

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING



Safe

Personal



Effective



TRUST BOARD PART 1 MEETING

12 JULY 2017, 14:00, SEMINAR ROOM 6, ROYAL BLACKBURN HOSPITAL

AGENDA

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

OPENING MATTERS				
TB/2017/092	Chairman's Welcome	Chairman	v	
TB/2017/093	Open Forum To consider questions from the public	Chairman	v	
TB/2017/094	Apologies To note apologies.	Chairman	v	
TB/2017/095	Declarations of Interest To note any new declarations of interest from Directors.	Company Secretary	v	
TB/2017/096	Minutes of the Previous Meeting To approve or amend the minutes of the previous meeting held on 3 May 2017.	Chairman	d✓	Approval
TB/2017/097	Matters Arising To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2017/098	Action Matrix To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2017/099	Chairman's Report To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2017/100	Chief Executive's Report To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information
QUALITY AND SAFETY				
TB/2017/101	Patient Story To receive and consider the learning from a patient story.	Director of Nursing	p	Information/ Assurance
TB/2017/102	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	Approval
TB/2017/103	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/2017/104	Serious Incidents Requiring Investigation Report To receive information in relation to incidents in month or that may come to public attention in month and be assured about the associated learning.	Medical Director	d✓	Information/ Assurance
STRATEGY				

TB/2017/105	Sustainability and Transformation Plan (STP) Update	Chief Executive	v	Information
ACCOUNTABILITY AND PERFORMANCE				
TB/2017/106	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: <ul style="list-style-type: none"> • 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/2017/107	Policy for the Review of Clinical Care following the death of a patient in Hospital	Medical Director	d✓	Information/ Assurance
GOVERNANCE				
TB/2017/108	Annual Audit Letter	Director of Finance	d✓	Approval
TB/2017/109	Audit Committee Update Report To note the matters considered by the Committee in discharging its duties (March and May 2017)	Committee Chair	d✓	Information
TB/2017/110	Finance and Performance Committee Update Report To note the matters considered by the Committee in discharging its duties (April and June 2017)	Committee Chair	d✓	Information
TB/2017/111	Quality Committee Update Report To note the matters considered by the Committee in discharging its duties (May 2017)	Committee Chair	d✓	Information
TB/2017/112	Remuneration Committee Information Report To note the matters considered by the Committee in discharging its duties (2017)	Committee Chair	d✓	Information
TB/2017/113	Trust Board Part Two Information Report To note the matters considered by the Committee in discharging its duties (3 May 2017)	Chairman	d✓	Information
FOR INFORMATION				
TB/2017/114	Any Other Business To discuss any urgent items of business.	Chairman	v	
TB/2017/115	Open Forum To consider questions from the public.	Chairman	v	
TB/2017/116	Board Performance and Reflection To consider the performance of the Trust Board, including asking: <ul style="list-style-type: none"> • 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 intelligence from local people's needs, trend and comparative information? • Does the Board give enough priority to engagement with stakeholders and opinion formers within and beyond the organisation? 	Chairman	v	

TB/2017/117	Date and Time of Next Meeting Wednesday 13 September 2017, 2.00pm, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.	Chairman	v	
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TRUST BOARD PART ONE REPORT

Item **96**

12 July 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 3 May 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

EAST LANCASHIRE HOSPITALS NHS TRUST
TRUST BOARD MEETING, 3 MAY 2017
MINUTES

PRESENT

Professor E Fairhurst	Chairman
Mr K McGee	Chief Executive
Mr S Barnes	Non-Executive Director
Miss N Malik	Non-Executive Director
Mrs C Pearson	Director of Nursing
Dr D Riley	Medical Director
Mr R Slater	Non-Executive Director
Mr R Smyth	Non-Executive Director
Mr J Wood	Director of Finance

IN ATTENDANCE

Ms S Ahmed	Member of the Public	Observer/Audience
Mr J Bannister	Director of Operations	
Mrs A Bosnjak-Szekeres	Associate Director of Corporate Governance/ Company Secretary	
Mrs G Ferris	Member of the Public	Observer/Audience
Mr K Griffiths	Director of Sustainability	
Mrs C Hughes	Director of Communications and Engagement	
Miss K Ingham	Company Secretarial Assistant	
Mr K Moynes	Director of HR and OD	
Canon M Wedgeworth	Associate Non-Executive Director	

APOLOGIES

Mr M Hodgson	Director of Service Development
Professor M Thomas	Associate Non-Executive Director
Mr D Wharfe	Non-Executive Director

TB/2017/066 CHAIRMAN'S WELCOME

Professor Fairhurst welcomed the Directors and the members of public to the meeting. She welcomed Canon Wedgeworth to the Board in his role as Associate Non-Executive Director.

TB/2017/067 OPEN FORUM

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

TB/2017/068 APOLOGIES

Apologies were received as recorded above.

TB/2017/069 DECLARATIONS OF INTEREST

No declarations of interests were made.

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

TB/2017/070 MINUTES OF THE PREVIOUS MEETING

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

RESOLVED: The minutes of the meeting held on 29 March 2017 were approved as a true and accurate record.

TB/2017/0471 MATTERS ARISING

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

TB/2017/072 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/2017/050: Patient Story – Mrs Hughes confirmed that she was working with the Patient Experience Team to develop a series of patient stories for publication.

TB/2017/053: Serious Incidents Requiring Investigation Report – Mrs Hughes reported that the Trust was revising the information provided to patients in relation to staying active and hydrated.

RESOLVED: The position of the action matrix was noted.

TB/2017/073 CHAIRMAN'S REPORT

Professor Fairhurst reported that she had recently represented the Trust at the East Lancashire Clinical Commissioning Group's (ELCCG) Staff Excellence Awards and confirmed that ELCCG had reciprocated by attending the Trust's STAR Awards event on 28 April 2017. She went on to report that she attended the Pennine System Leaders' System Design Event at Burnley Football Club. She was a member of the panel which provided an opportunity for senior leaders across Pennine Lancashire to respond to questions and comments from the public. The session, along with those that had taken place before it, informed the development of the 'Together Healthier' document that is due to be published soon.

Professor Fairhurst confirmed that she attended the Trust's STAR Awards. It was a fabulous opportunity to celebrate the fantastic work of the staff across the Trust.

RESOLVED: Directors received the report provided.

TB/2017/074 CHIEF EXECUTIVE'S REPORT

Mr McGee presented his report and confirmed that a significant amount of work was undertaken at national level around equality and diversity. He highlighted the links with the work that the Trust was carrying out, particularly the work around the Workforce Race and Equality Standard.

He reported that Mrs Erin Bolton, Bereavement Care Lead Nurse, had been awarded the Nurse of the Year Award by the British Journal of Nursing. Mrs Pearson commented that such recognition was a testament to the hard work and determination of Mrs Bolton and suggested that the Board may wish to receive a presentation from Mrs Bolton and her colleague Mrs Bardon, Bereavement Support Midwife at a future meeting.

Mr McGee reported that the Trust continues to work with the University of Central Lancashire (UCLan) on the development of the UCLan medical school and the intention to increase the number of students studying there in the coming years.

Directors noted the relocation of the Trust's Chemotherapy Unit to level four on the Royal Blackburn Hospital site. The new area is significantly larger than the previous one and offers an improved patient experience.

Mr McGee confirmed that he was proud to present the Employee of the Month award for March to Becky Slater who works in the Urgent Care Centre in Burnley. He went on to highlight a number of other items of news, including the development of the Trust's car parking facilities, the installation of new murals at the Blackburn Birth Centre and a donation

of medical equipment to the Neonatal service at Burnley General Hospital by Tauheedul Islam Girls High School and Sixth Form College.

In response to Cannon Wedgeworth's question regarding the links between positive placements and employment of junior doctors, Dr Riley confirmed that there was evidence to support the theory that a positive student placement was a factor in the successful appointment of junior doctors.

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

TB/2017/075 PATIENT STORY

Mrs Person introduced the item and Ms Whitley, IHSS Locality Lead and Mr Townsend, Intermediate Care Allocation Team Manager, joined the Board meeting to present the Patient Story. The Board watched a video of the work which the Community Team carries out and heard the case of a male patient who suffers from COPD and has multiple co-morbidities. The patient was admitted to the hospital on numerous occasions previously and the team has developed a plan whereby the patient can receive treatment with the stand-by medication that is ready and can be administered at home in order to avoid hospitalisation. The plan for the patient has been shared with various health and social care agencies involved in his care, so the ambulance services can make an assessment about the appropriateness of him staying at home and receiving treatment or being hospitalised. The patient has managed to have a holiday away for his birthday with his family with the careful management of his condition and input from the Community Team. The patient is on the palliative care register and wishes to receive care at home. The plan set up by the Community Team enables the realisation of his wishes.

The Board also heard the case of a female patient who was hospitalised last year with a fractured ankle. The patient is suffering from dementia and an extensive rehabilitation package was required when she was discharged from the hospital. ELHT's Intermediate Care Allocation Team enabled access to an appropriate nursing home and the Integrated Therapy Team at Rossendale assisted the patient in enabling her to walk again. When the patient was approaching discharge from the nursing home a capacity test regarding future care needs was carried out and established that the patient did not have capacity, but the patient wished to go home to continue her recovery. The Community Team put a care package in place for the patient. The patient has been home since September 2016 and is feeling well and had not had another fall since being discharged.

Mr Slater asked how easy it is to develop such bespoke service. Ms Whitley responded that

due to the integrated service it is possible to carry out one assessment and put in place a plan to which everyone works. Mr Townsend added that developing a bespoke care plan is not that difficult, but it is time consuming and also there is a need to accommodate any changes in the patients' care needs. Mr Slater went on to ask about the benefits that the service provides to the patients and the difference that it makes. Mr Townsend responded that the patients do not need to repeat themselves when discussing their care needs and the benefits are realised by everyone involved with the patients working towards the same goals and outcomes. Ms Whitley added that there is an intimate understanding of the patient and his/her needs and within a 24 hour timeframe the patient can be seen by everyone who needs to have an input into the care plan in order to avoid a hospital admission.

Miss Malik asked whether patients could refer themselves to the service. Ms Whitley responded in the affirmative and confirmed that the service is also working with the GPs in cases of first time referrals.

In response to Mr Griffiths' question about the benefit to the wife of the male patient whose story the Board heard, Ms Whitley responded that the service is able to provide comfort and assurance that she can contact them for help and advice on caring for her husband and also supporting the family to have time together at home, outside of the hospital environment.

Canon Wedgeworth commended the excellent service and asked whether the NHS is working with the Third Sector in providing it. Ms Whitley responded that the NHS is working closely with the Third Sector and other services in providing a personally tailored care plan to the patients. Mr Townsend added that the Trust is working with Age UK and the Trust makes many referrals to the Third Sector in order to utilise their resources to provide tailored care.

In response to Mr Wood's question on how the service is coping with the demand, Mr Townsend responded that the service is able to respond to the service users' needs by moving the workforce around the area and by reviewing patients daily in order to match the need with the workforce availability, but concluded that it is a daily challenge. Mr Townsend added that the demand is going up and the service is constantly looking to find ways to meet the rising demand.

Mr Bannister asked about the importance of the team functioning as a team of multi-professionals. Ms Whitley responded that it makes the biggest difference as there is no 'red tape' in agreeing the care packages. She stated that by acting as a multi-disciplinary team the professionals involved in the planning and the care complement each other, achieving the aims of the service faster. Mr Townsend added that there is also a good understanding

of the pressures that all those involved in the care face and the professionals are able to support each other and use the resources well.

Professor Fairhurst thanked the presenters and noted that this was the highest number of questions asked by the Board after a Patient Story, emphasising the importance of the collaboration between the acute, non-acute and Third Sector services in providing patient care. Professor Fairhurst expressed her hopes that more Patient Stories demonstrating such collaboration will be presented to the Board in the future.

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

TB/2017/076 CORPORATE RISK REGISTER

Dr Riley presented the report and highlighted the updates around the risks as detailed in the report.

In response to Miss Malik's question, Dr Riley confirmed that the Trust received the findings report of the Royal College of Psychiatrists following the review of the mental health services across East Lancashire. He reported that the findings and recommendations had been presented to the Trust's Executive Team and to the Accident and Emergency Delivery Board (AEDB). Whilst there were no immediate actions for the Trust, a number of recommendations had been made and were being implemented.

Mr Smyth observed that the risk relating to the refurbishment of ward areas remained at the same level as in the previous reports, despite the assurances given that work would be completed and asked for an update on progress. Mr Bannister reported that the Trust was working to create a 'de-camp' ward which would allow the refurbishment programme to progress at pace, however this has not been possible in recent months due to the ongoing high demand for beds across the Trust. He confirmed that a potential ward had been identified and as soon as flow in the Trust was at the appropriate level, the programme could recommence in its entirety. The refurbishment programme was ongoing, but had been slowed down significantly by the lack of a suitable 'de-camp' ward.

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

TB/2017/077 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 mitigate and manage the risks identified at Board level.

In response to Mr McGee's comments regarding the workforce challenges being seen in relation to the emergency care pathway, Dr Riley confirmed that the challenges would remain for the foreseeable future. The implementation of the locum agency rate cap in England did not assist the providers, as medical locums are willing and able to seek work in Scotland and Wales, where the caps are not in place. He went on to provide an overview of some of the work that is taking place internally to manage the issue, including the development of the Nurse Consultant and the Emergency Care Practitioner posts.

In response to Professor Fairhurst's question about the impact of the emergency care pathway pressures on the elective surgery, Dr Riley confirmed that, to date, elective procedures have been able to go ahead as planned and all performance indicators, with the exception of the four hour standard, have been met. Professor Fairhurst observed that whilst performance was currently good, it should be recognised that this level of performance may not be sustainable in the long term, as deteriorating performance within the emergency care would start to impact on performance in other areas.

Following a discussion around the difficulty recruiting to acute specialist roles and the need to utilise locum staffing, Professor Fairhurst offered the Board's support in considering and implementing alternative staffing methods. Directors discussed the need to undertake the workforce transformation to ensure that patients continue to receive high quality care through the emergency care pathway. Mr Moynes suggested that there was a need to have increased budget sharing in order to develop the workforce as needed. It was agreed that the Executive Directors would develop plans for the workforce transformation and explore the sharing of budgets across the organisation to assist the development of appropriate, non-traditional roles.

RESOLVED: **Directors received and noted the report provided.**
Executive Directors to develop plans for the workforce transformation and explore the sharing of budgets across the organisation to assist the development of appropriate, non-traditional roles.

TB/2017/078 SERIOUS INCIDENTS REQUIRING INVESTIGATION REPORT

Dr Riley presented the report and highlighted the two never events that occurred in April, both of which related to wrong site surgery, although they took place within different directorates. He confirmed that both have been reported through the necessary channels, duty of candour has been carried out and both incidents are subject to the required review

and investigation processes.

Directors noted the themed section of the report which focused on falls and the successful work taking place to reduce falls across the organisation.

In response to Mr Smyth's question, Dr Riley provided an overview of the timescales for duty of candour reporting and the process for completing a Strategic Executive Information System (STEIS) report. Dr Riley agreed to follow up on the supplementary question regarding the omission of one duty of candour instance as detailed in the report.

RESOLVED: Directors received the report and noted its content.
Dr Riley agreed to follow up on the omission of one duty of candour instance as detailed in the report.

TB/2017/079 WORKFORCE, RACE AND EQUALITY STANDARD (WRES) ACTION PLAN REPORT

Mr Moynes presented the report highlighting the plan to hold additional 'Big Conversation' events and the development of the WRES Steering Group. Mr Moynes confirmed that Dr Sebastian, Consultant Anaesthetist, has agreed to chair the group. Directors noted that the Trust has engaged the services of Diversity by Design and will be working with the company on the development of the Fanshawe Report. Diversity by Design also agreed to undertake some coaching sessions with Dr Sebastian in relation to his role as the WRES Steering Group Chair.

Professor Fairhurst commented that the work provided the Trust with a good opportunity to be at the forefront of equality and diversity work in the NHS. Miss Malik confirmed that she is also involved in the WRES Steering Group and that it was vital that the work was supported by the Board and the Executive Team.

Mr McGee confirmed that a discussion had taken place at the last Executive Team meeting around developing proposals for compassionate leadership and these proposals will be presented to a future Trust Board meeting.

Mr Barnes requested that suitable timeframes be included in the WRES action plan, in addition to the development of appropriate targets for achievement.

RESOLVED: Directors received the report and noted the information.
The Executive team will develop proposals for compassionate leadership and present them at a future Board meeting.
Suitable objectives and timeframes will be included in the WRES action plan.

TB/2017/080 APPRAISAL UPDATE REPORT

Mr Moynes presented the report and provided an overview of the benefits of appraisals for staff, managers and the Trust as a whole. Directors noted the positive work that had been carried out by the neighbouring Trusts, including Leeds University Hospitals NHS Trust and Wrightington, Wigan and Leigh NHS Foundation Trust. Mr Moynes suggested that the Trust should implement a three month window in which all staff employed under the terms of Agenda for Change should have their appraisal completed. Directors discussed the practicalities of this and agreed that it could be trialled in the Integrated Care Group (ICG) division prior to rolling it out across the Trust. Directors also agreed to halt pay progression for those staff that do not have a current appraisal, although no timeframe was agreed for implementation.

RESOLVED: Directors received the report and agreed a trial process for the completion of the appraisals in the ICG division followed by a roll-out across the whole Trust.

TB/2017/081 MANAGEMENT OF SICKNESS ABSENCE REPORT

Mr Moynes presented the report and confirmed that, whilst sickness absence rates had reduced, they were still higher than desired. Directors discussed the setting of a target and it was felt that the proposed target of 3.75% was not realistic or achievable at this time. Directors discussed the need to focus attention on the reduction of short term sickness absence across the organisation and it was agreed that rather than setting an unachievable target, a focus on reducing sickness absence in general should be the objective.

RESOLVED: Directors received the report and agreed that the focus on reducing sickness absence further should be maintained.

TB/2017/082 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 March.

a) Performance

Mr Bannister reported that the Referral to Treatment performance continued to be good, with 92.3% of patients seen within the required timeframes. He confirmed that there were 17,950 attendances in the emergency department in March, of which 14,980 were treated/admitted within the required four hours. Overall performance for the month was 83.5% against the

95% target.

Mr Bannister reported that performance against the ambulance handover compliance indicator was achieved at 92.2%. 2,428 of the 3,525 patients who were brought into the Trust via ambulance were handed over in less than 30 minutes.

There was one patient who waited over 52 week for treatment, but had now been seen and treated appropriately. Directors noted that the patient had a particularly complex medical history which had contributed to the delay.

The cancer figures for February showed that all cancer standards, bar the 62 days standard, have been achieved. The data for March indicated that the Trust went on to achieve the 62 days cancer standard in March, but the data needs to be validated and will be reported to the next Board meeting.

Professor Fairhurst congratulated the staff on achieving the targets despite the pressures. It was agreed that Mrs Hughes will contact the local press and share the Trust's performance data.

b) Quality

Dr Riley introduced the quality performance data and confirmed that no further confirmed MRSA infections have been reported in March. The Trust had one reported MRSA infection in 2016/17 that was detected in December. There were no CDiff cases in March and the year to date cumulative figure was 32 cases against the target of 28. The Target for the coming year is also set at 28. The superbug infection on Ward 20 has been contained and no further infections occurred. The ward was 'fogged' and re-opened.

Dr Riley reported to the Board that no never events were reported in March and the two cases in April were covered in the SRI report earlier on the agenda.

Dr Riley informed the Board members that the process for carrying out mortality reviews will be changing in line with the revised national process. The Royal College of Physicians and NHS England will be training up a number of the clinicians from the Trust to carry out structured judgement reviews under the new mortality review process.

c) Human Resources

Mr Moynes reported that there was an increase of 23 in the number of staff employed from the previous month, out of which 16 were nursing staff. There are further 126 nurses in the recruitment pipeline. He went on to confirm that the Core Skills Training compliance threshold has been increased to 90% and 9 areas out of 11 are rated 'green'. The Board

received detailed reports on the sickness absence and the appraisals earlier in the meeting.

d) Safer Staffing

Mrs Pearson reported that the nursing and midwifery staffing continued to be challenging in March. Six areas fell below the 80% average fill rate for registered nurses on day shifts and one area for registered midwives on night duty, an improvement in comparison to the previous month. Four of the wards fell below the 80% fill rate due to coordinator availability, which is in addition to the agreed safe staffing levels.

There were 4 red flag incidents reported. Following investigation, one was found to be an inaccurate recording. Two of the red flag incidents related to missed meal breaks and one related to the day-case unit where one nurse was looking after 5 patients. No harm was identified in any of the cases. Fourteen midwifery posts and all but one NICU post have been recruited to.

e) Finance

Mr Wood reported that the Trust achieved the target £14.2 million savings under the Safely Releasing Cost Programme (SRCP) for 2016/17. The financial year end surplus was £3.068 million, as a result of the national bonus from NHS Improvement, resulting in an overall successful financial position for the Trust. The Trust has also come under the £15.5 million agency cap for the year. The agenda cap will reduce to £13 million in 2017/18 and it will be more challenging for the Trust to achieve the target.

Canon Wedgeworth enquired about the potential use of the surplus. Mr Wood responded that due to the scarcity of capital funding the surplus is needed for the capital spending. He added that the Trust's capital plan is very ambitious and having the surplus is very important. Professor Fairhurst observed that with further reductions in the agency cap, the workforce development discussed earlier by the Board is absolutely vital as a mitigating factor.

Mr McGee expressed his appreciation for the hard work that staff carried out in achieving the financial targets and emphasised that not many Trusts are in such a positive financial position. He added that it is important to maintain the position going forward.

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

TB/2017/083 FREEDOM TO SPEAK UP/STAFF GUARDIAN ROLE

Mrs Barton and Ms Butcher provided a presentation to the Board in relation to the role of the

Staff Guardian. Ms Butcher provided an overview of the work planned for the future, including the development of a communications strategy regarding the staff changes being undertaken within the Team following Mrs Barton's retirement and the importance of maintaining the culture of being able to speak out safely.

Miss Malik asked whether there were any cases that had come through the team rather than going through a formal route. Mrs Barton responded in the affirmative and confirmed that those cases that had required formal input had been relocated to the most appropriate team within the Trust.

Mrs Pearson highlighted a case that she has been involved in prior to the creation of the Staff Guardian role and confirmed that the role would have most likely stopped the formal whistleblowing process taking place.

The Board thanked Mrs Barton for her services to the Trust and in her role as the Staff Guardian.

RESOLVED: Directors noted the content of the presentation.

TB/2017/084 DIRECTORS' REGISTER OF INTERESTS

Mrs Bosnjak-Szekeres introduced the report setting out the most up to date entries in the Directors' Register of Interests. The Board confirmed the presented Register and agreed that Directors will inform the Company Secretary about any changes before its inclusion into the Trust Annual Report for 2016/17

RESOLVED: Directors confirmed the Register and agreed its inclusion in the Annual Report for 2016/17 pending any changes from the members.

TB/2017/085 DELEGATION OF AUTHORITY FOR APPROVAL OF THE ANNUAL REPORT AND ACCOUNTS 2016/17

Mrs Bosnjak-Szekeres presented the item setting out the proposal for the delegation of authority by the Board to the Audit Committee for the approval of the Annual Report, the Audited Annual Accounts, the Annual Governance Statement and the Quality Accounts for 2016/17.

The Board agreed to delegate the authority to the Audit Committee to approve the Annual Report, the Audited Annual Accounts, the Annual Governance Statement and the Quality Accounts for 2016/17 at its meeting on the 26 May 2017 and authorised the Chair of the Audit Committee and the Director of Finance to submit the documents to the Department of

Health on the 1 June 2017.

RESOLVED: Directors received the report and noted its content.
Directors agreed to delegate authority to the Audit Committee for the approval of the Annual Report, Annual Accounts, Annual Governance Statement and Quality Account.

TB/2017/086 TRUST CHARITABLE FUNDS COMMITTEE UPDATE REPORT

Mr Barnes reported on the business conducted at the last meeting of the Charitable Funds Committee held on the 3 April 2017. Mr Barnes informed the Board that the Committee agreed to invite the Investment Fund Manager to its next meeting to discuss the performance of the fund and the service fees. Mr Barnes also briefed the members about the Fundraising Manager's role and the work planned on the Charity's governing documents.

RESOLVED: Directors received the report and noted its content.

TB/2017/087 TRUST BOARD PART TWO UPDATE REPORT

The report was presented to the Board for information.

TB/2017/088 ANY OTHER BUSINESS

No other matters were raised under this agenda item.

TB/2017/089 OPEN FORUM

Professor Fairhurst invited the members of the public to participate in the Open Forum. Ms Ahmed thanked Mr Moynes for the report on sickness absence and concluded that it is a complex area to manage. She expressed her appreciation of the difficult task ahead, based on her work in the public sector. Ms Ahmed asked Mr Moynes whether there is an added difficulty in managing sickness due to the nature of the NHS, where an infected staff member could infect patients. Mr Moynes responded in the affirmative and described the services available to staff in the Trust to ensure that they are supported in regaining their health before they return to work.

Ms Ahmed also praised the professional and efficient A&E service at the Trust, when she attended the hospital's emergency department with a relative recently. She stated that it was very busy and asked whether patients could attend alternative services when the A&E department is busy as she did not notice any information about it in the department. Mr

Bannister thanked Ms Ahmed for her observation and agreed to revisit the information in the department on alternative services for patients.

RESOLVED: **Mr Bannister to review the information on alternative services available to patients in the A&E department.**

TB/2017/090 BOARD PERFORMANCE AND REFLECTION

Professor Fairhurst invited comments and observations about the meeting from the Directors.

Mr Slater stated that he has found the Patient Story very useful, as he was not aware of the excellent service that is available to the patients.

Canon Wedgeworth agreed that the integrated community service was excellent and asked whether the service helps with delayed transfers of care and if it could be measured in some way. Professor Fairhurst said that there would be a way to measure the benefit of it. Dr Riley added that the Frailty Consultant, Dr Ekwegh is working with the team to avoid hospital admissions, but highlighted the differences in the service between the two commissioning areas.

Mr McGee observed that the Board had positive discussions and stated that the culture of the organisation is a very powerful tool in addressing issues such as sickness and appraisal levels.

Professor Fairhurst informed the members that the second bullet point in relation to the Board reflection will be removed from the agenda following the introduction of the Board strategy meetings.

TB/2017/091 DATE AND TIME OF NEXT MEETING

The next Trust Board meeting will take place on Wednesday 12 July 2017, 14:00, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.

TRUST BOARD REPORT

Item **98**

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No



East Lancashire Hospitals

NHS Trust

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2017/077: Board Assurance Framework	Executive Directors to develop plans for the workforce transformation and explore the sharing of budgets across the organisation to assist the development of appropriate, non-traditional roles.	Executive Directors	July 2017	Oral Report
TB/2017/078: Serious Incidents Requiring Investigation Report	Dr Riley agreed to follow up on the omission of one duty of candour instance as detailed in the report.	Medical Director	July 2017	Oral Report
TB/2017/079: Workforce, Race and Equality Standard (WRES) Action Plan Report	The Executive team will develop proposals for compassionate leadership and present them at a future Board meeting. Suitable objectives and timeframes will be included in the WRES action plan.	Director of HR and OD	To be confirmed	Agenda Item TBC
TB/2017/080: Appraisal Update Report	Directors agreed a trial process for the completion of the appraisals in the ICG division followed by a roll-out across the whole Trust.	Director of HR and OD	July 2017	Oral Report
TB/2017/085 Delegation of Authority for Approval of the Annual Report and Accounts 2016/17	Directors agreed to delegate authority to the Audit Committee for the approval of the Annual Report, Annual Accounts, Annual Governance Statement and Quality Account.	Audit Committee	July 2017	Oral Report

TRUST BOARD REPORT

Item **100**

12 July 2017

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	<p>Put safety and quality at the heart of everything we do</p> <p>Invest in and develop our workforce</p> <p>Work with key stakeholders to develop effective partnerships</p> <p>Encourage innovation and pathway reform, and deliver best practice</p>
Related to key risks identified on assurance framework	<p>Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives</p> <p>Recruitment and workforce planning fail to deliver the Trust objectives</p> <p>Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways</p> <p>Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust</p> <p>The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.</p>

Impact

Legal	No	Financial	No
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Safe | Personal | Effective



East Lancashire Hospitals

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Equality

No

Confidentiality

No

Previously considered by: N/A

Safe | Personal | Effective

National Updates

1. **Cyber Security** - After the recent cyber-attacks, NHSi and NHS England have been working with NHS Digital's CareCERT team to check that the NHS is protected against any further attacks.
2. **Application of HMRC's IR35 tax rule changes on NHS agency staff: updated guidance** - The IR35 tax rule changes, which came into force in April, shifted the responsibility for assessing whether IR35 applies from individuals to providers. NHSi's priority is to help encourage NHS providers to ensure that agency staff pay the correct tax, and following conversations with the sector we've [updated and amended our guidance](#). This is to ensure that there is no ambiguity in what trusts are expected to do.
3. **NHSi Letter from Jim Mackey** – The letter outlines the increased support NHSi will be providing to help Trusts manage PFI contracts better. There are two specific points that NHSi want to draw your attention to:
 - a) during June NHSi will be asking providers with PFI schemes to complete a survey with details of these and how you currently manage those contracts
 - b) NHSi will be organising an event for providers with early wave PFI schemes to discuss how to plan for these contracts ending
4. **Sustainability and Transformation Partnerships (STPs): update** - To build on the work of the first workshops, NHS England and NHS Clinical Commissioners are organising more events for lay members and NEDs – one to be held in the north of England (location TBC) on Monday 3 July, and the other in the south of England (location TBC) on Wednesday 5 July. NHSi are supporting the events which will provide the opportunity to:
 - a) review how STPs are developing
 - b) share examples about involving lay members/NEDs in STPs
 - c) look at the evolving challenges of being a lay member/NED voice in an STP
5. **A message to NHS staff : Jeremy Hunt, Secretary of State for Health** – Received on the 16th June @ 10:30 – “When I was first made Health Secretary I said it was the biggest privilege of my life, and so it has proved. What I didn't realise then was that it would also become my biggest passion –working in health is not just a job but a vocation. The election period reinforced more acutely than ever the incredible work of the NHS, particularly the way staff dealt first with the global cyber-attack and then with horrendous terror attacks in Manchester and London. After the Manchester

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bombing I met nurses caring for bereaved families with incredible compassion, whilst in London I heard stories of doctors who cycled the length of the city at 2am just because they wanted to help. These stories speak to a wider truth – NHS staff do an amazing job, often in the most difficult of circumstances. And it is this which brings us all together: our great belief in the NHS, what it stands for and what we believe it can be. Your compassion, energy, dynamism and total dedication, day in, day out, are truly humbling. When I look at what the NHS has achieved in recent years, I think you can feel very proud. Despite the financial crash and ensuing period of constrained budgets, today's NHS has some of its highest ever satisfaction ratings, carries out 5,000 more operations a day, has lower MRSA rates than France, Germany or Spain, and sees its highest ever survival rates for cancer, heart attacks and stroke. One of the biggest expansions of mental health provision in Europe is underway right here, and there's been a transformation in attitudes towards patient safety in the wake of Mid-Staffs. These achievements simply wouldn't have been possible without you, our world-class doctors, nurses, paramedics and everyone else who works every day, across the country, to make the NHS the best it can be.

