD	Equality & Diversity Manager	January 2018
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	• High profile bullying and harassment campaign with executive leadership on tackling bullying and harassment.	All divisions	March 2018
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	• Review of Bullying & Harassment policy • Encourage all staff to first pursue informal mechanisms to resolve issues i.e. Mediation, fair treatment champions, staff side, staff guardian, etc.	Bullying & Harassment working group	November 2017
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	• 2 way mentoring- build into the objectives of all managers above band 5 including VSM to mentor BME colleagues to share experience, in how to manage mixed groups of staff and improve opportunities so that BME colleagues have access to internal/informal networks (this way we are not recruiting/promoting from the same pond)	All Senior managers	March 2018

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	Indicator	Action planned	Responsible for action	Completion Date
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? B) Manager/team leader or other colleagues	• Tougher sanctions for those who are found to be discriminating, this will act as a deterrent. • Integrate diversity within the performance management processes, including measuring employees on their ability to work well with others and measuring managers on their ability to drive and implement diversity initiatives. Measurements for managers in their appraisals. 360 from staff contributing to measurement of achievement of the 'soft' targets e.g behaviour etc. • Continue with employee engagement activities so that views are sought out; staff are listened to and see that their opinions count and make a difference to Safe Personal Effective care.	Equality & Diversity Manager Staff Engagement Team	March 2018 Ongoing
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	• Senior executives must take accountability by ensuring executive sponsorship for this target; consider using positive action for next Board member recruitment. • Explore the introduction of a 'reciprocal mentoring scheme' for BME staff to be paired up with members of the Exec/managers that report directly to the Exec team. • Explore succession planning that considers positive action for all board and senior positions and development of the talent pool generally.	Trust Board Executive Team/Senior Managers	March 2018

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TRUST BOARD REPORT

13 September 2017

Item 135

Purpose Information Assurance

Title	Integrated Performance Report (April to July 2017)
Author	Mr M Johnson, Associate Director of Performance and Informatics
Executive sponsor	Mr J Bannister, Director of Operations

Summary: This paper presents the corporate performance data for the period April to July 2017.

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

Safe | Personal | Effective

failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	Yes

Previously considered by:

Board of Directors, Update
Corporate Report
Executive Overview Summary Improvement was seen in the delayed discharges of medically fit patients, however operational pressures continued during the period and the 4 hour target remained below the 95% threshold. The emergency department saw an increase in the ambulance handover times. Nurse and midwifery staffing improved slightly in June however remained challenging in July with 7 areas below the 80% average fill rate during the period. There were 5 further clostridium difficile infections detected this during the period. Despite all the pressures, the 18 week referral to treatment targets for the period have been achieved as well as the diagnostic 6 week target, although three patients had waited over 52 weeks during the period. There was one never event in July which will be investigated through the patient safety and risk committee. While we have seen expenditure pressures over the first four months of the financial year, we are reporting that we remain on target to achieve our control total, as well as an overall Finance and Use of Resources metric score of 2.

Introduction

This report presents an update on the performance for the period June 17 - July 17 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.

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There have been no further confirmed MRSA infections reported in the period. Year to date there has been one case attributed to ELHT.

There were five Clostridium difficile toxin positive isolates identified in the laboratory in the period which were post 3 days of admission. The year to date cumulative figure is 11 against the trust target of 28. The detailed infection control report will be reviewed through the Quality Committee.

C Difficile

The rate of infection per 100,000 bed days has decreased to 7.0 in July.
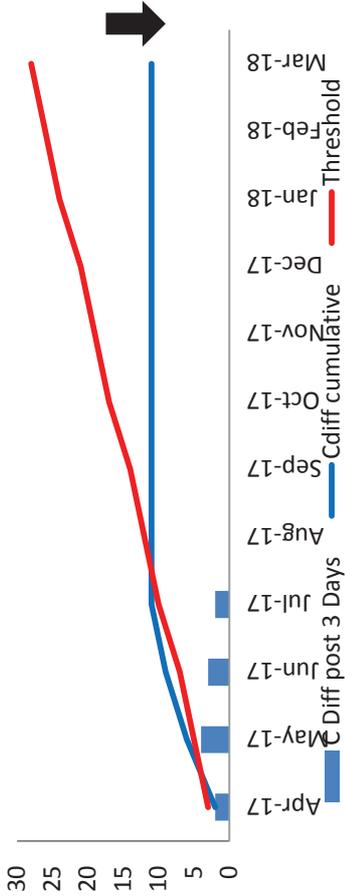
C Difficile per 100,000 occupied bed days

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.

C Difficile benchmarking

Cdiff Benchmarking for Acute Trusts per 100,000 occupied bed days, 2016-17
Trust Apportioned   Source: Public Health England

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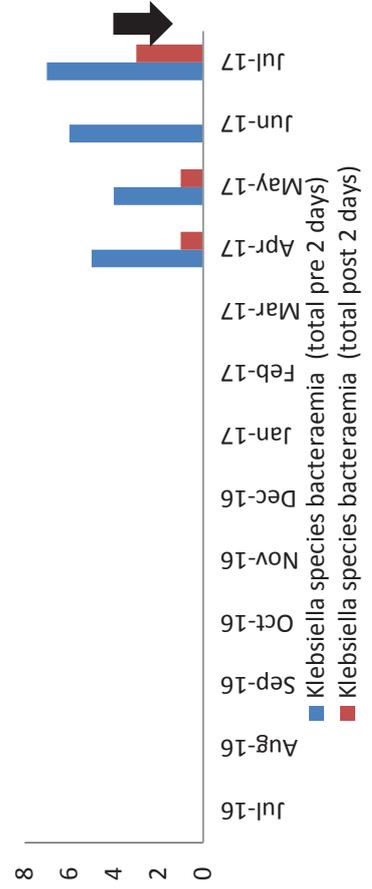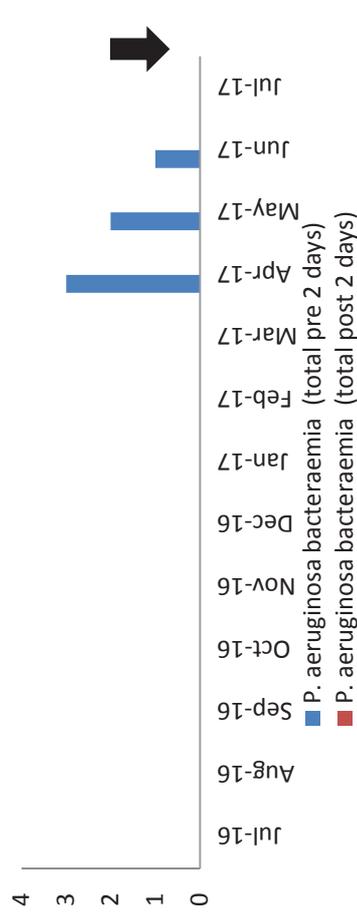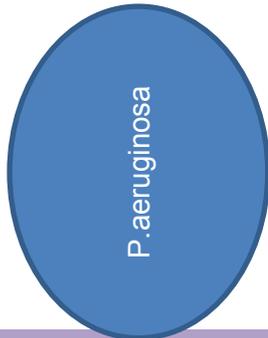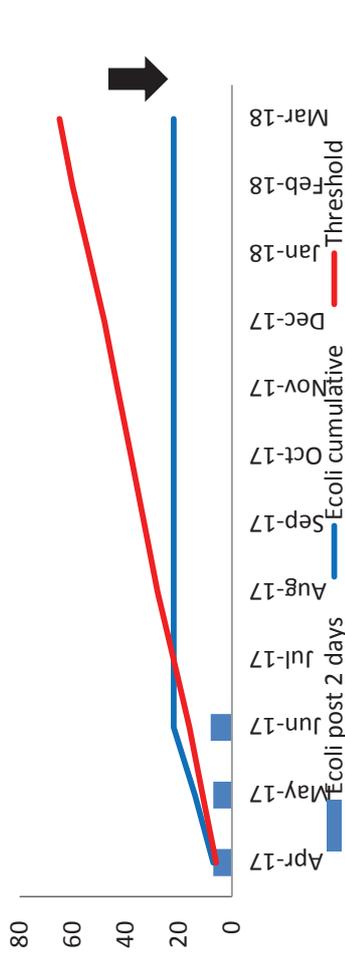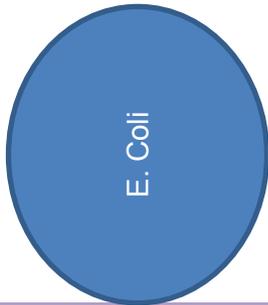
In response to Lord O'Neill's challenge to strengthen Infection Prevention and Control (IPC), the Secretary of State for Health has launched an important ambition to reduce Gram-negative Blood stream infections (BSIs) by 50% by 2021.

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 acheive a 10% reduction.

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

There were 8 E.coli bacteraemia detected in the period, which brings the year to date figure of 22 on trajectory.

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

E. Coli

P.aeruginosa

Klebsiella

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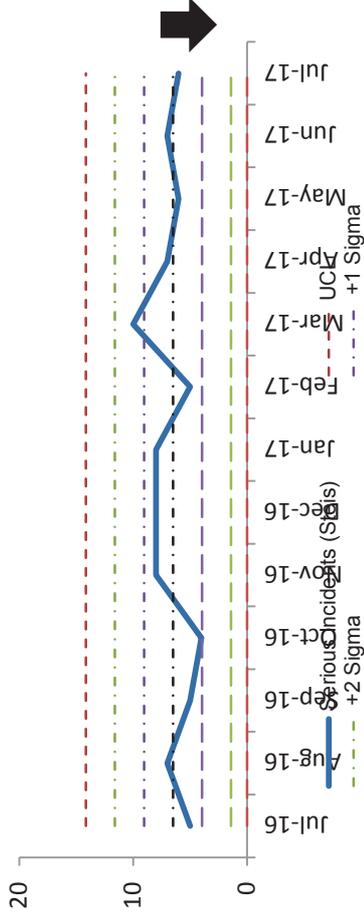
There was one never event reported to Steis in July relating to a surgical/ invasive treatment.

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

StEIS Category	June	July
Diagnostic Incident meeting SI criteria		1
Pressure Ulcer meeting SI criteria	4	1
Medical Device		1
Surgical/Invasive Treatment meeting SI criteria		1
Maternity/Obstetrics		2
Sub Optimal Care of the Deteriorating Patient	1	
Slips Trips and falls	2	

A detailed report providing assurance on the management of each of the STEIS reported incidents is submitted monthly to the Patient Safety and Risk Assurance Committee.
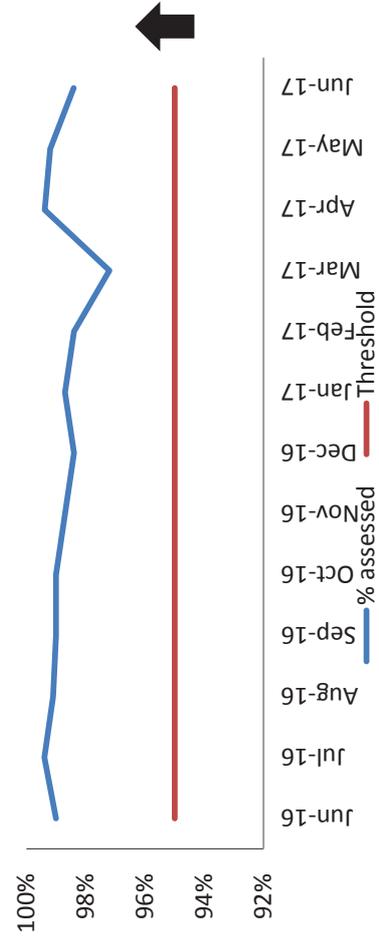
The Trust remains consistent with the percentage of patients with harm free care at 99.7% for July 2017 using the National safety thermometer tool.

For the period we are reporting the current position as two grade 3 hospital aquired, thirteen grade 2 hospital acquired and ten grade 2 community acquired pressure ulcers. All pending investigation.
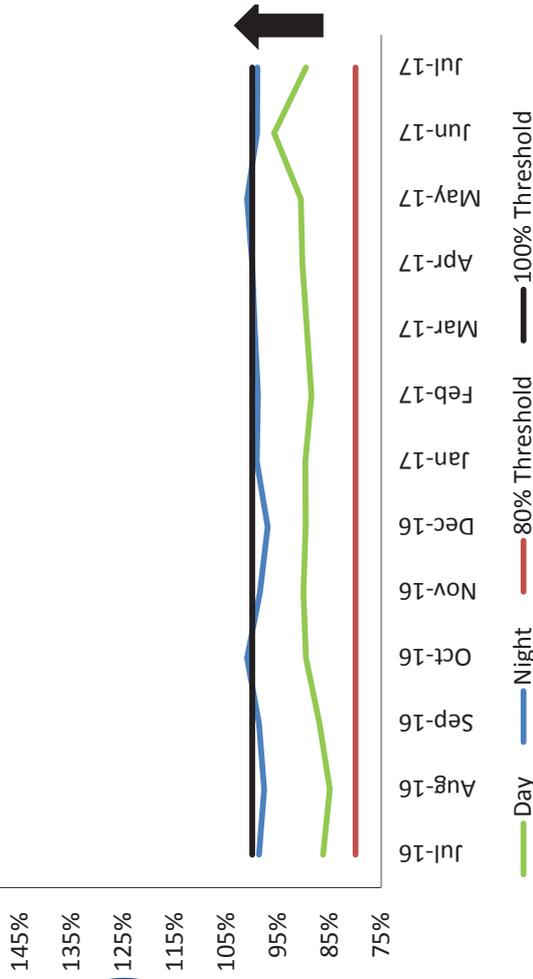
Serious Incidents

Serious Incidents (Steis)   UCL   +1 Sigma   +2 Sigma

% Harm Free Care from safety thermometer

SAFE

VTE assessment

Threshold   % assessed

Nursing and midwifery staffing improved slightly in June however remained challenging in July 2017.

Two areas in June and 5 areas in July fell below an 80% average fill rate for registered nursed on day shifts and 1 area in both June and July for registered midwives on night duty.

The causative factors remain as in previous months, compounded by vacancies and holiday period.

Of the 2 areas in June below the 80% on day shifts, both were due to coordinator unavailability, which is in addition to the agreed staffing levels.

Of the 5 areas below the 80% on day shifts in July, one was due to coordinator unavailability, which is in addition to the agreed safe staffing levels; Hartley Ward.

Night Shifts
Blackburn Birth Centre
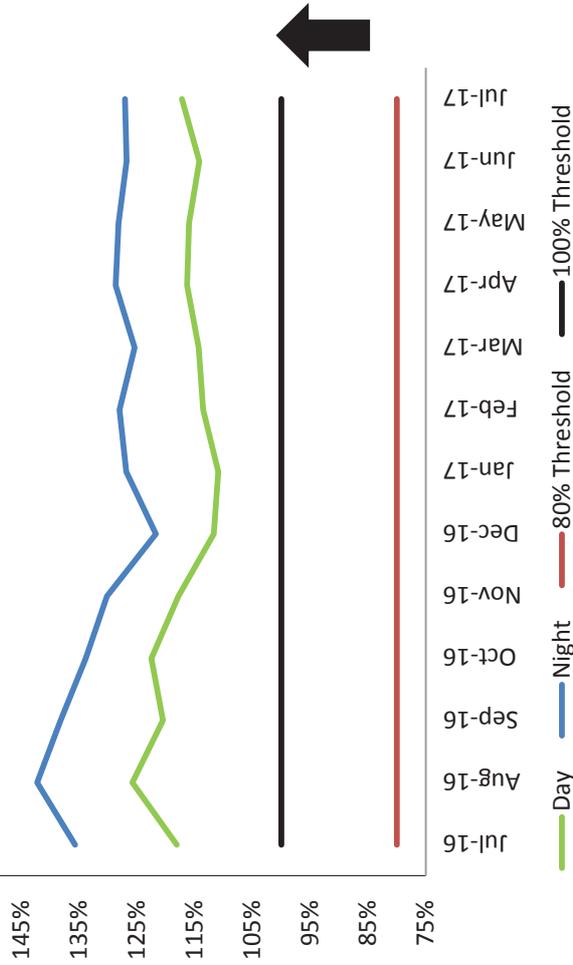
Blackburn Birth Centre is still experiencing difficulty staffing to the planned requirements due to sickness and maternity leave. To maintain safety and mitigate the risk numbers of women at any one time in labour have been reduced in line with the safe staffing.

Registered Nurses/Midwives

Care Staff

SAFE

Average Fill Rate

Month	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff
Jun-17	95.8%	114.2%	99.1%	126.8%	26325	9.07	2	0	1	1
Jul-17	89.6%	117.2%	99.0%	127.1%	23239	10.62	5	0	1	1

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

There was 1 red flag incident reported in June relating to inability to reliably carry out intentional rounding and 1 red flag incident in July, however this was related to the emergency department and not ward areas and is therefore being investigated as a separate issue.

Actions taken which cover the period:
Extra allocation on arrival shifts continue to be booked. Registered and non-registered.
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
On going active recruitment/open days

Family Care June 2017
Maternity

Month	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Staffed to full Establishment	01:30.3	01:30.4	01:30.2	01:30.6	01:30.1	01:29.2	01:28.8	01:29.2	01:31	01:30.2	01:30	01:29
Excluding mat leave and vacancies	01:31.5	01:31.9	01:30.6	01:31.2	01:31	01:30.8	01:30.3	01:30.4	01:32.1	01:30.7	01:31	01:30
With gaps filled through ELHT Midwife staff bank	01:29.7	01:28.4		01:29.4	01:29.2	01:29.4	01:29.4	01:29.3	01:31.2	01:29.3	01:30	01:28
					Bank Usage 13.31 WTE	Bank Usage 10.1 WTE	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

The midwife/birth ratios calculated using the Birth Rate Plus Tool from the 1st March 2017 to the 31st August 2017 is 1:28.85.
The staffing figures do not reflect how many women were in labour or acuity of areas.

Maternity Staffing Red Flags for June and July 2017

Six incidents were reported under Maternity Services "Red Flags" staffing category in June and nine in July in the red flags report on Datix. Five of the nine incidents reported in the red flags category in July were excluded from the report as they did not relate to inpatient services. A further five incidents and June and nine in July were reported under the staffing category. **No harm** was caused by any of the red flag events or staffing incidents reported and the appropriate actions and escalation occurred to ensure patient

Maternity

Maternity are currently awaiting 19WTE midwives to commence in post, the majority who don't qualify until September 17 but are anticipated to start before than as band 3's awaiting PIN's. Where the staffing ratios are not at the minimum levels, staff are rotated, dependant on acuity and services diverted to other areas of maternity to maintain safety. 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.

Paediatrics

Paediatrics continues to have staffing gaps due to vacancies; maternity leave and sickness absence in July, The planned verses actual nursing hours are significantly lower than in past months. Bank RSCNs have been used, where available, to mitigate the risks and ensure safe staffing. Also bank band 2 HCA's have been utilised to allow the band 3 HCA's to support the RSCN's with patient care. 8.80 WTE staff have been recruited and will commence in post in September/October. Further interviews are scheduled to continue to recruit to enable the service to fully back fill for staff on maternity leave and fill the forthcoming vacancies. Activity and acuity are closely monitored and recorded 3 times throughout the day on safe staffing. Lower acuity and occupancy in July has meant that agency staff has not been needed to be requested. Please see Appendix 2 for UNIFY data and nurse sensitive indicator report

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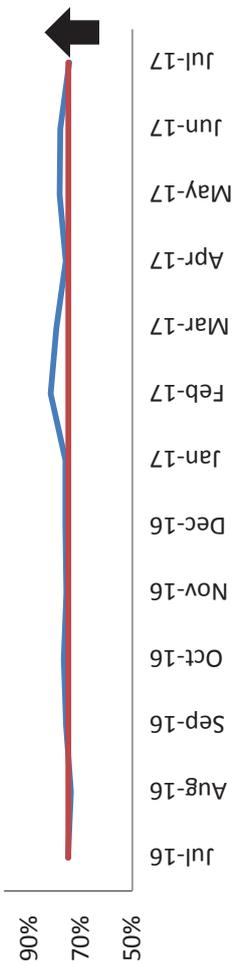
These metrics reflect national measurement methodology, which measures the proportion of patients that would recommend the Trust to friends and family. The latest Trust development authority thresholds have been included where available.

