East Lancashire Hospitals
NHS Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

Personal

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East Lancashire Hospitals NHS Trust

TRUST BOARD PART 1 MEETING

14 NOVEMBER 2018, 14:30,

SEMINAR ROOM 6, ROYAL BLACKBURN HOSPITAL

AGENDA

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

OPENING MATTERS				
TB/2018/108	**Chairman's Welcome**	Chairman	v	
TB/2018/109	**Open Forum** To consider questions from the public	Chairman	v	
TB/2018/110	**Apologies** To note apologies.	Chairman	v	
TB/2018/101	**Declaration of Interest Report** To note the directors register of interests and note any new declarations from Directors.	Chairman	v	Information/ Approval
TB/2018/102	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 12 September 2018.	Chairman	d✓	Approval
TB/2018/103	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2018/104	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2018/105	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2018/106	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information
QUALITY AND SAFETY				
TB/2018/107	**Patient Story** To receive and consider the learning from a patient story.	Director of Nursing	p	Information/ Assurance
TB/2018/108	**Corporate Risk Register** To receive an update on the Corporate Risk Register and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Medical Director	d✓	Information
TB/2018/109	**Board Assurance Framework** To receive an update on the Board Assurance Framework and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Medical Director	d✓	Approval

TB/2018/110	**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
TB/2018/111	**Flu Vaccinations Programme 2018/19**	Director of HR and OD	d✓	Information/ Assurance
STRATEGY				
TB/2018/112	**Lancashire and South Cumbria Integrated Care System (ICS) Memorandum of Understanding (MoU)**	Chief Executive	d✓	Information/ Approval
ACCOUNTABILITY AND PERFORMANCE				
TB/2018/113	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed: • Introduction (Chief Executive) • Performance (Director of Operations) • Quality (Medical Director) • Workforce (Director of HR and OD) • Safer Staffing (Director of Nursing) • Finance (Director of Finance)	Executive Directors	d✓	Information/ Assurance
GOVERNANCE				
TB/2018/114	**Emergency Preparedness Resilience Report**	Director of Operations	d✓	Information
TB/2018/115	**ELHT&Me Update Report**	Director of Communications and Engagement	d✓	Information/ Assurance
TB/2018/116	**Audit Committee Update Report** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information/ Assurance
TB/2018/117	**Finance and Performance Committee Update Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information/ Assurance
TB/2018/118	**Quality Committee Update Report** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information/ Assurance
TB/2018/119	**Remuneration Committee Update Report** To note the matters considered by the Committee in discharging its duties	Chairman	d✓	Information/ Assurance
TB/2018/120	**Trust Board Part Two Information Report** To note the matters considered by the Committee in discharging its duties	Chairman	d✓	Information
FOR INFORMATION				
TB/2018/121	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2018/122	**Open Forum** To consider questions from the public.	Chairman	v	

TB/2018/123	**Board Performance and Reflection** To consider the performance of the Trust Board, including asking: • Has the Board focussed on the appropriate agenda items? Any item(s) missing or not given enough attention? • Is the Board shaping a healthy culture for the Board and the organisation and holding to account? • Are the Trust's strategies informed by the soft intelligence from local people's needs, trends and comparative information? • Does the Board give enough priority to engagement with stakeholders and opinion formers within and beyond the organisation?	Chairman	v	
TB/2018/124	**Date and Time of Next Meeting** Wednesday 10 January 2019, 1.00pm, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.	Chairman	v	

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 102

14 November 2018

Purpose Action

Title	Minutes of the Previous Meeting
Author	Miss K Ingham, Assistant Company Secretary
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The minutes of the previous Trust Board meeting held on 12 September 2018 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

(102) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 2.30PM, 12 SEPTEMBER 2018

MINUTES

PRESENT

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

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Associate Director of Corporate Governance/ Company Secretary	
Mrs L Barnes	Head of Health and Wellbeing	For Items TB/2018/093 and TB/2018/094
Mr J Driscoll	Care Quality Commission (CQC)	Observer
Mr J Holden	Member of the Public	Observer
Miss K Ingham	Company Secretarial Assistant	Minutes
Mr A Mohammed	Siemens	Observer
Mr R O'Brien	Engagement Support Officer	Observer
Ms E Schofield	Deputy Director of HR and OD	For Item TB/2018/093 and TB/2018/094
Mrs A Sugden	Engagement Support Officer	Observer
Mr B Todd	Member of the Public	Observer