6. **Simon Stevens sets out next steps for NHS** - Speaking at this year's NHS Confederation annual conference, Simon Stevens outlined the five overarching priorities for the NHS over the coming year; improving A&E performance, strengthening access to GP services and primary care, improving cancer and mental health care, delivering financial balance and accelerating local care redesign and integration.
7. **Simon Stevens on how to repair a “fractured” care system** - Simon Stevens spoke about ending the “fractured” health and social care system that leaves too many patients “passed from pillar to post” by giving local leaders and communities more control over how they improve health and social care.
8. **NHS England strikes deal to make innovative breast cancer drug routinely available on the NHS** - NHS England has struck a deal with Roche to make the breast cancer drug Kadcyla available for routine use on the NHS. Rejected by NICE in 2015 as too expensive for routine funding, Kadcyla had been available through the Cancer Drugs Fund (CDF) since 2013. It will now be permanently funded, removing uncertainty for patients and giving doctors a further treatment option.
9. **New parts of the country set to benefit from expansion of diabetes prevention programme** - 13 new areas are now ready to offer a leading NHS prevention

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programme for patients identified as being at risk of developing Type 2 diabetes. Wave 2 of the Healthier You NHS Diabetes Prevention Programme is part of a wider package of measures to support people with diabetes and those on the cusp of it, to stay fit, well and prevent further deterioration. The programme, which is run collaboratively by NHS England, Public Health England and Diabetes UK, was officially launched last year with 27 areas covering 26 million people; almost half of the country.

10. **Jim Mackey, Chief Executive of NHS Improvement, praised system leaders for their efforts to bring the NHS' books back into balance** - Jim Mackey congratulated NHS providers on a 'fantastic achievement' in breaking even in the fourth quarter of 2016/17, but warned that tough times lie ahead. Mackey opened his speech saying that "Providers offered a cost reduction that, virtually in every system in the world, is impossible. I don't think anybody would reasonably expect the system to deliver this level of efficiency for this long, but you've managed to do it." The fourth quarter figures were published in the NHS Improvement's quarterly performance report on NHS providers.
11. **Health Education England Chief Executive Ian Cumming highlights the importance of workforce retention** - Health Education England Chief Executive Professor Ian Cumming delivered a key note speech at the NHS Confederation conference in Liverpool, looking at the need to be flexible and innovative in developing the NHS for today and tomorrow.
12. **Secretary of State Jeremy Hunt awards £20.74 million more to hospitals in England** - Jeremy Hunt announced a second wave of funding to ease pressure on hospital emergency departments. The funding will be used to help hospitals properly equip themselves ahead of winter, particularly to handle the large volumes of patients attending A&E.
13. **Driving improvement – Case studies from eight NHS Trust** - The Care Quality Commission (CQC) has published a report that explores how eight NHS trusts have been able to make significant improvements in the quality of care and improve their CQC rating. 'Driving improvement: case studies from eight NHS trusts,' reveals the journey of improvement travelled by eight trusts from the perspective of staff, patients and organisations that represent them, and highlights how engaging and empowering staff has been critical in driving up quality. **Professor Sir Mike Richards, CQC's Chief Inspector of Hospitals, said:** "Since introducing our comprehensive

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inspection programme in 2014, I have been encouraged by the number of NHS trusts that have made significant improvements in quality. We know from our inspections that strong leadership and a positive open culture are important drivers of change. “This report set out to build on that knowledge by exploring how leadership can drive improvement and identify what action has been taken to successfully deliver transformational change.

Local Developments

14. **ELHT celebrates ‘STAR’ staff at annual awards** – East Lancashire Hospitals NHS Trust praised the achievements of its most caring and committed staff at its annual staff awards ceremony on Friday 28th April 2017. Sixteen awards were presented to different teams and individuals from across the organisation, who have displayed their talent and dedication.
15. **Trust appoints Mike Wedgeworth MBE as Associate Non-Executive Director** - East Lancashire Hospitals NHS Trust (ELHT) has strengthened its board of directors with the appointment of Mike Wedgeworth MBE as the Trust’s newest Associate Non-Executive Director. Mr Wedgeworth, who is currently Chairman of Healthwatch Lancashire and formerly Chief Executive of Hyndburn Borough Council and Chair of Blackburn College, has held senior executive positions both locally and nationally for almost four decades. He now serves as an assistant priest at Blackburn Cathedral.
16. **Trust appoints new Staff Guardian for the freedom to speak up** - East Lancashire Hospitals NHS Trust (ELHT) has appointed Jane Butcher as its new Staff Guardian to speak up for staff who raise concerns. Jane brings a wealth of experience to the Staff Guardian role having served the NHS in East Lancashire and Blackburn with Darwen for almost two decades. Since beginning her career as an Admin Assistant at Burnley General Hospital, Jane has worked extensively in Burnley, Blackburn and Rossendale, most recently as Medical Staffing Manager at East Lancashire Hospitals NHS Trust.
17. **Celebrating International Nurses Day** – It was **International Nurses Day** on the 12th May and what a terrific day of fun it was. I’m delighted that our wonderful nurses are being celebrated across the Trust by their patients, their peers and their other colleagues. We’ve been looking at the changing styles in nursing uniforms over the decades and our nurses wore them with pride; children from the Blackburn High School came in to sing their praises and a local pianist played to his strengths with a

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little concert throughout the afternoon. Everyone was welcome to the party and there was an awful lot of cake! Seriously though, the NHS would not be the institution it is without its army of dedicated, caring staff and nurses are at its very heart. Thank you all.

18. Hospital staff ‘honoured and privileged’ by invite to Queen’s Garden Party -

Two long-serving staff at East Lancashire Hospitals NHS Trust (ELHT) this month will be walking through the Buckingham Palace gates and attending the Queen’s garden tea party after receiving their personal invites. Deputy Research and Development Manager Linda Gregson and Night Porter John Jackson, who have 75 years of NHS service between them, will be rubbing shoulders with the Royals on Tuesday 23 May. “When the invite was delivered, it was marked with the Lord Chamberlain’s stamp which was exciting,” said John. “One thing I’m looking forward to is my wife and I being in the presence of her majesty, as it will be something I will never forget.” John and Linda will be treated to an afternoon of tea and cakes and will walk around palace grounds with other guests at one of three annual summer events.

19. Team ELHT - As you know, a significant part of the NHS was hit by in an international cyber-attack last Friday and ELHT was one of the victims. When our whole computer system is affected by such a virus, the impact of that is felt by every single member of staff and every single patient, albeit some more than others. The potential for extensive and possible life-threatening disruption is massive. So many organisations were hit that the number of individuals who were at best inconvenienced and at worst put at risk of harm, must run into the hundreds of thousands. Here at ELHT I am grateful for the enormous efforts of all our fabulous staff who responded to this incident in the most professional way. As a result, disruption was minimised, service continued and harm avoided. However, there was inconvenience. People’s jobs were made incredibly difficult and their ability to go about their business – providing safe, personal and effective care – was hampered. Patients had to wait longer, diagnostic tests were delayed, procedures postponed. The Sunday Times was quite wrong though when it reported that ‘bypass surgery and transplants’ were abandoned at ELHT. They weren’t. We don’t even perform those.

20. Trust advice on Ramadan and fasting - Living amongst the rich cultural diversity of the East Lancashire Hospitals NHS Trust (ELHT) family, staff will probably know that the Muslim holy month of Ramadan has recently begun. During Ramadan, it is

obligatory for all adult Muslims to fast during daylight hours. However, with Ramadan falling at the longest time of year, fasts will be up to 19 hours long, and there are a number of issues Muslim patients and Trust staff and managers need to keep in mind. This is why the Trust has worked with the Hospital Muslim Chaplain, as well as the Lancashire Council of Mosques, to offer advice to both patients and staff.

21. **Come and remember your loved one at annual memorial service** - The fifth Blackburn with Darwen Memorial Service took place on Sunday, June 4, 2017. The 'Let Us Remember' annual event saw multi-faith residents who had lost a loved one in the past year, coming together to pay their respects and honour their lives. The function, held in Corporation Park, was especially poignant this year in light of the recent tragic bombing in Manchester. Supported by Blackburn Cathedral, Blackburn with Darwen Interfaith Forum and Blackburn with Darwen Council, the memorial was founded by Blackburn coroner of 15 years, Michael Singleton, who is due to retire this year.
22. **Memorandums of understanding and a special birthday** - I recently signed a 'Memorandum of Understanding' with Blackburn College. Both the college and the Trust are really committed to promoting the value of the links between us and to exploring any opportunities for joint working. I am especially excited about the potential of a combined 3 – 5 year workforce plan that looks to deliver effective development and future proofing of our workforce as well as a growth in meaningful jobs and useful apprenticeships for local people. We really value our relationship with the college and are happy that it continues to go from strength to strength. Both organisations are crucial to the local community – socially and economically. This is a great example of the importance of authentic stakeholder engagement where two separate organisations are working together for the good of local people, and for each other. **Rakehead Rehabilitation Centre** celebrated its **30th Birthday** at this year's annual summer garden party. Past and present patients, staff and families enjoyed the stall, raffle, tombola and cake. Well done to all the therapy teams who came together to host this event. Rakehead is a wonderful facility and it is greatly appreciated by everyone who is treated there. It's fantastic to have reached this milestone, and to celebrate it in this way.
23. **Robo-Op a first in Lancashire** - After installing the first surgical robot in Lancashire, East Lancashire Hospitals NHS Trust leads the way once more by being the first in the region to use the equipment to carry out colorectal surgery. The Trust installed

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the £1.3 million Da Vinci robot in the theatres at the Royal Blackburn Teaching Hospital in June 2015 to carry out prostatectomies (removal of the prostate gland) for prostate cancer and have continued to grow the number of procedures they can carry out using the robot. So far, five patients have had robotic colorectal surgery at the Royal Blackburn Teaching Hospital including robotic colorectal resections for cancer.

24. **Nursing Cadets Take Centre Stage at 1st East Lancashire Cadet Awards** - The high standard of nursing cadets studying at local colleges and working at East Lancashire Hospitals NHS Trust (ELHT) came under the spotlight at the first ever Cadet Awards which took place at the Royal Blackburn Teaching Hospital. Cadets **Charley Taylor** (Blackburn College), **Georgia Spencer** (Burnley College) and **Fiona Brotherton** (Nelson and Colne College) each received 'Special Merit Awards' from the hospital's Director of Nursing, Christine Pearson. And to cap a fantastic first Cadet Awards ceremony, **Georgia Spencer** from Burnley College was named the overall '**Cadet of the Year**'.
25. **Celebrations as 5000th baby born at Blackburn Birth Centre** - An Accrington couple are celebrating the birth of their little bundle of joy — the 5,000th baby to be born at Blackburn Birth Centre. Kinga Foley, 28, gave birth to seven pound four ounce (3.37kg) son Logan at 11.30pm on Saturday 10th June. Proud mum Kinga said finding out her new arrival was the 5,000th baby to be delivered at the birth centre on Park View Road came as a surprise.
26. **Stepping Stones Child Development Centre celebrates new opening in Haslingden** - The new Stepping Stones Child Development Centre in Haslingden has officially opened its doors with over 50 guests attending a ceremony to mark the occasion. A children's service run by East Lancashire Hospitals NHS Trust (ELHT), Stepping Stones has moved to new and improved accommodation within Haslingden Health Centre to better suit the needs of children and families. The refurbished premises represent a significant investment by East Lancashire Hospitals.
27. **M&S volunteers 'spark' new life into hospital garden** - Patients, staff and visitors to Pendle Community Hospital are celebrating a renovated roof garden which has been spruced up by a team of community volunteers from the Marks & Spencer (M&S) store in Burnley. As part of Marks & Spencer's '**Spark Something Good**' community programme, volunteers planted new bushes and installed flowerpots and window boxes which are now being enjoyed by patients and families visiting the Hospital. And right on cue, days of heavy rain gave way to glorious sunshine as

volunteers celebrated the much improved roof garden last week.

28. **Community hospitals to introduce car park charges** - New parking charges are to be introduced at East Lancashire's three NHS community hospitals. From **Saturday 1st July** patients, staff and visitors to Pendle, Clitheroe and Accrington Victoria community hospitals will need secure payment to park. The revised pricing aims to be as fair and equitable as possible for all car park users. Income from car parking charges is used to cover the cost of providing parking and running costs, which includes maintenance and upkeep. This enables ELHT to protect funds set aside for patient care.
29. **I hope you will join me in wishing...** - our HR team 'good luck' for an event that took place on the 24th June as they, together with our nurse leadership, pressed on with our **new campaign to attract as many new nurses to the trust as possible**. Our campaign #recruitmentatelht has recently been launched June and our second recruitment day will be held in on the 22nd July. As you all know, we really do '*care to make a difference*' and this Trust is a great place to work, so if there is anything you can do to help us recruit more staff, do let us know.
30. **Hospital staff show support for Armed Forces Day** - East Lancashire Hospitals NHS Trust marked Reserves Day on Wednesday 21st June 2017 by raising the Union Jack to demonstrate their support for the Armed forces and members of staff who also serve as Reserves. Attending the event was Mr Rob Salaman, a Consultant Vascular surgeon at Royal Blackburn Teaching Hospital; along with Catherine Wright and Vicki Brindle both Sisters on the Acute Medical ward. Rob and Catherine both serve as Majors with the Manchester Field hospital, 207 division and Reserves Day allowed both to temporarily step out of their roles at the hospital and transform into their military positions.
31. **ELHT and UCLan strengthen partnership** - The University of Central Lancashire (UCLan) has cemented its position at the heart of the region's health and social care training by forming a strategic alliance with East Lancashire Hospitals NHS Trust (ELHT). The 10-year agreement between the two organisations means they will work together to meet the region's healthcare needs and enable the NHS workforce in Lancashire to work at an optimum level, directly benefitting the patients of East Lancashire. UCLan already trains doctors in the area, in partnership with ELHT. As an area with acute medical workforce needs, the long-term strategic alliance will deliver clinical placements, joint research programmes across Pennine Lancashire

and shared academic and clinical staff posts.

Summary and Overview of Board Papers

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

Summary of Chief Executive's Meetings for May 2017

02/05/17	Meeting with Simon Fanshaw – RBH
03/05/17	System Teleconference – RBH
03/05/17	Telephone Call with the GGI - RBH
03/05/17	Trust Board – RBH
04/05/17	A&E Delivery Board – Nelson
05/05/17	System Teleconference – RBH
05/05/17	Lancashire Chief Executives Meeting – Preston
05/05/17	Telephone Call with Haelo – RBH
05/05/17	Telephone Call with the GGI - RBH
10/05/17	System Teleconference – RBH
10/05/17	Patient Safety Awards Judging Day – London
10/05/17	Invitation to CHKS Top Hospitals Awards – London
11/05/17	Meeting with Ernst & Young - London
11/05/17	Additional meetings in London – London
12/05/17	HSJ Invitation to attend round table – London
15/05/17	Telephone call with Simon Fanshaw – RBH
16/05/17	Systems Teleconference – RBH
16/05/17	Systems Teleconference to discuss DTOC – RBH
17/05/17	NHSE Central Teleconference - RBH
18/05/17	Meeting – Buckinghamshire
19/05/17	System Teleconference – RBH
19/05/17	Meeting with GMAHSN – RBH
19/05/17	Meeting with Sandy Bradbrook – Preston
22/05/17	System Teleconference – RBH
22/05/17	Meeting with Burnley Council CEO – RBH
22/05/17	Meeting with NWAS – RBH
23/05/17	Telephone Call with Chair of NLAG - RBH

24/05/17	System Teleconference – RBH
24/05/17	Meeting to discuss collaboration – RBH
25/05/17	Meeting with Blackburn with Darwen Council CEO – RBH
25/05/17	Meeting with NW Coroner – Blackburn Town Council
26/05/17	System Teleconference – RBH
26/05/17	Team Brief – RBH
26/05/17	Team Brief – BGH
30/05/17	System Teleconference – RBH
30/05/17	Meeting at Stepping Stones – Blackburn
31/05/17	System Teleconference – RBH

Summary of Chief Executive's Meetings for June 2017

01/06/17	Meeting with the GGI = RBH
01/06/17	A&E Delivery Board – Walshaw House, Nelson
02/06/17	Lancashire CEO's Meeting – Preston
02/06/17	Meeting with Ric Whalley – RBH
05/06/17	Meetings at North Lincolnshire & Goole NHS FT
06/06/17	Meetings at North Lincolnshire & Goole NHS FT
07/06/17	Meetings at North Lincolnshire & Goole NHS FT
08/06/17	Meeting in Buckinghamshre
09/06/17	Systems Teleconference – RBH
09/06/17	Telephone call with ELCCG Mark Youlton – RBH
09/06/17	MOU signing with Blackburn College – RBH
12/06/17	Systems Teleconference – RBH
12/06/17	Meeting with Burnley CEO – RBH
13/06/17	AE Delivery Board Planning Meeting – RBH
13/06/17	Meeting with Russ McLean – RBH
14/06/17	Systems Teleconference – RBH
14/06/17	NHSE/NHSI Phase 2 DTOC visit programme – RBH
14/06/17	NHS Confederation – Liverpool
15/06/17	NHS Confederation – Liverpool
20/06/17	Meeting with Groundwork - RBH
20/06/17	Meeting with LTH – Preston
21/06/17	Programme Board Meeting – Preston

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21/06/17	System Leaders Forum – Blackburn
22/06/16	Telephone call with Jane Higgs – RBH
22/06/17	Telephone call with Jan Ledward – RBH
22/06/17	ELHT/UCLan Medical School Conference – Blackburn
22/06/17	Meeting with HEE CEO – Blackburn
23/06/17	Systems Teleconference – RBH
23/06/17	Meeting with GGI – Leeds
23/06/17	ELHT/NHSI Meeting – Leeds
26/06/17	Lancashire & South Cumbria Winter Review Event – Blackpool
27/06/17	Meeting with CIRCLE – RBH
27/06/17	Telephone call with the GGI - RBH
27/06/17	Meeting in Buckinghamshire
28/06/17	Meeting in Buckinghamshire
29/06/17	Meeting in Buckinghamshire
30/06/17	Systems Teleconference - RBH
30/06/17	Team Brief – RBH
30/06/17	Team Brief – BGH
30/06/17	Team Brief – PCH

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
12/07/16	Trust Board – RBH
13/07/17	Star Awards – RBH
14/07/17	Meeting with GGI – RBH
17/07/17	Interviews for Programme Director – RBH
18/07/17	Lord Carter Visit – RBH
18/07/17	SSNAP Team Visit – RBH
19/07/17	Programme Board Meeting – Lancaster
19/07/17	Meeting with the EU Federation – RBH
20/07/17	Action on A&E Meeting – Liverpool

24/07/17	ELTH/CCG Meeting – RBH
24/07/17	Elective Centre Opening – BGH
25/07/17	Meeting with Russ McLean – RBH
26/07/17	TAHF Programme Executive Team – Blackburn
26/07/17	System Leaders Forum – Blackburn
27/07/17	Quarterly Review Meeting with NHSI – RBH

TRUST BOARD REPORT

Item

102

12 July 2017

Purpose Information
Assurance

Title

Corporate Risk Register

Author

Mr N Smith, Risk Manager

Executive sponsor

Dr D Riley, Medical Director

Summary: A copy of the current Corporate Risk Register is provided indicating changes in the register since the last report to the Trust Board.

Recommendation: Directors are requested to receive and review the report and approve changes in the Corporate Risk Register

Report linkages

Related strategic aim and corporate objective

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

Related to key risks identified on assurance framework

Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives
Recruitment and workforce planning fail to deliver the Trust objectives
Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways

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

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

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

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: The report and the updated Corporate Risk Register will be presented to the Quality Committee on the 26th July 2017.

Introduction

1. The Risk Assurance Meeting has delegated responsibility for verifying and monitoring the Corporate Risk Register on a monthly basis. The Risk Manager additionally meets with each Risk Owner or Risk Handler as appropriate to monitor any changes to the risks, the risk management action plans and controls and assurances on an on-going basis.
2. Work is on-going to ensure that all risk handlers and executive leads have easier access to risk related information through the Trust's Risk Management system, Datix. This will continue as part of the Datix transformation project, a task and finish group reporting to the Patient Safety and Risk Assurance Committee which will provide assurance to the Quality Committee. Leads have now been provided with access to the dashboard module which provides a live view of risks within divisions and directorates.

Risks de-escalated and removed from the Corporate Risk Register. (Appendix 1)

- 6912 - Failure to meet ICO requirements will lead to ICO interventions and financial penalties
- 7017 - Aggregated Risk – Failure to meet internal and external activity targets in year will result in loss of autonomy for the Trust
- 6828 - Aggregated Risk – Failure to deliver stroke care within national guidance will adversely impact patient care and attract financial penalties
- 1660 - Failure to provide refurbished ward areas due to delays in refurbishment programme impacting on regulatory, contractual & national performance targets

Corporate Risk Register

3. The current Corporate Risk Register is attached at Appendix 2. Members are asked to note the assurances provided in relation to the ongoing management of the risks on the Corporate Risk Register and approve the paper. A full review of the Corporate Risk Register will be undertaken with risk leads on a monthly basis.

Title:	Failure to meet ICO requirements will lead to ICO interventions and financial penalties				
ID	6912	Current Status	Live Risk Register – all risks accepted	Opened	04/07/16
Initial Rating	Likelihood: 5 Consequence: 4 Total: 20	Current Rating:	Likelihood: 3 Consequence: 4 Total: 12	Target Rating:	Likelihood: 2 Consequence: 4 Total: 8
Risk Handler:	Angela Bosnjak-Szekeres	Risk Owner:	Michelle Brown	Linked to Risks:	
What is the Hazard:	<ul style="list-style-type: none">Insufficient resources to support current demand for Data Protection / Freedom of Information / Information Governance (including potential litigation) requests have resulted in a number of ICO decision notices over the last six months		What are the risks associated with the Hazard:	<ul style="list-style-type: none">Current involvement by ICO in a number of FOI and DPA requests escalates to enforcement action / sanctions resulting in potential finesFurther decision notices being issued due to poor information governance practice across the TrustContinued decline in IG toolkit score jeopardising contracts with CCG	
What controls are in place:	Report to Information Governance Steering Group on FOI compliance Annual IG Toolkit audit		Where are the gaps in control:		
What assurances are in place:			What are the gaps in assurance:		
Actions to be carried out		Action assigned to	Anticipated completion date	Progress Report	
Information Governance Audit commissioned by the SIRO		MIAA	June 2017	Report presented to the Trust Audit Committee on the 3 rd July 2017	
IG action plan to be presented and progress report to the September Audit Committee		SIRO	30 th August 2017		
Notes: Additional staffing has been identified by the Company Secretary to manage the FOI function. As a result this risk has been reduced to 12.					

East Lancashire Hospitals

NHS Trust

Title:	Aggregated Risk – Failure to meet internal and external activity targets in year will result in loss of autonomy for the Trust				
ID	7017	Current Status	Live Risk Register – all risks accepted	Opened	01/09/16
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 3 Consequence: 3 Total: 9	Target Rating:	Likelihood: 3 Consequence: 3 Total: 9
Risk Handler:		Risk Owner:	John Bannister	Linked to Risks:	1489 (DCS), 2310 (CEO), 4118 (FC), 6487 (ICG), 6509 (FC), 6893 (ICG)
What is the Hazard:	Non achievement of internal and external activity targets will result in increased external scrutiny and potential special measures		What are the risks associated with the Hazard:	<ul style="list-style-type: none"> • Patient harm due to late/ no treatment • Reputation of the Trust • Special measures • Contractual penalties 	
What controls are in place:	<ul style="list-style-type: none"> • Monitoring at Trust, Divisional, Directorate and service level Reporting to commissioners • Reporting externally to regulators • Data uploads e.g. HED • Strong monitoring of performance standards 		Where are the gaps in control:	Demand for non-elective services impacting on planned service delivery	
What assurances are in place:	<ul style="list-style-type: none"> • Action plans are in place for recovery of exceptions to performance reported on an ongoing basis • Close monitoring of planned actual activity and areas of pressure • Continual monitoring and reporting of exceptions to expected performance • Performance management processes in place to support appropriate escalation of issues and management of exceptions to expected performance 		What are the gaps in assurance:		

	<ul style="list-style-type: none"> •Reviewed at Trust Board meeting and supporting committees •Ongoing review at Executive Team meetings weekly 		
Actions to be carried out	Action assigned to	Anticipated completion date	Progress Report
<p>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.</p> <p>Risk last reviewed on 5th July 2017. Next review date 5th August 2017 and through the review dates of the linked risks.</p>			

East Lancashire Hospitals

NHS Trust

Title:	Aggregated Risk – Failure to deliver stroke care within national guidance will adversely impact patient care and attract financial penalties				
ID	6828	Current Status	Live Risk Register – All risks accepted	Opened	03/05/16
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 3 Consequence: 3 Total: 9	Target Rating:	Likelihood: 2 Consequence: 3 Total: 6
Risk Handler:	Nick Roberts	Risk Owner:	John Bannister	Linked to Risks:	2051 (DCS), 6893 (ICG) 2256 (ICG)
What is the Hazard:	<ul style="list-style-type: none">• Lack of capacity combined with a model focused on inpatient care is leaving some patients without the level of quality care expected• Therapy services do not meet the recommended levels of intervention in terms of frequency, intensity and range of service deliveries.		What are the risks associated with the Hazard:	<ul style="list-style-type: none">• Compliance against the quality indicators within SSNAP• Care is provided below the standard expected by non-stroke specialists and will impact on patient outcome.• Lack of therapy support leads impacts on outcomes, clinical flow, length of stay & performance	
What controls are in place:	<ul style="list-style-type: none">• Ongoing monitoring of SSNAP data• Ongoing identification, and where possible, transfer of stroke patients not on stroke unit.• Prioritisation of stroke services by therapies staff		Where are the gaps in control:	Unplanned demands for service	
What assurances are in place:	<ul style="list-style-type: none">• Monitoring through Stroke Steering Group• Reporting to Operational Delivery Board• Reporting to Divisional Quality and Safety Board		What are the gaps in assurance:		
Actions to be carried out		Action assigned to	Anticipated completion date	Progress Report	
Stroke Business Case to be considered at July ODB		John Banister	31 st July 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.					