In July the number that would recommend A&E to friends and family was down on last month at 74.6% with a response rate of 18.6%

The proportion that would recommend inpatient services was also down on last month at 97.7%. The response rate was 49.5%.

Community services would be recommended by 96.5% and maternity 98.0%

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

CARING

Friends & Family A&E

Friends & Family Inpatient

Friends & Family Community

Friends & Family Maternity

— Threshold

— % would recommend

The Trust opened 23 new formal complaints in July and 34 in June.

The number of complaints closed in June and July was 95.

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 July the number of complaints received is shown as 0.2 Per 1,000 patient contacts.

An external audit on has been completed which gave significant assurance on the Trust's complaint process. All recommendations made in the final report have now been

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

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

Complaints per 1000 contacts

— Rate — Threshold

CARING

Patient Experience

July 2017 Totals

July 2017 Totals	No.	Overall %	Dignity %	Information %	Involvement %	Quality %
Trust	2073	97	98	97	99	97
Integrated Care Group - Acute	561	97	99	99	98	96
Integrated Care Group - Community	378	99	100	99	100	100
Surgery	332	97	99	96	99	98
Family care	535	97	97	96	98	97
Diagnostic and Clinical	267	97	96	97	98	97

June 2017 Totals

June 2017 Totals	No.	Overall %	Dignity %	Information %	Involvement %	Quality %
Trust	1728	97	99	97	99	97
Integrated Care Group - Acute	530	97	99	98	99	96
Integrated Care Group - Community	295	99	100	99	100	100
Surgery	199	98	98	98	99	99
Family care	439	97	98	94	95	98
Diagnostic and Clinical	261	96	97	96	99	98

The latest indicative 12 month rolling HSMR (April 16 – March 17) is reported 'as expected' at 95.3 against the monthly rebased risk model.

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

No further learning disability related deaths since January 2017
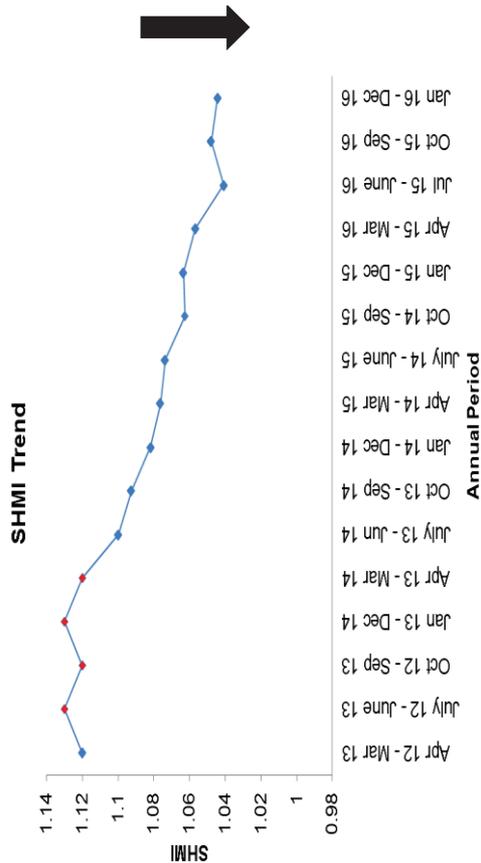
The latest Trust SHMI value as reported by the Health and Social Care Information Centre and Care Quality Commission has improved to 1.04 and is still within expected levels, as published in June 2017.

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.

Dr. Foster Indicative HSMR monthly Trend

SHMI Published Trend

Dr Foster Indicative HSMR rolling 12 month

	DFI Rebased on latest month Apr 16 – Mar 17 (Risk model Dec 16)
TOTAL	95.3 (CI 90.8 – 100.1)
Weekday	94.9 (CI 89.7 – 100.4)
Weekend	96.7 (CI 87.7 – 106.5)
Deaths in Low Risk Diagnosis Groups	67.3 (CI 39.2 – 107.8)

EFFECTIVE

Commissioning for Quality and Innovation (CQUIN)

The CQUIN scorecard incorporating the monthly metrics is in development and will be available for quarter 2.

For 2017-19, the Trust is expected to work towards achieving the following national schemes which will span 2 years in line with the Trust contract:

    I. NHS Staff Health and Wellbeing
    II. Proactive and safe discharge
    III. Reducing the impact of serious infections
    IV. Improving services for people with mental health needs who present to A & E
    V. Advice and Guidance (Year 1)/Preventing ill health by risky behaviours (Year 2)
    VI. Personalised care/support planning

In addition, the Trust is obliged to comply with Specialised Services CQUIN schemes where services are in place. Schemes for ELHT for 2017 being:

    * Improving HCV treatment pathways through ODNs
    * Medicines Optimisation (2year scheme)
    * Nationally Standardised Dose Banding Adult Intravenous SACT (2 year scheme)
    * Neonatal – Community Outreach Team

NHS England's (NHSE) Lancashire Area Team's (LAT) Public Health CQUIN for 2017/18 is building upon the 2016/17 breast screening scheme aimed at strengthening patient and public participation. The outputs of the CQUIN are to submit an agreed action plan in Quarter 1 and monitor implementation and outputs through remaining quarters.

The Quarter 1 submissions to CSU, Specialised Commissioning and NHSE LAT were made within timescales for schemes where evidence was due at Quarter 1. Feedback has been recieved from NHS England stating achievement on the Neonatal Community Outreach team CQUIN with further information requested on the Medicines Optimisation and Improving HCV treatment pathways through ODNs. Feedback on all other schemes is awaited as regards achievement/payment. Sepsis remains outstanding due to the data lag.

All CQUIN schemes have been assigned clinical and managerial leads and are managed by the divisional teams. Monitoring and updates are provided through the Trust's Clinical Effectiveness Committee and Contract and Data Quality Steering Group.

RESPONSIVE

A&E 4 hour standard % performance, including National average
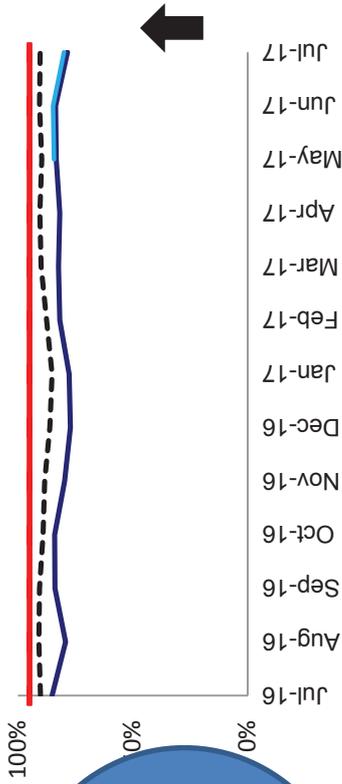
Overall performance against the ELHT Accident and Emergency four hour standard was reported as 81.1% in June and 78.5% in July, below the 95% threshold. The performance against the Pennine A&E Delivery Board four hour standard was reported as 84.7% in June and 80.0% in July
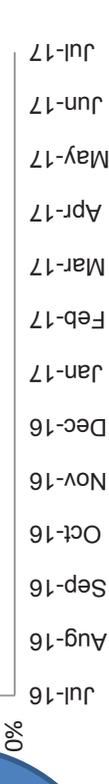
The number of attendances during the period was 36,193 and of these 29,769 were treated and left the department within 4 hours. (Pennine A&E Delivery Board)
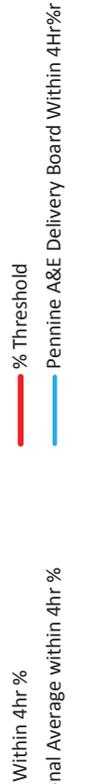
25 out of 138 reporting trusts with type 1 departments achieved the 95% standard on all types for June. (National data reported one month behind)

Chart legend:
- ELHT Within 4hr
- National Average within 4hr %
- % Threshold
- Pennine A&E Delivery Board Within 4Hr%r

Chart x-axis: Jul-16, Aug-16, Sep-16, Oct-16, Nov-16, Dec-16, Jan-17, Feb-17, Mar-17, Apr-17, May-17, Jun-17, Jul-17
Chart y-axis: 100%, 0%, 0%
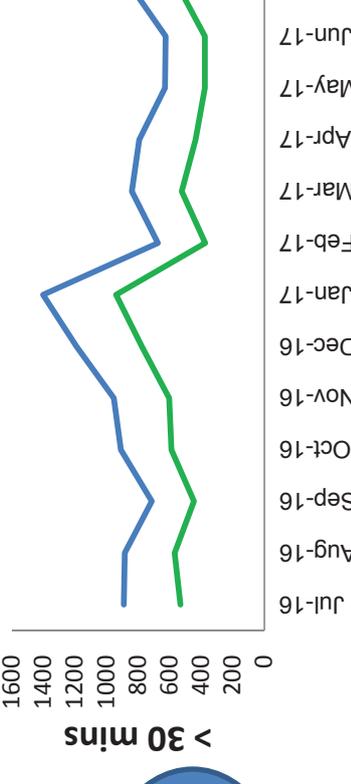
Handovers

There were 20 breaches of the 12 hour trolley wait standard from decision to admit during the period, 18 of which were mental health breaches. Mental Health demand and the timely availability of mental health beds remain an issue. 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 increased to 854 for July compared with 626 for June. During the period, 2962 handovers were within 15 minutes of arrival and a further 2515 were 15-30 minutes.

Chart legend:
- Over 30 Minutes
- HAS Confirmed Penalty Over 30 Minutes

Chart title: > 30 mins
Chart y-axis: 0, 200, 400, 600, 800, 1000, 1200, 1400, 1600
Chart x-axis: Jul-16, Aug-16, Sep-16, Oct-16, Nov-16, Dec-16, Jan-17, Feb-17, Mar-17, Apr-17, May-17, Jun-17, Jul-17
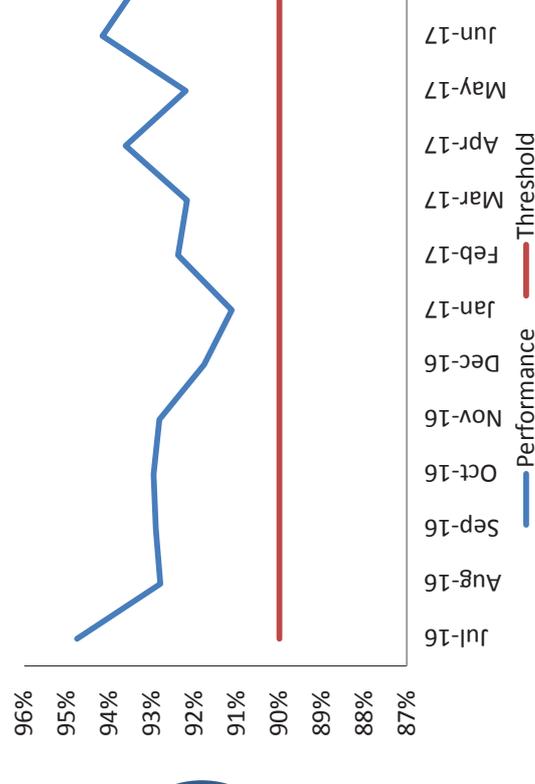
HAS Compliance

The validated NWAS penalty figures are reported for the period as;- 289 missing timestamps, 795 handover breaches (30-60 mins) and 135 handover breaches (>60 mins).

The ambulance handover compliance indicator measures the compliance with PIN entry on completion of patient handover. This was achieved at 94.2% in June and 93.3% in July, which is above the 90% threshold.

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

Chart legend:
- Performance
- Threshold

Chart y-axis: 87%, 88%, 89%, 90%, 91%, 92%, 93%, 94%, 95%, 96%
Chart x-axis: Jul-16, Aug-16, Sep-16, Oct-16, Nov-16, Dec-16, Jan-17, Feb-17, Mar-17, Apr-17, May-17, Jun-17, Jul-17
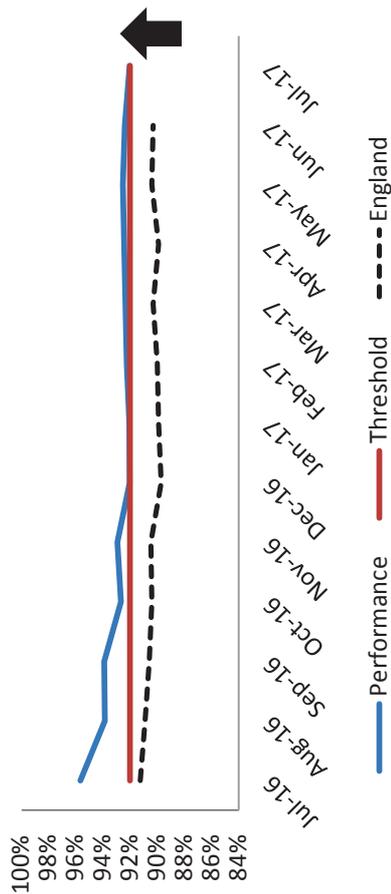
RTT Ongoing

The 18 week referral to treatment (RTT) % ongoing position has been achieved in June and July with 92.4% and 92.0% patients, respectively, waiting less than 18 weeks to start treatment at month end.

There was one patient waiting over 52 weeks at the end of June and two patients at the end of July. All have now been treated.

RTT Ongoing 0-18 Weeks
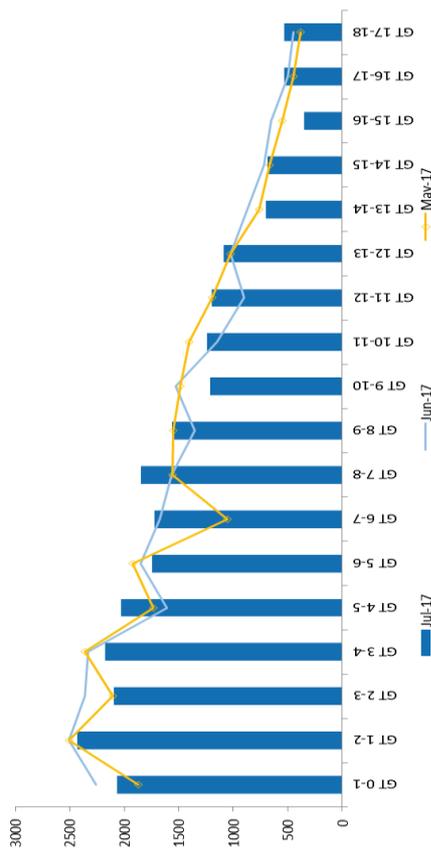
The total number of on-going pathways has marginally decreased in July to 27,405 from 27,407 in June. There has been an increase in patients waiting over 18 weeks at the end of July to 2185 from last month's 2087.

The median wait has increased slightly in July to 6.8 weeks from 6.6 in June.

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 a slight deterioration of the ongoing standard nationally (reported 1 month behind), with 90.3% of patients waiting less than 18 weeks to start treatment in June, compared with 90.4% in May.
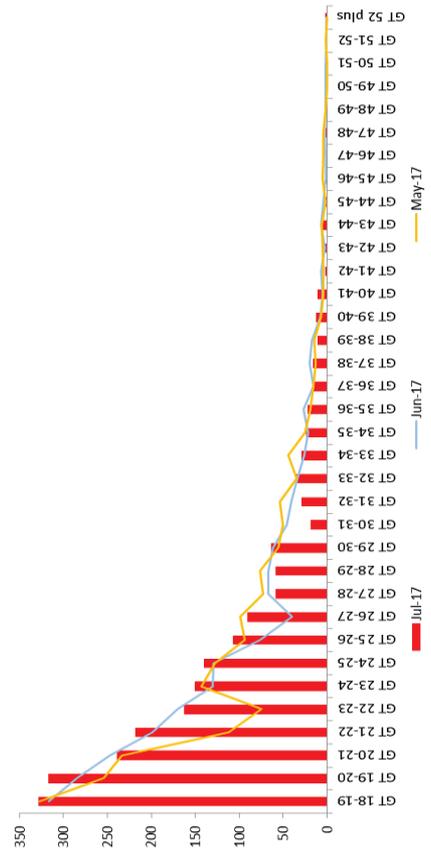
The cancer 2 week wait for GP referrals standard was acheived in June at 95.5%
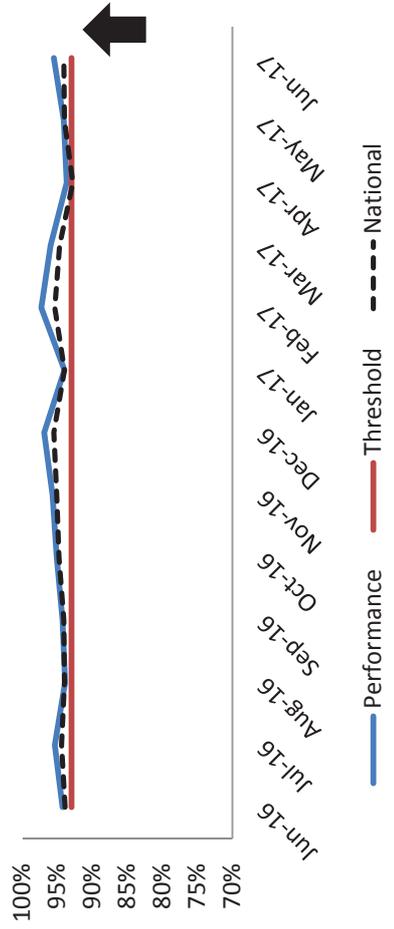
The 2 week breast symptomatic standard was met in June at 95.7%
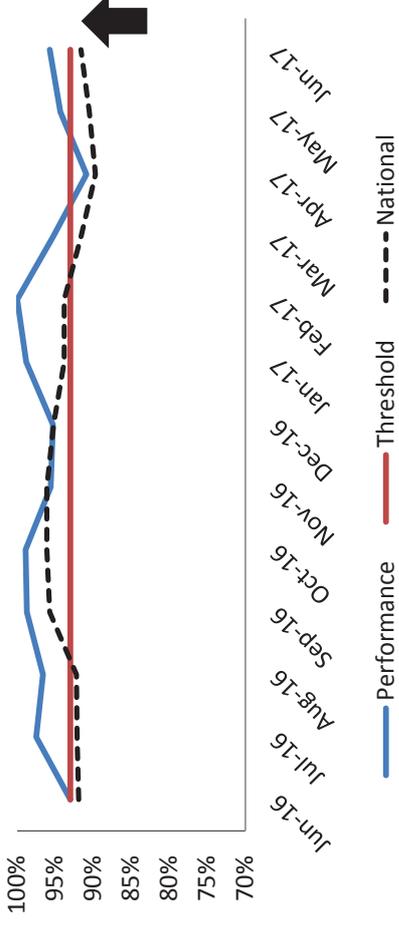
The 31 day target was acheived in June at 99.5%