Mrs S Ridehalgh	Patient Experience Facilitator	For Item TB/2018/089
Mrs A Ward	Patient	For Item TB/2018/089

APOLOGIES

Mr S Barnes	Non-Executive Director
Mr R Slater	Non-Executive Director

TB/2018/079 CHAIRMAN'S WELCOME

Professor Fairhurst welcomed the Directors to the meeting. She extended a warm welcome to the members of the public and particularly to Mr Driscoll, the Lead Inspector from the Care Quality Commission who would be observing the Board meeting.

TB/2018/080 OPEN FORUM

Mr Todd asked about the recent Never Events that had taken place, why they had occurred and the actions that had taken place to learn from the incidents. Dr Riley confirmed that there had been no Never Events reported since April 2018 but, a number of Never Events had occurred in the previous financial year. He provided an overview of the Never Events and confirmed that whilst they were classed as events that should never happen, they do occur across the entirety of the NHS on occasion. He also confirmed that the number of such events has remained stable in the last five years. Dr Riley reported that a full report on this matter was presented to the Trust Board meeting that took place in March 2018. The report included the learning from the events and the improvements that had taken place as a result of the incidents. The report can be accessed through the Trust website (item 13, pages 67 to 94).

Mr Todd went on to comment that the signage at the Burnley site was difficult and not conducive to visitors finding their way around the site. Mr Bannister agreed with this comment and confirmed that, as part of the developments at the Burnley General Teaching Hospital site, a significant piece of work was being undertaken to address this issue.

RESOLVED: **Mr Bannister to provide an update on the work being carried out at the Burnley General Teaching Hospital site in relation to improving signage.**

TB/2018/081 APOLOGIES

Apologies were received as recorded above.

TB/2018/082 DECLARATIONS OF INTEREST

Mrs Bosnjak-Szekeres presented the Directors' Register of Interests report for approval and confirmed that the register is available for the general public to view.

Directors approved the Directors' Register of Interests, pending the inclusion of Mr Wharfe's declaration regarding his appointment as a Trustee of Pendleside Hospice.

RESOLVED: Directors noted the position of the Directors' Register of Interests and approved it pending inclusion of Mr Wharfe's aforementioned declaration.

TB/2018/083 MINUTES OF THE PREVIOUS MEETING

Directors having had the opportunity to review the minutes of the previous meeting approved them as a true and accurate record pending the following correction:

TB/2018/060: Chief Executive's Report – Mrs Hughes confirmed that the launch of the £1 million appeal (ELHT&Me) did not take place in July. The launch had taken place earlier in the year, but the promotion of the appeal continued during July.

RESOLVED: The minutes of the meeting held on 11 July 2018 were approved as a true and accurate record pending the aforementioned correction.

TB/2018/084 MATTERS ARISING

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

TB/2018/085 ACTION MATRIX

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

TB/2018/062: Corporate Risk Register - Mr McGee reported that there had been a number of regional events relating to mental health since the last meeting and as a result the Trust was in the process of considering whether or not to register with the CQC for the provision of mental health services (sectioning).

TB/2018/065: Staff Guardian Annual Report – Mr Moynes confirmed that the messages for publication to staff were being developed and would be cascaded within the coming two weeks.

TB/2018/067: Integrated Performance Report (safer staffing) – Mrs Pearson confirmed

that the Trust was working with UCLan to review the educational requirements of the potential cohort of nurses from Kosovo.

TB/2018/071: Quality Committee Update Report – Mrs Pearson confirmed that the Trust had been successful in being revalidated as a UNICEF Baby Friendly Gold Award organisation.

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

Mrs Pearson will provide an update at the next meeting regarding the work being undertaken with UCLan to review the educational requirements of the potential cohort of nurses from Kosovo.