The Trust SSNAP data has improved significantly from an historical E to a current position of C
Risk last reviewed on 4th July 2017. Next review date 4th August 2017

East Lancashire Hospitals

NHS Trust

Title:	Failure to provide refurbished ward areas due to delays in refurbishment programme impacting on regulatory, contractual & national performance targets				
ID	1660	Current Status	Live Risk Register – all risks accepted	Opened	17/10/12
Initial Rating	Likelihood: 5 Consequence: 4 Total: 20	Current Rating:	Likelihood: 4 Consequence:3 Total: 12	Target Rating:	Likelihood: 3 Consequence: 4 Total: 12
Risk Handler:	Jim Maguire	Risk Owner:	John Bannister	Linked to Risks:	
What is the Hazard:	<ul style="list-style-type: none">Failure to gain access to patient occupied areas without patients being present will not allow PFI partners access to undertake statutory maintenance work, additional refurbishment work and Trust cleaning programs to be undertaken.Failure to undertake the refurbishment programme at the Royal Blackburn Hospital site will impact on the Trust’s ability to achieve regulatory, contractual and national performance targets and achieve a sustainable financial position.		What are the risks associated with the Hazard:	<ul style="list-style-type: none">Backlog maintenance continues to increase having a long and medium term impact on the physical estate and environment and implications for the PFI contract.Failure to implement the refurbishment programme may lead to suboptimal environments for the delivery of care and an inability to demonstrate compliance with regulatory and contractual requirements. This will impact on the delivery of care, trust performance, the imposition of financial penalties and reputational damage and may result in a requirement to derogate PFI provider from contractual responsibilities.	
What controls are in place:			Where are the gaps in control:		
What assurances are in place:			What are the gaps in assurance:		
Actions to be carried out		Action assigned to	Anticipated completion date	Progress Report	
A comprehensive mitigation plan, gaps analysis and action plane has been requested by the Director of Operations		J Maguire	31 st July 2017		
Notes: Discussions will be held regarding the likelihood score given the lack of reported incidents and on-going discussions with PFI partners. Risk last reviewed on 5th July 2017. Next review date 4th August 2017					

East Lancashire Hospitals

NHS Trust

Title:	Failure to meet service needs at times of increased attendance in ED/UCC/MAU 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:	Jill Wild	Risk Owner:	John Bannister	Linked to Risks:	
What is the Hazard:	<ul style="list-style-type: none"> Increases in the volume of attendances in the Emergency Departments can lead to increased and 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:	<ul style="list-style-type: none"> 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:	<ul style="list-style-type: none"> 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 		Where are the gaps in control:	Trust has no control over the number of attendees accessing ED/UCC services	

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NHS Trust

	<ul style="list-style-type: none">• ED/UCC/AMU will take stable 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:	<ul style="list-style-type: none">• 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		Action assigned to	Anticipated completion date	Progress Report
All current planned actions completed as shown in “what controls are in place”				
Final amendment of Trust Full Capacity protocol and ratification at Operational Delivery Board		Chris Pearson/Damian Riley/Tony McDonald	August 2017	
Notes: Mitigating actions are deployed on a daily basis at an operational level to reduce the risk to patient care.				
Risk last reviewed on 5 th July 2017. Next review date 5 th August 2017				

East Lancashire Hospitals

NHS Trust

Title:	Aggregated risk – Failure to reduce medical locum costs will adversely impact financial sustainability and patient care				
ID	5790	Current Status	Live Risk Register – All risks accepted	Opened	11/09/15
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 3 Total: 9
Risk Handler:	Simon Hill	Risk Owner:	Damian Riley	Linked to Risks:	908 (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:	<ul style="list-style-type: none"> Escalating costs for locums Breach of agency cap Unplanned expenditure Need to find savings from elsewhere in budgets 	
What controls are in place:	<ul style="list-style-type: none"> 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:	<ul style="list-style-type: none"> 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.
Risk last reviewed on 5th July 2017. Next review date 5th August 2017

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NHS Trust

Title:	Aggregated risk – Failure to reduce nursing and midwifery agency costs will adversely impact financial sustainability and patient care				
ID	5791	Current Status	Live Risk Register – all risks accepted	Opened	11/09/15
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 3 Consequence: 5 Total: 15	Target Rating:	Likelihood: 4 Consequence: 2 Total: 8
Risk Handler:		Risk Owner:	Christine Pearson	Linked to Risks:	3804 (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:	<ul style="list-style-type: none"> • Breach of agency cap • Agency costs jeopardising budget management 	
What controls are in place:	<ul style="list-style-type: none"> • 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:	<ul style="list-style-type: none"> • Unplanned short notice leave • Non elective activity impacting on associated staffing • Break downs in discharge planning • Individuals acting outside control environment 	

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NHS Trust

What assurances are in place:	<ul style="list-style-type: none">• Daily staffing teleconference with Director of Nursing• 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	What are the gaps in 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 5th July 2017. Next review date 5th August 2017				

East Lancashire Hospitals

NHS Trust

Title:	Aggregated Risk – Failure to meet internal and external financial targets in year will adversely impact the Continuity of Service Risk Rating				
ID	7010	Current Status	Live Risk Register – all risks accepted	Opened	25/08/16
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 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:	<ul style="list-style-type: none"> • 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:	<ul style="list-style-type: none"> • 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 		Where are the gaps in control:	Individual acting outside control environment in place	

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NHS Trust

	policies on Trust intranet <ul style="list-style-type: none"> • Monthly reconciliation • Daily review of cash balances • Finance department standard operating procedures and segregation of duties 		
What assurances are in place:	<ul style="list-style-type: none"> • 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			
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 4th July 2017. Next review date 4th August 2017			

East Lancashire Hospitals

NHS Trust

Title:	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				
ID	3841	Current Status	Live Risk Register – all Risks accepted	Opened	04/08/14
Initial Rating	Likelihood: 3 Consequence: 3 Total: 9	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 2 Consequence: 2 Total: 4
Risk Handler:	Deborah Sullivan	Risk Owner:	John Bannister	Linked to Risks:	
What is the Hazard:	Capacity pressures in the chemotherapy units at both Blackburn and Burnley sites due to staffing and accommodation. Therefore capacity could potentially be unable to meet the demand of the service. This is having a significant effect on staff workload pressures	What are the risks associated with the Hazard:	<ul style="list-style-type: none"> • Due to the increase in the number of patients requiring chemotherapy the chemotherapy units are at risk of being unable to cope with the demand of treatments required due to capacity issues. This could result in patients breaching and potentially serious errors could occur. In addition to the nursing staff, this presents pressure on the admin/reception support within the unit(s). • Accommodation in both units is not adequate 		
What controls are in place:	<ul style="list-style-type: none"> • All patients are scheduled using the Varian (medonc) oncology computer system to schedule chair and nurse time. • Nursing and clerical staff work across both sites to ensure adequate cover. • Ongoing staff recruitment • Development of business case for consideration 01/09/16 	Where are the gaps in control:	<ul style="list-style-type: none"> • Patient deferrals and unexpected emergency treatment mean the Varian system is not always efficient. • Unplanned leave • Lack of flexibility in accommodation • Lack of suitably qualified/experienced applicants for recruitment 		
What assurances are in place:	<ul style="list-style-type: none"> • Monitoring of chemotherapy activity is now included in the monthly cancer directorate meeting 	What are the gaps in assurance:			

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NHS Trust

	<ul style="list-style-type: none"> Monthly meetings taking place with Business manager cancer services, lead Macmillan cancer nurse, and the 2 chemotherapy sisters. 		
Actions to be carried out	Action assigned to	Anticipated completion date	Progress Report
The new chemotherapy unit opened in March 2017.	Juliette Brockfield	March 2017	Complete
Staff interviewed and recruited to the establishment.	Deborah Sullivan	August 2017	Awaiting for a number of staff start dates
Notes: This risk was reviewed at the Risk assurance Meeting on 6 Jun 2017. Risk last reviewed on 5th July 2017. Next review date 5th August 2017			

East Lancashire Hospitals

NHS Trust

Title:	Aggregated Risk - Failure to provide timely Mental Health treatment impacts adversely on patient care & safety and quality				
ID	7067	Current Status	Live Risk Register – all risks accepted	Opened	06/10/2016
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 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:	<ul style="list-style-type: none"> • 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:	<ul style="list-style-type: none"> • 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 		Where are the gaps in control:	<ul style="list-style-type: none"> • Unplanned demand • ELCAS only commissioned to provide weekday service • Limited appropriately trained agency staff available 	
What assurances are in place:	<ul style="list-style-type: none"> • Ongoing meetings with LCFT and commissioners • Regular review at Divisional and Executive team level 		What are the gaps in assurance:		
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 5th July 2017. Next review date 5th August 2017			

TRUST BOARD REPORT

Item **103**

12 July 2017

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 team have reviewed the Board Assurance Framework (BAF) risks and agreed to reduce the number of risks from six to five. The proposed risks for the current financial year are:

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 objective

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

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

Following recommendations made in a recent Internal Audit findings report it is proposed that the above risks be monitored at Board Sub-Committee level as follows:

- Risks 1, 3 and 5 be monitored at the Finance and Performance Committee and Quality Committee, where each Sub-Committee will discuss the elements of the risks according to their remits
- Risk 2 be monitored at the Quality Committee
- Risk four be monitored at the Finance and Performance Committee

The changes to the risk register are indicated in green.

Recommendation:

The revised BAF is presented to the Board for approval.

Report linkages

Related strategic aim and corporate objective

Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives

Recruitment and workforce planning fail to deliver the Trust objectives

Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways

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

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: NA

Ref	Principle Director(s)	Strategic Risk <i>What could prevent these objectives being achieved.</i>	Risk related to strategic objectives	Key Controls <i>What controls/ systems we have in place to assist in securing delivery of our objective.</i>	Potential Sources of Assurance <i>Where we can gain evidence that our controls/systems on which we are place reliance, are effective</i>	Initial Risk Score	Risk Tolerance Score	Current Risk Score	Likelihood x Consequence	Annual Risk Score 2017/18	Gaps in Control <i>Where we are failing to put controls/ systems in place. Where we are failing in making them effective.</i>	Gaps in Assurance <i>Where we are failing to gain evidence that our controls/ systems, on which we place reliance, are effective.</i>	Actions Planned / Update <i>Dates, notes on slippage or controls/assurance failing.</i>
						Q1	Q2	Q3	Q4				
BAF/01	Director of Service Improvement/ Medical Director	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives	Aligned to Strategic Objectives 1,2,3 and 4.	Integrated transformation plans agreed at organisational level, overarching tracker for transformation and SRCP, Transformation Board meetings (internal and external stakeholders), divisional Transformation Boards report into the Transformation Board that reports into the Finance & Performance Committee. Membership of the Pennine Lancashire Transformation Board (6 workstreams). Transformation/business plans linked to the clinical strategy, high level workforce and estate interdependencies identified. 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.	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 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.	15	10	12	3x4	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 programme needs to be developed 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.Recruitment Open Day held on 24 June targeted at B5/6 band nurses for the Emergency Department, supported by a social media and advertising campaign. First cohort of Associate Nurses pilot started in Trust.	

Ref	Principle Director	Strategic Risk <i>What could prevent these objectives being achieved.</i>	Risk related to strategic objectives	Key Controls <i>What controls/systems, we have in place to assist in securing delivery of our objective.</i>	Potential Sources of Assurance <i>Where we can gain evidence that our controls/systems on which we are place reliance, are effective</i>	Initial Risk Score	Risk Tolerance Score	Current Risk Score	Likelihood x Consequence	Annual Risk Score 2017/18				Gaps in Control <i>Where we are failing to put controls/systems in place. Where we are failing in making them effective.</i>	Gaps in Assurance <i>Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.</i>	Actions Planned / Update <i>Dates, notes on slippage or controls/assurance failing.</i>
						Q1	Q2	Q3	Q4							
BAF/02	Director of HR/OD	Recruitment and workforce planning fail to deliver the Trust objectives	Aligned to Strategic Objectives 2, 3 and 4.	<p>Transformation plans relating to workforce in place monitored through Transformation Board.</p> <p>Divisional Workforce Plans aligned to Business & Financial Plans, Divisional Performance Meetings, Reports to Finance & Performance Committee.</p> <p>Workforce Controls Group, One Workforce Planning Methodology across Pennine Lancashire. Joint SRO at Pennine Lancashire LDP level.</p>	<p>Performance measures, time limited focus groups with action plans, board and committee reports, regulatory and inspection agencies, stakeholders, internal audit.</p> <p>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</p> <p>WRES action plan with timelines in place. Regular reporting to the Board on progress. Work with the Fanshawe Report.</p> <p>Workforce Control Group regularly reports to the Executive on workforce control measures and indicators. Dashboard developed. Annual report to the Quality Committee.</p> <p>Medical and Non-Medical Agency Group in place. Dashboard presented to the executive monthly.</p>	16	10	12	3x4	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.	<p>Overseas recruitment campaigns, (the Philippines for nurses and India for Doctors) have been successfully completed. First recruits joined the Trust within the last three months.</p> <p>The Trusts recruitment and retention plan continues to be in place. We continue to embed to the 'Retire and Return' approach.</p> <p>The Trust ensures that all staff are involved, included and engaged with on key changes within the Trust using the Employee Engagement Strategy.</p> <p>WRES progress update report presented to the Trust Board in May 2017. Piloting parallel recruitment process re. unconscious bias</p> <p>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.</p> <p>Workforce Transformation Team in place. Recruitment Open Day held on 24 June targeted at B5/6 band nurses for the Emergency Department, supported by a social media and advertising campaign. First cohort of Associate Nurses pilot started in Trust.</p>	

Ref	Principle Director	Strategic Risk <i>What could prevent these objectives being achieved.</i>	Risk related to strategic objectives	Key Controls <i>What controls/systems, we have in place to assist in securing delivery of our objective.</i>	Potential Sources of Assurance <i>Where we can gain evidence that our controls/systems on which we are place reliance, are effective</i>	Initial Risk Score	Risk Tolerance Score	Current Risk Score	Likelihood x Consequence	Annual Risk Score 2017/18	Gaps in Control <i>Where we are failing to put controls/systems in place. Where we are failing in making them</i>	Gaps in Assurance <i>Where we are failing to gain evidence that our controls/systems, on which we place reliance, are</i>	Actions Planned / Update <i>Dates, notes on slippage or controls/assurance failing.</i>
BAF/03	Chief Executive/ Director of Finance/ Director of Service Improvement/ Medical Director	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	3,4,5	Senior Leaders' Forum meets to discuss strategy. Engagement by senior leaders in wider transformation programmes. Regular Board updates and decisions on key actions. Strengthen links between internal transformation and external change processes. Care Professional Group of Pennine Lancashire reporting to the Transformation Steering Group.	Verbal and written updates, where appropriate Board approvals will be established and permissions will be provided by the Board to let Executives to progress the generations of ideas and options with external stakeholders.	16	12	16	4x4	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. Lack of unified approach in relation to procurement by Commissioners. Priorities of CCGs to be aligned with priorities for pathway redesign (e.g. stroke).	Regular updates provided to Board and the Audit Committee. 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. Across the STP footprint the Medical Directors of the four Trusts agreed to focus on urology, vascular services, stroke, emergency department, interventional radiology and gastrointestinal bleed, and neonatology At STP level all providers met in June to formulate work programme - 3 categories of services agreed a) services that are fragile now, b) services where there is no immediate risks 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.
				At Pennine Lancashire level health improvement priorities agreed (HIMPs). HIMPs reporting to the Care Professionals Board	The Pennine Lancashire and STP Cases for Change have been published. Pennine Lancashire resource in post working on developing models of care against specific improvement priorities (paediatrics, respiratory and frailty). Health delivery partnerships at Pennine Lancashire level reviewed around the health improvement priorities and the majority are relatively well established with minor changes need to link into the new structures.								
					STP governance oversight forms part of the Audit Committee standing agenda for 2017/18.								
					Fostering good relationships with GP practices and Federations eg 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.								

Ref	Principle Director	Strategic Risk <i>What could prevent these objectives being achieved.</i>	Risk related to strategic objectives	Key Controls <i>What controls/systems, we have in place to assist in securing delivery of our objective.</i>	Potential Sources of Assurance <i>Where we can gain evidence that our controls/systems on which we are place reliance, are effective</i>	Initial Risk Score	Risk Tolerance Score	Current Risk Score	Likelihood x Consequence	Annual Risk Score 2017/18	Gaps in Control <i>Where we are failing to put controls/systems in place. Where we are failing in making them effective.</i>	Gaps in Assurance <i>Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.</i>	Actions Planned / Update <i>Dates, notes on slippage or controls/assurance failing.</i>
						Q1	Q2	Q3	Q4				
BAF/04	Director of Finance	The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework	3,4,5	<p>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.</p> <p>Monitoring through the Transformation Board, Finance and Performance Committee and Trust Executives.</p>	<p>Monthly reporting to Finance and Performance reports and the Board to reflect financial position. Separate reporting available to support assurances on the transformation programme.</p> <p>Regular Performance Review meetings between Executives and Divisions.</p> <p>Financial recovery plans developed and agreed.</p> <p>Financial recovery plan approved by Trust Board March 2017. Governance through PMO to be monitored by Finance and Performance Committee.</p>	16	12	16	4x4	16	<p>Additional workforce controls to remain in place. policies and procedures may require amendments where they are no longer fit for purpose.</p> <p>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.</p> <p>Gaps in control regarding funding for A&E and STF Funding - recovery plan underway</p>	<p>Utilise the internal audit programme to test for assurance on core controls, SRCP and transformation plans.</p>	<p>Regular updates to Board and Finance and Performance Committee</p> <p>Finance risk around A&E and STF funding identified and operational plans to recover are ongoing.</p> <p>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.</p>

Ref	Principle Director	Strategic Risk <i>What could prevent these objectives being achieved.</i>	Risk related to strategic objectives	Key Controls <i>What controls/systems, we have in place to assist in securing delivery of our objective.</i>	Potential Sources of Assurance <i>Where we can gain evidence that our controls/systems on which we are place reliance, are effective</i>	Initial Risk Score	Risk Tolerance Score	Current Risk Score	Likelihood x Consequence	Annual Risk Score 2017/18				Gaps in Control <i>Where we are failing to put controls/systems in place. Where we are failing in making them effective.</i>	Gaps in Assurance <i>Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.</i>	Actions Planned / Update <i>Dates, notes on slippage or controls/assurance failing.</i>
						Q1	Q2	Q3	Q4							
BAF/05	Director of Operations/ Director of Nursing/ Medical Director	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements	Aligned to strategic objectives 1, 3 and 4.	<p>Divisional business plans, weekly operational performance meetings, monthly divisional performance meetings feeding into the ODB and Finance and Performance Committee, emergency pathway and elective pathway work linking into the broader Trust wide transformation.</p> <p>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.</p> <p>Nursing Assessment Performance Framework received significant assurance from internal audit</p> <p>System wide approach as part of the new A&E Delivery Board.</p> <p>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.</p>	<p>IPR reporting to the ODB and at Board/Committee level, regular reporting to the NHSI, monthly integrated delivery meeting with the NHSI and A&E Delivery Board.</p> <p>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.</p> <p>Good rating overall from CQC.</p> <p>ED performance improvement action plan aligned with the NHSI Rapid Improvement Collaborative</p> <p>Cancer, RTT and 4 hour standard improvement plans underway and having an impact through enhanced operational meetings.</p> <p>In quarter 1 approximately five wards potentially eligible for silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments. First Silver Accreditation of a ward approved by the Trust Board on 29 March 2017.</p> <p>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.</p> <p>Significant reduction in the number of complaints upheld by the Ombudsman. Comprehensive system for addressing complaints. PLACE assessments - percentage improved in all areas.</p> <p>Positive patient survey with improvement areas identified.</p>	15	9	16	4x4	16				Staffing potentially not sufficient to deal with the impact of external environment & high demand, difficulties with discharges. Medical staffing gaps (gaps in rotas) affecting our ability to deliver service and affecting patient experience. Complaints are a potential source of action by the CQC.	<p>Risks around some of the national trajectories identified. Recovery plans are being implemented.</p> <p>Continued non-elective activity is placing pressure on the elective care and the RTT target.</p> <p>Funding to resource Nursing Assessment Performance Framework yet to be agreed. Assessments under the Framework to go through the Patient Safety & Risk Assurance Committee before presentation to the Quality Committee.</p>	<p>Timeline for the transformation of the emergency pathway plan agreed. Working as part of the Emergency Care Delivery Board to resolve demand issues and participating in the delayed discharge collaborative with the NHSI.</p> <p>Work on reducing the number of complaints, 50+ and 40+ days continues. 50+ days complaints reduced with 1 division still working on achieving this milestone. Process review to improve response times in underway. Review of the complaints element of the Patient Experience Strategy to be completed by September 2018.</p> <p>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.</p> <p>Board receives regular SRCP and transformation updates.</p> <p>Work on the Emergency Care Pathway and Model Wards continues including red and green days, discharge to assess and ambulatory emergency care. Work ongoing with NHSI and AQUA.</p> <p>Recovery plans being implemented around achievement of national trajectories. Improvement trajectory for Delayed Transfers of Care (DTC) to be put in place from May 2017. Improvement trajectory to reduce complex care trigger list is in place. DTOC visit by NHSI on 14 June.</p> <p>Nursing Assessment Performance Framework internal audit review received significant assurance and reported to the Audit Committee in July.</p>

TRUST BOARD REPORT

Item **104**

12 July 2017

Purpose Information Assurance

Title Serious Incidents Requiring Investigation Report

Author Mrs R 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 March and April 2017

This report also provides a summary themed analysis of Falls Prevention

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

Report linkages

Related strategic aim and corporate objective Put safety and quality at the heart of everything we do

Invest in and develop our workforce

Work with key stakeholders to develop effective partnerships

Encourage innovation and pathway reform, and deliver best practice

Related to key risks identified on assurance framework Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives

Recruitment and workforce planning fail to deliver the Trust objectives

Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways

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

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

rating.

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

Impact

Legal	Yes/No	Financial	Yes/No
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Equality	Yes/No	Confidentiality	Yes/No
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Previously considered by: NA

Part 1: Overview of SIRIS Reported

STEIS SIRIs reported in May and June 2017

- There were 13 Strategic Executive Information System (STEIS) events reported in May and June 2017. All will undergo Root Cause Analysis (RCA) which will be performance managed by the Trust's SIRI

No	Eir1	Division	Ward/ dept.	Description	Duty of Candour
1	eIR1118828	Medical	Ward B18, Blackburn	Sub optimal care of deteriorating patient	Complete
2	eIR1125366	Medical	Ward B4, Blackburn	Pressure Ulcer Grade 3	Complete
3	eIR1125615	Community	Patients Home (Burnley)	Pressure Ulcer Grade 3	Complete
4	eIR1100890	Medical	Ward C5 Blackburn	Sub optimal care of deteriorating patient	Complete
5	eIR1124901	Medical	Ward D1, Blackburn	Sub optimal care of deteriorating patient	Complete
6	eIR1126031	Corporate	Details if known identified in description	Cyber Attack	Not applicable
7	eIR1125456	Surgical & Anaesthetic Services	Gynaecology Theatre 3 BGH	Adverse Media interest - consent	Complete
8	eIR1125954	Medical	Ward C7, Blackburn	Sub optimal care of deteriorating patient	Complete
9	eIR1126614	Surgical & Anaesthetic Services	Ward C14, Blackburn	Pressure Ulcer	Complete
10	eIR1124683	Community	Olive House HFE	Pressure Ulcer	Complete
11	eIR1127479	Medical	Rehab Ward	Pressure Ulcer	Complete
12	eIR1127667	Medical	C5	Slip, Trips and falls	Complete
13	eIR1127871	Medical	AVH	Slips, trips and falls	Complete

- Please note the processes for StEIS reporting Grade 3 and above pressure ulcers has reverted to previous agreements which is once a pressure ulcer has been verified as grade 3 or above, these are StEIS reported at that stage.
- For pressure ulcers concluded as unavoidable, this means all correct procedures, policies and processes were followed and there were no further interventions that could have been carried out to prevent the pressure ulcer occurring. All go through a Root Cause Analysis (RCA) and supporting evidence is shared with commissioners. Unavoidable pressure ulcers are then de-escalated and removed from StEIS.

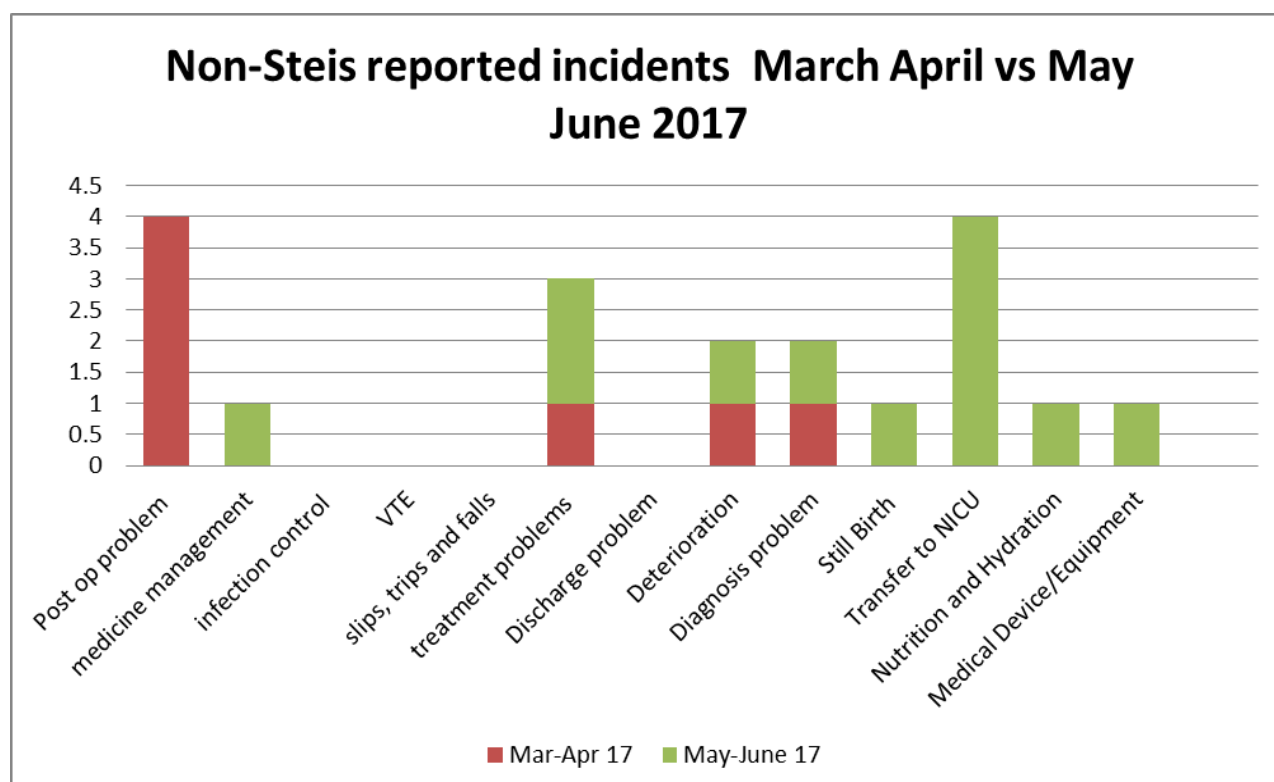
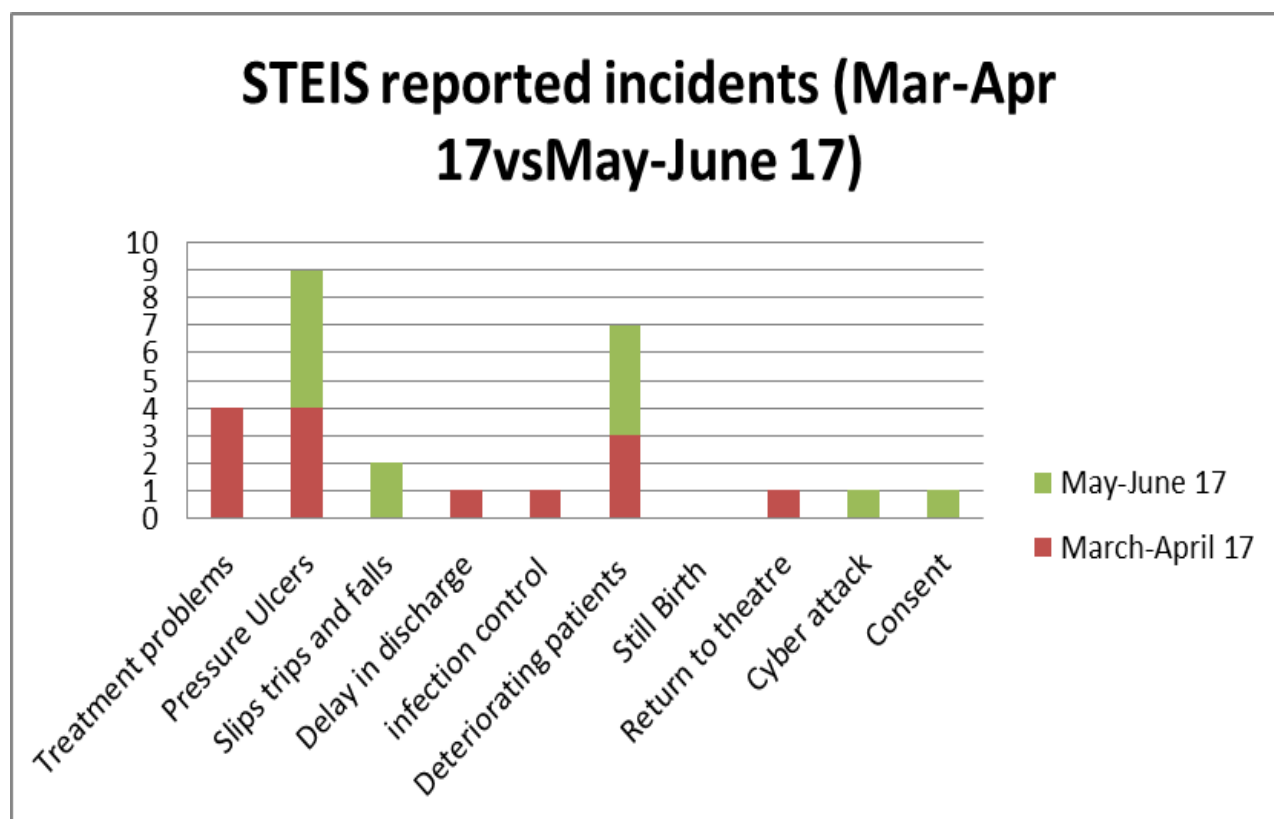
4. Based on the above StEIS incidents, for the incidents with the designation “G3 pressure ulcer (under investigation)” in the table above, de-escalation might be sought if the investigation concludes the pressure ulcer was unavoidable and the Committee/Board will be updated in future reports.

Non STEIS SIRIs reported in May and June 2017

5. There were 12 non-STEIS incidents deemed to be serious incidents requiring investigation in May and June 2017 compared to 7 in the previous reporting period. All will undergo RCA and will be performance managed by the Serious Incident Review Group (SIRG).