Cancer 2 Week

Cancer 2 Week - breast

Cancer 31 day

RESPONSIVE
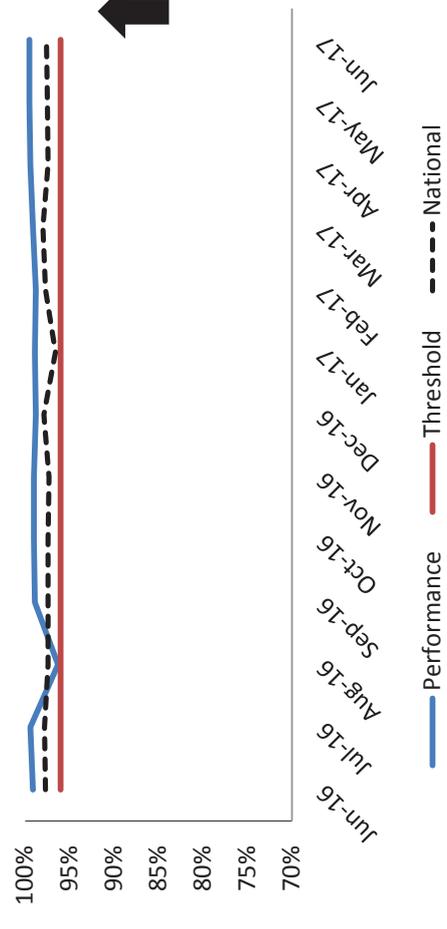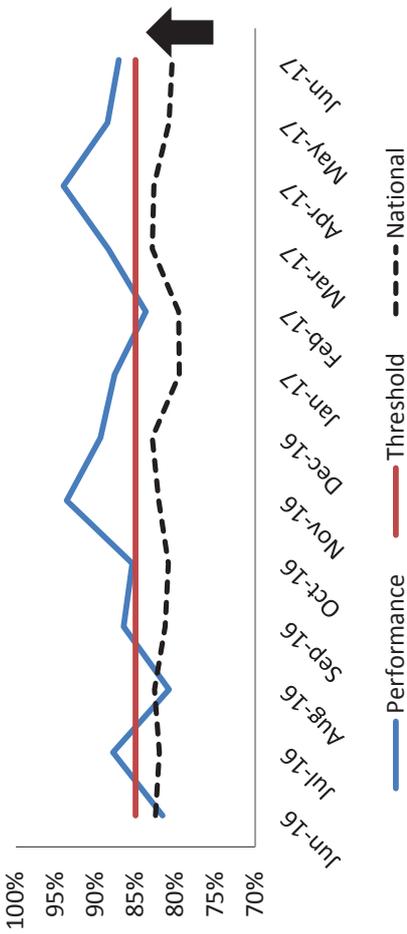
62 day performance was acheived in June at 87.1%
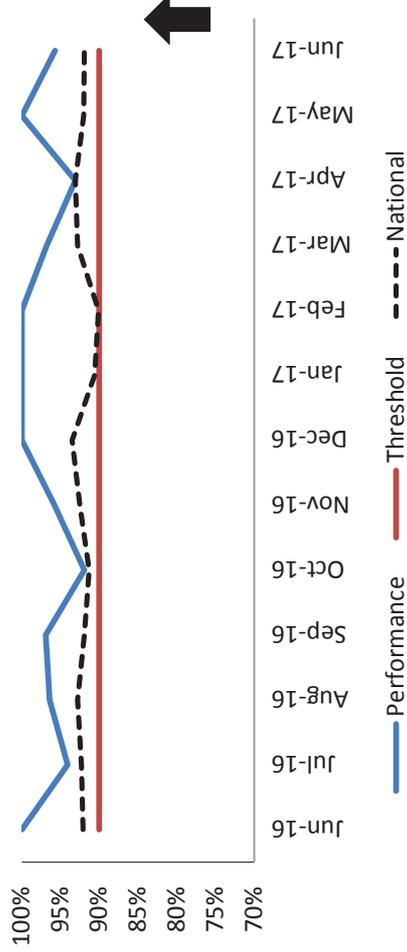
The 62 day consultant upgrade standard continued to be achieved in June at 95.7%
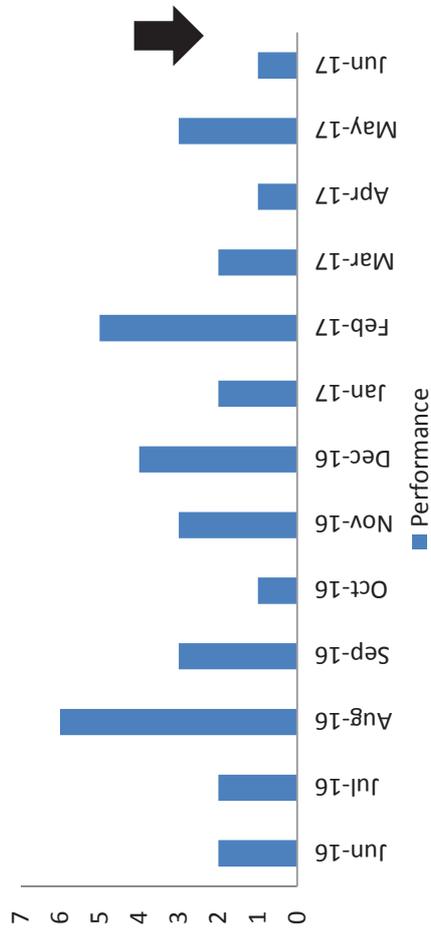
There was a patient treated after day 104 in June and this will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the Consultants involved in the pathway as required.

RESPONSIVE

62 Day Cancer

62 Day Consultant Upgrade

Cancer Patients Treated > Day 104

Delayed Discharges per 1000 bed days
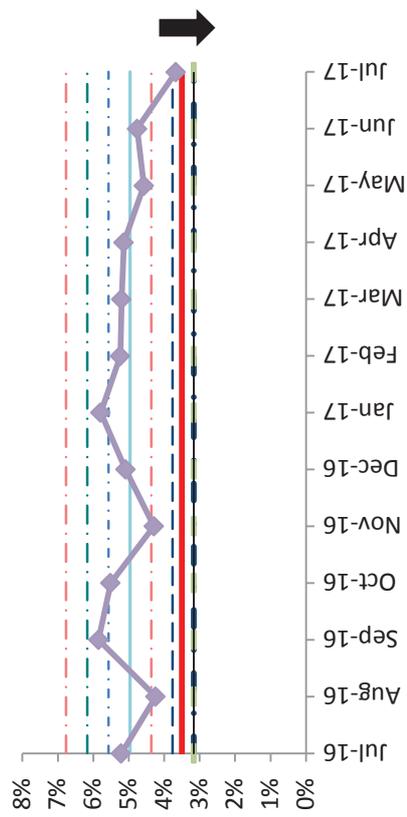
The number of delays reported against the delayed transfers of care standard has reduced iat the end of the period to 3.7% just above the threshold of 3.5%. This equates to an average of 30 beds lost per day. The top three reasons for the bed days lost due to delayed discharge are; 'Awaiting domicilliary package of care' (26%), 'Patient or family choice' (22%), Awaiting completion of assessment' (20%), 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
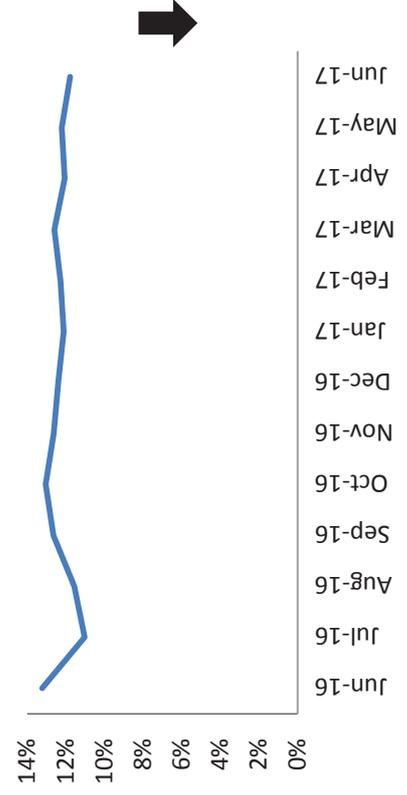
The emergency readmission rate has reduced from last month to 11.8% in June 2017 which has also reduced from 13.2% in June 2016.

Diagnostic Waits
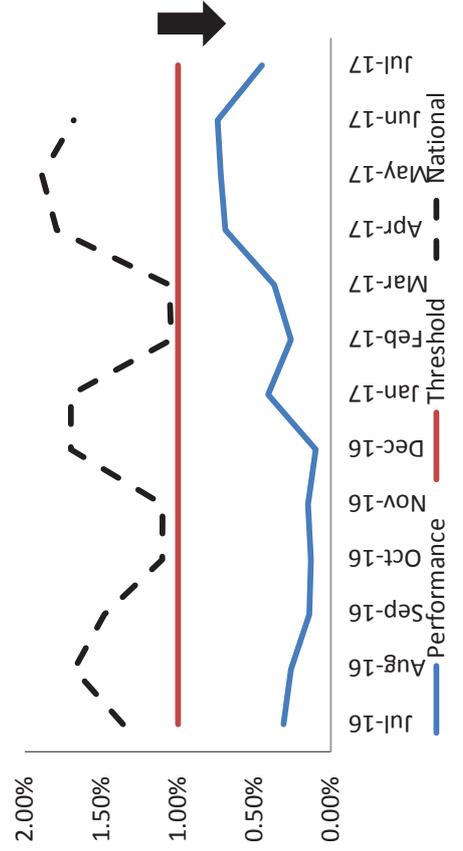
In June 0.7% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is within the 1% threshold. This had further reduced to 0.5% in July.

RESPONSIVE

RESPONSIVE

Average Length of Stay Benchmarking

Dr Foster Benchmarking April 16 - Mar 17

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	59,576	10,087	49,489	3.4	2.6	-0.8
Emergency	52,835	52,835	0	4.9	5.0	0.1
Maternity/ Birth	14,178	14,178	0	2.1	2.5	0.3
Transfer	197	197	0	10.9	34.3	23.4

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

Average Length of Stay

— Average LOS elective (excl daycase) — Average LOS non-elective
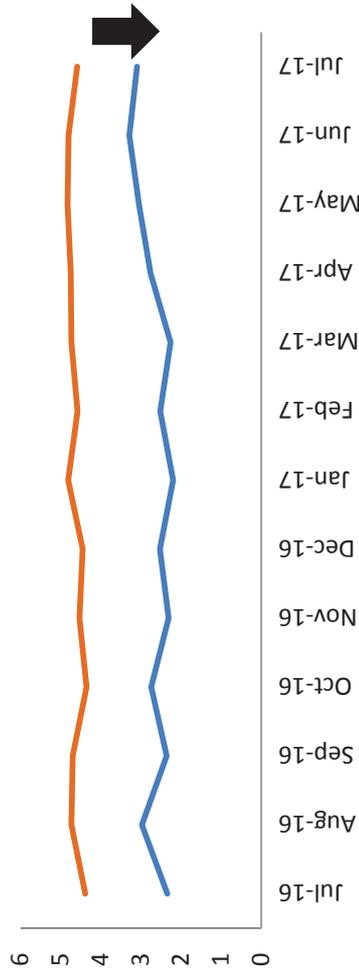
The Trust non elective average length of stay has reduced to 4.6 days in July, compared to 4.8 in June.
The elective length of stay (excluding daycase) has also reduced to 3.1 days from 3.3 last month.

Operations cancelled on day - 28 day standard

■ Not treated within 28 days of last minute cancellation due to non clinical reasons - actual

There was one 'on the day' cancelled operation not rebooked within 28 days in June. The procedure has now taken place and the full exception report will be reviewed through the Finance and Performance Committee.
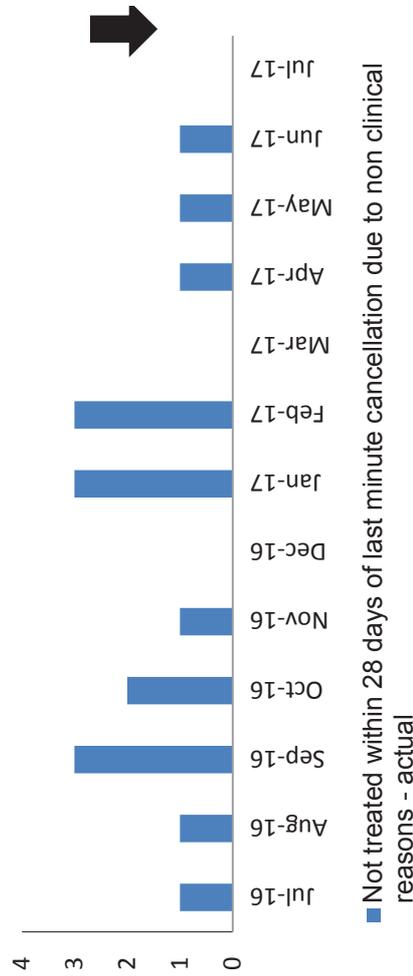
All 'on the day' cancelled operations were rebooked within 28 days in July.

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.
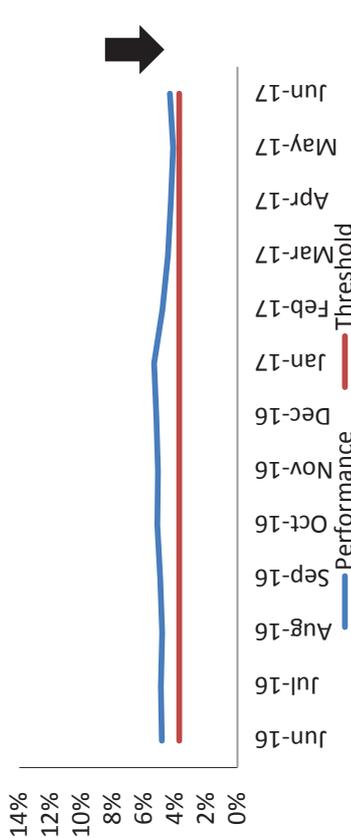
The sickness absence rate increased from 4.13% in May 2017 to 4.34% in June 2017. This is lower than the previous year (4.86%). Long term sickness currently stands at 3.07% and short term sickness at 1.27%

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 quarterley progress update will be provided to the Trust Board.
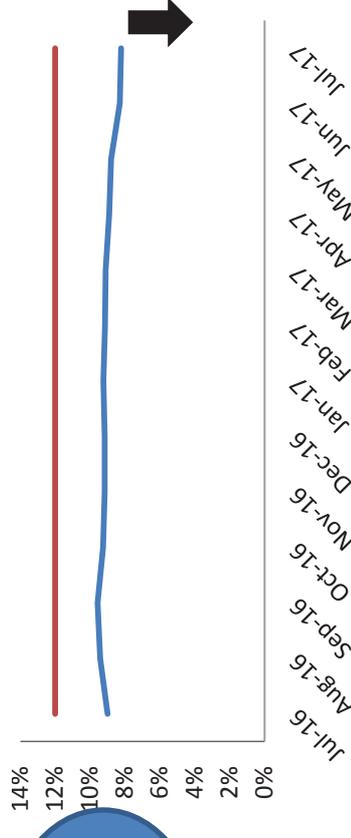
Overall the Trust is now employing 7094 FTE staff in total. This is a net decrease of 6 FTE from the previous month. The number of nurses in post at July 2017 stood at 2291 FTE which is a net decrease of 10 FTE since last month and a net increase of 237 FTE since 1st April 2013.

There are a further 108 nurses in the recruitment pipeline.

The vacancy rate for nurses now stands at 10.4% (265 FTE)

Sickness

— Performance — Threshold

Turnover Rate

— Performance — Threshold

WELL LED

**Vacancy Rate**

— Performance — Threshold

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 June 2017 the Trust spent £2,158,278 on bank and agency which increased slightly in July 2017 to £2,162,111. This was more than in July 2016 (£2,188,963)
Total expenditure to date for 2017/18 is £8,701,551

The appraisal rates for consultants and career grade doctors are reported cumulative year to date, April – July 2017 and reflect the number of reviews completed that were due in this period.
The consultant appraisal rate has increased on last month to 87%, along with an increase in the other medical staff appraisal rate to 97%.
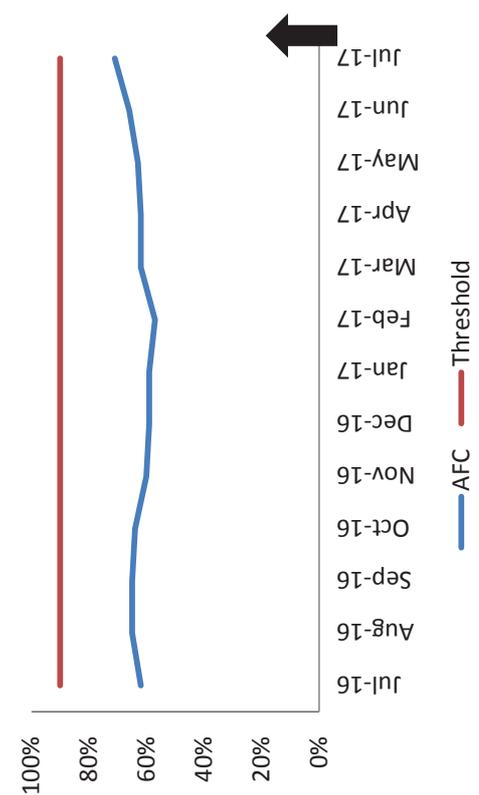
The AFC appraisal rates continue to be reported as a rolling 12 month figure and have increased in July to 71% from last month (66%), however is still below the threshold of 90%.
There has been a range of Trust wide actions to support compliance which are on-going. These actions are monitored through the Finance & Performance Committee.

WELL LED

Temporary costs and overtime as % total paybill

Legend: Temporary Staff — Threshold — Overtime

Appraisals, Consultant & Other Medical

Appraisal (Consultant)   Appraisal (Other Medical)

Appraisals AFC

Legend: AFC — Threshold

Job Plans

In April 2017 the Trust purchased an electronic job planning system (Allocate), which will ensure a consistent and fair approach to job planning which once embedded will be able to match job plans to the Trusts capacity and demand needs. Job Plans had been agreed prior to April 2017 ready for the roll out of e-Job Planning. During April to June the medical staffing department uploaded all existing job plans into the system ready for cascading to the departmental clinical directors, clinical leads and consultants. There are currently 265 job plans that have been uploaded. From June until August medical staffing have undertaken system software training on a one to one, small groups or at directorate/divisional meetings.

As of 1st September 2017, discussions should start to take place between consultant/s and Clinical Lead before job plans will be locked down and signed off as approved. With a new window period of job planning to commence in January 2018-March 2018, with the expectation that all job plans have been locked down by March 31st ready for the 2018/19 financial year.

Information Governance Toolkit
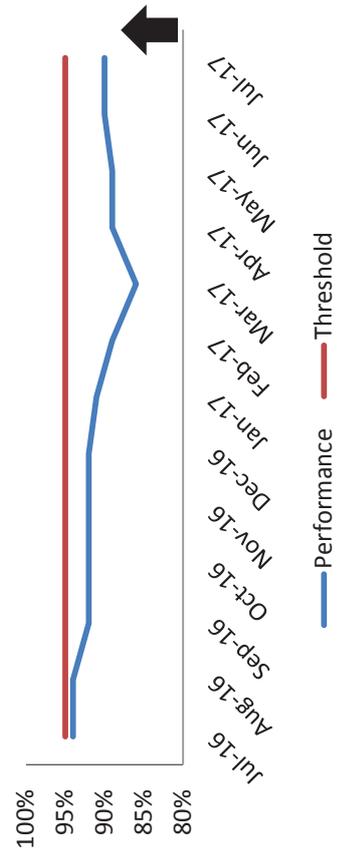
Information governance toolkit compliance has remained at 90% in July, below the 95% threshold.