TB/2018/086 CHAIRMAN'S REPORT

Professor Fairhurst provided an update about her Trust related activities since the last meeting. She reported that she had visited a number of the Trust's theatres with Mr McGee and Mr Wedgeworth and would be undertaking a number of staff walk rounds and 'Meet the Board' sessions in the coming weeks, including visiting staff who worked on night shifts. Directors noted that Professor Fairhurst had also visited Treatment Centres at Rossendale, Colne and Nelson, where the links between deprivation and health outcomes were clearly demonstrated.

Professor Fairhurst highlighted the discussions that she had undertaken with Professor Dominic Harrison, Director of Public Health at Blackburn with Darwen Borough Council in relation to having greater public health input into the Board discussions and the possibility of him or one of his colleagues attending future Board meetings. Directors noted that Professor Fairhurst had arranged a meeting of fellow Chairs across the Integrated Care System (ICS) partner organisations to focus on the issues that are common to all partners. It was agreed that regular meetings would be organised following this inaugural meeting. Professor Fairhurst confirmed that the discussions at the meeting included the emphasis on national bodies and regulators moving towards addressing system working and integration.

Finally, Professor Fairhurst confirmed that she and Mr McGee had attended the Health Expo earlier in the month, which was of particular interest this year as the Rt. Hon. Matt Hancock, the Secretary of State for Health and Social Care gave his first address to NHS leaders. He emphasised the dividends for Trusts regarding patient experience and efficiencies via the use of digital technology and suggested that this is a matter for consideration and action by Boards to ensure that the consequences of digitisation are beneficial for the population.

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

TB/2018/087 CHIEF EXECUTIVE'S REPORT

Mr McGee presented his report to Directors and echoed the Chairman's comments regarding the use of technology in the future in the NHS. He went on to highlight other priorities, including mental health and referenced the work that the Trust is undertaking with partners to move towards the provision of health and wellbeing services.

Directors noted that the NHS has been under significant pressure in recent months, particularly in terms of the emergency care pathway and the need to see and treat patients with respiratory issues due to the warm summer months. Directors briefly discussed the workforce, particularly the anticipated ways in which the future workforce may wish to be employed, i.e. part time or flexible working patterns; and the need to meet this demand, whilst adequately forecasting future workforce needs.

Mr McGee reported that the Trust seal had been used on two occasions, once in relation to the Charity and once in relation to an estates matter.

Mr McGee reported that the Trust was one of only four Trusts in the country chosen by the Royal Mint to cascade the commemorative NHS 10 pence pieces through its retail points.

He went on to confirm that he had been invited to speak at a number of national events, including the Expo and the Patient Safety Congress, where he spoke about the Trust's quality improvement journey.

Directors noted that the Trust had been awarded the prestigious Kate Granger Award for the second time in the awards' three year history. Mrs Pearson reported that the Nursing Assessment Performance Framework inspections continue and asked that the Board approve the revalidation of Ward C8 and Ward 15 as silver status wards. Directors approved this request.

RESOLVED: Directors received the report and noted its content.

TB/2018/088 HONORARY POSTS

Mr McGee referred Directors to the previously circulated report and confirmed that the Trust and UCLan were working closely together to provide students with high quality medical, nursing and Associate Health Practitioners education and training. As a result of the joint working, UCLan have awarded a number of individuals for the Trust with posts of Honorary Professors or Honorary Senior Clinical Lecturer. The individuals that have been awarded Honorary Professorships were: Professor Lee-Suan Teh; Professor Damien Lynch; Professor Robin Paton; Professor Scott Garg; Professor Anton Krige; and Professor Damian Riley. The members of staff who have been awarded the title of Honorary Senior Clinical

Lecturer are: Anna Macpherson; Chintan Sanghvi; Fawad Zaman; Fizan Younis; Gary Cousin; Iain Crossingham; John Dean; Manu Shah; Martin Maher; Naseem Ghazali; Nasira Misfar; Saifudin Khalid; Shalom Srirangam; Shenaz Ramtoola; Simon Hill; and Surya Narayan.

Directors noted the report and extended their congratulations to those individuals who had received the honours.