No	Eir1	Division	Ward/ dept.	Description	Duty of Candour
1	eIR1125179	Family Care	Childrens Medical Unit, Blackburn	Medication	Complete
2	eIR1127206	Surgical & Anaesthetic Services	Ward B14, Blackburn (Surgical Triage Unit)	Treatment problem/issue	Complete
3	eIR1126973	Family Care	Blackburn Birthing Centre	Maternity/Obstetrics (unexpected transfer to NICU)	Complete
4	eIR1124826	Surgical & Anaesthetic Services	Emergency Medicine Dept, Blackburn	Treatment problem/issue	Complete
5	eIR1125261	Medical	Ward C5 Blackburn	Oral Nutrition & Hydration	Complete
6	eIR1126051	Family Care	Birth suite BGH	Maternity/Obstetrics (Eclamptic fit)	Complete
7	eIR1124677	Family Care	Birth suite BGH	Maternity/Obstetrics (Still Birth 25+2)	Complete
8	eIR1125985	Medical	Acute Medical Unit B	Medical devices & equipment	Complete
9	eIR1126997	Family Care	Details if known identified in description	Neonatal / NICU	Complete
10	eIR1125908	Family Care	Birth suite BGH	Maternity/Obstetrics – Unexpected transfer to NICU	Complete
11	eIR1127553	Family Care	Birth Suite BGH	Unexpected transfer to NICU	Complete
12	eIR1126883	Diagnostic and Clinical Support	Breast Screening	Cancer misdiagnosis	Complete

STEIS & non STEIS SIRIs reported above compared with previous 2 months



Part 2: Antenatal and Newborn Screening Programme

Introduction

6. The Antenatal and Newborn Screening Programme covers the identification of eligible women and babies and the relevant tests undertaken by each screening programme. It includes acknowledgement of the referral by treatment or diagnostic services as appropriate (for individuals/families with screen-positive results), or the completion of the screening pathway. The screening programme consists of the following:
 - Sick cell and thalassaemia screening
 - Infectious diseases in pregnancy screening
 - Fetal anomaly screening
 - Newborn hearing screening
 - Newborn and infant physical examination
 - Newborn blood spot screening
7. In 2016 Family Care Division and the corporate quality and safety team identified there had been a number of screening incidents relating to the Antenatal and Newborn Screening Programme.
8. Data was extracted from the Datix system for the period April 2015 to October 2016 and analysed.

Review of incidents

9. A total of 29 incidents were reported from April 2015 to April 2017 (average 1.16 per month), these were all reviewed and during the review a number of incidents were identified as requiring further investigation.
10. Of those identified as requiring further investigation 4 related to the Newborn Blood Spot testing and 6 related to Fetal Anomaly Screening. Public Health England was notified, the incidents were StEIS reported and a cluster review of the 10 incidents was commissioned.
11. Those requiring further investigation were broken down in to two main categories:
 - a) Newborn Blood Spot testing.
 - i. This is offered to all babies in England and undertaken at 5 days of age. Newborn blood spot screening involves taking a blood sample from the baby's heel to find out if the baby has one of nine rare but serious congenital

or inherited health conditions. These are: Sickle cell disease (SCD)¹, cystic fibrosis (CF)², congenital hypothyroidism (CHT)³ and six inherited metabolic diseases (IMDs) - phenylketonuria (PKU), medium-chain acyl-CoA dehydrogenase deficiency (MCADD), maple syrup urine disease (MSUD), isovaleric acidaemia (IVA), glutaric aciduria type 1 (GA1) and homocystinuria (pyridoxine unresponsive) (HCU).⁴

- ii. Most babies screened won't have any of these conditions but, for those that do the benefits of screening are enormous as early treatment can improve their health and prevent severe disability, and even death.

b) Fetal Anomaly Screening

- i. The NHS Fetal Anomaly Screening Programme (NHS FASP) offers screening to eligible women in England for Down's (trisomy⁵ 21)⁶, Edwards' (trisomy 18)⁷ and Patau's (trisomy 13)⁸ syndromes; and screening for 11 specific fetal structural anomalies via ultrasound scan between 18+⁰ to 20+⁶ weeks.

¹ About 1 in 2,000 babies born in the UK has sickle cell disease. This is a serious inherited blood disease. Sickle cell disease affects haemoglobin, the iron-rich protein in red blood cells that carries oxygen around the body. Babies who have this condition will need specialist care throughout their lives.

² About 1 in 2,500 babies born in the UK has cystic fibrosis. This inherited condition affects the digestion and lungs. Babies with cystic fibrosis may not gain weight well and frequently have chest infections. Babies with the condition can be treated early with a high-energy diet, medicines, and physiotherapy. Although children with cystic fibrosis may still become very ill, early treatment can help them live longer, healthier lives.

³ About 1 in 3,000 babies born in the UK has congenital hypothyroidism. Babies with congenital hypothyroidism do not have enough of the hormone thyroxine. Without thyroxine, babies do not grow properly and can develop [learning disabilities](#). Babies who have the condition can be treated early with thyroxine tablets, and this allows them to develop normally.

⁴ About 1 in 10,000 babies born in the UK has PKU or MCADD. The other conditions are rarer, occurring in 1 in 100,000 to 150,000 babies. Without treatment, babies with inherited metabolic diseases can become suddenly and seriously ill. The diseases all have different symptoms. Depending on which one affects your baby, the condition may be life threatening or cause severe developmental problems. They can all be treated with a carefully managed diet and, in some cases, medicines as well.

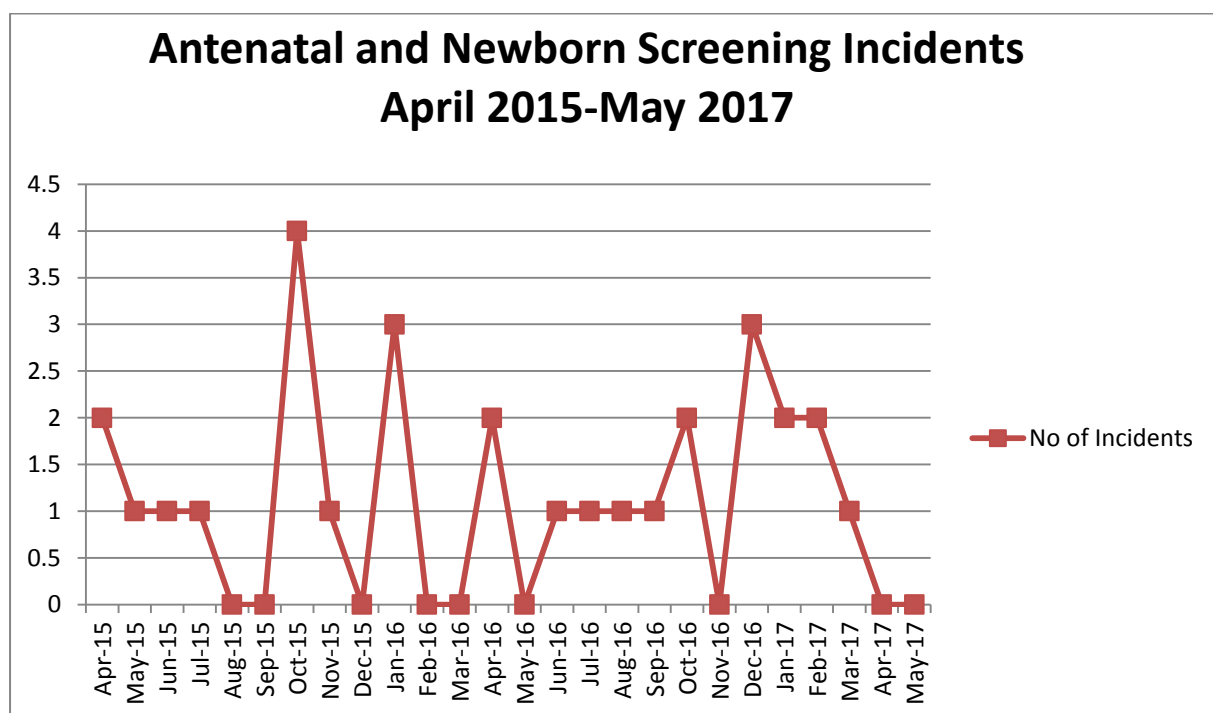
⁵ A trisomy is a chromosomal disorder characterised by an additional chromosome, so the person has 47 instead of 46. Down syndrome, Edward syndrome and Patau syndrome are the most common forms of trisomy.

⁶ With Down's syndrome there is an extra copy of chromosome 21 in each cell. It affects about 1 in every 1,000 births.

⁷ Babies with Edwards' syndrome have an extra copy of chromosome 18 in each cell. Most babies with Edwards' syndromes will die before they are born, be stillborn or die shortly after birth. Some babies may survive to adulthood but this is rare. Babies affected by Edwards' syndrome can have heart problems, unusual head and facial features, growth problems and be unable to stand or walk. Edwards' syndrome affects about 3 of every 10,000 births.

⁸ Babies with Patau's syndrome have an extra copy of chromosome 13 in each cell. Babies with Patau's syndrome have an extra copy of chromosome 13 in each cell. Most babies with Patau's syndromes will die

- ii. Combined screening is the most effective early screening test for Down's, Edwards' and Patau's syndromes⁹ The combined test involves measuring the fluid at the back of the baby's (known as the nuchal translucency) at the dating ultrasound scan, and taking a blood sample.
- iii. Quadruple screening is offered if a mother presents late for Combined Screening and is undertaken between 14+2 and 20+0 weeks of pregnancy. A blood sample from the mother determines levels of 4 different biochemical markers that together with maternal age can indicate whether there is a higher risk of Down's syndrome. This test is less effective than the Combined test and only detects Down's syndrome.
- iv. The Combined and Quadruple Screening test are not diagnostic they determine if the woman, or her baby, have a high or low chance of having a health problem. People found to have a high chance of a problem will be offered a second test, this is a diagnostic test and gives a more definite 'yes' or 'no' answer



before they are born, be stillborn or die shortly after birth. Babies affected by Patau's syndrome can have heart problems, a cleft lip and palate, growth problems, poorly formed eyes and ears, problems with their kidneys and be unable to stand or walk. Patau's syndrome affects about 2 of every 10,000 births

⁹ All babies born with Edwards' and Patau's syndromes will have a wide range of problems, which are usually extremely serious – these may include major brain abnormalities.

Lessons learnt and Action Plan

12. Failure to recognise screening incidents and report in a timely manner – there is clear guidance produced by NHS England and the NHS Screening Programmes that emphasises what a screening incident involves and the actions required if an incident occurs. From the analysis and investigation of each incident we have identified the below lessons to be learnt
 - a) The importance of ensuring the sample arrives at the Laboratory.
 - b) The impact on patients and their care if samples are not received appropriately.
 - c) Antenatal Screening Co-ordinator to be notified of all screening incidents until the changes on Datix are implemented.
 - d) Ensure the information contained with the booklet “Screening Tests for you and your baby” is shared with patients / parents and revisited throughout the pregnancy and postnatal period.
 - e) Midwives taking bloodspot samples must ensure the demographics match that of the infant prior to taking the sample, checking details with the mother.
 - f) Midwives completing birth records must ensure the bloodspot labels are generated and filed in the correct notes.
 - g) If mothers are transferred to the postnatal ward before all the birth documentation has been completed, the midwife responsible for completing the paperwork is also responsible for ensuring it is taken to the postnatal ward and filed appropriately.
 - h) The professional completing the discharge paperwork should ensure that the correct bloodspot labels are in the correct infants child health record (which is provided prior to discharge home and once the hearing screen has been completed).
 - i) Midwives should not to rely on a third party to deposit blood samples into the collection boxes when in community settings.
 - j) Continue to work with IT to scope the procurement of a Screening specific database with adequate resources to monitor fail safe systems as recommended by QA.
 - k) Review of mentorship/preceptorship documentation.
 - l) All midwives to be signed off as competent prior to undertaking screening tests.
 - m) All midwives and obstetricians who are involved in screening to undertake e-learning annually.
 - n) To undertake a bespoke session for Obstetricians and Midwives on antenatal and newborn screening.
 - o) Introduce Antenatal and Newborn Screening to the Obstetric teaching sessions
 - p) Increased training time for Screening.
 - q) Review of staffing dedicated to Screening to ensure that the roles are overarching and that all midwives have ownership of their responsibility and accountability for screening.
 - r) Amend Datix to incorporate a category for Antenatal and Newborn Screening.
 - s) Review and enhance failsafe system for the monitoring and transportation of bloods for Trisomy 13 Patau's / 18 Edward's / 21 Down's to the laboratory.
 - t) Implement a dedicated clinic for Quadruple screening.
 - u) Spot check audit of midwives diary to ensure compliance with documentation as to where bloods deposited.
 - v) Share findings from the cluster review across the service.
 - w) Contact all patients' / parents involved.
 - x) Review of staffing in clinic and develop a core team for screening.

- y) Review and update ELHT Maternity Services Clinical Guideline 28:Maternal and Neonatal Screening – Results and Communication version 4 to ensure it is reflective of and in line with national guidance and recommendations in respect of reference ranges for offering screening.
- z) Appoint a Consultant Obstetrician as the medical lead for Antenatal and Newborn Screening.
 - aa) Check with all women at 16 weeks gestation that they are content with their decision making in respect of Antenatal and Newborn Screening.
 - bb) To undertake a prospective audit over a 3 month period between 14 and 19 weeks gestation as to the process for obtaining blood for combined screening, the receipt of results, where combined screening is not possible that quadruple is offered an appointment is made and bloods obtained and the documentation in relation to this.
 - cc) To liaise with the Ultrasonographers to generate a report from CRIS of those women who requested combined screening and measurement of nuchal translucency was not possible to ensure these women are recalled for quadruple screening.

No	Action	By whom	By when	Evidence	RAG status
Information Technology					
1	Continue to work with IT to scope the procurement of a Screening specific database with adequate resources to monitor fail safe systems.	Dr S / MJ / AM / LE		IT system implemented	
2	Amend Datix to incorporate a category for Antenatal and Newborn Screening	CH / NS	31 st July 2017	Changes to Datix implemented	
Education					
1.	To undertake a bespoke session for Obstetricians and Midwives on antenatal and newborn screening.	Mr M / Mrs B	30 th September 2017	Bespoke session on Antenatal and Newborn Screening to be incorporated into and undertaken at the Audit Meeting. Audit Minutes.	
2.	Introduce Antenatal and Newborn Screening to the Obstetric teaching sessions	Mr M	31 st July 2017	Obstetric teaching agenda.	
3.	Review of mentorship/preceptorship documentation.	A-M W / BK	31 st July 2017	Amended preceptorship documentation	
4.	All midwives to be signed off as competent prior to undertaking screening tests.	Team Leaders / Ward Managers	This will be a continuous cycle particularly in respect of Band 5 midwives	Training records.	
5	All midwives and obstetricians who are involved in screening to undertake e-learning annually.	Team Leaders / Ward Managers / Screening Co-ordinator	31 st December 2017	Training database. This will be monitored on a quarterly basis through the ward dashboards presented at QSB.	

No	Action	By whom	By when	Evidence	RAG status
Organisational					
1.	Review of staffing dedicated to Screening to ensure that the roles are overarching and that all midwives have ownership of their responsibility and accountability for screening.	ED	31 st July 2017	All midwives understand their responsibility and accountability for screening and this is reflected through appraisals over the coming 12 months	
2.	Review and enhance failsafe system for the monitoring and transportation of bloods for Trisomy 13 Patau's / 18 Edward's / 21 Down's to the laboratory.	ED / CH/ JS / CB	31 st January 2017	Amended failsafe proforma	
3.	IOI Implement a dedicated clinic for Quadruple screening.	CB / ED	1 st March 2017	Clinic implemented	
4.	Spot check audit of midwives diary to ensure compliance with documentation as to where bloods deposited.	HD / ED	31 st March 2017	Audit data.	
5.	Share findings from the cluster review across the service.	ED / CH / JS / Mr M / JA	31 st March 2017	Share to Care minutes/In safe hands newsletter and Facebook page / Teaching session agendas / Audit minutes.	
6.	Contact all patients' / parents involved.	JS / ED/ CB,	When investigation signed off by PHE and CCG.	Patient letters.	
7	Review of staffing in clinic and develop a core team for screening.	ED / JS	31 st December 2017	Core screening team in place.	
8.1	Whilst guidance is being reviewed and updated all user email to be sent to all staff of the national guidance and reference range in respect ranges for offering screening.	JS	31 st March 2017	All user email	
8.2	Review and update ELHT Maternity Services Clinical Guideline 28: Maternal and Neonatal Screening – Results and Communication version 4 to ensure it is reflective of and in line	JS / MM	30 th June 2017	Guideline updated.	

No	Action	By whom	By when	Evidence	RAG status
	with national guidance and recommendations in respect of reference ranges for offering screening.				
9	Appoint a Consultant Obstetrician as the medical lead for Antenatal and Newborn Screening.	Divisional Director	30 th November 2016	Consultant appointed	
10	Check with all women at 16 weeks gestation that they are content with their decision making in respect of Antenatal and Newborn Screening.	All staff undertaking antenatal and newborn screening	30 th June 2017	All user email. In Safe Hands newsletter. In Safe Hands Facebook page. Share to care.	
11	To undertake a prospective audit over a 3 month period between 14 and 19 weeks gestation as to the process for obtaining blood for combined screening, the receipt of results, where combined screening is not possible that quadruple is offered an appointment is made and bloods obtained and the documentation in relation to this.	ED / CH/ JS / Mr M to co-ordinate – All staff	31 st August 2017	Audit completed, results analysed and actions implemented were appropriate	
12	To liaise with the Ultra sonographers to generate a report from CRIS of those women who requested combined screening and measurement of nuchal translucency was not possible to ensure these women a recalled for quadruple screening.	ED / CH/ JS	30 th June 2017	Reports generated.	

13. It must be noted that during the cluster review there was close engagement with public health England and the quality assurance team. The final report was shared with them prior to presentation at SIRI and recommendations requested by them incorporated into the report. Public Health England and the QA team attended SIRI to support Family Care Division and thanked them for their hard work in undertaking the review and working alongside them during the process. The review was undertaken by a Matron in Family Care division; however, she has no knowledge of maternity services or the antenatal and newborn screening programme. The medical lead was a Consultant Obstetrician who was new to the organisation and it was felt that these two would provide objectivity and be able to apply a “fresh eyes” approach and a level of scrutiny to the review therefore assurance could be provided.

TRUST BOARD REPORT

Item **106**

12 July 2017

Purpose Information
Assurance

Title	Integrated Performance Report May 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 at May 2017

Report linkages

Related strategic aim and corporate objective	<p>Put safety and quality at the heart of everything we do</p> <p>Invest in and develop our workforce</p> <p>Work with key stakeholders to develop effective partnerships</p> <p>Encourage innovation and pathway reform, and deliver best practice</p>
Related to key risks identified on assurance framework	<p>The Trust fails to deliver and develop a safe, competent workforce</p> <p>Partnership working fails to support delivery of sustainable safe, personal and effective care</p> <p>The Trust fails to achieve a sustainable financial position</p> <p>The Trust fails to achieve required contractual and national targets and its improvement priorities</p> <p>Corporate functions fail to support delivery of the Trust's objectives</p>

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	Yes

Previously considered by: NA

Board of Directors, Update

Corporate Report

Executive Overview Summary

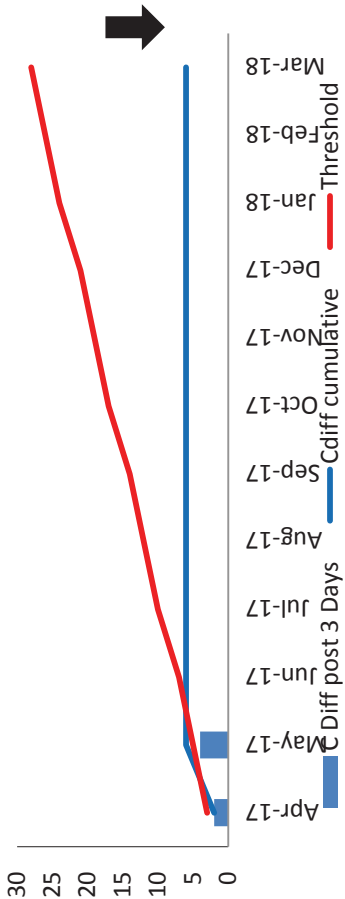
Significant operational pressures continued in May due to the level of demand for beds. The Trust saw a decrease in the number of delayed discharges of medically fit patients, however the non-elective length of stay has increased in May. The emergency department saw a decrease in the ambulance handover times, however pressures have continued and impacted the flow through the hospital, causing delays in the emergency department for patients waiting for beds.

Despite all the pressures, the 18 week referral to treatment targets for May have been achieved as well as the diagnostic 6 week target.

Introduction

This report presents the data relating to the period May 2017 and follows the NHS Improvement Single Oversight Framework. The narrative provides details on specific indicators under the five areas; Safe, Caring, Effective, Responsive, Well Led.

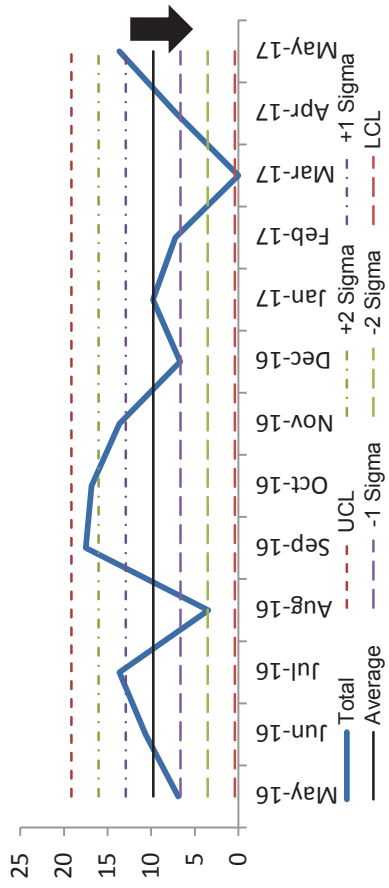
C Difficile



There have been no further confirmed MRSA infections reported in May, however 2 were identified in the laboratory and are awaiting attribution.

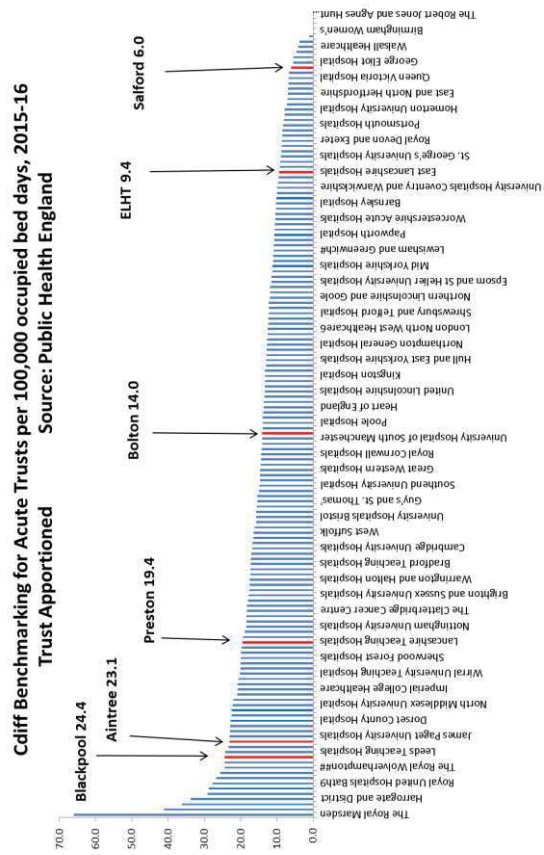
There were four Clostridium difficile toxin positive isolates identified in the laboratory in May which were post 3 days of admission. The year to date cumulative figure is 6 against the trust target of 28. The full exception report will be reviewed through the Quality Committee.

C Difficile per 100,000 occupied bed days



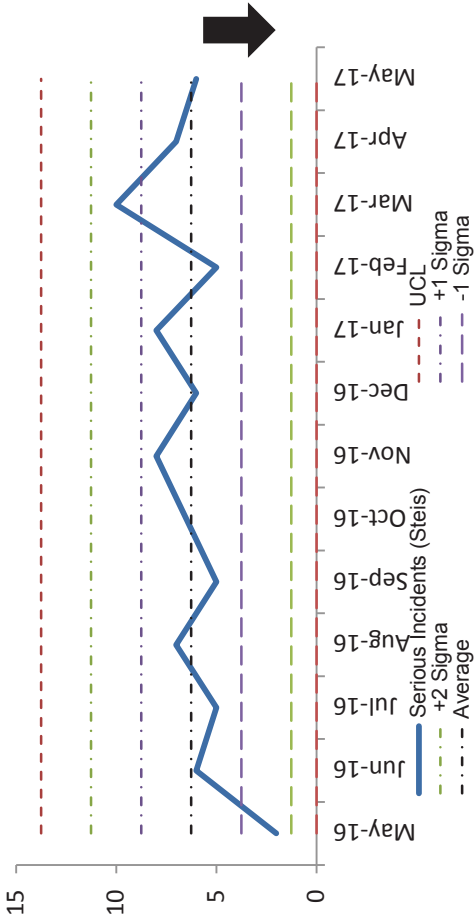
The rate of infection per 100,000 bed days has risen to 12.9 in May.

C Difficile benchmarking



ELHT ranked 31st out of 154 trusts in 2015-16 with 9.4 clostridium infections per 100,000 bed days. The best performing trust had 0 and the worst performer had 66 infections per 100,000 bed days.

Serious Incidents

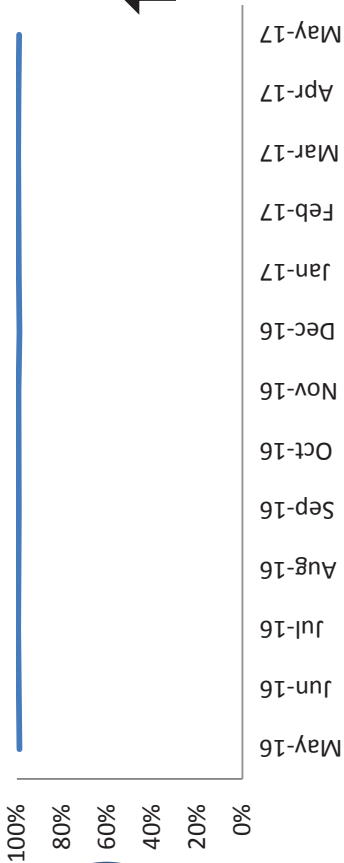


There were no never events reported to Steis in May.

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

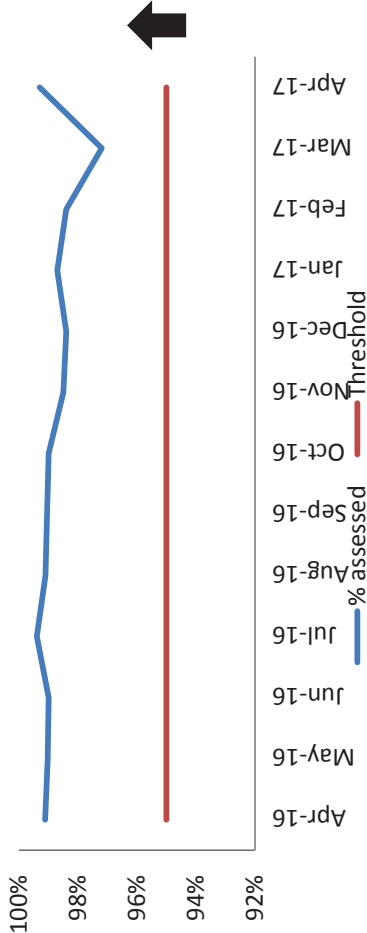
StEIS Category	No. of Incidents
Sub Optimal Care of the Deteriorating Patient	3
Pressure Ulcer	1
Adverse Media Coverage	1
Major Incident	1

% Harm Free Care from safety thermometer



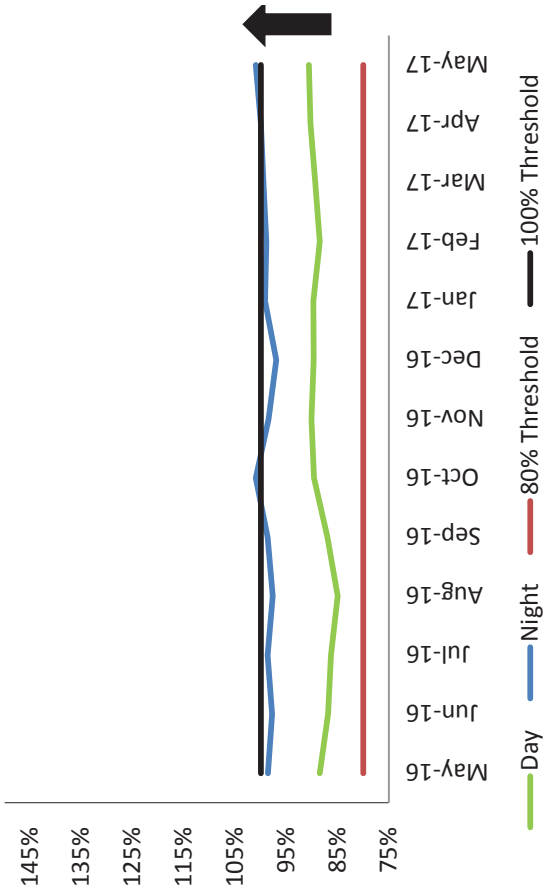
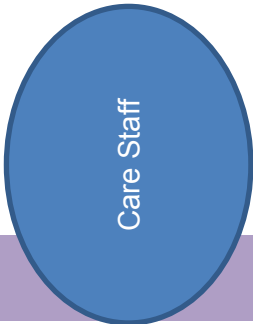
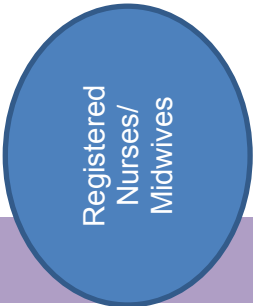
A detailed report providing assurance on the management of each of the STEIS reported incidents is submitted monthly to the Patient Safety and Risk Assurance Committee.