Chart: Performance and Threshold, Jul-16 to Jul-17, y-axis 80%–100%.

Legend: — Performance — Threshold

Core Skills Training % Compliance

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%

Four of the eleven areas are currently below target for training compliance, with improvement seen 'Basic life support' and 'Prevent health wrap' training.

The Trust's mandatory training programme was audited by the Mersey Internal Audit Agency in October 2016, following previous reviews in 2013/14 & 2014/15, which had given a limited assurance opinion. The report gave a 'Significant Assurance' for the learning system but a 'Limited Assurance' of the mandatory training compliance levels. An action plan to address the findings and recommendations from this audit has been developed. Progress against the action plan is being monitored by the Trust's Audit Committee.

	Target	Compliance at end July
Basic Life Support	90%	83%
Conflict Resolution Training Level 1	90%	96%
Equality, Diversity and Human Rights	90%	97%
Fire Safety	90%	84%
Health, Safety and Welfare Level 1	90%	95%
Infection Prevention	90%	94%
Information Governance	95%	90%
Prevent Healthwrap	90%	88%
Safeguarding Adults	90%	92%
Safeguarding Children	90%	93%
Safer Handling Theory	90%	95%

Finance & Use of Resource metrics

Area	Metric	Actual YTD		Forecast outturn	
		Performance	Score	Performance	Score
Financial sustainability	Capital service capacity	1.6	3	1.4	3
	Liquidity (days)	(6.2)	2	(10.8)	3
Financial efficiency	I&E margin	(0.2%)	3	(0.2%)	3
Financial control	Distance from financial plan	0.0%	1	0.0%	1
	Agency spend	10.1%	2	24.0%	2
Total			**2**		**2**

Break Even Duty

Legend: Cumulative Variance — Performance — Threshold

Efficiency Savings

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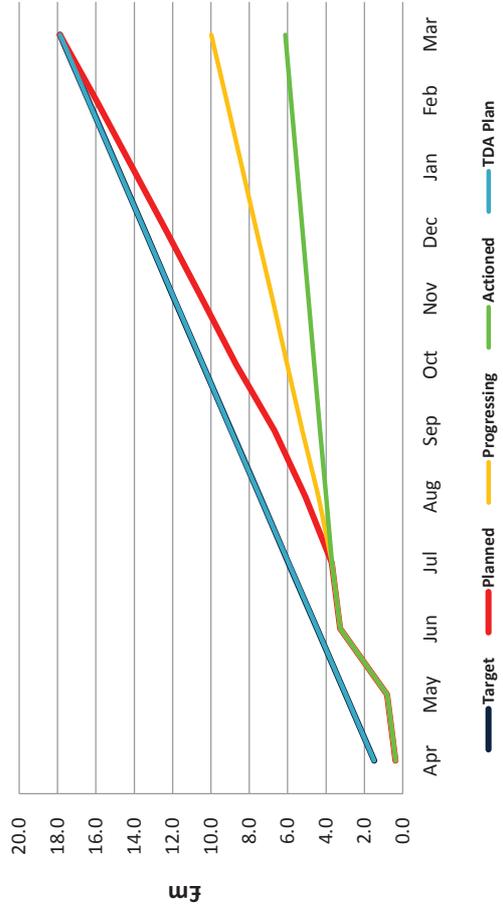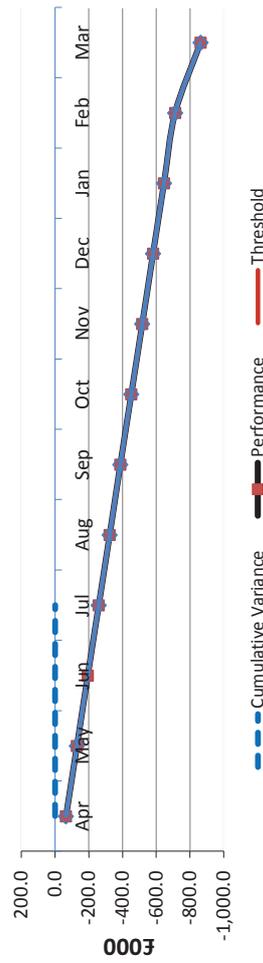
The Trust has a planned outturn position for 2017-18 of a deficit of £0.863m. This figure includes our notified non-recurrent STF allocation of £11.272m. Our control total for the year is a deficit of £12.135m, excluding the STF allocation. This is the figure that NHSI will monitor us against via the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

While we have seen expenditure pressures over the first four months of the year, we are reporting that we remain on target to achieve our control total.

These pressures are exacerbated by the Trust's current performance against target for four-hour A&E waits, which means that the Trust has missed out on £0.254m of its STF allocation for the first quarter. This remains a risk area for the Trust for the current and future quarters.

While the planned overall metric score for 2017-18 was limited to 3, mainly as a result of the planned £4.8m funding of the 2017-18 capital programme from cash reserves contributing to a liquidity rating of 4, the improvement in working capital that was achieved in 2016-17 means that an overall metric score of 2 is now forecast. The year to date position is also ahead of plan, with a lower than planned agency spend contributing to an overall score of 2, as well as the improved liquidity position.

The Trust has fully identified the SRCP schemes for 2017-18 at £17.8m. £6.1m of these schemes have been achieved to date. The position is reported in further detail in the Sustaining Safe, Personal and Effective Transformation paper.

Safe

	Threshold 17/18	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Monthly Sparkline
M64 CDIFF	28	4	1	5	5	4	2	3	2	0	2	4	3	2	
M64.1 Cdiff Cumulative from April	28	10	11	16	21	25	27	30	32	32	2	6	9	11	
M65 MRSA	0	0	0	0	0	0	1	0	0	0	0	1	0	0	
M124 E-Coli (post 2 days)	65	10	6	4	6	4	5	7	7	5	7	7	8	0	
M154 P. aeruginosa bacteraemia (total pre 2 days)											3	2	1	0	
M155 P. aeruginosa bacteraemia (total post 2 days)											0	0	0	0	
M156 Klebsiella species bacteraemia (total pre 2 days)											5	4	6	7	
M157 Klebsiella species bacteraemia (total post 2 days)											1	1	0	3	
M66 Never Event Incidence	0	1	0	0	0	0	0	0	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	0	
C28 Percentage of Harm Free Care	92%	99.4%	99.2%	99.1%	99.3%	99.2%	98.9%	99.1%	99.3%	99.3%	99.2%	99.0%	98.7%	99.7%	
M68 Maternal deaths	0	0	0	0	0	1	0	0	0	0	0	0	0	0	
C29 Proportion of patients risk assessed for Venous Thromboembolism	95%	99.4%	99.1%	99.0%	99.0%	98.5%	98.4%	98.7%	98.4%	97.2%	99.4%	99.2%	98.4%	0	
M69 Serious Incidents (Steis)		5	7	5	4	8	6	8	5	10	7	6	7	6	
M70 CAS Alerts - non compliance	0	0	1	2	0	0	0	0	0	0	0	0	0	0	
M146 Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80%	86%	85%	87%	90%	90%	90%	90%	89%	89%	90%	91%	96%	90%	
M147 Safer Staffing - Day-Average fill rate - care staff (%)	80%	118%	126%	121%	123%	118%	112%	111%	114%	114%	116%	116%	114%	117%	
M148 Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80%	99%	98%	99%	101%	99%	97%	99%	99%	100%	100%	101%	99%	99%	

	Threshold 17/18	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Monthly Sparkline
M149 Safer Staffing -Night-Average fill rate - care staff (%)	80%	136%	142%	138%	134%	130%	122%	127%	128%	125%	129%	128%	127%	127%	
M150 Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80%	0	15	21	21	9	5	5	7	11	6	6	3	2	5	
M151 Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80%	0	0	0	0	0	0	0	0	1	3	1	1	1	0	
M152 Safer Staffing - Day -Average fill rate - care staff- number of wards <80%	0	1	0	1	1	1	3	4	1	1	1	1	0	1	
M153 Safer Staffing - Night -Average fill rate - care staff- number of wards <80%	0	1	1	1	1	1	2	1	1	1	1	1	1	1	

Caring

	Threshold 17/18	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Monthly Sparkline
C38 Inpatient Friends and Family - % who would recommend	92.07%	98.5%	98.2%	98.4%	98.5%	97.7%	98.5%	98.1%	97.9%	97.0%	98.0%	98.4%	98.0%	97.7%	
C31 NHS England Inpatients response rate from Friends and Family Test		47.7%	51.2%	43.3%	43.2%	40.8%	51.2%	53.2%	47.4%	47.0%	49.4%	48.2%	43.1%	49.5%	
C40 Maternity Friends and Family - % who would recommend	91.86%	95.8%	97.0%	97.8%	97.3%	96.2%	98.3%	97.4%	97.9%	96.9%	96.2%	98.4%	98.9%	98.0%	
C42 A&E Friends and Family - % who would recommend	74.90%	75.0%	73.9%	75.8%	76.7%	75.7%	76.1%	76.0%	81.8%	79.6%	75.9%	78.3%	78.1%	74.6%	
C32 NHS England A&E response rate from Friends and Family Test		20.5%	21.5%	21.1%	20.8%	17.9%	19.1%	21.3%	21.2%	22.1%	20.9%	20.0%	16.8%	18.6%	
C44 Community Friends and Family - % who would recommend	88.62%	93.6%	94.3%	93.1%	92.5%	92.8%	92.8%	91.9%	93.1%	92.8%	93.1%	92.9%	95.8%	96.5%	
C15 Complaints – rate per 1000 contacts	0.4	0.2	0.3	0.2	0.2	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.2	
M52 Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Effective

		Threshold 17/18	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Monthly Sparkline
M73	Deaths in Low Risk Categories - relative risk	Outlier	81.1	85.1	82.7	86.5	82.7	91.6	75.9	65.0	95.4					
M74	Hospital Standardised Mortality Ratio - Weekday (DFI Indicative)	Outlier	96.3	97.7	97.0	98.7	95.6	96.2	94.7	95.6	94.9					
M75	Hospital Standardised Mortality Ratio - Weekend (DFI Indicative)	Outlier	98.3	97.7	98.3	97.0	99.1	99.4	97.8	98.1	96.7					
M54	Hospital Standardised Mortality Ratio (DFI Indicative)	Outlier	96.8	97.7	97.4	98.3	96.5	97.0	95.5	96.2	95.3					
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Outlier		1.05		1.04										
M159	Stillbirths	<5	5	3	7	1	4	1	3	3	1	1	2	3	4	
M89	CQUIN schemes at risk	0			3		1	1			3					

Responsive

		Threshold 17/18	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Monthly Sparkline
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95%	85.2%	79.3%	83.9%	84.1%	79.8%	77.3%	77.8%	81.9%	82.4%	81.8%	83.3%	83.6%	78.5%	
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95%	85.2%	79.3%	83.9%	84.1%	79.8%	77.3%	78.8%	82.8%	83.4%	82.7%	84.4%	84.7%	80.0%	
M62	12 hour trolley waits in A&E	0	7	9	2	3	3	0	16	7	5	1	5	13	7	
M81	HAS Compliance	90%	94.76%	92.80%	92.91%	92.96%	92.82%	91.77%	91.12%	92.39%	92.17%	93.62%	92.20%	94.16%	93.28%	
M82	Handovers > 30 mins ALL	0	891	884	714	909	954	1190	1402	674	840	793	629	626	854	
M82.ε	Handovers > 30 mins ALL (NWAS Confirmed Penalty)	0	533	569	446	590	604	776	940	376	524	436	377	378	552	
C1	RTT admitted: percentage within 18 weeks	95%	73.8%	79.0%	76.2%	78.1%	72.5%	75.3%	71.3%	70.7%	69.8%	68.4%	71.5%	71.4%	70.9%	
C3	RTT non- admitted pathways: percentage within 18 weeks	90%	93.8%	92.4%	92.0%	93.9%	92.7%	93.2%	91.3%	92.5%	92.0%	91.9%	94.3%	92.2%	91.8%	
C4	RTT waiting times Incomplete pathways	92%	95.7%	93.9%	93.9%	92.7%	92.9%	92.0%	92.0%	92.2%	92.3%	92.4%	92.5%	92.4%	92.0%	
C37.1	RTT 52 Weeks (Ongoing)	0	1	0	1	1	1	0	3	2	1	1	0	1	2	

Code	Indicator	Threshold 17/18	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Monthly Sparkline
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1%	0.3%	0.3%	0.1%	0.1%	0.2%	0.1%	0.4%	0.3%	0.4%	0.7%	0.7%	0.7%	0.5%	
C18	Cancer - Treatment within 62 days of referral from GP	85%	87.8%	80.8%	86.5%	85.4%	93.6%	89.4%	87.6%	83.7%	88.4%	94.0%	88.5%	87.1%		
C19	Cancer - Treatment within 62 days of referral from screening	90%	94.1%	96.4%	96.9%	91.9%	95.8%	100.0%	100.0%	100.0%	96.8%	93.1%	100.0%	95.7%		
C20	Cancer - Treatment within 31 days of decision to treat	96%	99.4%	96.3%	98.9%	99.0%	99.0%	98.8%	98.9%	98.8%	99.1%	99.4%	99.5%	99.5%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98%	98.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.7%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94%	97.7%	97.5%	94.3%	100.0%	94.7%	100.0%	95.9%	100.0%	95.3%	95.7%	100.0%	95.5%		
C24	Cancer - seen within 14 days of urgent GP referral	93%	95.4%	93.9%	94.3%	95.1%	95.7%	96.9%	94.0%	97.3%	96.0%	93.7%	94.1%	95.5%		
C25	Cancer - breast symptoms seen within 14 days of GP referral	93%	97.5%	96.6%	98.7%	98.9%	95.6%	95.3%	98.8%	100.0%	95.3%	90.9%	94.3%	95.7%		
C36	Cancer 62 Day Consultant Upgrade	85%	90.5%	82.4%	92.0%	83.3%	95.6%	94.1%	93.6%	89.3%	94.4%	93.3%	94.2%	96.8%		
C25.1	Cancer - Patients treated > day 104		2	6	3	1	3	4	2	5	2	1	3	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	1	1	3	2	1	0	3	3	0	1	1	1	0	
M55	Proportion of delayed discharges attributable to the NHS	3.5%	5.5%	4.5%	5.8%	5.5%	4.3%	5.1%	5.8%	5.2%	5.2%	5.1%	4.6%	4.8%	3.7%	
C16	Emergency re-admissions within 30 days		11.0%	11.6%	12.7%	13.1%	12.6%	12.4%	12.1%	12.3%	12.6%	12.1%	12.2%	11.8%	11.1%	
M90	Average LOS elective (excl daycase)		2.3	3.0	2.4	2.7	2.3	2.5	2.2	2.5	2.3	2.8	3.1	3.3	3.1	
M91	Average LOS non-elective		4.4	4.7	4.7	4.4	4.5	4.5	4.8	4.6	4.7	4.8	4.8	4.8	4.6	

Well led

Code	Indicator	Threshold 17/18	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Monthly Sparkline
M77	Trust turnover rate	12%	9.0%	9.4%	9.6%	9.3%	9.2%	9.2%	9.2%	9.1%	9.1%	8.9%	8.8%	8.3%	8.2%	
M78	Trust level total sickness rate	3.75%	4.9%	4.8%	5.0%	5.1%	5.1%	5.2%	5.4%	4.8%	4.5%	4.3%	4.1%	4.3%	4.3%	
M79	Total Trust vacancy rate	5%	8.0%	7.3%	6.2%	6.1%	5.7%	6.7%	6.5%	6.5%	6.1%	6.4%	6.9%	7.2%	7.1%	

Metric	Trend														Target
M80.3 Appraisal (AFC)	(sparkline)	71.0%	66.0%	63.0%	62.0%	62.0%	64.0%	60.0%	59.0%	57.0%	59.0%	65.0%	65.0%	62.0%	90%
M80.3: Appraisal (Consultant)	(sparkline)	87.0%	86.0%	81.0%	80.0%	50.0%	94.0%	95.0%	96.0%	99.0%	45.0%	37.0%	28.0%		90%
M80.4 Appraisal (Other Medical)	(sparkline)	97.0%	90.0%	100.0%	67.0%	72.0%	99.0%	99.0%	94.0%	99.0%	61.0%	52.0%	45.0%		
M80.2 Safeguarding Children	(sparkline)	93.0%	90.0%	90.0%	89.0%	91.0%	93.0%	93.0%	90.0%	90.0%	92.0%	93.0%	91.0%		90%
M80.2: Information Governance Toolkit Compliance	(sparkline)	90.0%	90.0%	89.0%	89.0%	92.0%	92.0%	92.0%	91.0%	89.0%	86.0%	92.0%	94.0%	94.0%	95%
F8 Temporary costs as % of total paybill	(sparkline)	8%	8%	8%	9%	9%	10%	9%	8%	8%	11%	10%	10%	9%	4%
F9 Overtime as % of total paybill	(sparkline)	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
F1 Cumulative Retained Deficit for breakeven duty (£M)	(sparkline)	(0.3)	(0.2)	(0.1)	(0.1)	(2.1)	(2.4)	(2.7)	(3.0)	(1.5)	1.5	(1.5)	(1.2)	(0.8)	(0.8)
F2 SRCP Achieved % (green schemes only)	(sparkline)	34%	32%	28%	18%	75%	81%	87%	99%	101%	101%	74%	71%	59%	100.0%
F3 Liquidity days	(sparkline)	(6.2)	(5.5)	(5.0)	(5.2)	(6.6)	(6.9)	(7.1)	(7.1)	(6.1)	(6.3)	(6.2)	(5.8)	(5.5)	>(14.0)
F4 Capital spend v plan	(sparkline)	41%	32%	38%	42%	80%	76%	74%	67%	77%	85%	76%	75%	73%	85%
F16 Finance & Use of Resources (UoR) metric - overall	(sparkline)	2	2	2	2	3	3	3	3	2					3
F17 Finance and UoR metric - liquidity	(sparkline)	3	3	3	3	2	2	3	3	2					3
F18 Finance and UoR metric - capital service capacity	(sparkline)	2	2	2	2	4	4	4	3	3					3
F19 Finance and UoR metric - I&E margin	(sparkline)	3	3	3	3	3	3	3	3	2					3
F20 Finance and UoR metric - distance from financial plan	(sparkline)	1	1	1	2	1	1	1	1	1					1
F21 Finance and UoR metric - agency spend	(sparkline)	2	2	2	1	3	3	3	3	3					1
F12 BPPC Non NHS No of Invoices	(sparkline)	95.7%	96.3%	96.5%	96.2%	96.5%	96.6%	96.8%	96.8%	96.7%	96.2%	96.4%	96.3%	96.2%	95%
F13 BPPC Non NHS Value of Invoices	(sparkline)	95.1%	96.0%	96.1%	95.3%	96.5%	96.6%	96.8%	96.8%	96.7%	95.8%	96.2%	96.0%	95.8%	95%
F14 BPPC NHS No of Invoices	(sparkline)	95.2%	95.1%	95.7%	95.7%	97.0%	96.7%	96.3%	96.2%	96.2%	95.8%	93.4%	93.7%	93.7%	95%
F15 BPPC NHS Value of Invoices	(sparkline)	97.6%	98.2%	99.1%	99.1%	99.2%	99.2%	98.9%	98.7%	98.7%	98.6%	96.6%	97.0%	96.6%	95%

East Lancashire Hospitals
NHS Trust

TRUST BOARD REPORT

Item   **137**

13 September 2017

Purpose   Information

Title	Doctors' Revalidation Report and Statement
Author	Mrs C Schram, Deputy Medical Director Professional Standards
Executive sponsor	Dr D Riley, Medical Director

Summary: This report provides assurance to the Board that statutory requirements for Medical Appraisal and Revalidation are being met.