RESOLVED: **Directors noted the report and congratulated those individuals who have received the honours.**

TB/2018/089 PATIENT STORY

Mrs Pearson introduced Mrs Ward who was in attendance to provide her account of care within the Trust as experienced from the point of view of a parent of a patient. She reported that her daughter who is now five years old has been regularly admitted to the Trust since she was 14 months old (around 26 admissions). Mrs Ward shared that with each admission there is the inevitable fear and apprehension felt by parents, particularly as her daughter has to be in isolation due to her condition. Mrs Walsh confirmed that the care team, who care for her daughter upon admission, do their utmost to look after her child, but also to provide care to the whole family. Mrs Ward confirmed that the care received by her daughter is always good and has improved each time her daughter has been admitted. She provided an overview of the agreed way in which the Trust communicates with her and her family in relation to her daughter and commented that since their regular consultant had gone on maternity leave, the communication had deteriorated slightly. However, the issues had been highlighted to the interim consultant and work was being undertaken to improve communication.

Professor Fairhurst thanked Mrs Walsh for sharing her story with the Board and attending the meeting.

Mrs Walsh and Mrs Ridehalgh left the meeting at this point

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

TB/2018/090 CORPORATE RISK REGISTER

Dr Riley referred Directors to the previously circulated report and confirmed that there were currently nine risks on the register. Two of the risks were presented for discussion prior to a recommendation being presented to the next meeting for formal approval about their inclusion on the register. They were noted to be risk 6664 - Potential loss of Vascular Centre

Status and income of £7.9m; and risk 7330 - Potential breach of Patient data, loss of and / or reduced income and failure to identify and monitor safeguarding concerns in a timely manner. Directors noted that there were no risks recommended for de-escalation or removal from the register.

RESOLVED: **Directors received the report and noted the potential changes to the register once internal risk management processes have been completed.**

TB/2018/091 BOARD ASSURANCE FRAMEWORK

Dr Riley presented the report and confirmed that the Board Assurance Framework (BAF) had been reviewed by the Audit Committee. He reported that the revised BAF includes a number of changes that were requested by the Committee, including the revision of the wording of BAF risk 3 to the following: *Lack of effective engagement within the partnership organisations (ICS and ICP) results in failure to work together causing a detrimental effect on the health and wellbeing of our communities.*

Mr Smyth stated that there were further refinements required to the document that would be considered by the Committee in the future.

Dr Riley suggested that as a result of the review of the BAF, particularly the risk around partnership working, it was an ideal opportunity to revisit and refresh the Trust's Clinical Strategy. It was agreed that Dr Riley and Mr Hodgson will work with Clinical Directors within the Trust to revise the document under the lens of working across the Integrated Care Partnership (ICP).

Professor Fairhurst suggested that a number of the controls included in the document could also be used as potential sources of assurance.

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

Dr Riley and Mr Hodgson will undertake a refresh of the Clinical Strategy in conjunction with the Clinical Directors under the lens of increased partnership working at ICP level.

TB/2018/092 SERIOUS INCIDENTS REQUIRING INVESTIGATION REPORT

Dr Riley reported that there had been 16 Strategic Executive Information System (StEIS) reportable incidents in June and July 2018,+ with a further nine incidents triggering internal Root Cause Analysis investigations, although not meeting the criteria for STEIS reporting.

He went on to provide an update on duty of candour and Directors noted that all but one of the incidents requiring duty of candour had taken place within the required 10 working day limit.

Dr Riley provided an overview of the 'ID Me' campaign and confirmed that it had been developed as part of the learning from a Never Event that had occurred in October 2017. Miss Malik commented that she had seen a significant amount of communication around the Trust in relation to the campaign and commended the work of the Trust's communications team for their efforts in designing and publicising the work.

In response to Mr Wedgeworth's question, Mrs Pearson provided an overview of the falls collaborative project and confirmed that a significant reduction in the numbers of falls with harm had been seen.

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

TB/2018/093 HEALTH AND WELLBEING STRATEGY

Mr Moynes presented an overview of the strategy and confirmed that the full document had been presented to the Quality Committee in July for discussion and recommendation to the Board. A full copy of the Strategy can be found here. Mr Moynes highlighted the achievements of the Trust to date, including the positive results from the national NHS Staff Survey; improvements in MSK services for staff; flu vaccinations; and the development of healthy food options for staff and the public.