VTE assessment



The Trust remains consistent with the percentage of patients with harm free care at 99.0% for May 2017 using the National safety thermometer tool.

For May 2017 we are reporting the current position as three grade 2 hospital acquired, one grade 2 community acquired, one grade 3 community acquired and one grade 3 hospital acquired pressure ulcers. All pending investigation.



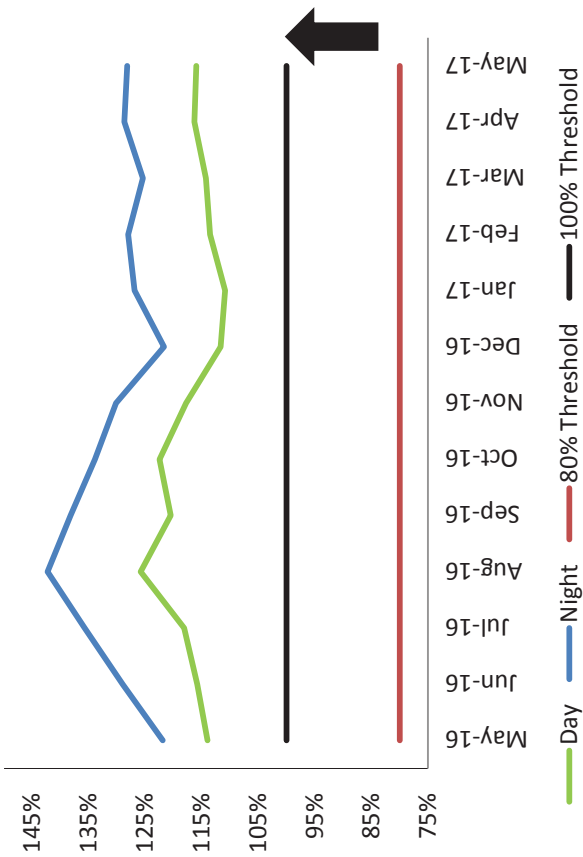
Nursing and midwifery staffing in May 2017 continued to be challenging. 3 areas fell below an 80% average fill rate for registered nurses on day shifts and 1 area for registered midwives on night duty.

The causative factors remain as in previous months, compounded by escalation areas being open. Of the 3 areas day shifts below the 80% average fill rate, 1 of those wards fell below the 80% due to coordinator unavailability, which is in addition to the agreed safe staffing levels, leaving 1 areas of concern.

Daylight Shifts
Reedyford

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.



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 incidents reported this month relating to inability to reliably carry out intentional rounding. No harm has been identified as a consequence. The red flag incident increased reporting last month appears to have been a glitch which has now been resolved.

Average Fill Rate				CHPPD		Number of wards < 80 %		
	Day		Night			Day		Night
month	Average fill rate - registered nurses / midwives. (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives. (%)	Average fill rate - care staff (%)	Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	registered nurses/ midwives	care staff
May-17	90.6%	116.0%	111.0%	128.2%	27653	8.90	3	1
							1	1

Actions taken:

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 May 2017 Maternity

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.

Month	Aug 16	Sept 16	Oct 16	Nov 16	Dec16	Jan 17	Feb 17	March 17	April 2017	May 2017
Staffed to full Establishment	1:30.3	1:30.4	1:30.2	1:30.6	1:30.1	1:29.2	1:28.8	1:29.2	1:31	1:30.2
Excluding mat leave and vacancies	1:31.5	1:31.9	1:30.6	1:31.2	1:31	1:30.8	1:30.3	1:30.4	1:32.1	1:30.7
With gaps filled through ELHT Midwife staff bank	1:29.7	1:28.4		1:29.4	1:29.2	1:29.4	1:29.4	1:29.3	1:31.2	1:29.3
					Usage 13.31WTE weekly	Bank Usage 10.10WTE	Bank Usage 6.165 WTE	Bank usage 8.225 WTE	Bank usage 5.66Per WTE	Bank usage 9.60WTE

Staffing Red Flags for May 2017

Seven incidents were reported under Maternity Services “Red Flags” staffing category in May in the red flags report on Datix. A further ten incidents were reported under the staffing category.

However on further analysis and cross referencing of the 17 some incidents appeared in both the staffing and red flags reports. No harm was caused by any of the red flag or staffing incidents reported and the appropriate actions and escalation occurred to ensure patient safety was maintained.

Maternity

Activity was high in May for births and inductions which resulted in staffing pressures and delays for women commencing their induction on the Central Birth Suite and women labouring on the Antenatal Ward. There were 2 ladies in the month of May where 1-1 care in labour was not provided for a period of time which was due to acuity and midwife shortages on the Central Birth Suite. A meeting has been arranged to review the induction process and pathways for induction of labour in order to prevent women labouring on the Antenatal Ward. No harm came to the mothers or babies in this instance. The uptake for the bank shifts has proved challenging since the reduction in the uplift of the bank pay.

Acuity is assessed twice daily with a multi-professional team in the safety huddles on Central Birth Suite, the huddles review the whole picture across ELHT Maternity Services and staff are redeployed accordingly to ensure safe staffing and maintain the quality and safety of patient care.

NICU

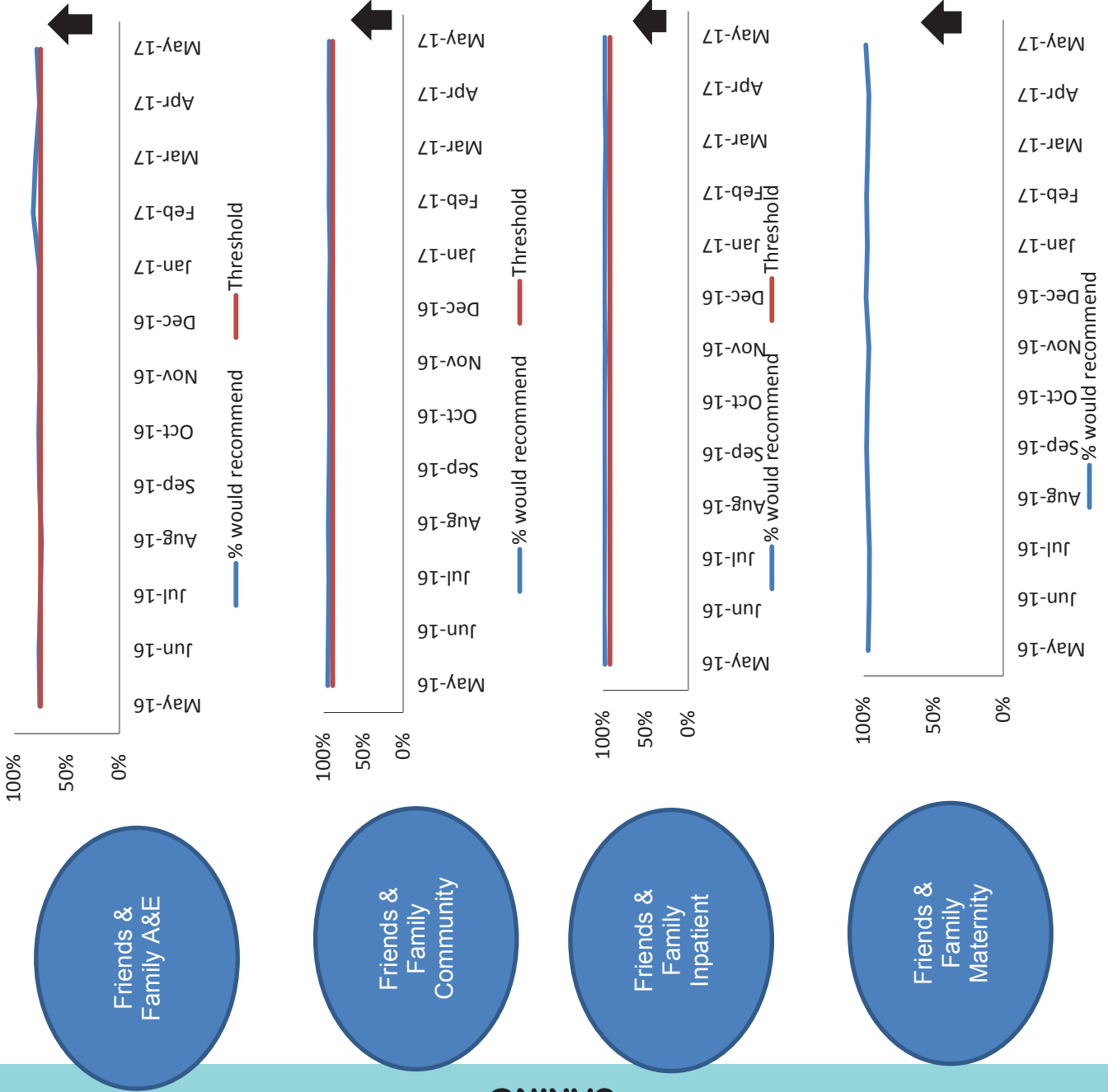
The uptake for the bank shifts has proved challenging since the reduction in the uplift of the bank pay.

Nurse staffing levels for the acuity are monitored throughout the day and if acuity changes shift's are put out to bank and agency to fill the gaps to ensure safe staffing and where necessary the unit is closed to external admissions to maintain safety.

Paediatrics

Paediatrics continues to have staffing gaps due to vacancies and maternity leave, bank and agency are used to mitigate the risk and ensure safe staffing. The HCA usage has been over what is established for due to the number of young people requiring 1-1 care whilst an inpatient. There are a number of student nurses ready to start but this will not be until the summer time.

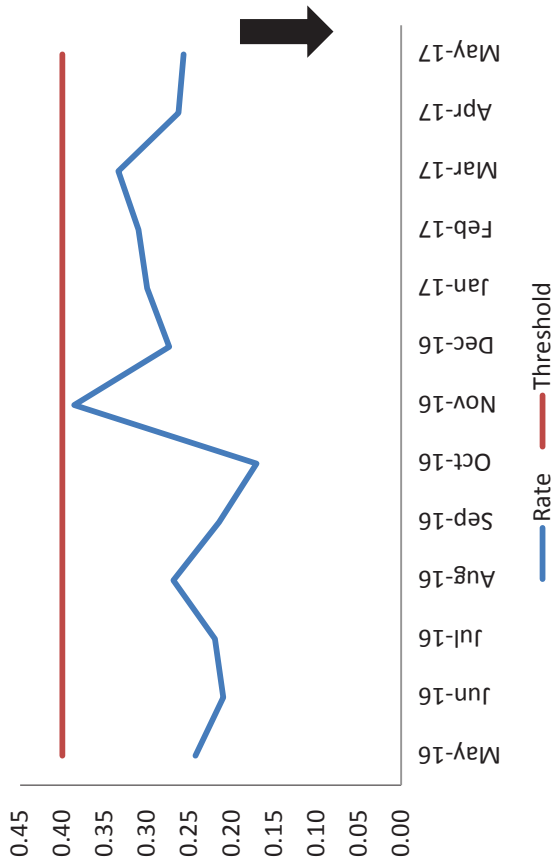
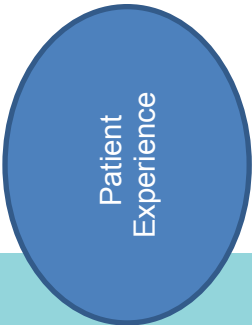
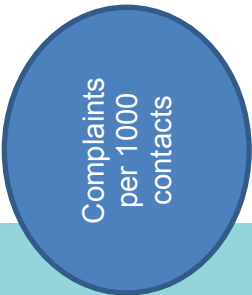
Please see Appendix 1 for UNIFY data and Appendix 2 for nurse sensitive indicator report



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 May the number that would recommend A&E to friends and family was up on last month at 78.3%. The proportion that would recommend inpatient services was unchanged on last month at 98.0%. Community services would be recommended by 92.9% and maternity 98.4%

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



The Trust received 29 new formal complaints in May compared to 30 in April and 43 in March. The number of complaints closed in May was 30

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 May the number of complaints received is shown as 0.3 Per 1,000 patient contacts.

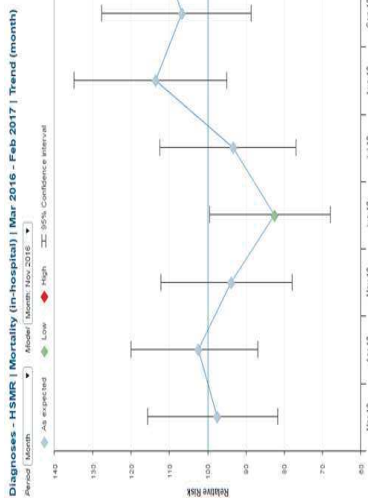
An external audit on has been completed which gave significant assurance on the Trust's complaint process. All recommendations made in the final report have now been completed.

May 2017 Totals	Overall		Dignity		Information		Involvement		Quality	
	No.	%	No.	%	No.	%	No.	%	No.	%
Trust	2282	97	2282	98	2282	97	2282	98	2282	96
Integrated Care Group - Acute	623	96	623	99	623	98	623	98	623	94
Integrated Care Group - Community	298	98	298	99	298	97	298	99	298	99
Surgery	365	98	365	99	365	98	365	98	365	99
Family care	671	97	671	97	671	95	671	99	671	98
Diagnostic and Clinical	213	96	213	98	213	96	213	99	213	97

The table demonstrates divisional performance from the range of patient experience surveys for May 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 competencies in May 2017.

Dr. Foster
Indicative
HSMR
monthly
Trend

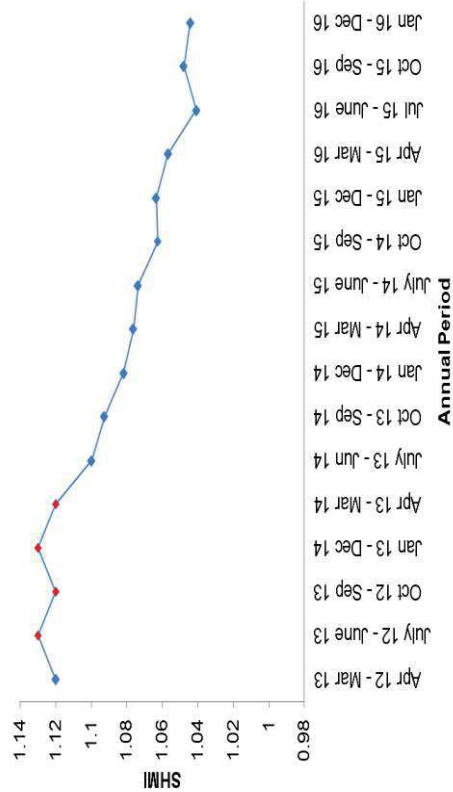


The latest indicative 12 month rolling HSMR (March 16 – February 17) is reported 'as expected' at 96.2 against the monthly rebased risk model.

There are currently eight 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

SHMI
Published
Trend

SHMI Trend



The latest Trust SHMI value as reported by the Health and Social Care Information Centre and Care Quality Commission has deteriorated slightly to 1.05, however is still within expected levels, as published in March 2017.

DFI
Indicative
HSMR rolling
12 month

DFI Rebased on latest month Mar 16 – Feb 17 (Risk model Nov 16)	
TOTAL	96.2 (CI 91.6 – 101.1)
Weekday	95.6 (CI 90.3 – 101.2)
Weekend	98.1 (CI 89.0 – 107.9)
Deaths in Low Risk Diagnosis Groups	65.0 (CI 37.2 – 105.5)

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

EFFECTIVE

CQUIN Scheme		Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Q1	Q2	Q3	Q4
national	NHS STAFF HEALTH & WELLBEING - Flu Vaccine Uptake	75%									82.1%	85%	86%	86%			82.1%	
national	SEPSIS PART A- screening in emergency department - Adult	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	- screening in emergency department - child	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
national	- antibiotic administration & review - adult - number eligible		4	6	0	4	1	1	1	0	0	0	2	2	10	6	1	4
national	- antibiotic administration & review - adult %		100.0%	66.7%	n/a	50.0%	100.0%	100.0%	100.0%	n/a	n/a	n/a	50.0%	100.0%	80.0%	66.7%	100.0%	75.0%
national	- antibiotic administration & review child - number eligible		0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
national	- antibiotic administration & review child %		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	100.0%	0.0%	n/a	n/a	n/a	100%
national	SEPSIS PART B- screening in an inpatient setting - adult	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
national	- screening in an inpatient setting -child	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
national	- antibiotic administration & review - adult - number eligible		8	5	2	1	1	1	3	4	1	1	3	4	15	3	8	8
national	- antibiotic administration & review - adult %		100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	66.7%	100.0%	93.3%	100.0%	88.0%	87.5%
national	- antibiotic administration & review - child - number eligible		0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
national	- antibiotic administration & review - child %		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	100.0%	0.0%	n/a	n/a	n/a	100.0%
national	ANTIMICROBIAL RESISTANCE PART B - Empiric Review of antibiotic prescriptions		84%	78%	74%	80%	82%	70%	79%	83%	88%	87%	91%	94%	79%	77%	83%	91%
local	SAVING BABIES LIVES - Induction rate		31.3%	31.5%	35.3%	34.2%	33.1%	37.6%	33.4%	36.0%	36.14%	36.5%	37.6%	40.2%	24.80%	25.60%	27.30%	38.00%
local	- Induction rate (FGR/ Reduced fetal movements) **		31.5%	29.3%	30.6%	26.9%	27.9%	26.0%	25.8%	19.7%	26.4%	26.2%	25.4%	26.8%	30.5%	27.2%	23.9%	26.2%
local	- No. Stillbirths, TOTAL		1	3	5	5	3	7	1	4	1	3	3	1	9	15	6	7
local	- No. Stillbirths, Avoidable		0	1	0	0	0	0	0	0	0	1	1	1	1	0	0	3
local	- No. Stillbirths, Unavoidable		1	2	5	5	3	7	1	4	1	2	2	0	8	15	6	4
local	-Smoking Status at Booking		18.2%	17.7%	17.6%	21.2%	18.0%	19.5%	18.3%	18.5%	21.5%	19.7%	19.2%	19.3%	17.8%	19.6%	19.4%	19.4%
local	-Smoking Status at Delivery		15.8%	16.2%	16.1%	17.9%	16.9%	17.7%	16.3%	17.5%	18.5%	17.4%	15.5%	16.5%	16.1%	17.5%	17.4%	16.5%
local	-Number of staff who have undertaken PROMPT (CTG training) - rolling 12 months			256			248			252			248		256	248	252	248
local	-Percentage of staff who have undertaken PROMPT (CTG training) - Rolling 12 months		86.6%	78.0%	76.0%	79.5%	80.9%	73.6%	71.7%	67.6%	74.1%	70.1%	71.3%	81.5%	76.0%	73.6%	74.1%	81.5%
local	-Training in the use of customised growth charts		90.2%	103.8%	90.2%	87.6%	80.6%	75.7%	77.9%	72.6%	74.1%	77.2%	81.2%	84.4%	90.2%	75.7%	74.1%	84.4%
local	-Feedback from women on information provided on reduced fetal movements		48.7%	47.0%	46.7%	51.8%	59.3%	43.2%	63.5%	100.0%	100.0%	96.8%	92.6%	91.6%	47.5%	51.0%	87.8%	93.7%
local	REFER TO PHARMACY - Referrals	Q1 1000 Q2 1300 Q3 1600 Q4 2000	1275				2168			2616			1646		1275	2168	2616	1646
Spec Comms	CANCER - Dose Banding		0%				67%			83%			61%		0%	67%	83%	61%

** Note:

Saving Babies Lives - Rates are for induction for FGR only as data quality issues identified with data collection for reduced movements

EFFECTIVE

The table shows the Quarter 4 position for which evidence was submitted within timescales to the CSU and Specialised Commissioners. Feedback from NHS England Greater Manchester Team is awaited regarding any outstanding requirements in relation to the dental CQUIN.

The CCG Quality Committee have formally written agreeing to full payment of Quarter 4 on all schemes except for sepsis and antibiotic consumption due to the data lag on these two schemes. Specialised Commissioners have confirmed full payment for both dose banding intravenous SACT drugs and neonatal prevention of hypothermia in preterm babies. Commissioners requested further data in relation to neonatal 2 year outcomes which was submitted and feedback is awaited.

The Hepatitis C scheme is subject to validation by the national team. Their draft report has been received via Specialised Commissioners for review and finalisation of Quarter 4 position.

Risks for quarter 4 have been identified around the following schemes:

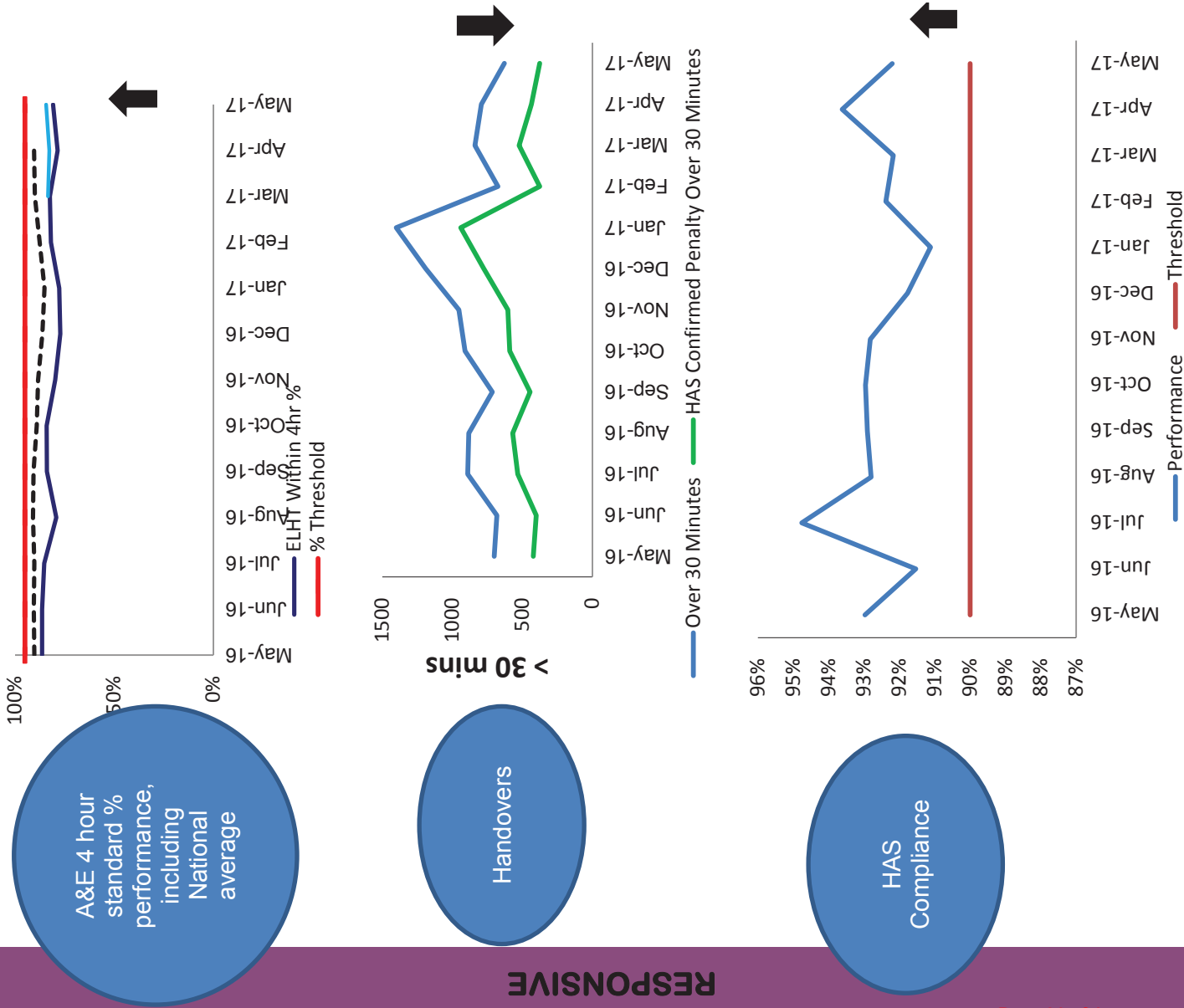
Sepsis – final position for antibiotic administration/3-day review emergency 80% and inpatient 89% against a nationally set threshold for Quarter 4 of 90% for full payment. The underperformance on both indicators relates to a single patient – looking at combined compliance at patient level gives a performance of 92%. The data has been submitted to the CSU who are supportive of the Trust's position and will present to the CCG's Quality Committee who make the final decision regarding payment.

Antibiotic Consumption per 1000 Admissions – there has been an increase in piperacillin/tazobactam dispensing with final published data reported as 2014/15 105.1 against 108.2. Although the Trust position is lower than the national benchmark this does pose a risk of 0.2% of the total scheme value. 2016/17

Hepatitis C - Risk has been identified around achievement of the Hepatitis C CQUIN, which is a specialised commissioner CQUIN.

For 2017-19, the Trust is expected to work towards achieving 6 of the national schemes which will span 2 years in line with the Trust contract.

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.



Overall performance against the ELHT Accident and Emergency four hour standard was reported as 80.8%, below the 95% threshold. The performance against the Pennine A&E Delivery Board four hour standard was reported as 84.4%

The number of attendances during the month was 18,970 and of these 16,008 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 April. (National data reported one month behind)

There were 5 breaches of the 12 hour trolley wait standard from decision to admit during May. All 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.

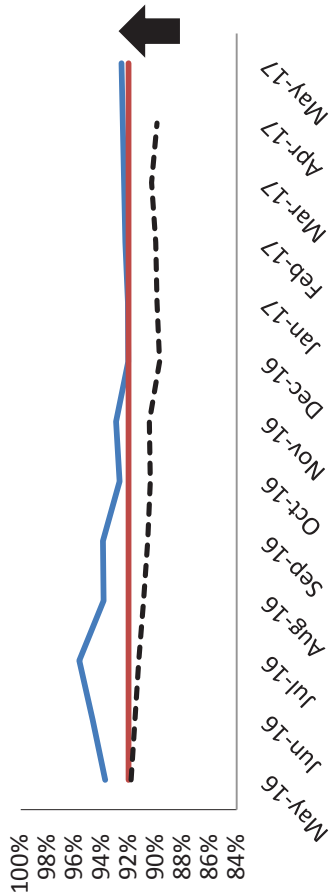
The number of handovers over 30 minutes decreased to 629 for May compared with 793 for April. 1252 handovers were within 15 minutes of arrival and a further 1064 were 15-30 minutes.

The validated NWAS penalty figures for May are reported as:- 169 missing timestamps, 332 handover breaches (30-60 mins) and 45 handover breaches (>60 mins).

The ambulance handover compliance indicator measures the compliance with PIN entry on completion of patient handover. This was achieved at 92.2% in May, which is above the 90% threshold.

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

RTT
Ongoing



The 18 week referral to treatment (RTT) % ongoing position has been achieved with 92.5% patients waiting less than 18 weeks to start treatment at end of May, which is an improvement on last month (92.4%) and above the 92% target.

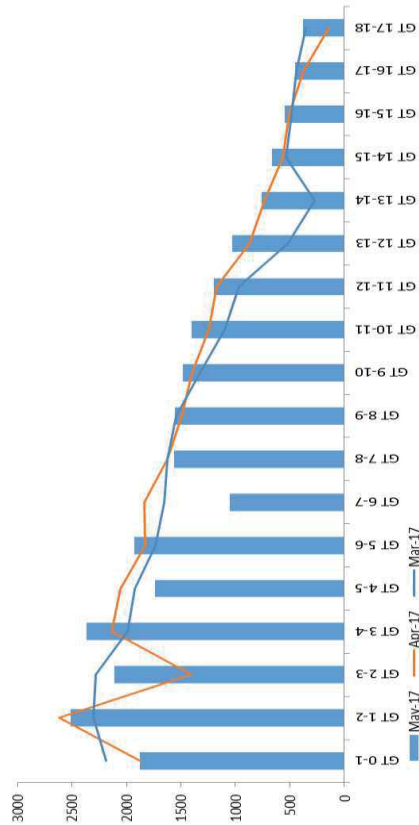
The total number of on-going pathways has increased slightly to 26,591 from 25,838 last month. There has been a small increase in patients waiting over 18 weeks at the end of the month to 1987 from last month's 1960.

The median wait has increased slightly in May to 7.0 weeks from 6.7 in April.

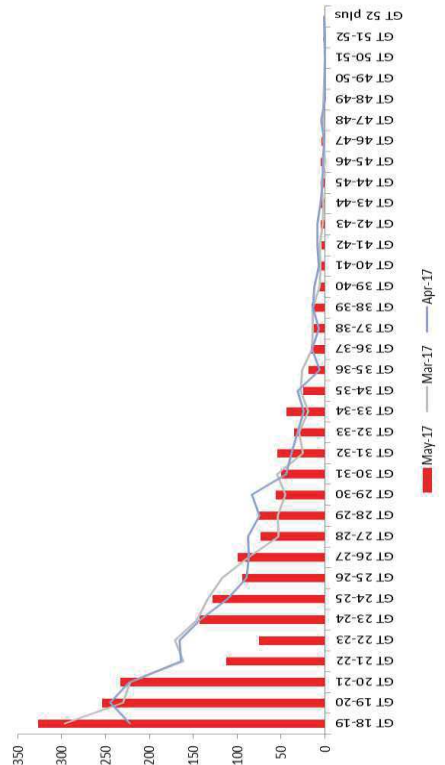
Although no longer a national target, the proportion of admitted and non-admitted patients is included on the scorecard for information.