Recommendation: The Board are 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
Related to key risks identified on assurance framework	Recruitment and workforce planning fail to deliver the Trust objectives

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: NA

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East Lancashire Hospitals
NHS Trust

Annual Board Report Appraisal and Revalidation ELHT 2017

Executive summary

1.   This is the seventh annual report on doctors' appraisal to come to the Board, the fourth since Revalidation was introduced in 2012. This year, 2016.2017, was Year 4 of Revalidation, during which 17 doctors had a revalidation recommendation made at ELHT.

2.   As appraisal and revalidation for doctors is now well embedded at ELHT, this report follows an exception reporting format in contrast to previous years where the template provided for the Appraisal and Revalidation Annual Report in NHS England's Framework for Quality Assurance of Appraisal and Revalidation was mandated.

3.   There were 410 doctors with a prescribed connection to ELHT as their Designated Body (DB) in 2016.2017. These are Consultants, SAS doctors and Clinical Fellows. This number changes over the year as doctors start and leave. Doctors in training have a prescribed connection to Health Education Northwest (HENW) with the Postgraduate Dean as their Responsible Officer and are not included in this report.

Purpose of the Paper

4.   This report provides assurance to the Board that statutory requirements for Medical Appraisal and Revalidation of these doctors are being met. This allows the 'Compliance Statement' (see Appendix 1) to be signed off by the Board. NHS England requires the Compliance Statement to be submitted by 29.09.2017.

Governance Arrangements

5.   The organisational structures and responsibilities for medical appraisal and revalidation are described in detail in Trust policy HR46v3. This is due for review in December 2017. This policy covers roles and responsibilities, the organisation and governance of appraisal and revalidation as well as the process, inputs and outputs of the appraisal itself.

6.   A Peer to peer review of appraisal and revalidation systems for acute providers in Lancashire and South Cumbria was carried out between March and May 2017. This provided significant assurance about our processes and outcomes. (Appendix 2)

7.   We currently have 69 active appraisers (for 410 appraisees). On-going training and support to appraisers is through appraiser network evenings, and direct support from

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the Appraisal Lead and Appraisal Administrator. Appraisee support is provided on an individual level as necessary, with full resources available for support on MyL2P, the web based appraisal and revalidation system we use.

8. With appraisal now firmly embedded (see below for appraisal rates), as notified in last year's report, we have moved away from the time consuming quality assurance (QA) of every appraisal, to formal QA of 20% of appraisals. New appraisers have 3 appraisals QA'd and need to achieve a top score on 3 before sampling commences.

9. As it is now becoming more common for appraisers to appraise someone outside their own specialty (as accepted by GMC and NHS England), we have developed a 'Guideline for Specialty Specific Appraisals'. Whilst the GMC is clear about the six types of supporting information a doctor must provide at appraisal (CPD, Quality Improvement, Significant Events, Patient Feedback, Colleague Feedback, Complaints and Compliments), the specific information that a doctor will bring will vary. This will depend not only on the specific nature of the doctor's work, but also on the requirements of specialty and/or professional organisations, e.g. royal colleges, and on local agreements.

10. The guideline clarifies what is expected as supporting information for each specialty at ELHT.

Performance Data

11. The Annual Organisational Audit (Appendix 3) was submitted to NHS England in May 2017. In summary, table 1 summarises the position of medical appraisal on 31.03.2017.

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	No. prescribed connections	Completed appraisal 2016.2017	Approved incomplete/missed appraisal 2016.2017	Unapproved incomplete/missed appraisal 2016.2017	Total	% completed appraisal 2015.2016	% completed appraisal 2016/2017 national acute trusts	% completed ELHT appraisal 2015.2016	% completed ELHT appraisal 2014.2015	% completed ELHT appraisal 2013.2014
Consultants	275	269	6	0	275	**98%**	94%	95%	91%	94%
SAS doctors	130	124	6	0	130	**95%**	87%	88%	89%	91%
Temporary/short term doctors	5	4	1	0	5	**80%**	80%	86%	67%	73%
Total	410	397	13	0	410	**97%**	90%	93%	86%	91%

12.   Appendix 4 Summarises the reasons for the 13 approved/incomplete missed appraisals.

13.   Between 1.04.2016 and 31.03.2017 seventeen recommendations regarding revalidation were made to the GMC. The Table below shows the trends since revalidation commenced.

14.   Of note is that, similar to last year, numbers of doctors due for revalidation were low, in keeping with the GMC's requirement to revalidate all doctors with prescribed connection at the start of Revalidation in the first 3 years. This does mean that as it stands, 131 recommendations are due next year.

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Year	Cohort	No. of Recommendations	Recommend (%)	Deferral (%)	Non-engagement	Deferrals UK wide
Year 0: 2013	Clinical Leaders	30	30 (100%)	0		10%
Year 1: 2013.2014	Senior Doctors	85	82 (96%)	3 (4%)		16%
Year 2: 2014.2015	Mainly Consultants	127	109 (90%)	12 (10%)		16%
Year 3: 2015.2016	All	127	108 (85%)	18 (14%)	1 (0.7%)	17%
Year 4: 2016.2017	All	17	14 (82%)	3 (18)%	0	N.K.

15.   In 2016.2017 all recommendation bar one was made on time. One recommendation was a day late. This is thought to be due to a malfunction of the GMC recommendation website.

Recruitment and engagement background checks

16.   Provider Boards have an overseeing role in ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

17.   Vacancies for Medical Staff are advertised through TRAC, the Trust recruitment system that is built around the NHS Employment Check Standards (gold standard). The system prompts the administrator for certain checks throughout the process. This includes checks for identity (passport) and qualifications. As TRAC will not allow the administrator to progress with the recruitment if the documentation is not provided, no candidate can be employed without the correct documentation being received.

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18. When employing a doctor from an agency ELHT does not go outside of the Agency Framework. The agencies on the Framework are bound by the same employment checks, however, the medical staffing team double check all documentation received from the agency in the format of a compliancy check pack. This is held centrally on the Locum Inbox.

19. An additional employment check has recently been instigated, following advice from the GMC. Doctors who are new to the GMC register have an approved practice setting (APS) restriction on their registration until their first revalidation. This means that they cannot practise unless they have a prescribed connection to a designated body. If a doctor has an APS restriction, our employment services will ensure the doctor has an RO connection before adding them to a locum bank or issuing a zero hours contract.

Monitoring performance, Responding to Concerns and Remediation

20. ELHT HR policy 039 (v4) details the processes to be followed for the investigation, monitoring and response to concerns about a doctor's practice. The policy was reviewed last year, and following consultation with the LNC, a number of changes made regarding responsibilities, responding to claims, and conduct of hearings.

21. HR policy 66 v1.1 sets out the approach and processes for remediation and is due for review in January 2018.

Appendix 3 Annual Organisational Audit

2016-17 East Lancashire NHS Trust

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22.　Appendix 4 Audit of all missed or incomplete appraisals auditAppendix 5 Audit of concerns about a doctor's practice, summarises all performance concerns arising in 2015-2017, and includes a breakdown of ethnicity and gender. Statistically the numbers are too small to draw any significant conclusions. However, we will continue to monitor these numbers and at appointment of new consultants what additional support they might need, particularly if coming from a non NHS background.

Risk and Issues

23.　The peer review process referred to in paragraph 3 identified a number of challenges that were in common with the other acute providers in the region (and likely nationally):

a)　From an administrative point of view, management of doctors new to the NHS, doctors on short term contracts, and up to date information on starters and leavers,

b)　Timely information about doctors' performance from locum agencies, and information flows about concerns about doctors between Responsible Officers,

c)　'Governance' input into appraisals (complaints, incidents, claims) needs to improve. Current management systems (e.g. Datix) due not allow recording by name of 'implicated' employee. Consequently, data extractions by 'open field' mentions are often incomplete and/or erroneous.

24.　Common approaches to these challenges are in progress, through the RO and appraisal lead networks.

Recommendations

25.　The Board is asked to:

a)　Receive this annual report and note that it will be shared, along with the annual audit, with the higher level Responsible Officer at NHS England.

b)　Approve the 'statement of compliance' (appendix 1) confirming that the organisation, as a designated body, is in compliance with the regulations.

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Appendix 1 Designated Body Statement of Compliance

The Board of East Lancashire Hospitals NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   > Comments: Dr Damian Riley Executive Medical Director

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   > Comments: Yes, see Annual Report 2016.2017

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   > Comments: Yes, see Annual Report 2016.2017

4. Medical appraisers participate in on going performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   > Comments: Yes, see Annual Report 2016.2017

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   > Comments: Yes, see Annual Report 2016.2017

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   > Comments: Yes, see Annual Report 2016.2017

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   > Comments: Yes, ELHT policy HR 39

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

   > Comments: Yes, ELHT policy HR 46

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[1] Doctors with a prescribed connection to the designated body on the date of reporting.

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9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

> Comments: Yes, see Annual Report 2016.2017

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

> Comments: Yes, see Annual Report 2016.2017

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _   Signed: _ _ _ _ _ _ _ _ _ _
[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _

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[2] Doctors with a prescribed connection to the designated body on the date of reporting.

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Report following Peer Review of East Lancashire Hospitals NHS Trust Appraisal & Revalidation Processes

By

Lancashire Teaching Hospitals NHS Trust

Date of Review: 8th May 2017

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Report Authors: **Dr Geraldine Skailes (Lead Reviewer)**
                                    Lisa Eccles (Reviewer)

1.0 Introduction

The peer review process has been implemented across the north region with the aim of supporting designated bodies and reducing inconsistencies in revalidation processes.

Each designated body will undergo a peer review at least once in the revalidation cycle.

The process of peer review involves a review and sharing of good practice, making recommendations to the reviewee and the wider regional revalidation team on areas for improvement/opportunities for consistency.

2.0   Documents provided to the review team prior to the peer review

East Lancashire Teaching Hospitals (ELTH) provided Lancashire Teaching Hospitals (LTH) with a pack of pre-visit information which consisted of the following:

- Trust Annual Reports 2014-15 & 2015-16
- Appraisal Policy
- Policy for Responding to Concerns about Performance (HR39)
- ELHT Annual Organisational Audit 2014-15 and 2015-16

This information was reviewed by Lancashire Teaching Hospitals prior to the review and key themes were collated for further discussion.

3.0   Attendance at the Review

The following people attended the peer review:

Trust	Name and Title
Lancashire Teaching Hospitals (LTH)	Dr Geraldine Skailes (GS) Deputy Medical Director & Appraisal Lead
	Lisa Eccles (LE) Medical Workforce Manager
	Rhona Haslam (RH) Revalidation and Appraisal Manager
East Lancashire Hospitals (ELHT)	Mrs Catharina Schram (CS) Deputy Responsible Officer Deputy Medical Director - Professional Standards
	Mrs Uma Krishnamoorthy (UK) Clinical Lead for Revalidation and Appraisal Clinical Director to Medical Director's office
	Lynda Calverley (LC) Revalidation and Appraisal Administrator

4.0 Agenda

The agenda from the review was as follows:

1	Welcome and introductions	Dr Gerry Skailes
2	Short presentation of appraisal and revalidation at East Lancashire Teaching Hospitals NHS Foundation Trust (ELHT)	Mrs Krishnamoorthy
3	Review of documentation provided	All
4	Questions and Answers	All
5	Option to break for discussion with equivalent roles	All
6	Break to agree key points for initial feedback	LTHTR review team
7	Informal feedback	Dr Geraldine Skailes
8	AOB and timeline for report.	All

5.0 Summary of discussions

The next section of this report sets out the areas of discussion and comments made by the review team. Highlighted in bold italics are areas for consideration by the ELHT team.

Areas to consider and discuss	Comments
Doctors attached to the Designated body	ELHT had 412 doctors connected through GMC connect on the 31/03/2017. It was noted that Revalidation Recommendations - there were 17 revalidation recommendations made during 2015/2016, these were as follows: • Positive Recommendations - 17 • Deferrals - 0 • Non-Engagement - 0 There are 72 trained appraisers (completing 5-8 appraisals per year), The AOA comparator data for 2015/16 showed that ELHT were above the sector average for appraisal completion for all grades with a total of 92.5% of completed appraisals within 2015/16, the remaining 7.5 were classified as approved incomplete/missed. There were no non-engagers during this AOA period. It was noted that until March 2015 ELHT were unable to report on appraisals signed off within the 28 day period, but this had been resolved with the implementation of MyL2P.

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MyL2P Appraisal System	MyL2P was implemented in ELHT April 2015 for all medical appraisals and this has been a success to date.
	The system includes a checklist, developed by the ELHT Team (which MyL2P has since rolled out to other trusts throughout the country which is completed by the appraisee & appraiser. This checklist helps to ensure high quality of inputs and outputs - demonstrated through Audit of Appraisal output Quality Assurance outcomes. This has been shared at Regional Appraisal Lead Network as well as at the National Conference for Appraisal Leads in 2016 (Leeds).
	A monthly statement is generated from MYL2P by the revalidation administrator showing upcoming appraisals and this is used to monitor and remind clinicians of appraisals due.
	The Appraisal Administrator sends out individual quarterly status reports to all appraisers which details their appraisee activity/month due etc.
	The Appraisal Administrator also generates a four month forward report of all revalidations due, giving the status of each doctor in being revalidation ready
	It was noted by the review team that within the MyL2P system the RO was able to add relevant information documents and link to relevant guidance. To supplement this there is also a resources section on Intranet and on MyL2P for shared learning and this is updated regularly.
Quality Assurance and Training	It was noted that ELHT had established an effective QA process with up to April 2016 100% appraisal summaries being quality assured. As quality of appraisals had improved significantly, it had been agreed that only 20% of all appraisals completed would be QA'd from May 2016, as is the case with most Acute Trusts in the UK
	It was discussed during the review whether QA would focus on new appraisers to ensure they meet the requirements and have feedback following completing their first appraisal. New appraisers will have the first 3 consecutive appraisal completions reviewed in a detailed manner using Progress Tool with individual feedback provided by the Appraisal Lead. If the score is less than 14 or other issues are identified on QA review, then a 1:1 meeting is organised to support their future development. The detailed QA review would then continue until they reach the level where they can be included in the 20%.
	It was noted that a series of trust wide appraisal training workshops took place in 2015/2016 and more were planned for later this year from June 2017. All new appraisers Receive a

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	competency assessed training programme that the trust formally commissions every year from an external supplier. That supplier is Edgecumbe.
	In 2015/16 3 network/update sessions for appraisers held, it was noted that roughly half of appraisers attended each one of these, as noted in audit. The appraisal team had written to all appraisers individually in order to increase future attendance.
	The Appraisal Administrator produces a quarterly newsletter in conjunction with the Appraisal Lead and Deputy Medical Director for Professional Standards. This was shared regionally in 2014 & 2015.
	Appraisal Lead meets new consultants for face to face induction on A&R matters and an induction with the Appraisal Administrator (individual and group sessions) applies for all other grades.
Governance Data	The Appraisal Administrator is responsible for obtaining the governance information for upcoming appraisals. Once received the revalidation administrator forwards each doctor their individual governance data prior to appraisal meeting.
	Although this process was working, it was noted that this can be time consuming for the administrator.
	Dr Foster COB data, is provided for all consultants but not currently available for other grades as is the case throughout the UK.
	It was noted that ELHT had developed a standard template for doctors to complete if they work elsewhere (Letter of Good Standing). It was noted however that currently no governance information was forwarded to other organisations in such situations unless a doctor requests this. This challenge is not unique to ELHT and is a wider issue to be discussed at the central peer review meeting for provision of governance information for doctors visiting from other NHS Trusts.
Strengths Identified	There were a number of strengths identified within ELHT processes (see details under Quality Assurance and Training). Additionally:
	Committed Appraisers (68 active)
	Strong Leadership through the Revalidation Team and Clinical Leaders within the organisation
	Strong communication between the revalidation and appraisal team was noted and this includes regular meetings to ensure

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	processes are being adhered to.

The revalidation team work closely with a number of other core teams, including the governance, HR, Medical staffing, Learning hub and Post graduate medical education teams.

Development of specialty specific templates recently implemented

Proactive Approach to National Reports and NHS England updates.

Quarterly Report sent to appraisers listing appraisees and appraisal due date's supports ensuring appraisals are completed on time.

Implementation of a priming appraisal for doctors new to the UK which enables the new starter to become familiar with the appraisal process and enables the doctor to agree a PDP.

There is a good process within MyL2P for sharing RO Notes for doctors with concerns so that this can feed into appraisal.

There is a Standard Operating Procedure in place for appraisal team and Medical Staffing Team regarding the management of starters and leavers.

ELHT presents at regional and national forums for Appraisal Leads and ROs and are actively involved with Networks. |
| **Challenges Identified** | There were a number of challenges identified by ELHT, these included:

Lack of full time Administrator support for the process, it was noted that the current revalidation appraiser was not 100% allocated to this role over the four days per week worked as she also has diary scheduling and purchase order responsibility for an external management consultant.

Given that the current administrator is only Band 4 there is scope for the trust to strengthen and enhance this further with higher banding and added support

It was recognised that across the network there were variations in the band paid to administrators and the PA allocation given to appraisal leads, we felt this was something that could be discussed at the central peer review meeting.

Changes within the Medical staffing department had impacted on the timeliness/compliance of reports related to managing new starters and leavers despite the SOP in place. |

| | Changes within Governance Team & Team roles had impacted on receipt of data reports recently but this is expected to improve once the appointments to the role were in place. This was something the group felt may be discussed at the central peer review meeting. |
| | Increase in numbers of doctors new to the UK who had not undertaken the appraisal process before and therefore needed additional support from the Appraisal Administrator especially at year end. |

6.0   Informal Feedback provided on the day

Dr Skailes presented informal feedback at the end of the peer review meeting. She advised that the review team had been extremely impressed with ELHT's revalidation and appraisal systems and what had been demonstrated was that ELHT had very robust systems in place which had been developed over time.

Dr Skailes also noted that the Quality Assurance (QA) audit had shown a really good example of improving the QA process and this has allowed ELHT to now be more selective around numbers of appraisals QA'd and the move from 100% to 20% sampled at QA review..

Dr Skailes also recognised the impact of the implementation of the MYL2P system and in particular use of the checklist that was originally developed by the ELHT Team and subsequently rolled out to other trusts by MyL2P.

Dr Skailes stated the review team were very impressed and interested in the development of the specialty specific template at ELHT and recognised this as something which requires development at LTH and asked whether this could be shared.

Overall the review team felt that ELHT had demonstrated a huge amount of work to develop and maintain their revalidation and appraisal systems and the challenges identified were not unique to ELHT and these were being addressed as appropriate.

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NHS
England

Dr Mike Prentice
Revalidation Lead
NHS England
Quarry House
Quarry Hill
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PA Contact Details:
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Tel: 0113 825 3052
21 July 2017

Our Ref: 206
Publications Gateway Reference 06810

Dr Damian Riley
Responsible Officer
East Lancashire NHS Trust

Dear Dr Riley

Medical Revalidation Annual Organisational Audit (AOA) Comparator Report for: 206 - East Lancashire NHS Trust

I am writing to thank you for submitting a response to the NHS England 16/17 Annual Organisational Audit (AOA) exercise.

Please find enclosed a report that sets out your response to the exercise. The report also compares your organisation's submission with that of other designated bodies across England, both in a similar sector and nationwide.