Professor Fairhurst commented that it was significant what could be achieved with concentrated effort and engagement from staff. Mrs Anderson agreed and went on to suggest that organisations that provide great care tend to be those that have high levels of staff engagement and staff health and wellbeing. Following a brief discussion, Directors approved the strategy for implementation.

RESOLVED: **Directors received the strategy, noted its contents and approved it for implementation.**

TB/2018/094 CULTURE AND LEADERSHIP

Mrs Lee Barnes and Ms Emma Schofield attended the meeting to provide a presentation on the findings from the discovery phase of the Compassionate Leadership work which is taking place within the Trust. Mrs Barnes confirmed that the Trust had concluded the first of the three stages associated with the work. The presentation included the following: the

importance of this work to the Trust; the intended benefits of the work; a brief summary of the programme; a summary of the oversight and governance structure (Enabling Group and Change Team); the discovery phase diagnostic tool and findings; an overview of the findings from the culture focus groups, Board interviews and leadership behaviours survey; and the intended next steps for progression into the design phase (phase two of three) which is due to commence in February 2019. In response to Mrs Pearson's question, Mrs Barnes confirmed the timeline for the feedback of the findings and the next steps across the Trust. Directors noted that the Change Team would receive the feedback initially, followed by the Board and then a detailed communications plan would be used to provide feedback to the wider Trust staff.

Directors noted that the next steps include working with Dr Katy Steward to develop a rich picture of the organisation, developing good examples of compassionate leadership within the Trust and concentrating efforts in areas where further work is required. Initially, the Trust will develop a policy around early management of conflicts which will be published in November 2018.

Professor Thomas commented that compassionate leadership was not about being nice, but about having difficult conversations and holding people to account in a kind and supportive way.

Directors thanked Mrs Barnes and Ms Schofield for providing a comprehensive presentation of the work and commented that they looked forward to receiving further updates on the future stages of the work.

RESOLVED: **Directors received the report provided and noted its contents. A detailed communications plan to disseminate the learning from phase one of the work to staff will be developed in conjunction with the Trust's Communications Team.**

TB/2018/095 INTEGRATED PERFORMANCE REPORT

Mr McGee introduced the report to the Directors and confirmed that the report related to the period to the end of July 2018. He commented that there had been significant operational pressures in the last few months, but he was pleased that the quality metrics remain in a strong position, particularly performance in relation to the Referral To Treatment (RTT) standard, finance and stroke.

a) Performance

Mr Bannister reported that the number of patients who attended the Trust through the emergency care pathway was 17,668 in July, with 14,805 being treated and leaving the department within 4 hours. He confirmed that overall performance against the four hour emergency department standard was 89.3% and work was ongoing to improve performance further. Directors noted that there were 37 reported breaches of the 12 hours trolley wait standard in the month, all were noted to be patients awaiting mental health assessments or admission to mental health beds.

Mr Bannister reported that the number of ambulance handovers which were in excess of 30 minutes increased to 568 in July, compared with 497 in June 2018. The average handover time increased in July to 19:30 minutes from 18:41 minutes in June. Directors noted that the 18 week RTT position was achieved, with 92.5% patients waiting less than 18 weeks to start treatment and there were no patients waiting over 52 weeks for treatment in July 2018.

Mr Bannister confirmed that the cancer two week wait for GP referrals standard was not achieved in June. Performance was 91.1% against the 93% standard. As a result, the quarter 1 performance also fell below the standard at 92.5%. He went on to report that the two week breast symptomatic standard was also not achieved in June. The performance was 85.4% against the 93% requirement. Mr Bannister suggested that this was partially due to an increase in demand as a result of national cancer awareness campaigns.

The cancer 31 day standard was achieved in June at 97.6%, above the 96% standard. The quarter 1 standard was also achieved at 97.9%. Directors noted that the cancer 62 day treatment standard was not achieved in June and it was below the 85% threshold, at 82.6%; however, the quarter 1 performance was achieved at 87.5%.