The latest published figures from NHS England show a deterioration of the ongoing standard nationally, with 89.9% of patients waiting less than 18 weeks to start treatment in April, compared with 90.3% in March.

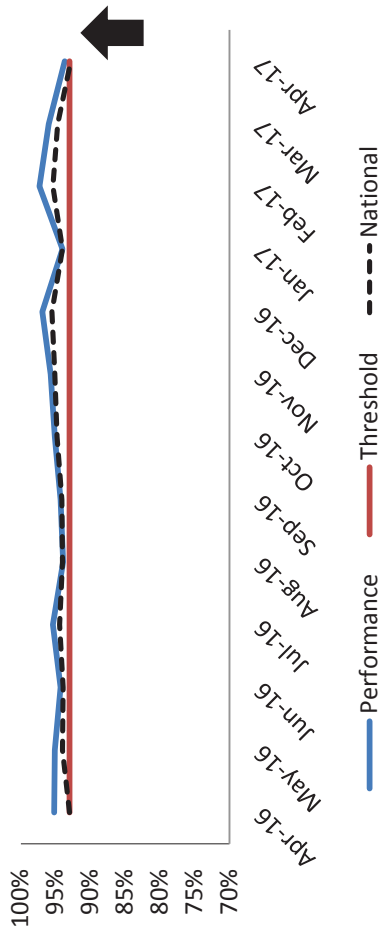
RTT
Ongoing
0-18
Weeks



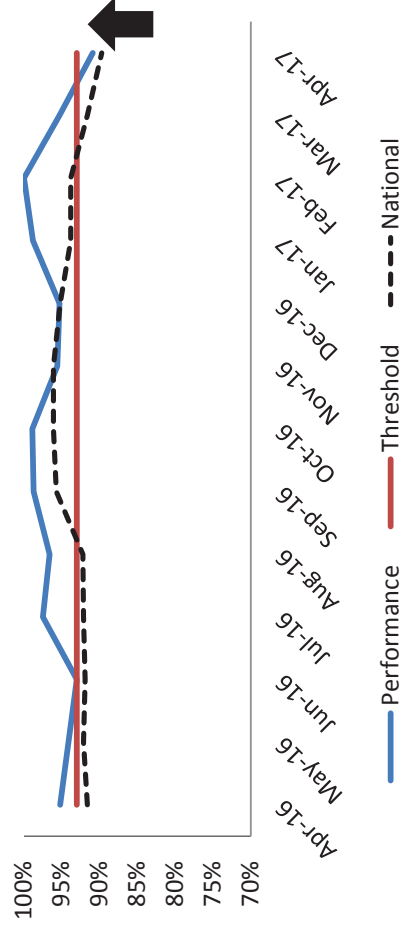
RTT Over
18 weeks



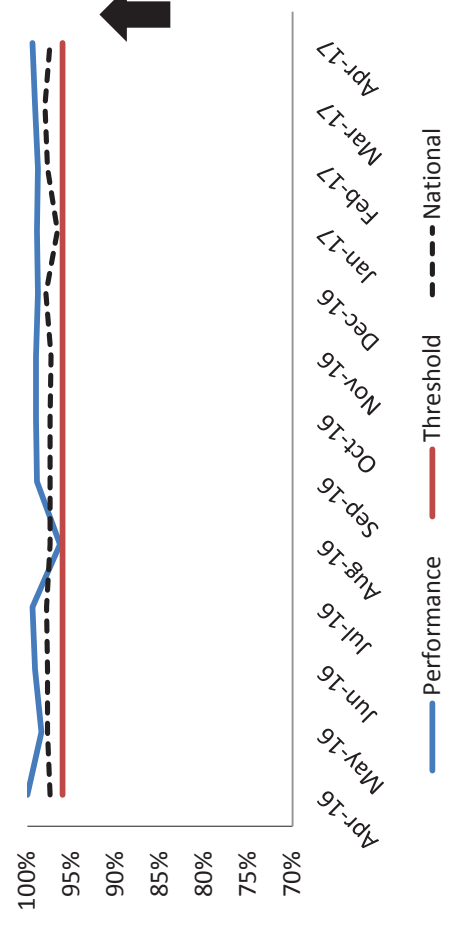
Cancer 2
Week



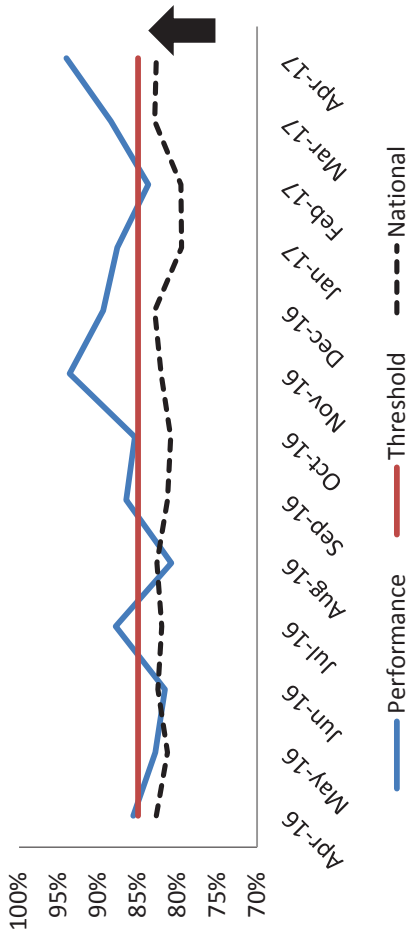
Cancer 2
Week -
breast



Cancer 31
day

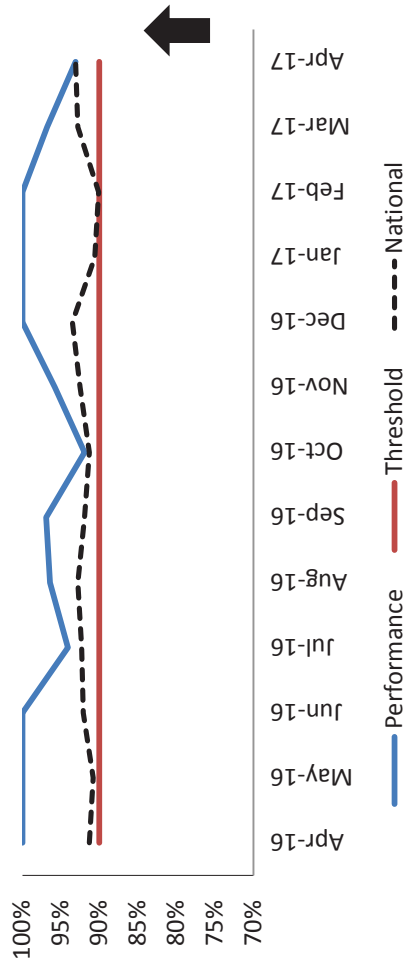


62 Day Cancer



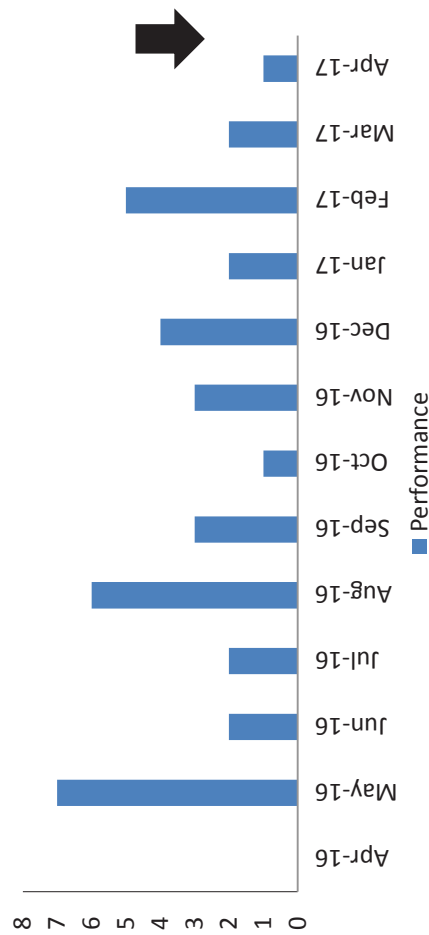
62 day performance was achieved in April at 94%

62 Day Consultant Upgrade



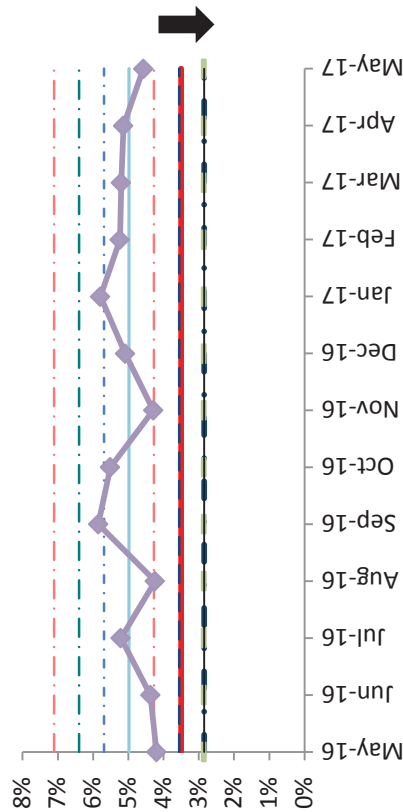
The 62 day consultant upgrade standard continued to be achieved in April at 93.3%

Cancer Patients Treated > Day 104



There was 1 patient treated after day 104 in April 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.

Delayed Discharges per 1000 bed days



The number of delays reported against the delayed transfers of care standard has reduced to 4.6% however still remains above the threshold of 3.5%. This equates to an average of 38 beds lost per day. The top three reasons for the bed days lost due to delayed discharge are: 'Awaiting completion of assessment' (30%), 'Patient or family Choice' (18%), 'Awaiting further non acute NHS Care' (17%).

The failure of this target is multi-factorial, linked to complex discharge processes involving ELHT and partners.

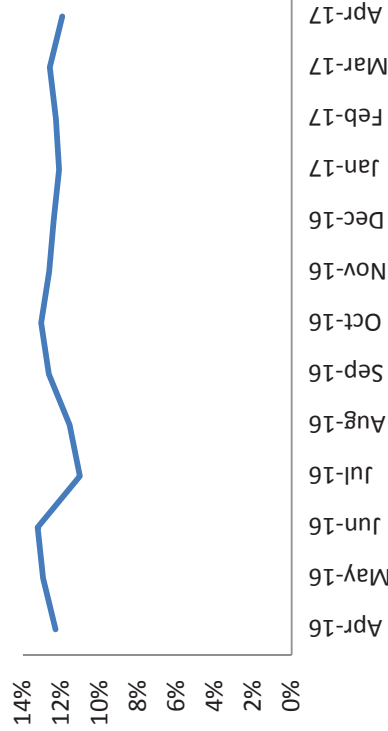
There is now daily reporting at individual patient level in each category of delay so that any trends or specific issues can be escalated for resolution to the relevant partners. The Integrated Discharge Service operational team are attending an allocation meeting at regular points in the day to

progress cases and ensure we are prioritising our work in accordance with organisational clinical flow demands.

Progress is reported across the IDS hub as required to expedite any barriers to progressing transfers of care.

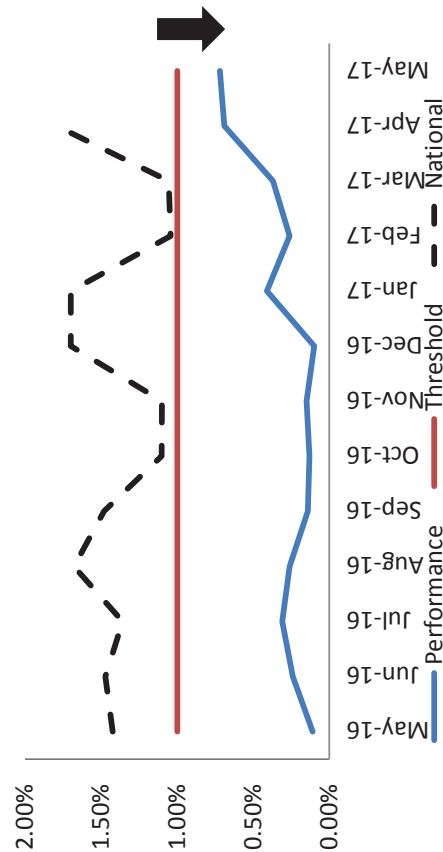
There is a full action plan which is monitored through the Finance & Performance Committee.

Emergency Readmissions



The emergency readmission rate is reported at 12.0% in April 2017 compared with 12.3% in April 2016.

Diagnostic Waits



In May there was 0.7% of patients waiting longer than 6 weeks for a diagnostic procedure, which is within the 1% threshold.

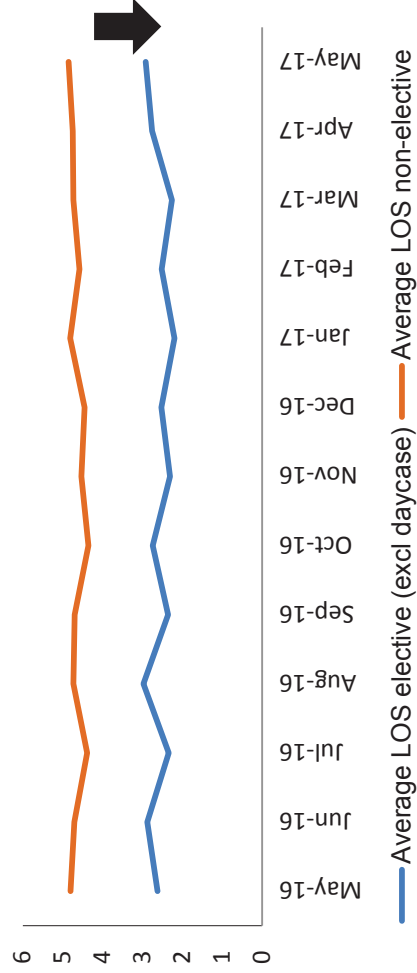
Average Length of Stay VS expected, March 16 - February 17, Dr. Foster

Average Length of Stay

Operations cancelled on day - 28 day standard

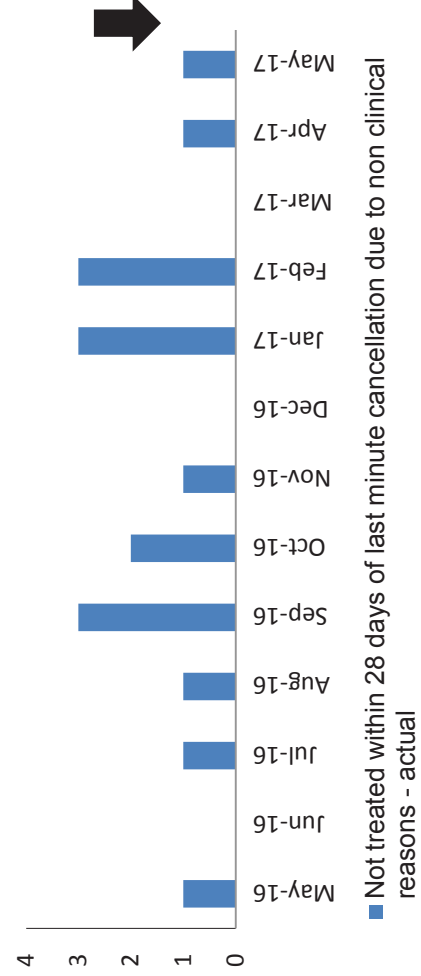
RESPONSIVE

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	58,628	9,973	48,655	3.4	2.6	-0.8
Emergency	53,022	53,022	0	4.9	5.0	0.1
Maternity/ Bi	14,228	14,228	0	2.2	2.5	0.3
Transfer	198	198	0	10.8	33.9	23.1



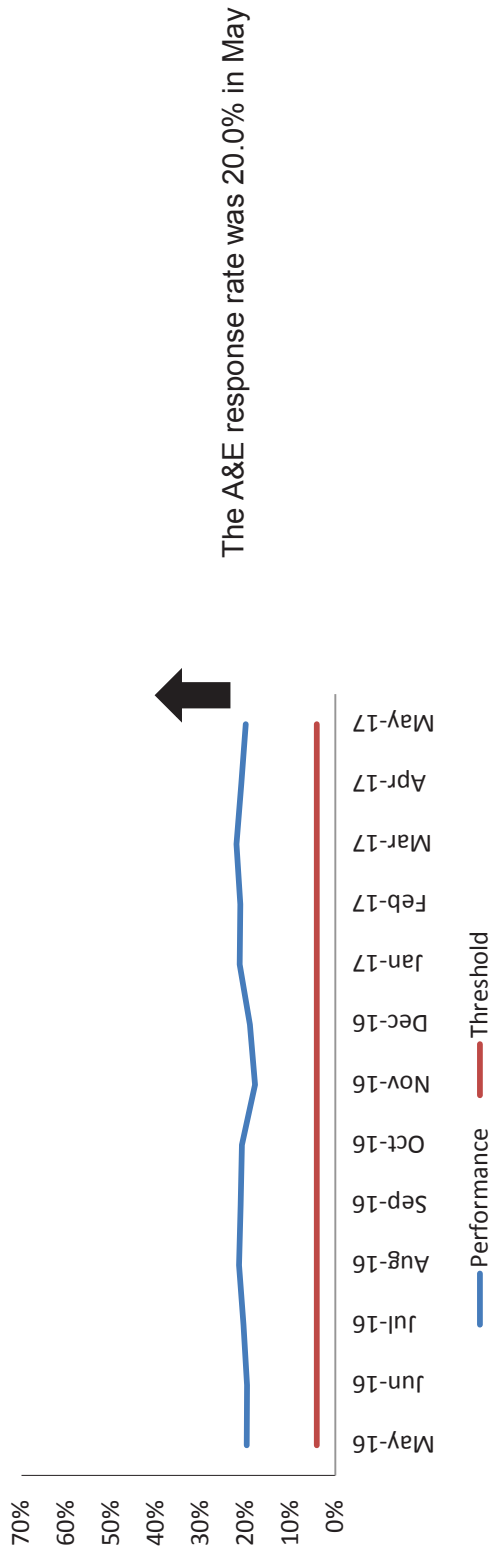
The Trust non elective average length of stay has increased to 4.9 days in May, compared to 4.8 in February.
The elective length of stay (excluding daycase) has increased on last month to 2.9 from 2.8

There was one 'on the day' cancelled operation not rebooked within 28 days in May. The procedure has now take place and the full exception report will be reviewed through the Finance and Performance Committee. Regular monitoring of patients that had procedures cancelled on the day to ensure dates are offered within the 28 days. Risks are escalated to senior managers and escalated at the weekly operations meeting.

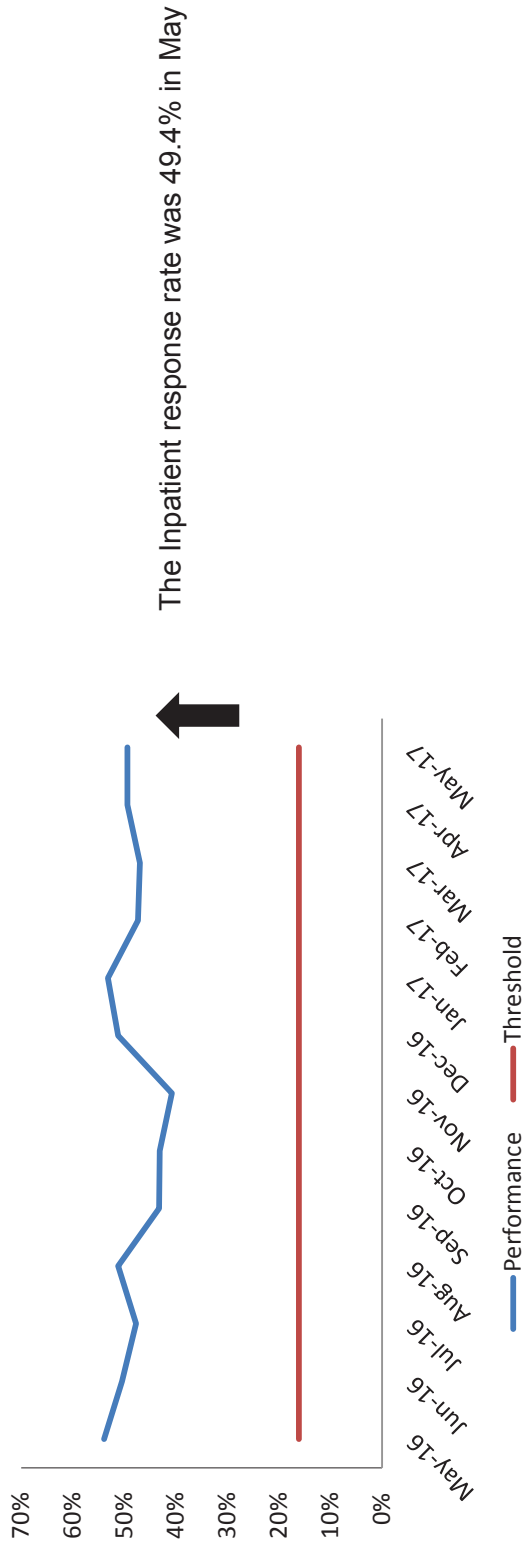


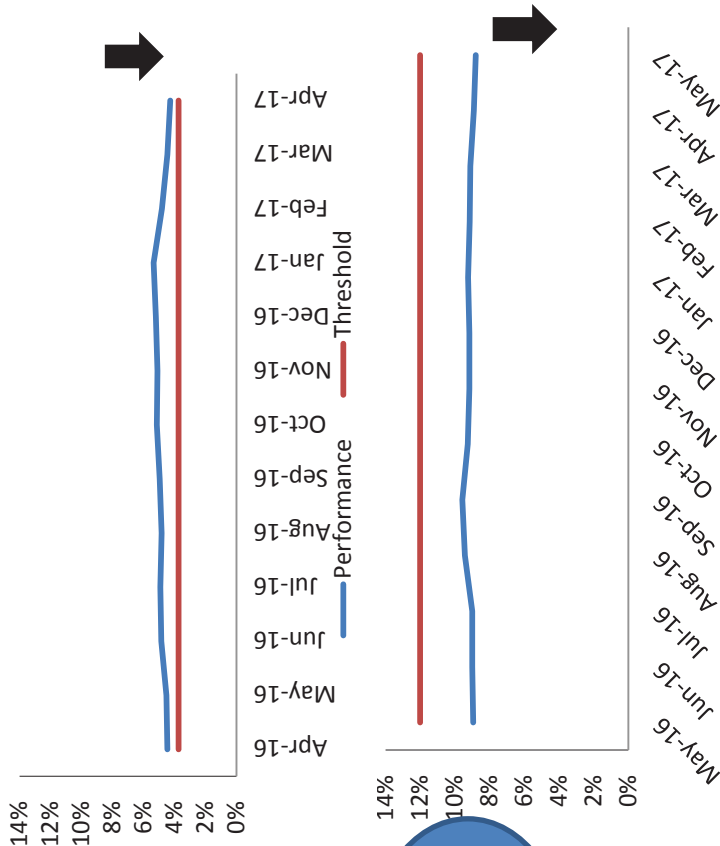
Not treated within 28 days of last minute cancellation due to non clinical reasons - actual

Friends & Family A&E Response Rate



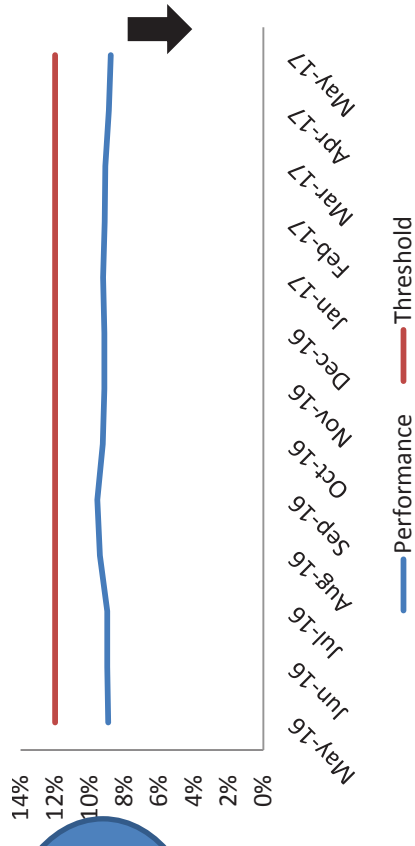
Friends & Family Inpatient Response Rate





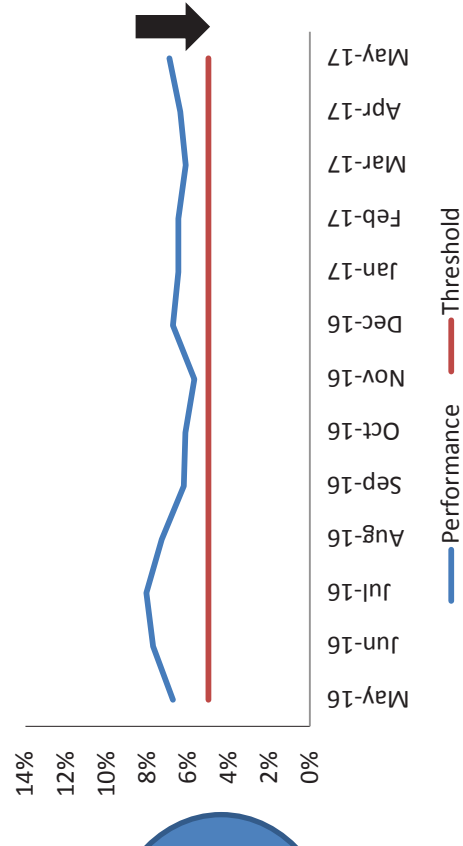
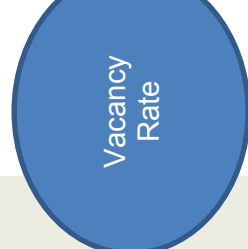
The sickness absence rate decreased from 4.45% in March 2017 to 4.27% in April 2017. This is lower than the previous year (4.46%). Long term sickness currently stands at 3.02% and short term sickness at 1.25%.

High sickness rates continue to pose a financial risk as bank and agency expenditure increases to cover shifts. The level of sickness absence overall has decreased in the last two months but remains above the targeted level and we must remain vigilant in monitoring and management practices. Long Term sickness attributed to anxiety/stress and musculoskeletal problems continue to be the main reasons for sickness absence.

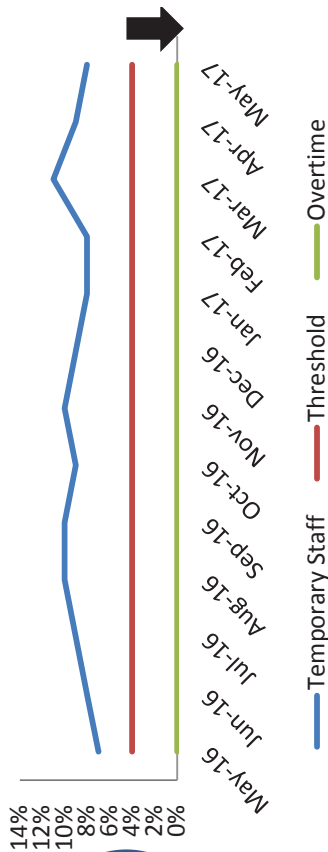


Overall the Trust is now employing 7098 FTE staff in total. This is a net increase of 21 FTE from the previous month. The number of nurses in post at Apr 2017 stood at 2301 FTE which is a net increase of 16 FTE since last month and a net increase of 247 FTE since 1st April 2013.

There are a further 93 nurses in the recruitment pipeline.

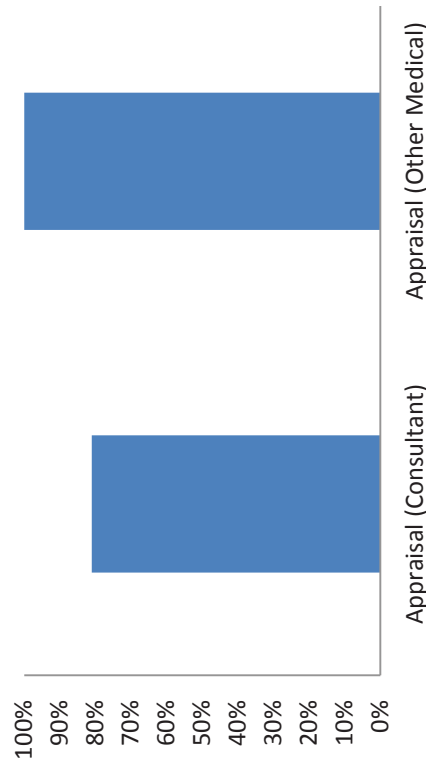
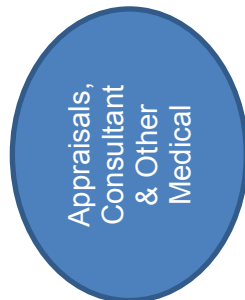


The vacancy rate for nurses now stands at 9.8% (250 FTE)



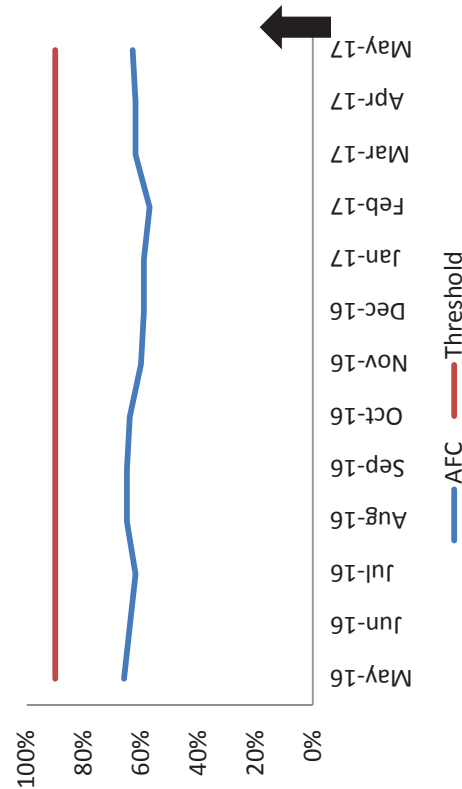
In 2015/16 East Lancashire Hospitals NHS Trust spent £24.6m on temporary staffing. This represented 8% of the overall pay bill. (9% 2014/15; 8% 2013/4; 5.5% 2012/13). For the year ending 2015/16 the Trust spent £24,607,589 (£16,469,869 agency; £8,137,720 bank).