The AOA exercise is designed to help designated bodies assure themselves and their boards (or equivalent management bodies) that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, and the arrangements for medical appraisal and responding to concerns, are in place and functioning effectively. Similarly, it provides a mechanism for assuring NHS England that the systems in place are functioning effectively and consistently.

In this the fourth year of the AOA, and the eighth consecutive year of monitoring medical revalidation, I am pleased to report a continuing upward trend, not only in the overall appraisal rate, but also the improvement of the system in general. I would like to thank you once again for your continued work to ensure that thorough revalidation and clinical governance processes are in place across the healthcare system.

On reviewing the results presented below, designated bodies should produce an action plan to address any development needs that are identified. If you need support in improving any element of your revalidation systems, your local revalidation team (contact details below) can help you.

Your higher level responsible officer	Dr Mike Prentice
Your local revalidation team's lead contact	Joanne Smith
Your local revalidation team's contact details	england.revalidation-north@nhs.net

Board-level accountability for the quality and effectiveness of these systems is important and this report, along with the resulting action plan, should be presented to the board, or an equivalent management body. Including the report in an NHS organisation's Quality Account is also good practice.

This letter has been sent to the responsible officer recorded in the AOA return at 31 March 2017. If you are no longer the responsible officer, please pass this report on to the new responsible officer immediately, or to the Chief Executive of the organisation. If there are any changes to notify, or you have any queries, please contact your local revalidation team.

Please note that for transparency and openness, your submitted AOA return will be shared with your higher level responsible officer and some elements of the return will be shared with the appropriate regulatory bodies.

A more detailed report including the anonymised results of all organisations involved in this AOA exercise will be published in the autumn.

I would like to take this opportunity to thank you for providing assurance to your higher level RO, and to NHS England, of your processes.

Further information on revalidation can be found at www.england.nhs.uk/revalidation

Yours sincerely

Dr Mike Prentice
Revalidation Lead
NHS England

cc: Your higher level responsible officer

cc: Your local revalidation team's lead contact

YOUR ANNUAL ORGANISATIONAL AUDIT

Analysis is based on the total of 821 returns from designated bodies (DBs) to the 2016/17 Annual Organisational Audit (AOA) exercise for the year ending 31 March 2017 which had been received by NHS England by 21 July 2017

The following information is presented as per your own AOA submission.

Name of designated body:	East Lancashire NHS Trust
Name of responsible officer:	Dr Damian Riley
Sector:	Acute hospital/secondary care non-foundation trust
Prescribed connection to:	NHS England (Regional Team - North)

Please note:

a) In some instances, data was not suitable for comparative reporting. In these cases your own response may be reported, but comparative data is not. An explanation is given for this within the report. If you require further information on these areas, please contact your local revalidation lead:

Joanne Smith at england.revalidation-north@nhs.net.

b) Only the questions asked are presented below. Please refer to AOA 2016/17 for the full indicator definitions if required.

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2016/17 AOA indicator SECTION 1: The Designated Body and the Responsible Officer	Your organisation's response Your organisation's response	Same sector: DBs in sector: 54 No. of DBs in same sector and (%) that said 'Yes'	All sectors: Total DBs: 821 No. of DBs in all sectors and (%) that said 'Yes'
1.4	A responsible officer has been nominated/appointed in compliance with the regulations.	Yes	54 (100.0%)	816 (99.4%)
1.5	Where a conflict of interest or appearance of bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?	Yes	This question is not applicable to many DBs	
1.6	In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.	Yes	52 (96.3%)	801 (97.6%)
1.7	The responsible officer is appropriately trained and remains up to date and fit to practice in the role of responsible officer.	Yes	54 (100.0%)	813 (99.0%)
1.8	The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.	Yes	54 (100.0%)	816 (99.4%)
1.9	The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.	Yes	54 (100.0%)	808 (98.4%)

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2016/17 AOA indicator SECTION 1 (cont.): The Designated Body and the Responsible Officer		Your organisation's response	Same sector: DBs in sector: 54	All sectors: Total DBs: 821
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
1.10	The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.	Yes	54 (100.0%)	813 (99.0%)
1.11	The governance systems (including clinical governance where appropriate) are subject to external or independent review.	Yes	53 (98.1%)	801 (97.6%)
1.12	The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation. (*including peer review, internal audit or an externally commissioned assessment)	Yes	47 (87.0%)	655 (79.8%)

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2016/17 AOA indicator

SECTION 2: Appraisal

2.1	Number of doctors with whom the designated body has a prescribed connection as at 31 March 2017	Your organisation's response No. of doctors (in organisation)	Same sector: DBs in sector: 54 Total no. of doctors (in SAME sector)	All sectors: Total DBs: 821 Total no. of doctors (across ALL sectors)
2.1.1	Consultants	275	15381	50102
2.1.2	Staff grade, associate specialist, specialty doctor	130	4084	11974
2.1.3	Doctors on Performers Lists	0	2	46345
2.1.4	Doctors with practising privileges	0	9	2377
2.1.5	Temporary or short-term contract holders	5	4495	17825
2.1.6	Other doctors with a prescribed connection to this designated body	0	153	6823
2.1.7	**Total number of doctors with a prescribed connection**	410	24124	135446

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Official

2016/17 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 54	All sectors: Total DBs: 821
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2017 who had a completed annual appraisal between 1 April 2016 – 31 March 2017**	Your organisation's response and (%) calculated appraisal rate	Completed appraisals (Measure 1a & 1b) Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	269 (97.8%)	93.6%	91.7%
2.1.2	Staff grade, associate specialist, specialty doctor	124 (95.4%)	87.5%	87.0%
2.1.3	Doctors on Performers Lists	N/A	50.0%	95.2%
2.1.4	Doctors with practising privileges	N/A	88.9%	87.4%
2.1.5	Temporary or short-term contract holders	4 (80.0%)	80.6%	78.8%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	86.3%	91.2%
2.1.7	**Total number of doctors who had a completed annual appraisal**	397 (96.8%)	90.1%	90.7%

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2016/17 AOA indicator SECTION 2 (cont): Appraisal	Your organisation's response	Same sector: DBs in sector: 54	All sectors: Total DBs: 821
	Approved incomplete or missed appraisal (Measure 2)		
	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1 **Number of doctors with whom the designated body has a prescribed connection on 31 March 2017 who had an Approved incomplete or missed appraisal between 1 April 2016 – 31 March 2017**			
2.1.1 Consultants	6 (2.2%)	3.5%	4.7%
2.1.2 Staff grade, associate specialist, specialty doctor	6 (4.6%)	6.6%	7.4%
2.1.3 Doctors on Performers Lists	N/A	50.0%	4.2%
2.1.4 Doctors with practising privileges	N/A	0.0%	10.3%
2.1.5 Temporary or short-term contract holders	1 (20.0%)	11.9%	12.6%
2.1.6 Other doctors with a prescribed connection to this designated body	N/A	8.5%	6.4%
2.1.7 **Total number of doctors who had an approved incomplete or missed appraisal**	13 (3.2%)	5.6%	6.0%

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2016/17 AOA indicator SECTION 2 (cont): Appraisal	Your organisation's response	Same sector: DBs in sector: 54	All sectors: Total DBs: 821
	Unapproved incomplete or missed appraisal (Measure 3)		
	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1 Number of doctors with whom the designated body has a prescribed connection on 31 March 2017 who had an Unapproved incomplete or missed annual appraisal between 1 April 2016 – 31 March 2017			
2.1.1 Consultants	0 (0%)	2.9%	3.5%
2.1.2 Staff grade, associate specialist, specialty doctor	0 (0%)	5.9%	5.6%
2.1.3 Doctors on Performers Lists	N/A	0.0%	0.6%
2.1.4 Doctors with practising privileges	N/A	11.1%	2.3%
2.1.5 Temporary or short-term contract holders	0 (0%)	7.5%	8.6%
2.1.6 Other doctors with a prescribed connection to this designated body	N/A	5.2%	2.4%
2.1.7 Total number of doctors who had an unapproved incomplete or missed annual appraisal	0 (0%)	4.3%	3.3%

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2016/17 AOA indicator SECTION 2 (cont.): Appraisal		Your organisation's response	Same sector: DBs in sector: 54	All sectors: Total DBs: 821
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
2.2	Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded.	Yes	This question is not applicable to many DBs	
2.3	There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group).	Yes	54 (100.0%)	799 (97.3%)
2.4	There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.	Yes	54 (100.0%)	801 (97.6%)
2.5	There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.	Yes	52 (96.3%)	793 (96.6%)
2.6	The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection.	Yes	54 (100.0%)	806 (98.2%)
2.7	Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.	Yes	52 (96.3%)	793 (96.6%)

2016/17 AOA indicator SECTION 3: Monitoring Performance and responding to concerns	Your organisation's response	Same sector: DBs in sector: 54	All sectors: Total DBs: 821
SECTION 4: Recruitment and Engagement	Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
3.1 There is a system for monitoring the fitness to practice of doctors with whom the designated body has a prescribed connection.	Yes	53 (98.1%)	809 (98.5%)
3.2 The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health and fitness to practice concerns) which is ratified by the designated body's board (or an equivalent governance or executive group).	Yes	54 (100.0%)	808 (98.4%)
3.3 The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.	Yes	53 (98.1%)	802 (97.7%)
3.4 The designated body has arrangements in place to access sufficient trained case investigators and case managers.	Yes	51 (94.4%)	765 (93.2%)
4.1 There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).	Yes	54 (100.0%)	813 (99.0%)

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2016/17 AOA indicator SECTION 5: Comments		Your organisation's response
5.1	Reasons for Approved Delays (Appraisals under Measure 2): 13	
	New to UK and first job in UK and appraisal within 3 months of joining ELHT: 3	
	Health Factors including maternity: 3	
	New starter and appraisal within 3 months of joining ELHT: 2	
	Sabbatical Career Break: 1	
	Holidays/Diary difficulty in scheduling appointment: 3	
	Other MHPS Investigation in progress: 1	

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Appendix 4 Audit of all missed or incomplete appraisals audit

Doctor factors (total)	Number
Maternity leave during the majority of the 'appraisal due window'	1
Sickness absence during the majority of the 'appraisal due window'	2
Prolonged leave during the majority of the 'appraisal due window'	2
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	6
New starter more than 3 months from appraisal due date	0
Postponed due to incomplete portfolio/insufficient supporting information	1
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factors (On-going investigation)	1
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
(describe)	
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

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Appendix 5 Audit of concerns about a doctor's practice 2016.2017

Audit Methodology: Analysis of 18 months of data (Dec 2015 to May 2017) on Doctors in Difficulty database: 72 cases

Data:
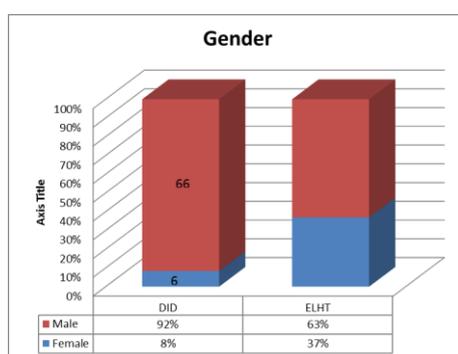
Ethnicity	DID no's	DID %	ELHT %
White - British	16	22%	35%
White - Any other White background	8	11%	10%
Mixed - White & Black African		0%	0%
Mixed - White & Asian		0%	1%
Mixed - Any other mixed background	1	1%	1%
Asian or Asian British - Indian	11	15%	20%
Asian or Asian British - Pakistani	16	22%	13%
Asian or Asian British - Bangladeshi	3	4%	1%
Asian or Asian British - Any other Asian background	6	8%	5%
Black or Black British - Caribbean		0%	0%
Black or Black British - African	3	4%	3%
Black or Black British - Any other Black background		0%	1%
Chinese		0%	2%
Any Other Ethnic Group	8	11%	3%

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NHS

East Lancashire Hospitals

Type

- capability
- conduct
- conduct and capability
- health

28%

3%

7%

63%

No's by grade

Concerns by Quarter

No's by specialty

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East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD REPORT
13 September 2017

Item	138

Purpose Information

Action

~~Monitoring~~

Title	Emergency Preparedness and Resilience Annual Statement
Author	Mrs B Mitchell, Emergency Planning Manager
Executive sponsor	Mr J Bannister, Director of Operations

Summary: This paper describes the current position of ELHT with regard to emergency preparedness and outlines the annual workplan for 2017/18.

It includes the Statement of Compliance with the NHS England Core Standards for EPRR Audit, which finds the Trust *Fully Compliant.*

Report linkages

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

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

Impact (delete yes or no as appropriate - if yes, give reasons)

Legal	**Yes**	Financial	**Yes**
Compliance with Health & Social Care Act 2012		Investment in resources will be required	
Compliance with Civil Contingencies Act 2004 and subsequent amendments			
Equality	No	Confidentiality	No

Previously considered by:

Emergency Preparedness and Organisational Resilience Committee, 6 September 2017

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Executive Summary

This paper summarises the current position of the Trust in relation to emergency preparedness and business continuity arrangements, incorporating information gained from an audit against the EPRR core standards supplied annually by NHS England.

It looks at how the Trust might improve practice, what it needs to commit in terms of resources and sponsorship to enable sustainable improvement and contains an annual work plan (at Annex C) to implement the required change.

Throughout the paper, effort has been made to identify the least disruptive, most effective changes to produce the maximum desired response.

The Core Standards annual audit for 2017/18 demonstrates a level of Full Compliance, which this Board is asked to ratify (Annex A).

Trust activity in EPRR over the preceding 12 months

1. Since the last annual report, there has been activity in this area of practice which describes a clear improvement process.

2. In 2013/14, the percentage of core standards complied with was 77%. Last year, it was 91%. This year we are declaring 100% compliance.

3. The Trust has substantially altered its approach to documentation of business continuity plans. The concept of discreet service level plans, creates in silos, containing detailed standard operating procedures for every eventually has been discontinued. Four major threats to the continuity of services have been identified:

   - Loss of staff
   - Loss of resources/systems
   - Denial of premises
   - Overwhelming demand for a service or services, impacting on delivery

4. A corporate business continuity plan, which outlines the organisation's strategy, is being created to link the EPRR workstream with overall organisational performance. The intention is to gain a better understanding of day to day activity, to inform the planning for response in the face of disruptive events.

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5. Once the planning programme has been fully developed, each Directorate, Division and Department will have contingency plans to deal with the most severe threats to continuity, as part of the Business Continuity Planning programme. Separately, key services, such as Emergency Department, Switchboard and Surgery/Critical Care, have their own specific Major Incident Response Plans, which form a foundation for the overarching Corporate Major Incident Plan.

6. 2017 saw a development in the governance arrangements for EPRR, designed to support the development and implementation of preparedness plans at every level of functioning. The Deputy Director of Operations is the Trust Lead on EPRR matters, reporting to the Accountable Emergency Officer. The Emergency Planning Manager (EPM) is the Trust subject matter expert on the development and implementation of plans and strategies.

7. Trust EPRR Plans are now consulted on and ratified by the Emergency Preparedness and Operational Resilience Committee, (EPORC - a strategic level group, chaired by the Trust EPRR Lead) which reports to the Operational Delivery Board. A sub group of the EPORC is the Organisational Planning and Resilience Group (OPRG), working at operational level to implement business continuity/contingency planning, via Divisional Lead staff, reporting to EPORC for governance purposes. The OPRG is in the process of establishing its workplan. Policies and protocols are owned/developed by departments and divisions, passing through Policy Council and subsidiary governance groups toward ratification.

8. Three exercises took place across the Trust in 2016/17, Starlight 3, 4 and 5, testing the major incident communication cascade arrangements. The Trust has robust communications in this area, as a result of commitment and hard work by the Switchboard Manager and her team.

9. The HazMat/CBRN decontamination arrangements in ED have also been tested per schedule and improvements to the system/repairs to equipment were effected as a result.

10. A training needs analysis of on call strategic/tactical level staff led to the creation of Information Guides relating to individual elements of Major Incident

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Management and a schedule of drop-in training sessions to refresh the knowledge and skills of these staff.

11. The Trust provided Loggist Training to staff from the Lancashire and South Cumbria CCGs at the request of NHS England.

12. Technological advances include updating of the Intranet page relating to Emergency Planning with more comprehensive information for Trust staff around preparedness. A SharePoint group for debriefing key staff has been established and was used successfully for debriefing from Winter Surge in 2016/17 and the Cyber Attack. Survey Monkey debriefing has been introduced for front line staff, it proved effective in first use. The debriefing developments allow lessons from experience to be quickly identified, in a safe environment which can support and signpost staff to resources as needed. It allows the use of face to face meetings to be targeted to their best effectiveness.

13. The Trust used the Command & Control system in response to the surge in demand following the 2016 Christmas/2017 New Year holiday period; they were also invoked for the standby request for support from the NHS in Manchester, following the terror attack in May 2017.

14. The national level Command & Control arrangements were invoked for response to the May 2017 WannaCry cyber-attack on NHS systems. As the attack escalated, the system was able to dynamically manage effects on critical systems and service delivery, with minimal cancellation of elective activity.

15. Command and control arrangements worked well on each occasion, providing the required level of coordination.

16. A detailed report, as provided to the CCGs, explaining how we meet the core standards, is annexed to this report (Annex B).

17. A report relating to the Deep Dive component of the annual audit may be found at annex D.

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Conclusion

18. The Trust is achieving its best ever level of compliance with the EPRR core standards.

19. We have a solid core of staff trained to respond in a major incident (on call directors, managers, clinicians, loggists and an operational CBRN cadre in ED).

20. Our biggest challenge is expanding on and supporting effectively the collaborative approach to resilience and business continuity needed to align the Trust with ISO 22301. This task requires ongoing commitment and increased resource to achieve success. Having a single subject matter expert (the EP Manager), without technical or clerical support, to deliver the necessary input at divisional and service level has an impact on this Trust's ability to deliver on this target in a timely fashion. The 2018 work plan incorporates a development of the EPRR team. NHS England and CQC will be monitoring this area of work very closely in near future.

Annexes:

Annex A	Emergency Preparedness, Resilience and Response (EPRR) Assurance 2017-18 statement of compliance.
Annex B	EPRR Core Standards assurance compliance narrative.
Annex C	Annual EPRR work plan for the Trust in 2018.
Annex D	NHS England deep dive audit around EPRR governance: questions and answers.
Annex E	Emergency Preparedness and Organisational Resilience Committee terms of reference.
Annex F	Organisational Planning and Resilience Group terms of reference.

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Emergency Preparedness, Resilience and Response (EPRR) Assurance 2017-18

STATEMENT OF COMPLIANCE

East Lancashire Hospitals Trust has undertaken a self-assessment against the NHS England Core Standards for EPRR (v5.0).

Following self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating the following level of compliance against the 2017-18 standards: **Full**

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with **one to five** of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed
Partial	Arrangements are in place however the organisation is not fully compliant with **six to ten** of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address **11 or more** core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as Red	Standards rated as Amber	Standards rated as Green
60	0	0	60
Acute providers: **60**** Specialist providers: **51**** Community providers: **50**** Mental health providers:**48**** CCGs: **38**			

Also includes HAZMAT/CBRN standards* applicable to providers: **Standards: *Acutes **14** / Specialist, Community, Mental health **7** **Ambulance Service are required to report statements for 3 compliance levels as stated on page 6 of the Gateway letter 06967**

Where areas require further action, this is detailed in the attached *EPRR Work Plan* and will be reviewed in line with the organisation's governance arrangements.