In addition, the 62 day screening standard continued to be achieved in June at 92.3% and quarter 1 was also met at 92.9%. Directors noted that clinical and operational plans have been developed and implemented to recover the position, including a temporary increase in capacity. Monitoring of this work will take place through the Operational Delivery Board and the Finance and Performance Committee and the Quality Committee.

Delayed transfers of care stands at 3.4% for July, which is under the national threshold of 3.5%. Mr Bannister confirmed that further work was being carried out to improve performance and the Trust has set an internal target of 2.5%. There were 60 operations cancelled on the day in the reporting month of July and most of these were due to issues with bed capacity and complex clinical patients. Directors noted that all procedures were re-booked within the required 28 day period.

Mr Bannister confirmed that the Trust retained the Sentinel Stroke National Audit Programme (SSNAP) rating of A for the second quarter.

Mr Smyth asked whether there was a chance that the Trust would meet the cancer targets in the next reporting month. Mr Bannister confirmed that the 62 day and two week standards would be difficult to achieve, but work was ongoing to meet the standards. There have been increases in MRI and CT scan capacity to improve diagnosis/screening, but reporting on diagnostics was an issue, due to lack of capacity in the radiology service. Additional capacity has been put into this area for the short term and a longer term solution is being developed.

Mr McGee confirmed that the reputation of the Trust in relation to cancer services was good, particularly with breast and urology services, which has led to an increase in demand.

Mr Wedgeworth sought further information regarding the work that was being undertaken with Lancashire Care NHS Foundation Trust (LCFT) to reduce the issues being experienced in the emergency department for patients with mental health related problems. Mr Bannister confirmed that the Trust is working closely with LCFT in relation to managing these patients and suggested that the main issues for LCFT were bed availability and the need to manage complex long term patients.

Mrs Anderson asked why there had been such a sharp increase in the number of 12 hour waits in ED in the last two months. Mr Bannister confirmed that this was due to an increase demand and capacity constraints. In response to Mr Wharfe's question, Dr Riley confirmed that Public Health England do alert Trusts about the national campaigns, but it can be difficult to predict the increase in demand and therefore difficult to ensure adequate capacity.

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

b) Quality

Dr Riley reported that there had been one case of Clostridium Difficile in July, taking the total number identified in the year to 10. Directors noted that this was one case over the forecast year to date trajectory. There were no cases of MRSA identified in the month, therefore the total cases to date in the year remains at 1.

Dr Riley confirmed that the hospital standardised mortality ratio (HSMR) remains in the 'better than expected' category and the Summary Hospital Mortality Indicator (SHMI) remains in the 'as expected' range. He went on to conform that there were currently three conditions that were indicating slightly raised levels of mortality, all of which are regularly

monitored through the Mortality Steering Group. Directors noted that work is continuing in order to clear the backlog of Structured Judgement Reviews (SJRs). The backlog has decreased significantly since the increase in the number of staff who have now been trained to take part in the reviews. Dr Riley suggested that the low infection rates were a good reflection of the high quality care provide by the Trust and confirmed that the Trust had recently been commended by the national team regarding the consistent management of infection prevention and control.

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

c) Workforce

Mr Moynes reported that appraisal rates stand at 86% for the month of July and that 10 of the 11 Core Skills modules are exceeding their target. He went on to report that there are 139 nurses in the recruitment pipeline with a further 25 on the Global Learners Programme. He provided a brief update on the workforce transformation agenda; development of new roles; and upskilling of the workforce to meet future demand. Directors noted the results of the quarterly staff Friends and Family Test particularly that 77% of those who responded were likely to recommend the Trust as a place to work, and 85% of those that responded were likely to recommend the Trust as a place to receive treatment.

Mr Moynes confirmed that the annual staff flu vaccination campaign has commenced, and the annual NHS Staff Survey is due to commence in October 2018, with a closing date in early December 2018. Staff sickness is currently mirroring the national position; the two main causes of staff absence were noted to be stress/anxiety and musculoskeletal (MSK) issues. Mr Moynes confirmed that around 30 members of staff were dismissed in the last year for sickness related issues. Directors noted that the HR team will undertake a review of the staff sickness absence policy, particularly the sections relating to the reporting of sickness.