In April 2017 the Trust spent £2,259,205 on bank and agency. This was more than in April 2016 (£1,824,641) and less than in March 2017 (£2,907,173). Total expenditure to date for 2017/18 is £2,259,205



The appraisal rates for consultants and career grade doctors are reported cumulative year to date, April – May 2017 and reflect the number of reviews completed that were due in this period.

The consultant appraisal rate has increased on last month to 81% and the other medical staff appraisal rate has increased to 100%.



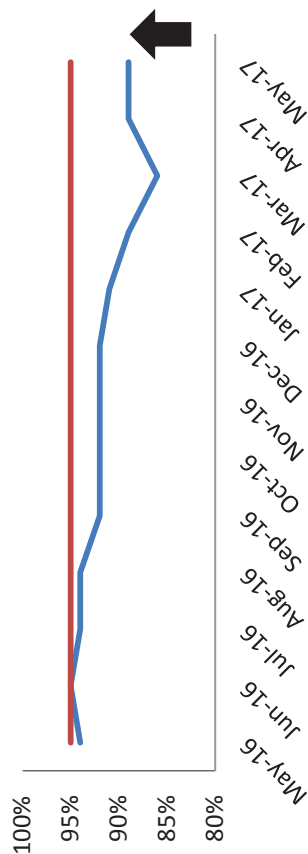
The AFC appraisal rates continue to be reported as a rolling 12 month figure and have increased in March to 63% from last month (62%), however is still below the threshold of 90% There has been a range of Trust wide actions to support compliance which are on-going. These actions are monitored through the Finance & Performance Committee.

Job Plans

	May-17
Trust Total	81%
Integrated Care Group	65%
Surgery	90%
Family Care	79%
Diagnostics & Clinical Support	85%

The current job plan completion figure for 2017/18 at the end of May was 81% The Deputy Medical Director is working closely with the Divisional Directors to ensure that job plans are undertaken.
A new electronic job planning system has been purchased and is in process of being implemented. Implementation is making good progress and training for consultants is

Information Governance Toolkit



Information governance toolkit compliance has remained below the 95% threshold in May at 89%

Core Skills Training % Compliance

	Target	Compliance at end May
Basic Life Support	90%	79%
Conflict Resolution Training Level 1	90%	90%
Equality, Diversity and Human Rights	90%	92%
Fire Safety	90%	84%
Health, Safety and Welfare Level 1	90%	82%
Infection Prevention	90%	81%
Information Governance	95%	89%
Prevent Healthwrap	90%	90%
Safeguarding Adults	90%	89%
Safeguarding Children	90%	92%
Safer Handling Theory	90%	93%

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. The threshold has been set at 90% for all areas except Information Governance which has a threshold of 95% Five of the eleven areas are currently below target for training compliance.

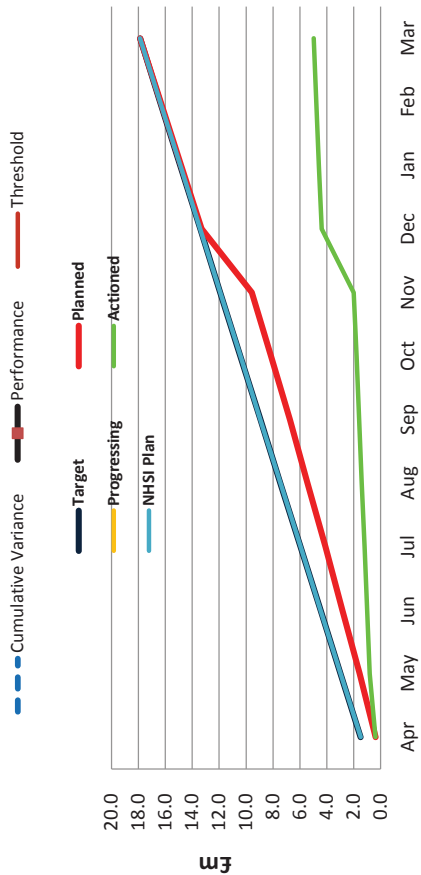
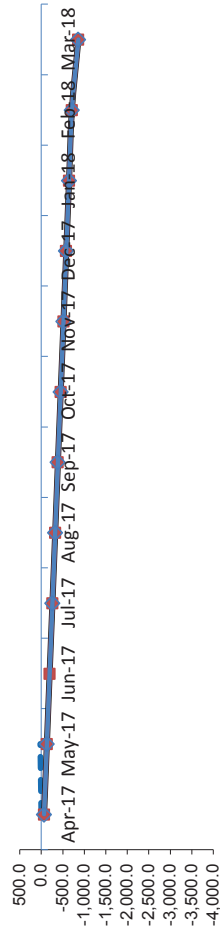
The Trust's mandatory training programme was audited by the Mersey Internal Audit Agency in October 2016, following previous reviews in 2013/14 & 2014/15, which had given a limited assurance opinion. The report gave a 'Significant Assurance' for the learning system but a 'Limited Assurance' of the mandatory 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.

Finance & Use of Resource metrics

Break Even Duty

Efficiency Savings

Area	Metric	Actual YTD Performance	Forecast outturn	Score
Financial sustainability	Capital service capacity			3
	Liquidity (days)	1.5 (5.0)	1.4 (10.8)	3
Financial efficiency	I&E margin			3
		(0.2%)	(0.2%)	
Financial control	Distance from financial plan			1
	Agency spend	0.0% 14.7%	0.0% 24.0%	2
Total				2



The Trust has a planned outturn position for 2017-18 of a deficit of £863,000. This figure includes our notified non-recurrent STF funding of £11.272m. Our control total for the year is a deficit of £12.135m, which excludes the STF. This is the figure that NHSI will monitor us against via the Single Oversight Framework.2.

Although we have seen expenditure pressures over the first 2 months of the year, we are reporting that we remain on target to achieve our control total, however our planned deficit may be higher than anticipated due to the STF criteria.

Revised guidance has recently been received which indicates that our quarter 1 risk

to the STF due to the ED 4 hour standard will be in the region of £422,700.

The 'Finance and use of resources metrics score' (current and FOT) is 2, (1 being the best level of performance and 4 being in financial special measures).

The 5 metrics all score an equal weighting with the overall score being calculated as the average of the 5.

The Trust has fully identified the SRCP schemes for 2017-18 at £17.8m. £4.9m of these schemes have been achieved to date. The position is reported in further detail in the Sustaining Safe, Personal and Effective Transformation paper.

we have seen a deterioration to our cash position predominantly related to the non-payment of our STF funding from Q3 2016/17 to the present day. The amount now owing equates to £9.2 million. We have escalated this to our CCG's and NHSI and we await further communication in relation to this.

APPENDIX 1



Safe															
	Threshold 17/18	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Monthly Sparkline
M64 CDIFF	28	2	3	4	1	5	5	4	2	3	2	0	2	4	
M64.1 Cliff Cumulative from April	28	3	6	10	11	16	21	25	27	30	32	32	2	6	
M65 MRSA	0	0	0	0	0	0	0	0	1	0	0	0	0	0	
M66 Never Event Incidence	0	0	0	1	0	0	0	0	0	0	0	0	2	0	
M67 Medication errors causing serious harm (Steis reported date)	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
C28 Percentage of Harm Free Care	92%	98.8%	99.1%	99.4%	99.2%	99.1%	99.3%	99.2%	98.9%	99.1%	99.3%	99.3%	99.2%	99.0%	
M68 Maternal deaths	0	0	0	0	0	0	0	1	0	0	0	0	0	0	
C29 Proportion of patients risk assessed for Venous Thromboembolism	95%	99.0%	99.0%	99.4%	99.1%	99.0%	99.0%	98.5%	98.4%	98.7%	98.4%	97.2%	99.3%	98.2%	
M69 Serious Incidents (Steis)		2	6	5	7	5	4	8	6	8	5	10	7	6	
M70 CAS Alerts - non compliance	0	0	0	0	1	2	0	0	0	0	0	0	0	0	
M146 Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80%	89%	87%	86%	85%	87%	90%	90%	90%	90%	89%	89%	90%	91%	
M147 Safer Staffing -Day-Average fill rate - care staff (%)	80%	114%	116%	118%	126%	121%	123%	118%	112%	111%	114%	114%	116%	116%	
M148 Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80%	99%	98%	99%	98%	99%	101%	99%	97%	99%	99%	100%	100%	101%	
M149 Safer Staffing -Night-Average fill rate - care staff (%)	80%	122%	129%	136%	142%	138%	134%	130%	122%	127%	128%	125%	129%	128%	
M150 Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80%	0	11	17	15	21	21	9	5	5	7	11	6	6	3	
M151 Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80%	0	0	0	0	0	0	0	0	0	0	1	3	1	1	
M152 Safer Staffing - Day -Average fill rate - care staff- number of wards <80%	0	0	1	1	0	1	1	1	3	4	1	1	1	1	
M153 Safer Staffing - Night -Average fill rate - care staff- number of wards <80%	0	1	1	1	1	1	1	1	2	1	1	1	1	1	

Caring															
	Threshold 17/18	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Monthly Sparkline
C38 Inpatient Friends and Family - % who would recommend	92.07%	97.9%	98.6%	98.5%	98.2%	98.4%	98.5%	97.7%	98.5%	98.1%	97.9%	97.0%	98.0%	98.0%	
C31 NHS England Inpatients response rate from Friends and Family Test		54.0%	50.5%	47.7%	51.2%	43.3%	43.2%	40.8%	51.2%	53.2%	47.4%	47.0%	49.4%	49.4%	
C40 Maternity Friends and Family - % who would recommend	91.86%	96.7%	95.9%	95.8%	97.0%	97.8%	97.3%	96.2%	98.3%	97.4%	97.9%	96.9%	96.2%	98.4%	
C42 A&E Friends and Family - % who would recommend	74.90%	75.7%	76.3%	75.0%	73.9%	75.8%	76.7%	75.7%	76.1%	76.0%	81.8%	79.6%	75.9%	78.3%	
C32 NHS England A&E response rate from Friends and Family Test		19.8%	19.7%	20.5%	21.5%	21.1%	20.8%	17.9%	19.1%	21.3%	21.2%	22.1%	21.0%	20.0%	
C44 Community Friends and Family - % who would recommend	88.62%	94.9%	94.3%	93.6%	94.3%	93.1%	92.5%	92.8%	92.8%	91.9%	93.1%	92.8%	93.1%	92.9%	
C15 Complaints – rate per 1000 contacts	0.4	0.2	0.2	0.2	0.3	0.2	0.2	0.4	0.3	0.3	0.3	0.3	0.3	0.3	
M52 Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Effective															
	Threshold 17/18	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Monthly Sparkline
M73 Deaths in Low Risk Categories - relative risk	Outlier	71.6	77.3	81.1	85.1	82.7	86.5	82.7	91.6	75.9	65.0				
M74 Hospital Standardised Mortality Ratio - Weekday (DFI Indicative)	Outlier	96.1	95.9	96.3	97.7	97.0	98.7	95.6	96.2	94.7	95.6				
M75 Hospital Standardised Mortality Ratio - Weekend (DFI Indicative)	Outlier	102.0	100.2	98.3	97.7	98.3	97.0	99.1	99.4	97.8	98.1				
M54 Hospital Standardised Mortality Ratio (DFI Indicative)	Outlier	97.6	97.0	96.8	97.7	97.4	98.3	96.5	97.0	95.5	96.2				
M53 Summary Hospital Mortality Indicator (HSCIC Published data)	Outlier		1.04			1.05									
M89 CQUIN schemes at risk	0		0			3			1			3			

Responsive															
	Threshold 17/18	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Monthly Sparkline
c2 Proportion of patients spending less than 4 hours in A&E	95%	86.4%	86.4%	85.2%	79.3%	83.9%	84.1%	79.8%	77.3%	77.8%	81.9%	82.4%	78.6%	80.8%	
	95%	86.4%	86.4%	85.2%	79.3%	83.9%	84.1%	79.8%	77.3%	78.8%	82.8%	83.4%	82.7%	84.4%	
M62 12 hour trolley waits in A&E	0	3	3	7	9	2	3	3	0	16	7	5	1	5	
M81 HAS Compliance	90%	92.97%	91.54%	94.76%	92.80%	92.91%	92.96%	92.82%	91.77%	91.12%	92.39%	92.17%	93.62%	92.20%	
M82 Handovers > 30 mins ALL	0	701	682	891	884	714	909	954	1190	1402	674	840	793	629	
M82.1 Handovers > 30 mins ALL (NWAS M82.1 Confirmed Penalty)	0	423	402	533	569	446	590	604	776	940	376	524	436	377	
c1 RTT admitted: percentage within 18 weeks	95%	81.8%	79.2%	73.8%	79.0%	76.2%	78.1%	72.5%	75.3%	71.3%	70.7%	69.8%	68.4%	71.5%	
c3 RTT non-admitted pathways: percentage within 18 weeks	90%	94.4%	95.0%	93.8%	92.4%	92.0%	93.9%	92.7%	93.2%	91.3%	92.5%	92.0%	91.9%	94.3%	
c4 RTT waiting times Incomplete pathways	92%	93.7%	94.7%	95.7%	93.9%	93.9%	92.7%	92.9%	92.0%	92.0%	92.2%	92.3%	92.4%	92.5%	
c37.1 RTT 52 Weeks (Ongoing)	0	2	1	1	0	1	1	1	0	3	2	1	1	0	
c17 Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1%	0.1%	0.2%	0.3%	0.3%	0.1%	0.1%	0.2%	0.1%	0.4%	0.3%	0.4%	0.7%	0.7%	
c18 Cancer - Treatment within 62 days of referral from GP	85%	82.8%	81.6%	87.8%	80.8%	86.5%	85.4%	93.6%	89.4%	87.6%	83.7%	88.4%	94.0%		
c19 Cancer - Treatment within 62 days of referral from screening	90%	100.0%	100.0%	94.1%	96.4%	96.9%	91.9%	95.8%	100.0%	100.0%	100.0%	96.8%	93.1%		
c20 Cancer - Treatment within 31 days of decision to treat	96%	98.4%	99.1%	99.4%	96.3%	98.9%	99.0%	99.0%	98.8%	98.9%	98.8%	99.1%	99.4%		
c21 Cancer - Subsequent treatment within 31 days (Drug)	98%	100.0%	100.0%	98.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
c22 Cancer - Subsequent treatment within 31 days (Surgery)	94%	100.0%	97.8%	97.7%	97.5%	94.3%	100.0%	94.7%	100.0%	95.9%	100.0%	95.3%	95.7%		
c24 Cancer - seen within 14 days of urgent GP referral	93%	95.1%	94.3%	95.4%	93.9%	94.3%	95.1%	95.7%	96.9%	94.0%	97.3%	96.0%	93.7%		
c25 Cancer - breast symptoms seen within 14 days of GP referral	93%	94.1%	93.0%	97.5%	96.6%	98.7%	98.9%	95.6%	95.3%	98.8%	100.0%	95.3%	90.9%		
c36 Cancer 62 Day Consultant Upgrade	85%	92.9%	91.1%	90.5%	82.4%	92.0%	83.3%	95.6%	94.1%	93.6%	89.3%	94.4%	93.3%		
c25.1 Cancer - Patients treated > day 104		7	2	2	6	3	1	3	4	2	5	2	1		

M9	Urgent operations cancelled for 2nd time	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	0	1	1	3	2	1	0	3	3	0	1
M55	Proportion of delayed discharges attributable to the NHS	3.5%	4.4%	4.6%	5.5%	4.5%	5.8%	5.5%	4.3%	5.1%	5.8%	5.2%	5.2%	5.1%
C16	Emergency re-admissions within 30 days		13.0%	13.2%	11.0%	11.6%	12.7%	13.1%	12.6%	12.4%	12.1%	12.3%	12.6%	12.0%
M90	Average LOS elective (excl daycase)		2.6	2.9	2.3	3.0	2.4	2.7	2.3	2.5	2.2	2.5	2.3	2.8
M91	Average LOS non-elective		4.8	4.7	4.4	4.7	4.7	4.4	4.5	4.5	4.8	4.6	4.7	4.8
														4.9

Well led															
	Threshold 17/18	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Monthly Sparkline
C31 NHS England Inpatients response rate from Friends and Family Test	16%	54.0%	50.5%	47.7%	51.2%	43.3%	43.2%	40.8%	51.2%	53.2%	47.4%	47.0%	49.4%	49.4%	
C32 NHS England A&E response rate from Friends and Family Test	4%	19.8%	19.7%	20.5%	21.5%	21.1%	20.8%	17.9%	19.1%	21.3%	21.2%	22.1%	21.0%	20.0%	
M77 Trust turnover rate	12%	8.9%	9.0%	9.0%	9.4%	9.6%	9.3%	9.2%	9.2%	9.2%	9.1%	9.1%	8.9%	8.8%	
M78 Trust level total sickness rate	3.75%	4.5%	4.9%	4.9%	4.8%	5.0%	5.1%	5.1%	5.2%	5.4%	4.8%	4.5%	4.3%		
M79 Total Trust vacancy rate	5%	6.7%	7.7%	8.0%	7.3%	6.2%	6.1%	5.7%	6.7%	6.5%	6.5%	6.1%	6.4%	6.9%	
M80.3 Appraisal (AFC)	90%	66.0%	64.0%	62.0%	65.0%	65.0%	64.0%	60.0%	59.0%	59.0%	57.0%	62.0%	62.0%	63.0%	
M80.3: Appraisal (Consultant)	90%	12.0%	21.0%	28.0%	37.0%	45.0%	50.0%	94.0%	95.0%	92.0%	96.0%	99.0%	80.0%	81.0%	
M80.4 Appraisal (Other Medical)		16.0%	31.0%	45.0%	52.0%	61.0%	72.0%	99.0%	95.0%	94.0%	99.0%	99.0%	67.0%	100.0%	
M80.2 Safeguarding Children	90%	88.0%	90.0%	91.0%	93.0%	92.0%	91.0%	93.0%	93.0%	90.0%	90.0%	88.0%	89.0%	90.0%	
M80.2: Information Governance Toolkit Compliance	95%	94.0%	95.0%	94.0%	94.0%	92.0%	92.0%	92.0%	92.0%	91.0%	89.0%	86.0%	89.0%	89.0%	
F8 Temporary costs as % of total payroll	4%	7%	8%	9%	10%	10%	9%	10%	9%	8%	8%	11%	9%	8%	
F9 Overtime as % of total payroll	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
F1 Cumulative Retained Deficit for breakeven duty (£M)	(0.8)	(0.6)	(0.9)	(1.2)	(1.5)	(1.8)	(2.1)	(2.4)	(2.7)	(3.0)	(1.5)	1.5	(0.1)	(0.1)	
F2 SRCP Achieved % (green schemes only)	100.0%	54%	56%	59%	71%	74%	75%	81%	87%	99%	101%	101%	18%	28%	
F3 Liquidity days	>(14.0)	(5.9)	(5.6)	(5.5)	(5.8)	(6.2)	(6.6)	(6.9)	(7.1)	(7.1)	(6.1)	(6.3)	(5.2)	(5.0)	
F4 Capital spend v plan	85%	91%	79%	73%	75%	76%	80%	76%	74%	67%	77%	85%	42%	38%	
F16 Finance & Use of Resources (UoR) metric - overall	3						3	3	3	3	2	2	2	2	
F17 Finance and UoR metric - liquidity	3						2	2	3	3	2	2	3	3	
F18 Finance and UoR metric - capital service capacity	3						4	4	4	3	3	3	2	2	
F19 Finance and UoR metric - I&E margin	3						3	3	3	3	3	2	3	3	
F20 Finance and UoR metric - distance from financial plan	1						1	1	1	1	1	1	2	1	
F21 Finance and UoR metric - agency spend	1						3	3	3	3	3	3	1	2	

F12 BPPC Non NHS No of Invoices	95%	96.3%	96.0%	96.2%	96.4%	96.3%	96.5%	96.6%	96.8%	96.8%	96.8%	96.7%	96.2%	96.5%	
F13 BPPC Non NHS Value of Invoices	95%	96.7%	95.7%	95.8%	96.2%	96.0%	96.5%	96.6%	96.8%	96.8%	96.8%	96.7%	95.3%	96.1%	
F14 BPPC NHS No of Invoices	95%	95.3%	93.2%	93.7%	93.4%	93.7%	97.0%	96.7%	96.3%	96.2%	95.8%	95.7%	95.7%	95.7%	
F15 BPPC NHS Value of Invoices	95%	95.8%	95.9%	96.6%	96.6%	97.0%	99.2%	99.2%	98.9%	98.7%	98.7%	98.6%	99.1%	99.1%	

TRUST BOARD REPORT

Item **107**

12 July 2017

Purpose Information

Title Policy for the Review of Clinical Care following the death of a patient in Hospital

Author Dr I Stanley, Deputy Medical Director/Director of Infection Prevention & Control

Executive sponsor Dr D Riley, Executive Medical Director

Summary: This paper seeks to re-define the review of deaths occurring within ELHT in light of our own four year experience and the recently published national guidance.

Recommendation: The Board is asked to note the national and local developments with regard to the process for reviewing mortality and to accept the proposed changes in the process for local review.

Report linkages

Related strategic aim and corporate objective Put safety and quality at the heart of everything we do
Encourage innovation and pathway reform, and deliver best practice

Related to key risks identified on assurance framework Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways
The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal No Financial No

Equality No Confidentiality No

Previously considered by: Mortality Steering Group

Introduction

1. There has been a great deal of attention paid to the review of deaths in Hospital since the Frances and Keogh reports. Within ELHT all deaths have been subject to a Primary Mortality Review with escalation to a Secondary Mortality Review if certain criteria are met. This process has been variably successful but has also placed an excessive burden upon some clinical teams to complete the reviews in a timely manner.
2. Lessons learned from Mortality Reviews are not necessarily well publicised and shared and lessons to be learned from reviews of patients discharged alive are also being missed.
3. Nationally there has been a review of learning from deaths and both the Care Quality Commission (CQC) and NHS Improvement (NHSI) have published guidance (this is applicable to adult patients).
4. This paper seeks to re-define the review of deaths occurring within ELHT in light of our own four year experience and the recently published national guidance.

Which cases should be reviewed?

5. Currently, all deaths are reviewed. Some weeks this can be up to 50 deaths which require review. Whilst the Primary Mortality Review housed on the Datix system is a short screening process, this still imposes a significant burden upon hard-pressed medical staff. In addition we are missing potential learning from review of live discharges.
6. Our current guidance for automatically triggering a detailed Secondary Mortality Review captures the following groups:
 - a) Death after an elective admission
 - b) Death in an 'alerting' diagnostic group
 - c) Death following a serious complication (e.g. Fall, VTE, HCAI)
 - d) Deaths categorised as 'low risk'
 - e) Deaths where the Primary Mortality Review has addressed concerns about care
 - f) Deaths as a result of a serious incident requiring investigation (SIRI)
7. In addition all deaths involving patients with Learning Disabilities or severe mental illness are reviewed by the L&D Group. Approximately 10% of Primary Mortality Reviews trigger a more detailed Secondary Mortality Review. It could be argued that, for the work

involved, the return from Primary Reviews does not justify the time investment from already hard-pressed Consultants.

8. The national guidance ('Learning from Deaths') recommends that as a minimum the following cases should be reviewed:
 - a) All deaths where family, carers or staff have raised a concern about the quality of care provision
 - b) All deaths of those who are identified to be significantly disadvantaged, particularly all deaths of those with Learning Disabilities and all deaths of those with severe mental illness
 - c) All deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised through whatever means (e.g. HSMR, CQC Alert, SHMI, Audit)
 - d) All deaths of patients subject to care interventions from which a patient's death would be wholly unexpected (e.g. relevant elective procedures)
 - e) Deaths where learning will inform the organisations existing or planned quality improvement (QI) work
 - f) A further sample of other deaths should be selected that do not fit the identified categories, to ensure that there is an overview of where learning and improvement is needed most overall. This could be a random sample or targeted to specific areas or times of admission
9. Comparing the cases currently reviewed at the Trust with the list suggested by NHSI/CQC there is a reassuring similarity. The only additional groups to be reviewed would be where QI work might benefit from learning derived from reviews and the 'random' sampling of cases. Of note, the national guidance does not say that every death needs review.
10. It is, therefore, proposed that the process of Primary Mortality Review of every death is abandoned and that the focus of death review work switches to the groups listed below:
 - a) Death after an elective procedure
 - b) Death in an alerting diagnostic group
 - c) Death following a serious complication
 - d) Deaths categorised as low risk (after coding)
 - e) Deaths as a result of a SIRI

- f) Deaths where family, carers or staff have raised a concern about the quality of care provided
 - g) Deaths where learning will inform QI work
 - h) 'Random/targeted' sampling of other deaths
 - i) Deaths following re-admission to hospital within 30 days of discharge
11. The process for review of Learning Disability and Mental Health deaths, deaths in children and stillbirths will remain unaltered. The Primary reviews undertaken weekly by the Critical Care MDT should also continue. Identification of these cases will be crucial and will require close collaboration between a number of key departments:
- a) Quality & Safety Unit
 - i. To identify cases as a result of a SIRI
 - ii. To identify cases where a family or carers have raised a concern about care provision (via PALS/CCG 'soft intelligence' and bereavement services)
 - iii. To identify diagnostic groups where QI work is on-going/planned so that deaths can be reviewed
 - b) Information Department
 - i. To identify alerting groups which require a detailed death review to occur
 - ii. To identify 'low risk' deaths
 - iii. To identify deaths following deaths following re-admission within 30 days
 - c) Coding Department
 - i. To identify deaths occurring following an elective procedure
 - ii. To identify deaths as a result of a serious complication

The cases will require identification, categorisation into group and then presented to the Mortality Steering Group (MSG) so that identified individuals can be tasked with undertaking the review, identifying learning and feeding back to MSG.

How will deaths be reviewed?

12. Currently, we use a Secondary Mortality Review to undertake a detailed review of care provided to identify any lapses in care and to determine (via a 'Hogan Score') the 'avoidability/preventability' of that particular death.

13. There will be a national, standardised process for the review of deaths (Structured Judgement Review (SJR)), published by the Royal College of Physicians (RCP). This is currently undergoing review and Phase 1 testing by a number of organisations. Until this process is nationally released we will continue to use our current SMR methodology. Once SJR is released and appropriate training provided we will move over to this methodology.

Who will undertake Mortality Reviews?

14. A detailed Secondary Mortality Review takes between 30 minutes and an hour. It is not yet known if the SJR methodology will have a greater or lesser time requirement. It is estimated that we would undertake about 10-15 SMRs/SJRs per week. This means that a group of individuals would need to share the workload. To ensure consistency of performance this group needs to be fairly small but not so small that the workload is too great.
15. Whilst SJR details are not yet available the best learning from Mortality Reviews occurs with a multidisciplinary approach. Mortality Review is also an excellent learning opportunity for Doctors in training.
16. It is therefore proposed that reviews are undertaken by trained individuals comprising of senior medics, senior nurses and senior trainee doctors. Other specialist advice may be sought for specific cases. Each member of the review team will need to be trained and will need appropriate time allocated within job plans to undertake the reviews. It would seem appropriate to identify 4 – 5 staff to undergo training and be allocated 2 hours each per week to undertake the reviews.
17. With appropriate specialist training (a training programme has been promised by CQC/NHSI) should come objectivity and so reviewers should be able to review any case they are presented with.