I confirm that the above level of compliance with the EPRR Core Standards has been or will be confirmed to the organisation's board / governing body.
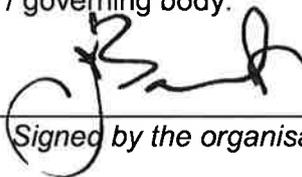
Signed by the organisation's Accountable Emergency Officer

15/09/2017	04/09/2017
Date of board / governing body meeting	*Date signed*

EPRR NHS England Core Standards Audit 2017/18 narrative for East Lancashire Hospitals Trust.

B Mitchell Emergency Planning Manager   July 2017

Introduction

1. In this year, we declare this Trust to be <u>fully compliant</u> with the 60 Core Standards which apply to acute hospital trusts and community service providers.

2. Plans, protocols, minutes of any group/committee meetings, debrief reports and training data are available on request to evidence this standard of compliance.

3. This does not mean that we do not have work to do in the coming year. We need to strive to maintain these core standards alongside developing robust business continuity and recovery arrangements, which will improve our overall organisational resilience.

4. This narrative details the evidence gathered to demonstrate that the core standards are met.

5. It will not take account of the Deep Dive questions for 2017/18; these standards will be covered in a separate paper, *Deep Dive Standards for 2017/18: Spotlight on Governance.*

Narrative: section by section

Governance and duty to assess risk: core standards 1-7

6. We have an Accountable Emergency Officer in our Executive Director of Operations, John Bannister, who is responsible for this agenda at a strategic level. We also have a committed lead on tactical and operational implementation for Emergency Preparedness, Resilience and Response (EPRR) in our Deputy Director of Operations, Tony McDonald.

7. Our Emergency Planning Manager is appropriately qualified and experienced to act as a Subject Matter Expert on EPRR and ISO 22301, advising and supporting the development of robust arrangements at all levels of Trust activity.

8. In the year 2016/17, East Lancashire Hospitals Trust (ELHT) faced several challenging incidents: repeated industrial action by the BMA Junior Doctors, a nation-wide cyber-attack on NHS IT systems with Trust wide impact on services and a request to be on standby to receive patients from the Manchester Arena bomb attack in May 2017. In preparation for the prospect of receiving casualties from the

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Manchester incident, we cleared 15% of our bed stock, including 33% of our ICU capacity, within twelve hours.

9. On each of these occasions, we responded by invoking the command and control structures detailed in the corporate major incident plan. Using this system of incident management, the risk to the organisation, its staff and patients was mitigated to the lowest level and the majority of core services were maintained. Our local CCG co-located their urgent care lead in our Incident Coordination Centre.

10. Following each incident, there was a full debrief, giving rise to lessons identified. From these, action plans were formulated and implemented, giving rise to the revision of plans and protocols.

11. We also exercise our communication arrangements for major incidents every six months, with the Starlight suite of exercises. Starlight 4 took place on 27 January 2017.

12. Table top exercises form part of the On Call staff annual training.

13. All learning is shared via the governance group for EPRR, the Emergency Preparedness & Operational Resilience Committee (EPORC), which reports directly to Board. There are terms of reference for this committee, detailing its aim, objectives, scope and membership.

14. All plans and protocols are subject to scrutiny by this committee and ratified as appropriate. All EPRR documentation is strictly version controlled.

15. The committee draws from all areas of the organisation at a tactical/strategic level. Our local CCG has ad-hoc membership of this governance committee.

16. Prior to June 2017, this function was fulfilled by the Emergency Preparedness Group. The EPG was restructured to give more robust governance and to facilitate the inclusion of business continuity in the EPRR agenda. Minutes for EPG/EPORG are available for scrutiny on request.

17. There is a sub-group (the Organisational Resilience Group-ORG) which is responsible for embedding EPRR culture; also for direct implementation and monitoring of business continuity arrangements.

18. *We believe that these arrangements make us compliant with Core Standards 1-7. Also, this evidence demonstrates part compliance with Core Standard 24*

Duty to maintain plans: core standards 8-21 and 24-29

19. The Trust has a corporate Major Incident Plan, which determines the strategic/tactical level of response. Divisions and departments have their own major incident response or incident contingency plans, which underpin the corporate plan, forming the basis of the Trust preparedness. These plans and procedures are being

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revised on a rolling programme, via the work of EPORC, to align with ISO 22301 (the current standard for business continuity).

20. The Trust has plans for the contingencies listed in core standard 24. However, all current planning (whilst recognising the need for bespoke planning in certain circumstances) follows the All Hazards Approach (Quantarelli 1985, *Organizational Behaviour In Disasters And Implications For Disaster Planning*).

21. The structure of the corporate major incident plan (MIP) lends itself to sub plans being integrated across the organisation and bound together in implementation by the MIP.

22. The planning process is linked to the organisation's risk profile, the Lancashire Resilience Forum risk register and conforms to all current legislation and recommended practice. Our plans are open to scrutiny by the CCG and other stakeholders.

23. The command and control structure for the Trust makes clear how a critical or major incident is declared and managed. Operational Pressure Escalation Levels (OPELs) are also considered in the identification and response to critical incident status. Departmental and Divisional level business continuity incidents would be determined by trigger points identified in the Divisional/Departmental plans.

24. The fire evacuation plan for the various sites identifies safe havens for patients and staff in case of evacuation. Plans are aligned to *Planning for the Shelter and Evacuation of people in healthcare settings Gateway Reference: 02810 (2014)*

25. There are robust links to the Trauma, Critical Care and Burns networks at regional level. Our plans take into account the structures put in place by the networks and mutual aid plans across the patch are currently being revised/ratified.

26. The various incidents during 2017 demonstrated that mitigation could be achieved using the strategies in Trust plans. Identification of critical functions and mitigation of associated risk was carried out in the response to all incidents. The nature of the incident determines the priorities of the response and recovery.

27. Following all incidents and exercises, a debrief takes place. There is a dedicated Microsoft SharePoint site on the Trust account aimed at debriefing Command Staff and Survey Monkey has proved successful in gathering the views of operational staff. Both of these measures are designed to be used, alongside live debriefing, in order to cause as little disruption to service delivery as possible.

28. Action plans are produced from debriefs after events or exercises and their progress monitored by EPORC.

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29. In 2017/18, the work plan will involve the revision of business continuity arrangements and gap analysis via exercising to reinforce and develop the level of cover.

30. There is an Incident Coordination Centre (ICC) set up at Royal Blackburn Teaching Hospital, based in Trust HQ. There are clear instructions for staff to commission and run the ICC, with particular emphasis on set up, roles and available equipment. Action cards are located in the MIP.

31. All plans are prepared with the requisite consideration for legislation and good practice. The Cabinet Office *Expectations and indicators of good practice set for category 1 and 2 responders (2013)* informs planning, alongside the LRF plans and the county risk register.

32. As previously stated, consultation on plans is done via EPORC, where the CCG Emergency Planning Officer has an open ad-hoc membership.

33. Plans are revised every two years or in light of experience/legislation or guidance changes.

34. The Trust has in place an official visitors' access policy, which is the responsibility of the Communications Department. It details how visits by VIPs will be managed, including in the event of a visit pursuant to a major incident.

35. *We believe that these arrangements make us compliant with Core Standards 8-21 and 24-29.*

Command and Control (C2): core standards 30-36

36. The Trust operates a comprehensive On Call arrangement, pivoting on the key roles of Director On Call (DOC), Senior Manager On Call (SMOC) and Senior Clinician On Call (SCOC).

37. In the event of a major incident, the DOC assumes the role of Incident Commander, the SMOC becomes the Incident Manager and the SCOC performs a liaison role between the Tactical and Operational levels of command, enabling the Incident Commander to be fully aware of clinical priorities as the incident progresses.

38. Divisions and departments also operate on call rotas for key staff to ensure that the operational response is properly resourced.

39. The DOC, SMOC and SCOC staff receive training on an annual basis which is based on the NHS England core competencies and National Occupational Standards AA1, AA2, AA3, AG1, AG2, AG3.

40. The primary ICC is housed within the Royal Blackburn site, with contingencies to set up elsewhere being finalised in the year 2017/18.

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41. There is a comprehensive and regularly updated handbook for set up and operation, which is available in hard copy in the Major Incident Storeroom in Trust HQ, on the Intranet and on the common data drive, all accessible to on call staff.

42. The Major Incident Plan (corporate)-MIP- details the roles and activity required at a strategic/tactical level, including action cards for all roles.

43. Each Division/Department has their response plan, which is instigated on the declaration of an incident.

44. The Trust trains loggists and registers them with Public Health England. Loggists ensure that key decisions, actions and rationales are effectively recorded in a standard format.

45. The arrangement for compiling situation reports and for running command meetings is detailed in the MIP at Annex E & F.

46. Access to specialist advice would be via PHE/Toxbase (operational staff) and STAC (command staff). There is a trained cadre of staff at the Royal Blackburn site, with limited but valuable immediate working knowledge of the technical aspects of HazMat/CBRNe response. They have access by telephone to specialists on a 24/7 basis.

47. Specialist information relating to specific types of incident is regularly accessed from PHE sources online and posted strategically in the Emergency Department.

48. *We believe that these arrangements make us compliant with Core Standards 30-36.*

Duty to communicate with the public: core standards 37 & 38

49. The Trust has a communications strategy in place to deal with the role of warning and informing in the event of an incident.

50. This strategy covers the duty to warn and inform the public, as well as processes for ensuring our staff and patients are suitably supported, informed and reassured.

51. The Communications Team have arrangements in place to support our senior staff when dealing with the media; managing the media on site during an incident; working in conjunction with the Lancashire Strategic Media Cell and NHS England Regional Media personnel to ensure a consistent and accurate message across all outlets, including digital media.

52. Social media, email, text messaging, telephony and print media all form part of the Communication Strategy.

53. All communication activity during an incident and recovery period is appropriately recorded, by the responsible Communications Officer.

54. During the recent cyber-attack, when there was a short term failure of the telephone system and longer term disruption to data reporting systems and email, a range of

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communications options were employed. What's App groups for clinical, administrative and technical staff proved useful. Written briefings were prepared and copied for physical delivery to sites across the Trust footprint.

55. The Trust was able to communicate with external stakeholders via telephone and email within a short time, as key equipment was very quickly restored to accommodate this.

56. The Trust also has an analogue telephone line, independent of the switchboard and a satellite telephone which permits access to wi-fi. This is designed to give resilient communication with external agencies for our command staff in the most challenging of circumstances.

57. We believe that these arrangements make us compliant with Core Standards 37 & 38

Cooperation: core standards 40,41,42,45 & 48

58. This Trust is not directly active in the LRF, as this role is largely assumed by the Head of EPRR for NHS England (Lancashire & South Cumbria). We are in regular contact with NHS England and receive updates/exchange information, minutes and plans via the Head of EPRR as an intermediary.

59. We have mutual aid arrangements in place across the county, as well as agreements with the Trauma, Critical Care and Burns Networks around our capacity and status as a receiving hospital in the event of necessity.

60. We are actively engaged with other responders via the Local Health Resilience Partnership and have a designated Corporate Lead for EPRR.

61. We have and maintain a list of multi-agency contacts across the county for the purpose of seeking aid in an incident and for working together at the planning stage. We make full use of Resilience Direct as a communication tool across agencies.

62. The MIP contains detail (as does the training for senior on-call staff) of how the Trust supports NHS England and works with the CCG in both planning and response phases.

63. We believe that these arrangements make us compliant with Core Standards 40,41,42,45 & 48

Training & Exercising: core standards 49-52

64. We have a current training plan, an annual training needs analysis for senior staff and loggists.

65. Our ongoing exercising consists of regular communications exercises and table top exercises for senior staff.

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66. During 2016/17, we participated in a live EMERGO exercise and a pandemic flu exercise with other local providers and the CCG.

67. The work plan for 2017/18 will include increasing the frequency of communications exercises to quarterly and conducting wider scale/multi agency table top exercises.

68. Training and updating is offered on an annual basis to all on call staff and loggists. Training records are maintained by the Emergency Planning Manager.

69. *We believe that these arrangements make us compliant with Core Standards 49-52*

HAZMAT/CBRN RESPONSE CORE STANDARDS: core standards 53-66

Preparedness: core standards 53-57

70. In the event of an incident requiring decontamination of self-presenting cases, there is a specific protocol (ELHT/C117 Policy for the Treatment of Patients following Potential Exposure to CBRN (Chemical, Biological, Radiological, Nuclear) Contaminants). This would be used in conjunction with the Emergency Department Major Incident Response Plan and the Trust Major Incident Plan.

71. There is a cadre of CBRNe response trained staff in the ED staffing complement who are able to access and implement the protocols and plans.

72. A system of work for responding to a CBRNe incident and appropriate documentation is in place and managed by a Specialist Nurse Practitioner within the department.

73. As previously stated, ED have a cadre of trained staff on rotas to cover the department, with access to laminated action and protocol cards, which include the contact details for specialist advice from the local PHE centre.

74. Contact details for specialist advice are also held by the on call team in the ICC as a backup measure.

75. *We believe that these arrangements make us compliant with Core Standards 53-57*

Decontamination equipment: core standards 58-62

76. The specialist nurse practitioner with responsibility for the maintenance of CBRNe/HazMat equipment keeps records of checks. The data is held on ED and is open for inspection by the EP Manager on request.

77. The decontamination tent and associated equipment is inspected and maintained by the portering chargehand responsible for the erection of the equipment in an incident and is recorded.

78. There is a schedule of maintenance for the suits, tents, pumps, radiation monitors and other equipment. The tents were replaced in 2015. The suits are maintained to the schedule determined by their expiry dates. Two suits are currently in the process of being refurbished by Respirex. The RAMGENE monitors are maintained by Christie Hospital trust under a service level agreement.

79. The protocol for disposal of used PPE is per the NHS England guidelines of May 2014.

80. *We believe that these arrangements make us compliant with Core Standards 58-62*

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Training: core standards 63-66

81. The current HazMat/CBRN Lead was a member of 204 Field Hospital, Territorial Army until recently, has since updated their knowledge and skills on a North West Ambulance Service CBRN "Train the Trainer" course in 2016 and has also attended training at Pennine Acute Hospital Trust.

82. The Trust internal training programme is under regular review. It is based upon National Occupational Standards, current Department of Health guidance relating to both wet and dry decontamination and the JESIP IOR protocols. Our Infection Protection and Control Team are responsible for the fit testing and ordering of FFP3 masks. Our CBRN Lead in ED is responsible for Respirated Protective Equipment training.

83. The Trust has trained several staff in a dedicated CBRN cadre based in the Emergency Department, using the NWAS and the Pennine Acute training programmes.

84. Regular training of staff in reception areas to recognise and respond to the potential for a contaminated casualty forms part of the CBRN Lead's responsibility. All training is based on the Initial Operating Response (IOR) guidance.

85. *We believe that these arrangements make us compliant with Core Standards 63-66*

Conclusion

The Trust Accountable Emergency Officer declares Full Compliance with the EPRR Core Standards for 2017/2018.

Annual workplan 2017/18 East Lancashire Hospitals Trust Emergency Preparedness and Organisational Resilience.

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Improvement Plan 2017/18

Organisation: East Lancashire Hospitals Trust

Plan owner: Deputy Director of Operations and Trust EPRR Lead

Core Standard reference	Core Standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline

In 2017/18, as we have declared full compliance with the 60 core standards in the 2017 audit, we will be submitting an annual workplan which is not linked to the core standards.

However, we will also be working to maintain full compliance for 2018.

Annual workplan 2017/18 East Lancashire Hospitals Trust Emergency Preparedness and Organisational Resilience.

Proposed work plan to improve preparedness and resilience in 2018/19

Number	Action needed	Lead person responsible	Deadline
1	The Trust will develop a new corporate resilience (business continuity) strategy	T. McDonald/EPM	February 2018
2	All Divisions will develop a resilience (business continuity) plan which links to the overarching Trust strategy	Divisional General Managers	June 2018
3	All Divisions and Departments/Services/Wards will have an identified Resilience Lead	Divisional General Managers	December 2017
4	Templates and advice for completion will be submitted to Emergency Preparedness and Organisational Resilience Committee (EPORC) for discussion/ratification/distribution	T. McDonald/EPM	November 2017
5	The EPRR Team under the Deputy Director of Operations will be developed and supported to deliver on all aspects of the EPRR agenda over 2018/19	T. McDonald	April 2018
6	A Trust wide EPRR Training and Exercising calendar will be produced for 2018/19. This will include the quarterly frequency of the communication cascade Exercise Starlight	EPM	May 2018
7	The EPRR Team will report to Quality Committee bi-annually and Trust Board annually.	T. McDonald	ongoing

NHS England EPRR audit: Deep Dive Standards for 2017/18: Spotlight on Governance.

B Mitchell Emergency Planning Manager   August 2017

Questions and answers

1. The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a public Board/Governing Body meeting for sign off within the last 12 months.
   The annual submission of the EPRR report to the Trust Board each September documents the progress the Organisation has made in terms of the EPRR agenda and meeting the national core standards required by NHS England. We are compliant with this standard.

2. The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.
   This forms part of the Trust's annual report. We could improve our accountability by publishing a separate summary on the public website in 2018/19.

3. The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.
   The Trust Board needs to appoint a candidate to this role, to work alongside the Trust EPRR Lead and the Emergency Planning Manager.

4. The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function
   In previous years, the Emergency Preparedness Group fulfilled this function. It has recently been succeeded by the Emergency Preparedness and Organisational Resilience Committee, which reports to the Operational Delivery Board and drives the strategic development and governance of emergency plans and business continuity arrangements, meshing them with good practice in day to day operations.

5. The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group
   The Accountable Emergency Officer is the Director of Operations. He has delegated the Lead role in developing the EPRR agenda to the Deputy Director of Operations. However, he is briefed on the activity of the Committee and attends on an ad-hoc basis.

6. The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings.
   Once again, this function is overseen by the AEO but delegated to the Trust EPRR Lead, the Deputy Director of Operations. Regular attendance will be maintained by appropriate representatives at LHRP meetings throughout 2018/19.

Conclusion

The Trust is substantially compliant with the identified good practice suggested by these deep dive questions. However, work will take place in 2018/19 to recruit and retain a non-executive director to lead on emergency preparedness issues as well as developing the ELHT website to provide EPRR information to the public.

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**Emergency Preparedness and Organisational Resilience Committee
Terms of Reference version 1.2 (June 2017)**

1. Purpose

- To lead the Trust's arrangements for responding to, dealing with and recovering from major incidents or disruptive events impacting on service delivery.

- To provide a consultative body, ensuring that all stakeholders in the process contribute to the formulations of plans and guidance for dealing with major incidents or disruptive events impacting on service delivery.

- To align the Trust business continuity arrangements to the local and county health economy.

- To ensure that the Trust meets its statutory duties in relation to the Civil Contingencies Act 2004, the Health and Social Care Act 2012, Care Quality Commission Outcomes and the current NHS Operational Framework.

- To ensure the annual NHS England for Emergency Preparedness, Response & Resilience (EPRR) Core Standards Audit is completed involving all stakeholders and that the Trust remains compliant with these standards.

2. Aim

To lead, on behalf of the Trust, the implementation of emergency response and business continuity requirements of the NHS England Emergency Preparedness, Response & Resilience (EPRR) Guidance and ISO 22301, as it applies to this organisation.

3. Objectives

A. Lead the development and maintenance of an agreed and robust emergency plan, which conforms to current guidance and NHS England EPRR Guidance.

B. lead the development and maintenance of an agreed and robust corporate business continuity strategy, which conforms to current guidance and NHS England EPRR Guidance

C. Support the Trust to develop appropriate infrastructure and processes to implement the plans.

D. Ensure that the Trust emergency and contingency responses are robust and regularly tested, in line with NHS England EPRR Guidance.