Mrs Pearson confirmed that the first six candidates from the Global Learners Programme have had their visas confirmed and will commence in the Trust earlier than initially planned.

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

The HR team will undertake a review of the staff sickness absence policy, particularly the sections relating to the reporting of sickness.

d) Safer Staffing

Mrs Pearson reported that nursing and midwifery staffing continued to be a significant challenge for the Trust during July, with nine areas falling below the 80% fill rate for registered nurses on day shifts. Factors affecting the situation included the increased use of escalation areas; the start of the school holiday period; and increased levels of staff sickness. As a result, the Trust increased the number of registered nurses on both day and night shifts to manage this issue. Directors noted that the Blackburn Birth Centre had a number of issues in relation to midwife staffing on night shifts and reduced the number of births that took place at the centre, by referring expectant mothers to other birth centres run by the Trust, in order to mitigate any potential risks to patients.

Mrs Pearson confirmed that there were no harms as a result of the red flag incidents reported in the month. Directors noted that further mitigation in relation to staffing risks was carried out in the form of additional care/support staff being included on the rotas. Mrs Pearson confirmed that Safe Staffing conference calls continue to take place on a daily basis and where staff moves are undertaken, the decisions are taken based on the acuity of patients.

She went on to report that 20 new Nursing Associates have commenced employment with the Trust and the second cohort is due to quality in March 2019. Directors noted the UNIFY upload information and ward summary documents appended to the report.

Directors were informed that the Trust currently has the lowest number of open complaints since Mrs Pearson commenced in post in 2014. Members discussed the way in which patients and family members make complaints, including comments via social media platforms, particularly Facebook.

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

e) Finance

Mr Wood reported that the Trust remained on target to achieve the required year-end financial control total, but confirmed that there were risks associated with the plan, specifically the achievement of Safely Releasing Costs Programme (SRCP) schemes, as the majority of schemes are scheduled to release savings in the latter part of the financial year. Directors noted that income has increased in month, which is reflective of the pressures that have been seen, particularly the number of attendances at the Trust's Emergency Department and non-elective care pathways. Mr Wood confirmed that the Trust's cash

balance has remained positive since the last meeting; therefore, it is unlikely that a loan will be required until the next financial year.

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

TB/2018/096 EMERGENCY PREPAREDNESS STATEMENT

Mr Bannister reported that the statement would normally have been presented to the September meeting for review and approval for submission; however, due to the delay in receiving some of the required data from the Local Health Resilience Partnership, it was not possible to present the document to the Board. He went on to report that the Trust would be in a position to declare full compliance against the assessment criteria for the second year running. Due to the timeline for approval and submission of the annual return, it was agreed, that the Board will delegate the authority to Mr Bannister to approve the documentation for submission at the end of September and the documents would be presented to the next Board meeting for information.

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

The Board delegated the authority to the Director of Operations to approve and submit the documents by the prescribed deadline.

The documents will be submitted to the Board for information at the November meeting.

TB/2018/097 ANNUAL BOARD REPORT RELATING TO MEDICAL APPRAISALS

Dr Riley presented the report for assurance and approval prior to submission. He reported that there are 437 doctors in the Trust who have a prescriber connection and that 97% of these (423) have completed their appraisal and/or revalidation in the reporting year. He went on to report that the remaining 14 doctors all have valid reasons for non-completion of their appraisal, such as being on maternity leave or long term sick leave. Directors noted that there were 79 trained appraisers in the Trust, with 20% of appraisals being undertaken by external appraisers in order to quality assure the process.

In response to Ms Malik's question, Dr Riley confirmed that there was no data to suggest that more/less causes for concern were reported against doctors from BME backgrounds. The report was approved for signature and submission to the Regulator.