Board Reporting

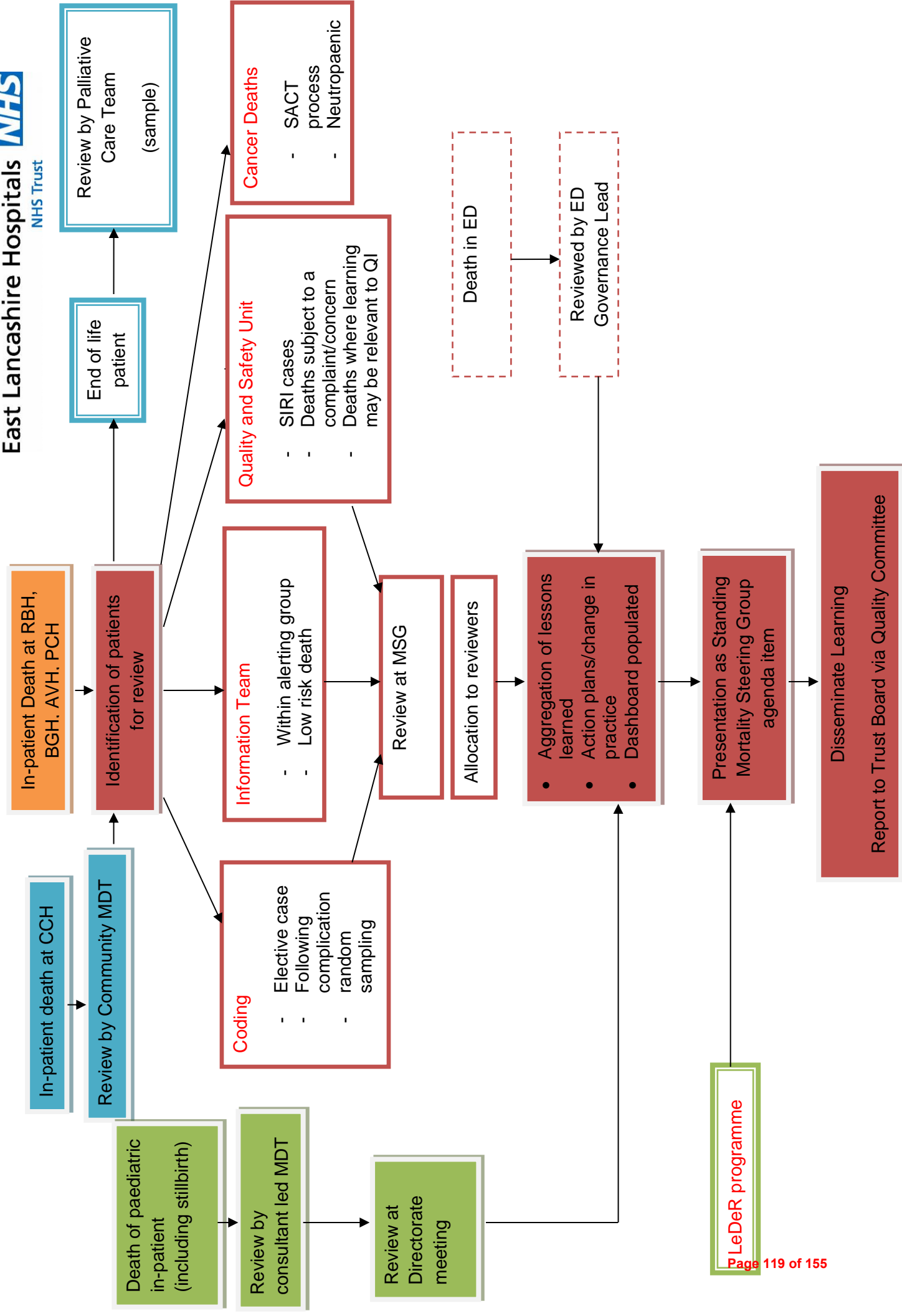
18. Data relating to mortality will be reviewed at MSG, which meets monthly. As part of the SJR process a suggested data dashboard will be provided to enable consistent reporting to Board. Once the dashboard is published MSG will report to Board via the Quality Committee using the dashboard and accompanying narrative to detail themes identified and action taken as a result.

Links to Governance Processes

19. If SJR identifies significant concerns relating to care then a further multidisciplinary panel review of the case would be triggered. This panel would consist of a senior clinician, senior nurse and trainee doctor (all trained in mortality reviews). They would assess the case and determine if the identified concerns meant that the death was potentially avoidable. This review may then trigger a full RCA and Steis reporting. The summary of reviews, lessons learned and categorisation of the death will need to be collected centrally; the Datix Risk Management System will be used for this.

Conclusion

20. Quality Committee is asked to note the national and local developments with regard to the process for reviewing mortality and to accept the proposed changes in the process for local review. In particular that every death will not be reviewed but that there will be a more focused approach using standardised methodology. This will require training of individuals, time allocated within job plans (cost of approximately 30,000 per year) and may lead to an initial increase in StEIS reports and RCA's undertaken.



TRUST BOARD REPORT

12 July 2017

Item **108**

Purpose Information
Assurance

Title Annual Audit Letter

Author Ms H Green, External Audit Manager

Executive sponsor Mr J Wood, Director of Finance

Summary:

The Annual Audit Letter was presented to the Audit Committee on 3 July 2017. The Board is asked to note 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
Related to key risks identified on assurance framework	Encourage innovation and pathway reform, and deliver best practice
	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives
	Recruitment and workforce planning fail to deliver the Trust objectives
	Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways
	Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust
	The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: Audit Committee (July 2017)



The Annual Audit Letter for East Lancashire Hospitals NHS Trust

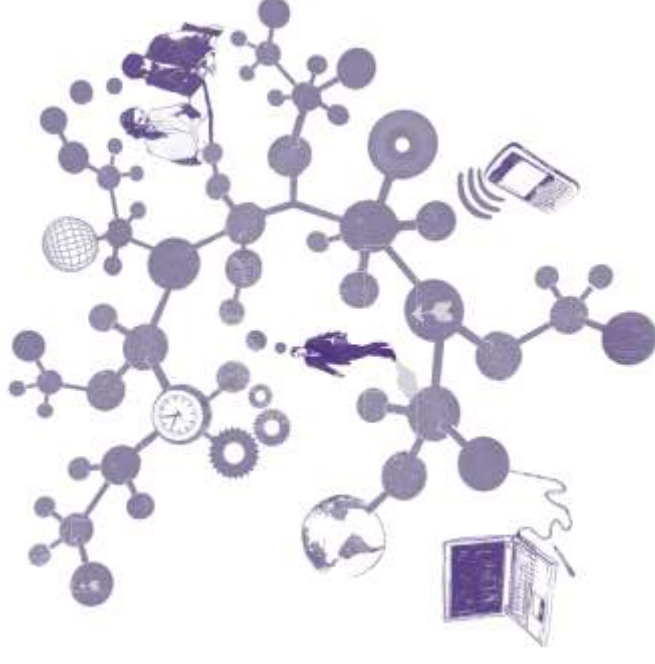
Year ended 31 March 2017

23 June 2017

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Executive summary

Purpose of this letter

Our Annual Audit Letter (Letter) summarises the key findings arising from the work that we have carried out at East Lancashire Hospitals NHS Trust (the Trust) for the year ended 31 March 2017.

This Letter is intended to provide a commentary on the results of our work to the Trust and its external stakeholders, and to highlight issues that we wish to draw to the attention of the public. In preparing this letter, we have followed the National Audit Office (NAO)'s Code of Audit Practice and Auditor Guidance Note (AGN) 07 – 'Auditor Reporting'.

We reported the detailed findings from our audit work to the Trust's Audit Committee as those charged with governance in our Audit Findings Report on 26 May 2017.

Our responsibilities

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

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

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

Our work

Financial statements opinion

We gave an unqualified opinion on the Trust's financial statements on 26 May 2017.

Value for money conclusion

We were satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources. We reflected this in our report on the financial statements on 26 May 2017.

Consolidation template

We also reported on the consistency of the consolidation schedules submitted to the Department of Health with the audited financial statements. We concluded that these were consistent.

Use of statutory powers

We did not identify any matters which required us to exercise our additional statutory powers.

Certificate

We certify that we have completed the audit of the accounts of East Lancashire Hospitals NHS Trust in accordance with the requirements of the Code of Audit Practice.

Quality Accounts

We have completed a review of the Trust's Quality Account and issued our report on 23 June 2017. We concluded that the Quality Account and the indicators we reviewed were prepared in line with the Regulations and guidance, except that the indicator reporting the percentage of patients risk-assessed for VTE did not meet the six dimensions of data quality due to errors in the data for months one to eleven.

Working with the Trust

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

- An efficient audit – we delivered an efficient audit with you in May, delivering the accounts 6 days before the deadline, releasing your finance team for other work.

- Improved financial processes – we worked with you improve your fixed assets reconciliations
- Understanding your operational health – through the value for money conclusion we provided you with assurance on your operational effectiveness.
- Providing assurance over data quality – we provided assurance over two key indicators and highlighted the need to improve the reliability of data regarding VTE risk assessments.
- Sharing our insight – we provided regular audit committee updates covering best practice. We also shared our thought leadership reports.

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

Grant Thornton UK LLP
June 2017

Audit of the accounts

Our audit approach

Materiality

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

We determined materiality for our audit of the Trust's accounts to be £6,731,000 which is 1.5% of the Trust's gross revenue expenditure. We used this benchmark as in our view, users of the Trust's financial statements are most interested in where it has spent the income it made in the year.

We also set a lower level of materiality for related party transactions and senior officer remuneration.

We set a lower threshold of £250,000 above which we reported errors to the Audit Committee in our Audit Findings Report.

The scope of our audit

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

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

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

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

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

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

Audit of the accounts

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

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
The revenue cycles include fraudulent transactions Under ISA (UK and Ireland) 240 there is a presumed risk that revenue may be misstated due to the improper recognition of revenue. For this Trust, we concluded that the greatest risk of material misstatement related to the occurrence of healthcare income including STF income and existence of associated receivables.	As part of our audit work we: <ul style="list-style-type: none">documented our understanding of management's controls over revenue recognitionreviewed and tested revenue recognition policiestested material revenue streams, including STF income	Our audit work did not identify any issues in respect of revenue recognition.
The Expenditure cycle includes fraudulent transactions Practice Note 10 suggests that the risk of material misstatement due to fraudulent financial reporting that may arise from the manipulation of expenditure recognition needs to be considered, especially where the body is required to meet targets. We concluded that the greatest risk of material misstatement related to the completeness of operating expenses and creditor balances.	As part of our audit work we: <ul style="list-style-type: none">tested journal entriesdocumented our understanding of management's controls over expenditure recognitionreviewed and tested expenditure recognition policiessample tested material non pay expenditure streamsreviewed the creditors listing and tested a sample of after-date payments for unrecorded liabilitiesreviewed the process for identifying year-end accruals to identify potential unrecorded liabilities	Our audit work did not identify any significant issues in relation to expenditure recognition.
Going Concern In light of the financial pressures facing the NHS, the Trust's P deficit control total and significant savings requirements for 2016/17 and 2017/18, there were uncertainties about the appropriateness of the going concern assumption for the Trust's financial statements. There was a risk that the Trust does not adequately disclose uncertainties about the appropriateness of the going concern assumption in preparing its financial statements.	As part of our audit work we: <ul style="list-style-type: none">reviewed management's assessment of going concern assumptions and supporting information (2017/18 and 2018/19 financial plan and cash flow forecasts)reviewed the completeness and accuracy of disclosures on material uncertainties with regard to going concern in the financial statements.	Our audit work did not identify any significant issues in relation to going concern assumption for the preparation of the accounts.

Audit of the accounts

Audit opinion

We gave an unqualified opinion on the Trust's financial statements on 26 May 2017, in advance of the national deadline.

The Trust made the accounts available for audit in line with the national timetable for submission, and provided a good set of working papers to support them. The finance team responded promptly and efficiently to our queries during the course of the audit.

Issues arising from the audit of the accounts

We reported the key issues from our audit to the Trust's Audit Committee on 26 May 2017.

We were pleased to report that issued raised in the previous year in respect of the asset register had been addressed by management.

Annual Governance Statement and Annual Report

We are also required to review the Trust's Annual Governance Statement and Annual Report. It provided these on a timely basis with the draft accounts with supporting evidence. We agreed a small number of amendments to the AGS and Annual Report.

Value for Money conclusion

Background

We carried out our review in accordance with the NAO Code of Audit Practice, following the guidance issued by the NAO in November 2016 which specified the criterion for auditors to evaluate:

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

Key findings

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

The key risk we identified and the work we performed is set out in the table on page 9.

As part of our Audit Findings report agreed with the Trust in May 2017, we agreed recommendations to address our findings.

Overall VfM conclusion

We are satisfied that in all significant respects the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2017.

Value for Money conclusion

Table 2: Value for money risk

Risk identified	Work carried out	Findings and conclusions
<p>Financial sustainability</p> <p>The Trust is on track to deliver its agreed control total of a £3.7m deficit in 2016/17, including the delivery of a £14.0m safely releasing costs programme (SRCP). However, the savings delivered in 2016/17 include a significant proportion of non-recurrent savings.</p> <p>The Trust will need to deliver a further £14.0m of savings in 2017/18, and address the recurrent financial gap offset by non-recurrent savings in 2016/17. This will be challenging in the context of the operational pressures facing the Trust.</p>	<p>We reviewed the Trust's arrangements for putting together and agreeing its budget, including identification of savings plans, for 2017/18. We also reviewed the Trust's arrangements for updating, agreeing and monitoring its sustainability and operational plans, and for communicating key findings to the Trust Board and Finance Committee.</p>	<p>Whilst successful in delivering significant savings in 2016/17, The Trust faces a challenging financial plan for 2017/18 and 2018/19. With a recurrent financial gap of over £19m, significant savings are required over the next two years to deliver the agreed control totals.</p> <p>The Trust has engaged the Board and Finance and Performance Committee in the 2017-19 financial planning process. Reports have clearly identified the national and local pressures, key assumptions and risks to the financial plan. Contract values for the next two years have been agreed with commissioners, and the Trust is clear about the scale of savings required and risks to delivery.</p> <p>Through the PMO, work has continued on transformation schemes and SRCP savings, with regular reporting to the Finance & Performance Committee or Trust Board during the year. The SRCP tracker continues to be used to monitor progress and drive delivery, with key risks and issues clearly highlighted in reporting to Trust Board (part 2). The Trust has identified schemes that it expects to deliver the required savings in 2017/18, although detailed plans for delivery still need to be developed in some areas.</p> <p><i>The Trust should ensure that all identified savings are fully supported by clear plans for delivery. These plans should be formulated and agreed before, or soon after, the start of the financial year in order to maximise the chances of successful delivery.</i></p> <p>Integrated performance reporting has been refined during 2016/17, with reports now formatted to follow the NHS Improvement Single Oversight Framework. Performance reports to Trust Board are comprehensive but understandable, setting out performance against key indicators with explanatory narrative in a clear and understandable way. Each section of the performance report follows the same structure – current position, risks, forecast and actions - and reports are balanced with clear explanation of poor or weaker areas of performance, and actions in progress to address these.</p>

Quality Accounts

The Quality Account

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

Scope of work

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

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

Quality Account Indicator testing

We tested the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE)
- Rate of clostridium difficile infections.

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

Key messages

- We confirmed that the Quality Account had been prepared in line with the requirements of the Regulations.
- We confirmed that the Quality Account was consistent with the sources specified in the DH Guidance.
- We confirmed that the commentary on indicators in the Quality Account was consistent with the reported outcomes.
- We have qualified the indicator reporting the percentage of patients risk-assessed for VTE because errors identified indicate that the data may not be accurate or valid.

Conclusion

As a result of this we issued a qualified conclusion on the Trust's Quality Account on 23 June 2017.

Appendix A: Reports issued and fees

We confirm below our final fees charged for the audit and related services, and confirm there were no fees for the provision of non audit services.

Fees

	Planned £	Actual fees £	2015/16 fees £
Statutory audit	64,937	64,937	64,937
Charitable fund	2,693	2,693	2,693
Total fees (excluding VAT)	67,630	67,630	67,630

Fees for other services

Service	Fees £
Audit related services Assurance on your quality report	6,000

Reports issued

Report	Date issued
Audit Plan	February 2017
Audit Findings Report	May 2017
Annual Audit Letter	June 2017
Quality Account	June 2017
Charitable Funds	October 2017 (Planned)

Non-audit services

- For the purposes of our audit we have made enquiries of all Grant Thornton UK LLP teams providing services to the Trust.



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TRUST BOARD REPORT

Item **109**

12 July 2017

Purpose Information Assurance

Title	Audit Committee Update Report (May 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 26 May 2017.

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Audit Committee Update: 26 May 2017

At the meeting of the Audit Committee held on 26 May 2017 members considered the following matters:

1. The Committee received the external auditors findings report in relation to the Trust's Annual Accounts and Annual Report. An overview of the report was presented and it was noted that the accounts had been prepared to a high standard with no issues identified in relation to property, plant and equipment and the issues raised in 2015/16's accounts had been rectified. Members noted the section of the report which referred to the unadjusted misstatement in the accounts relating to the Trust's decision not to accrue for annual leave entitlement owed to staff at the year end. The total understatement totalled £1,800,000, and as such was not a materiality issue.
2. Members received the Trust's audited annual accounts and financial statements for review and approval for submission to the regulator. The Committee noted that the Trust had met all its financial targets for the year 2016/17. An overview of the reasons for the increase in the Trust's estate valuation was provided for the benefit of members was provided. Members approved the final accounts and financial statements for submission to the regulator on 1 June 2017 was required.
3. Following approval of the Annual Accounts and Financial Statements, members agreed that the letter of representation could be signed following the conclusion of the meeting.
4. The Committee received the Trust's Annual Report and Annual Governance Statement for review and approval. The Committee members approved both documents for submission to the regulators pending the correction of typographical errors/presentational changes.
5. The Committee received the updated management responses to risk and fraud report. Colleagues from Grant Thornton (external auditors) reported that a review of the paper had been undertaken as part of the review of the annual accounts and confirmed that it provided an accurate reflection of the Trust's position. The report was approved by the committee.
6. Members received the Going Concern report and received an overview of the content. Members queried the receipt and use of non-recurrent funding in future years. It was confirmed that the use of non-recurrent funds (predominantly Sustainability and Transformational Funds (STF)) had been included in the report in case the cash position of the Trust required support, although it was highly unlikely

East Lancashire Hospitals NHS Trust

that it would be required. It was agreed that the wording in the report required amendment to accurately reflect the reasons for the inclusion of non-recurrent funds. Pending the aforementioned amendment, the Committee approved the report for submission.

7. Representatives from Grant Thornton presented the audit findings relating to the Trust's Quality Account and confirmed that testing of indicators had been carried out by Mersey Internal Audit Agency (MIAA). Members noted that Venous thromboembolism (VTE) had featured as an indicator for the past three years and that the required improvements had not been seen in the year, therefore a qualified opinion would be given in relation to this matter. Members noted that there were no issues arising in relation to the Clostridium Difficile indicator and there were no issues found in terms of the form and content review that had been completed. Committee members requested that the Quality Committee consider this matter as a matter of urgency. They requested that a report from the Quality Committee be brought back to the next available Audit Committee meeting.
8. The Committee received, discussed and approved the Trust's statement regarding Modern Slavery. The statement has been signed by the Director of Finance and the Chair of the Audit Committee and published on the Trust's website. The statement can be viewed on the Trust's website here: <http://www.elht.nhs.uk/about-us/publications.htm>

Kea Ingham, Company Secretarial Assistant, 29 June 2017

TRUST BOARD REPORT

Item **110**

12 July 2017

Purpose Information
Assurance

Title	Finance and Performance Committee Update Report (April and June 2017)
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Mr David Wharfe, Non-Executive Director, Committee Chair

Summary: The report sets out the matters discussed and decisions made at the Finance and Performance Committee meeting held on the 24 April and 28 June 2017.

Report linkages

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

rating.

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Finance and Performance Committee Update Report: 24 April 2017

At the last meeting of the Finance and Performance Committee held on 24 April 2017 members considered the following matters:

1. The Committee received the Integrated Performance Report, including an overview of the current financial position for the month of March 2017. As a result of the discussions around this item, the members requested an update at the next meeting in relation to IR35 arrangements.
2. The Committee received the Blood Sciences tender. The document set out a number of potential next steps, following discussion it was agreed that the Committee would recommend a three year extension to the current contract to the Board. It was agreed that the next steps would be to work to bring the service in line with the wider work of the Sustainability and Transformation Plan (STP) area.
3. The Committee received the Capital Plan update and noted the categorisation of the schemes. Members noted that £1,250,000 had been set aside to develop the Information Technology infrastructure in prior to the implementation of electronic patient records; £8,000,000 had been assumed for redevelopment on the RBH site. Following a discussion it was agreed that the Divisional General Manager for Estates and Facilities would be invited to the September 2017 meeting to review potential plans for car parking arrangements.
4. Members of the Committee received the Sustaining Safe, Personal and Effective Care 2017/18 update report. Non-Executive members requested that an update be provided at the next meeting in relation to pressures regarding the elective centre and possible double running of wards. It was agreed that an overview of the discussions around potential additional funding for the emergency care pathway would be provided to a future meeting. Members noted that Divisional recovery plans focused on the strengthening of financial controls. The Committee requested that a quantified two year plan be presented at the next meeting. Non-Executive members discussed the governance arrangements for the Transformation Board meetings.
5. The Committee received an update relating to the Lancashire Procurement Cluster. Non-Executive members suggested that the cluster should cover the whole of the STP area so that the optimal amount of savings could be achieved.
6. The Committee received an update report on tenders, an update regarding CQUIN planning, the Carter Review report, Estates Strategy update and the results of the

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Committee Self-Assessment survey. The Committee also received the minutes of the Contract and Data Quality Board for information.

At the last meeting of the Finance and Performance Committee held on 28 June 2017 members considered the following matters:

7. Members received an update in relation to the IR35 legislation and noted that the Trust had seen an impact in the availability of locum staff, but that most individuals who the legislation would apply to have moved across to the Trust's staff bank.
8. The Committee received the Integrated Performance Report and noted that overall performance against financial and constitutional indicators was good, albeit with risks identified in the financial outturn, the cash position and 4 hour achievement.
9. Members discussed the reporting arrangements for the Fire Safety, it was noted that reporting to the Board on this matter will be carried out via the Quality Committee.
10. Members received the detailed finance report and noted that Sustainability and Transformational Funding (STF) monies had not been received from the centre at this time. The Committee received an update in relation to the newly issued guidelines for achievement of STF monies in 2017/18. The Non-Executive Members of the Committee suggested that there was a need for continued transparency and prudence in the management of finances in the current year in order to achieve the control total and receive 70% of the STF monies, the remaining 30% would be split equally between the achievement of primary care streaming and achievement of the four hour standard. Due to the non-receipt of STF monies there had been a significant deterioration in the cash position, which may lead to the need to take out a loan from the centre if monies are not received by the end of quarter two (September 2017). It was agreed that this issue would be escalated to the Board for information and appropriate action.
11. The Committee received the Sustaining Safe, Personal and Effective Care 2017/18 report and a presentation accompanying the report was given. The presentation gave an overview of the transformational programmes and it was noted that the majority of savings in the current year would come from traditional Safely Releasing Costs Programme (SRCP) schemes with significant savings in 2018/19 coming from the productivity and efficiency workstream. Members also noted the alignment of schemes/workstreams with the work of the Local Delivery Plan (LDP) and STP areas.

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12. The Committee received an update in relation to tenders and it was confirmed that the Trust had won the Dexa Scanning tender, however the outcome of the Alternative Provider Medical Services (APMS) tenders had been delayed due to purdah.
13. Members received the Lancashire Procurement Cluster Business Case for approval along with a presentation regarding the case. Members noted that the business case had been approved by Blackpool Teaching Hospitals NHS Foundation Trust and Lancashire Teaching Hospitals NHS Foundation Trust at their recent equivalent Committees. The members noted that Lord Cater of Coles would be undertaking a visit to the Trust in relation to this work on 18 July 2017 and that, pending approval at the Committee the service would be implemented in September ready for TUPE of staff in October 2017. The hosting arrangements for the service were discussed and it was noted that East Lancashire Hospitals NHS Trust were the preferred host and this had been agreed by the three members of the cluster. It was confirmed that the Committee had been given delegated authority to approve the business case on behalf of the Trust Board. Following discussion amongst the members the business case was approved.
14. Members received a presentation on the Trust's use of East Lancashire Financial Services (ELFS). The presentation covered the current services that are provided by ELFS and the cost to the Trust of these services. It was agreed that the Trust would undertake a procurement exercise and scope out a possible joint venture for the future.
15. The Committee received an update report on tenders and the minutes of the Contract and Data Quality Board for information.

Kea Ingham, Company Secretarial Assistant, 29 June 2017

TRUST BOARD REPORT

Item **111**

12 July 2017

Purpose Information
Assurance

Title Quality Committee Summary Report (May 2017)

Author Miss K Ingham, Company Secretarial Assistant

Executive sponsor Ms N Malik, Committee Chair

Summary: The report sets out the matters discussed and decisions made at the Quality Committee meetings held on 31 May 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 and the organisation's corporate objectives
Recruitment and workforce planning fail to deliver the Trust objectives
Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways
Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust
The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.
The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of

failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Quality Committee Update: 31 May 2017

1. At the last meeting of the Quality Committee held on 31 May 2017 members considered the following matters:
2. The Committee received the End of Life Care Annual Report and noted the progress made over the course of 2016/17. Members noted and approved the priorities that had been proposed for the forthcoming year.
3. The Committee received a report on two recent Never Events, both relating to wrong site surgery. Whilst both incidents related to wrong site surgery, they occurred independently of each other and occurred within different specialities. Members received an overview of the learning from both cases and the changes to practice that had taken place.
4. Members received a report in relation to Registered and Non-Registered Professional Judgement Review of Nursing Staffing. Members noted the proposed workforce developments, particularly the harmonising of shift patterns for nursing/care staff, which will be progressed through the required internal routes, including discussions with the Trust's Joint Negotiation Consultative Committee (JNCC) and Unions.
5. The Committee received the Nursing and Midwifery Revalidation Team Report. For the purpose of this item, Miss Malik declared that she was a member of the Nursing and Midwifery Council (NMC) Fitness to Practice Panel. Members noted that the outcome of the recent internal audit of the process used within the Trust had received high assurance and would be used as a benchmark for other Trusts.
6. Members received the UNICEF UK Baby Friendly Initiative Report and noted that the Trust had had an initial progress visit and a further visit to assess the Trust was planned for 27 June 2017. Should the assessment visit be successful, the Trust would be awarded 'gold' status. Members noted that if this was to happen the Trust would be the first in the UK to achieve such status. A further update will be provided to the Committee following the visit.
7. The Committee received the proposed Policy for the Review of Clinical Care Following the Death of a Patient in Hospital for discussion and recommendation to the Trust Board. Members noted that the proposed process for conducting reviews had been aligned to the national guidelines and that time would need to be allocated in a small number of individual job plans to conduct this work, with a recurrent cost of £30,000 per annum. The Committee were informed that the formalisation of the

policy may lead to an initial increase in incident reporting. Members agreed to recommend the policy to the Trust Board for adoption.

8. The Committee received the Winter Planning 2016/17 Evaluation Report for information and it was confirmed that this item had also been presented to the Accident and Emergency Delivery Board (AEDB), alongside a number of recommendations that would inform the 2017/18 winter plan.
9. Members received the Raising Concerns Annual Report for information and noted that Mrs Jane Butcher had been recruited to the role of Staff Guardian following Mrs Lynne Barton's retirement in May 2017.
10. Members were advised that, following discussions at the Audit Committee regarding the Venus Thromboembolism (VTE) section of the Quality Account, an action had been allocated to the Committee. The Quality Committee were asked to undertake sufficient work to provide assurance to the Audit Committee that the issues highlighted were being addressed. An action plan, complete with timescales for delivery was requested to the next Quality Committee for monitoring.
11. The Committee also received the Serious Incidents Requiring Investigation (SIRI) Report, Nursing Strategy Update, Quality Dashboard, Corporate Risk Register, a proposal for a Quality Improvement Award Scheme and Summary Reports from the following Sub-Committee Meetings:
 - i. Patient Safety and Risk Assurance Committee (Annual Report)
 - ii. Infection Prevention and Control Committee (April 2017)
 - iii. Health and Safety Committee (April 2017)
 - iv. Internal Safeguarding Board Committee (May 2017)
 - v. Patient Experience Committee (April 2017)
12. A more detailed summary of this meeting will be available once the report has been presented to the Trust Board in July 2017.

Kea Ingham, Company Secretarial Assistant, 30 June 2017

TRUST BOARD REPORT

Item **112**

12 July 2017

Purpose Information Assurance

Title	Remuneration Committee Information Report (May and June 2017)
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The list of matters discussed at the Remuneration Committee's held on 3 May and 14 June 2017 are presented for Board members' information.

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

Report linkages

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

rating.

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

Remuneration Committee Information Report: 3 May 2017

1. At the meeting of the Remuneration Committee held on 3 May 2017 members considered the following matters:
 - a) Proposed 1% Pay Award for Executive Directors

Remuneration Committee Information Report: 14 June 2017

2. At the meeting of the Remuneration Committee held on 14 June 2017 members considered the following matters:
 - a) Chief Executive's Annual Appraisal

Kea Ingham, Company Secretarial Assistant, 29 June 2017

TRUST BOARD REPORT

Item **113**

12 July 2017

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 3 May and 14 June 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
Related to key risks identified on assurance framework	Encourage innovation and pathway reform, and deliver best practice
	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives
	Recruitment and workforce planning fail to deliver the Trust objectives
	Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways
	Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust
	The Trust fails to achieve a sustainable financial

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position and appropriate continuity of service risk rating.

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: n/a

Trust Board Part Two Information Report: 3 May 2017

1. At the meeting of the Trust Board on 3 May 2017, the following matters were discussed in private:
 - a) Round Table Discussion: Local Delivery Plan, Sustainability and Transformation Plan Update
 - b) Round Table Discussion: Healthier Together: Health Improvement Partnerships
 - c) Round Table Discussion: NHS Provider Briefings on Purdah
 - d) Blood Sciences Tender
 - e) Sustaining Safe, Personal and Effective Care 2016/17 Update Report
 - f) Tenders Update
 - g) Draft Annual Governance Statement
 - h) Draft Annual Report 2016/17
 - i) Draft Annual Accounts 2016/17
 - j) Draft Quality Account 2016/17
 - k) Serious Untoward Incident Report
 - l) Safe Working Hours: Doctors and Dentists
 - m) Doctors with Restrictions
 - n) Board Sub-Committee Membership and Chairmanship Report
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.

Trust Board Part Strategy Session: 14 June 2017

3. At the Trust Board Strategy Session 14 June 2017, the Board received assurance regarding the recent Cyber Attack.

Kea Ingham, Company Secretarial Assistant, 29 June 2017