E. Lead delivery and monitoring of arrangements for all staff to be aware of the roles and responsibilities for themselves and the organisation, in relation to the emergency and contingency plans.

F. Providing evidence to demonstrate that staff are adequately trained and prepared to implement plans at organisational, divisional and departmental levels, including out of hours and on-call arrangements.

March 31 2017 v 1.0

G. Coordinate the development of continuity plans for business areas and ensure their arrangements are congruent with the overarching corporate business continuity plan, aligned with ISO 22301.

H. Provide a forum for informing the Trust's plans for responding to hazards/threats; including support for the development of risk identification, notification, assessment and mitigation on a service specific basis. Contribute to the Corporate Risk Register as and when appropriate.

I. Act as a forum for sharing information and good practice about EPRR and Business Continuity across the wider Health Family.

J. Ensure a coordinated approach to incident management and business continuity across the organisation to meet business objectives in relation to emergency and continuity planning and Care Quality Commission Outcomes.

K. Act to formulate and agree strategy and plans prior to formal ratification by Trust Committees and the Board.

4. Membership

Core members:

Chair: Deputy Director of Operations, Lead for EPRR

Vice-Chair: Head of Patient Flow & Site Operations

Subject Matter Experts:
- Associate Director of Quality & Safety
- Emergency Planning Manager
- Estates & Facilities Division
- Performance & Informatics Division

Representative of Clinical Division Triumvirates:
- Diagnostic & Clinical Services Division
- Family Care Division
- Integrated Care Group
- Surgery & Anaesthetics Division

Ad-hoc members
Ad-hoc members will usually be SMEs from various functions, often invited by their DGM or the Chair. It is the responsibility of the person inviting an ad hoc member to notify the Chair in advance and ensure that the person receives the proper documentation to inform their attendance.

The following list is illustrative rather than exhaustive:
- HR representative
- Emergency Department representative
- Security Manager
- Procurement representative
- Infection Control representative

March 31 2017 v 1.0

5. Frequency of meeting

Bi-monthly. For review in twelve months

6. Reporting Framework

Accountable Emergency Officer to report quarterly to the Operational Delivery Board

Accountable Emergency Officer to prepare Annual Report for Trust Board

To oversee the Trust Operational Resilience and Planning Group

7. Structure

```
Trust Leads                          Meeting Structure
     |                                      |
Director of                          Board Level
Operations &                         Committees
Accountable                               |
Emergency Officer                    Emergency
     |                               Preparedness &
Deputy Director of                   Organisational
Operations & Trust                   Resilience
Lead for EPRR                        Committee
     |                                    |
  +-----+-----+                      Operational
  |           |                      Resilience &
Trust       Head of Patient          Planning Group
Emergency   Flow & Site
Planning    Operations
Manager
```
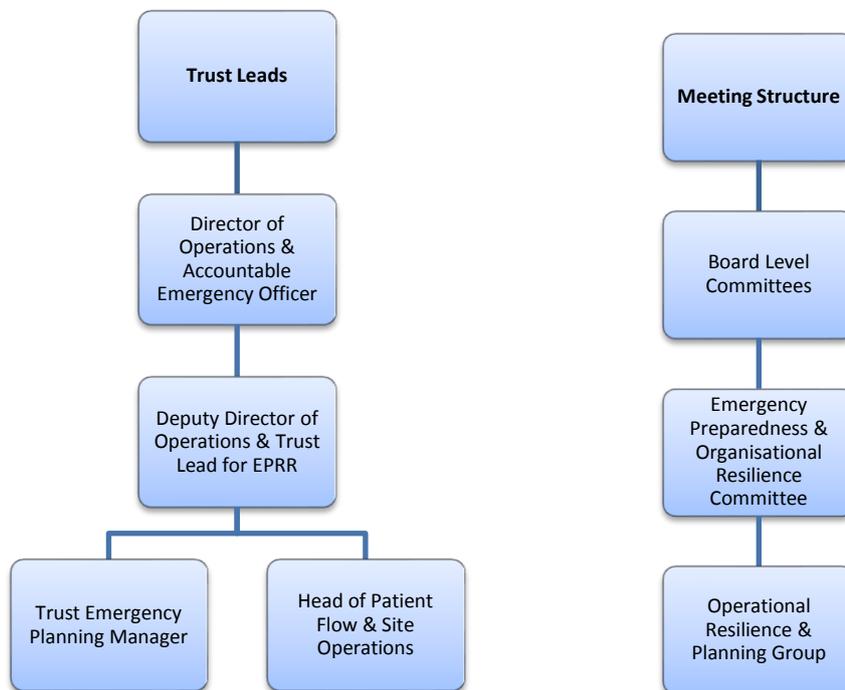
8. Secretariat

The secretariat will be the PA to the Deputy Director of Operations

9. Quorum

75% attendance at all meetings required throughout the year.

The group will be quorate when 25% of members are present, including Chair or Vice-Chair.

March 31 2017 v 1.0

OPERATIONAL PLANNING & RESILIENCE GROUP

TERMS OF REFERENCE – AUGUST 2017

1. **Purpose**

The primary purpose of the Operational Planning & Resilience Group is to formulate, oversee and review specific operational plans for key pressure periods as such as winter, bank holidays and festivals, along with a year round focus on organisational resilience and escalation planning. The group will report back through the ODB and Trust Board framework for governance and assurance purposes.

2. **Specific Objectives**

- To enable the development of robust cross-divisional operational and escalation plans

- To provide a bi-weekly peer support and review environment

- To provide assurance to the Trust Board regarding business continuity

3. **Membership, Frequency and Reporting Arrangements**

The following constitute the membership of this Group:

- Head of Patient Flow & Site Operations (Chair)
- Head of EBME and Operational Projects (Vice Chair)
- Emergency Planning Manager
- Head of Estates & Facilities
- Assistant Director of Performance and Information
- Medical Staffing Manager
- Human Resources representative
- Emergency Department representative
- Acute Medicine representative
- Surgery & Anaesthetics Division representative
- Family Care Division representative
- Adult Community Services representative
- Therapies Services representative
- Pharmacy Directorate representative
- Hospital Social Work Teams representative
- Patient Flow Team representative
- Infection Control Team representative
- Rota Co-ordinators – ICG & SAS (and Family Care where required)

Other relevant colleagues will attend by invite or on request.

Meetings will be held on a bi-weekly basis initially.

The group will report into the Emergency Preparedness and Organisational Resilience Committee (EPORC)..

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TRUST BOARD REPORT

13 September 2017

Item	**139**
Purpose	Information
	Assurance

Title	Audit Committee Update Report (July 2017)
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 meeting held on 3 July 2017.

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

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Impact

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Equality	No	Confidentiality	No

Previously Considered by: NA

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Audit Committee Update: 3 July 2017

At the meeting of the Audit Committee held on 3 July 2017 members considered the following matters:

1. The internal audit reports listed below were presented to the Committee, all of which received significant assurance from the internal auditors:

    a) Clinical Audit

    b) Financial Systems

    c) Sharps Management

    d) Governance Structures – Health & Safety

    e) Backlog Maintenance

    f) CQUINS

    g) Nursing Assessment Performance Framework

    h) Safeguarding

2. The Committee received the management response updates in relation to the following areas:

    a) Cyber Security Action Plan Update:

        i.   The original cyber security action plan had been superseded following the cyber-attack that took place on 12 May 2017.

        ii. Good progress was being made in relation to addressing the actions listed in the plan.

        iii. The Trust's patch management system has been revised as a result of the cyber-attack and software patches are now rolled out immediately rather than undergoing testing prior to roll out.

        iv. NHS Digital have provided a framework for self-assessment of cyber security and the Trust was working to ensure compliance with the framework by the end of August.

        Members felt that that assurance had been gained regarding the Trust's response to the recent cyber-attack and that the action plan was being completed in an appropriate timeframe.

    b) Sickness Absence Update and Policy Review

        i.   Members received an overview of 'Project Elevate' which is being run within the Integrated Care Group to reduce sickness absence.

        ii. Members received an overview of the work that was being carried out across the whole Trust, including better use of the sickness absence policy, training

for managers, better use of occupational health services and increased mediation facilities.

   c) Consultant Job Planning

      i. All consultants have their job plans uploaded to the Allocate software package planned and have received training on the system.

      ii. Between 1 September and 31 December 2017 the job plans will be reviewed and approved by the Medical Director.

      iii. All job plans will link into the business planning cycle.

3) The Committee received a progress report from the external auditors. The external auditors also presented the annual audit letter. Members approved the letter in principle and recommended the letter to the Board for formal approval. The letter was presented to the Trust Board meeting on 12 July 2017 and approved as required.

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 received the Counter Fraud Service Annual Report which summarised the investigations that had been undertaken in the year and those that had been carried forward into 2017/18. Members discussed the standards for the providers' self-assessment that was included in the report, particularly the two standards under 'holding to account' which were rated as amber.

6) The Committee received an overview of the Lancashire and South Cumbria Sustainability and Transformation Partnership (STP) governance proposal. Members received an update in relation to the STP landscape since the outcome of the General Election, including the drive for STP areas to progress towards Accountable Care System status in the future. The Committee discussed the potential issues around conflicts of interest by co-opting officers from a number of different organisations into the proposed structures. The Committee members suggested that clarity was required about whether Boards would be formally consulted on the proposal and whether amendments and suggestions could be requested.

7) The Committee received an overview of the recently revised national guidelines in relation to declarations of interest and the work that would be undertaken within the Trust to determine those staff members who would be required to make declarations on an annual basis. Members discussed the new guidelines in relation to

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acceptance of gifts of cash, vouchers and donations not being acceptable whilst small gifts were permissible. It was agreed that the Trust would be explicit in its policy in relation to what was and was not permissible. It was agreed that the section of the policy relating to requirement to publish the register of interests would be clear, as it was not explicit in the wording of the model policy document.

8) Members received the annual publication regarding the Trust's register of interests and noted that a group will be developed to oversee the implementation of the declaration of interests policy. Communication around the need to declare any interests, gifts, hospitality and sponsorship will be developed and cascaded across the Trust and will be particularly focused on medical and pharmacy staff. It was agreed that a verbal report will be presented to the next meeting regarding implementation of the new policy.

9) Members noted that the Quality Committee had been asked to oversee the improvements required in relation to the VTE assessments as highlighted in the recent qualified opinion of the Trust's Quality Account. It was agreed that the Committee would receive an update report on this matter at the next meeting.

10) The Committee also received reports in relation to the Board Assurance Framework Methodology; Committee Self-Assessment results and meeting and attendance review.

Kea Ingham, Company Secretarial Assistant, 2 August 2017

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NHS
East Lancashire Hospitals
NHS Trust

TRUST BOARD REPORT

Item **140**

13 September 2017

Purpose Information

Assurance

Title	Quality Committee Summary Report (July 2017)
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Ms N Malik, Committee Chair

Summary: The report sets out the summary of the Annual Report of the Infection Prevention and Control Committee and the Director of Infection Prevention and Control received by the Quality Committee at its meeting on 26 July 2017 and other matters discussed and decisions made at that meeting.

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

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failure to fulfil regulatory requirements

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Equality	No	Confidentiality	No

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Quality Committee Update: 26 July 2017

At the last meeting of the Quality Committee held on 26 July 2017 members considered the following matters:

1. The Committee received the Infection Prevention and Control Annual Report 2016/17, an overview of the report is provided below:

    a) The report summarises the work of the Infection Prevention and Control (IPC) Team during 2016/17, the progress made and the infection prevention and control challenges that have been faced by the Trust.

    b) All NHS Organisations must ensure that they have effective systems in place to control healthcare associated infections. The prevention and control of infection is part of the Trust's overall risk management strategy. Evolving clinical practice presents new challenges in infection prevention and control, which require continuous review. Emphasis is given to prevention of healthcare associated infections, the appropriate use of antibiotics and the improvement of cleanliness in the hospital.

    c) The Infection Prevention and Control Team took part in the NHS Improvement IPC Collaborative in 2016. A Prompt to Protect Campaign was devised as a quality initiative to improve hand hygiene and basic infection prevention practices. A video was produced and is included in the back to basics teaching package. There has been a 24% improvement in hand hygiene in the ward areas that have taken part in the campaign this year.

    d) The trajectory for Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemias for the year 2016/2017 was to have no more than 0 bacteraemias; the year end outturn attributable to the Trust was 1. The national target of MRSA screening for all eligible elective and emergency admissions has continued satisfactorily.

    e) The post 3 days trajectory target set for Clostridium difficile infections for 2016/2017 was 28 cases and the outturn was 32. This included the mandatory inclusion criterion for reporting all diarrhoea samples from patients aged two years and above and also diagnosis of Pseudomembranous colitis (PMC) by CT and endoscopy.

    f) The number of outbreaks due to Norovirus/diarrhoea and vomiting this year has decreased yet again with the number of patients affected/bed days lost also reduced. There has been one outbreak that resulted in the closure of two wards

to prevent further spread. This was due to the spread to five patients of highly resistant organisms (Carbapenemase –producing Enterobacteriaceae).

g) The Trust continues to work on the implementation of all current national initiatives to control hospital acquired infections. Work has continued to ensure compliance with the Care Quality Commission (CQC) standards and with the Health Act 2008. An Aseptic Non-Touch Technique (ANTT) program continued to improve and standardise aseptic technique throughout the Trust with special focus on updating staff assessments and groups, such as new starters. Presentations were made at various clinical audit meetings to educate and update on the importance of ANTT. ANTT is included in the Infection Prevention and Control section of the DVD and booklet for core skills training.

h) Staff mandatory training has changed from 1st April 2016 and now staff will complete infection prevention online training and quiz every three years with additional training as required if locally identified.

i) New starters now have 'essential to role' training such as ANTT and hand hygiene completed locally in the ward/department.

j) Hand hygiene remains pivotal to good infection control practice and every opportunity has been taken to re-enforce good practice. The "World Hand Hygiene Day" was held across both sites with stalls on main entrance, ward visits with Glo-box and '5 moments' leaflets given to staff on wards.

k) The Infection Prevention & Control Team has had significant issues with staffing through nursing vacancies/sickness and difficulties in recruiting to the vacant Consultant Microbiologist post.

l) The Consultant Microbiologists and the Antibiotic Pharmacist continue to work together reviewing guidelines and embedding the Antimicrobial Formulary (available on the intranet) across the Trust, with Grand Rounds and FY1/FY2 teaching. The antibiotic audits during increased incidence of C. difficile on wards continued. The Trust antimicrobial formulary continued to be reviewed in 2016/17 by the Antimicrobial Stewardship Committee.

m) The Junior Doctor's Antibiotic Audit was developed further and quarterly audits continued in 2016/17 with audit presentations in Medical Audit meetings and Grand Rounds. This information is disseminated via the Director of Infection Prevention and Control (DIPC) report to all Divisions, via the Divisional Audit Lead and presented at Infection Prevention Committee.

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n) Antibiotic Stewardship Programme continued to be pursued with weekly MDT Clostridium Difficile ward rounds, antibiotic audit ward rounds, Infection Prevention & Control Nurses and ward pharmacist notifications.

o) There has been an active audit programme to include environmental audits of clinical areas and compliance with the Hand Hygiene Policy. During 2016/17, Infection Control policies have been developed or reviewed to ensure they incorporate current best practices.

p) Cleaning and domestic services continue to deliver a high standard of hospital cleanliness and have received encouraging Patient Led Assessment of the Care Environment (PLACE) inspection reports.

2. Members noted that the Infection Prevention and Control Annual Report had been submitted to the Quality Committee before being formally considered at the Infection Prevention and Control Sub-Committee. The report has since been considered by the Sub-Committee approved with no changes.

3. The full Infection Prevention and Control Annual Report is available via the Company Secretariat.

4. The Committee received the Health and Safety Annual Report and noted the work being carried out in relation to 'safer sharps', fire safety and control of substances hazardous to health (COSHH). Members discussed the representation of staff side at the Sub-Committee meetings and whilst it was noted that the designated health and safety representative from staff side had been unable to attend the meetings, a general representative from staff side had been in attendance at meetings.

5. Members received the Fire Safety Annual Report and noted the progress being made in relation to the identification of fire wardens and completion of fire risk assessments. Members were provided with an overview of the recent information requests from NHS Improvement in relation to the use of cladding on buildings and noted that the Trust had been identified as presenting a low risk. This was noted to be because there are no buildings within the Trust owned estate that are over 18 meters high or have retrofitted cladding. The Committee received confirmation that the Trust is taking additional steps to engage with local fire and rescue services to ensure that buildings are as safe as possible in relation to fire safety.

6. Members received the Maternity and Paediatric Review of Nursing Staffing. Members noted the current and proposed workforce developments and received an overview of the current contracting agreement with the Commissioners for the

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payment of care throughout the maternity pathway. The Committee noted that active recruitment was being undertaken in these areas to increase the establishment.

7. The Committee received the Nursing Assessment Performance Framework (NAPF) Report and noted that there had been two ward areas that had been through the SPEC Panel process and had achieved 'silver ward status', a further two wards are ready to go through the process and dates are being arranged for the panels. Members noted that Mersey Internal Audit Agency had undertaken a review of the NAPF process and significant assurance had been received. There is a plan to roll out assessments to community services in mid-August following a successful pilot. Members discussed the current resource within the team to manage the proposed workload and it was noted that an increase in capacity was required to manage future demand. The Committee noted that the framework had been presented at regional events and similar processes are being considered at two hospitals within the North West.

8. Members received the Venus Thromboembolism (VTE) Risk Assessment Reporting Process and Plan, following a request made by the Audit Committee to review and monitor the action plan. The Committee received an overview of the context and background for the work and confirmed their support for the action plan and the work being undertaken to address the issues raised in the audit findings report. Members noted that the Audit Committee had requested a follow up report at the next meeting.

9. Members received the proposed Quality Strategy for 2017-19 and noted that it brought together all of the quality improvement work that was being undertaken throughout the Trust into one document. A small number of inclusions were suggested and pending these amendments the document was approved for publication.

10. The Committee also received the Serious Incidents Requiring Investigation (SIRI) Report, Quality Dashboard, Corporate Risk Register, results of the Committee Self-Assessment and Summary Reports from the following Sub-Committee Meetings:

a) Patient Safety and Risk Assurance Committee (May 2017)

b) Health and Safety Committee (May and June 2017)

    i. The Committee received and noted the amended terms of reference for the Health and Safety Committee.

c) Patient Experience Committee (April and June 2017)

d) Clinical Effectiveness Committee (June 2017)

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Kea Ingham, Company Secretarial Assistant, 4 August 2017

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TRUST BOARD REPORT

13 September 2017

Item	141

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 12 July 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

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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

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Trust Board Part Two Information Report: 12 July 2017

1. At the meeting of the Trust Board on 12 July 2017, the following matters were discussed in private:

    a) Round Table Discussion: Potential Buddying Arrangements

    b) Round Table Discussion: Sustainability and Transformation Plan Update

    c) Future Investment Strategy in Cardiology Equipment

    d) Sustaining Safe, Personal and Effective Care 2016/17 Update Report

    e) Tenders Update

    f) Pathology Managed Service Procurement Lessons Learnt

    g) Fire Safety Update: Cladding

    h) Serious Untoward Incident Report

    i) Doctors with Restrictions

2. The matters discussed were private and confidential and/or identified individuals and/or were commercially sensitive at this time and so the decision was taken that these items should not be discussed in the public domain. As these items progress, reports will be presented to Part 1 of Board Meetings at the appropriate time.

Kea Ingham, Company Secretarial Assistant, 2 August 2017

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