RESOLVED: **Directors approved the report for submission to the Regulator.**

TB/2018/098 **AUDIT COMMITTEE UPDATE REPORT**

Mr Smyth presented the report and confirmed that the Committee had received a number of management responses to limited assurance reports, including Bank and Agency Staffing and Divisional Risk Registers. In addition, the Committee had received the annual report of the Anti-Fraud Specialist and an overview of the findings from the anti-fraud inspection that took place in May 2018. Mr Smyth confirmed that the Committee members had also held a separate meeting to review the BAF in detail, which had recommended a number of changes (as detailed in the BAF presented to the Board earlier in the meeting). As a result of that meeting, it was agreed that a series of follow up meetings would be undertaken to review specific elements of the BAF, with the first meeting being scheduled for 1 October, to discuss BAF risks 2 and 5 with the responsible Directors in attendance.

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

TB/2018/099 **FINANCE AND PERFORMANCE COMMITTEE UPDATE REPORT**

Mr Wharfe presented the report and highlighted the tenders update report that had been presented to the Committee and noted the Trust's success in being awarded a number of contracts in the past year. In addition, the Committee has spent a significant amount of time discussing the Trust's financial position and the impact of SRCP/transformation schemes during the remainder of the financial year. He reported that members of the Committee had expressed their concerns about the back loading of SRCP schemes and as a result, it was agreed that the Divisions will be asked to present their schemes, advising the Committee on the progress made and any blockers to achievement of the programme, along with a rolling programme for the coming two years. The Family Care Division will present their scheme to the next meeting of the Committee.

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

TB/2018/100 **QUALITY COMMITTEE UPDATE REPORT**

Ms Malik presented the report and suggested that the vast majority of the items covered within the report had already been discussed over the course of today's Board meeting. She highlighted the presentation of the Annual Report of the Director of Infection Prevention and Control (DIPC) to the Committee and provided a brief overview of the discussions that had taken place on the matter at the meeting. Directors noted that the Committee members had

spent some time discussing the issues relating to the consistently high volume of mental health patients being seen at the Trust. Those discussions were similar to the ones that members had at today's meeting.

Ms Malik confirmed that she had now handed over the chairing of the Committee to Mrs Anderson. Professor Fairhurst thanked Miss Malik, on behalf of the Trust Board, for chairing the Committee until Mrs Anderson came into post.

RESOLVED: Directors received the report and noted its content.

TB/2018/101 TRUST CHARITABLE FUNDS COMMITTEE UPDATE REPORT

Mr Smyth presented the report on behalf of Mr Barnes. He highlighted the discussions that had taken place at the last Committee meeting regarding the way in which the £1 million appeal would be used, including the agreement to fund a 'big ticket' item, such as an MRI scanner, pending costings and Corporate Trustee approval. Mrs Hughes confirmed that £350,000 had been raised for the appeal since its launch in February 2018. Directors noted that the charity was working on fundraising for an endoscopy suite at the Burnley General Teaching Hospital site in conjunction with another local charity. Mr McGee commented that the donations and pledges received recently were reflective of the generosity of the population in the area. Mrs Hughes confirmed that a paper will be presented to the next Board meeting to provide an overview of the strategy and the work undertaken on increasing pledges/donations from corporate entities.

RESOLVED: Directors received the report and noted its content.

TB/2018/102 REMUNERATION COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

TB/2018/103 TRUST BOARD PART TWO INFORMATION REPORT

The report was presented to the Board for information.

TB/2018/104 ANY OTHER BUSINESS

Mrs Hughes confirmed that the Trust's Annual General meeting would take place on Wednesday 19 September 2018 at 4.00pm in the Learning Centre, Royal Blackburn Teaching Hospital. The meeting will be followed by the Trust's final NHS 70th anniversary tea party.

RESOLVED: Directors noted the information provided.

TB/2018/105 OPEN FORUM

Mr Todd commented that the sound amplification system had not been well utilised at the meeting and suggested that a training session for Board members take place about how to use the system.

Members of the Culture and Leadership team expressed their thanks for being invited to attend the Board meeting.

Mr Todd commented that the NHS was a wonderful institution and that there was much to be proud of.

TB/2018/106 BOARD PERFORMANCE AND REFLECTION

Professor Fairhurst invited comments and observations about the meeting from the Directors. The Directors commented that the members had attended to a range of matters and had received good levels of assurance. Mr McGee made reference to the work being undertaken in relation to the Culture and Leadership project and commented that it would be a significant piece of work in the coming years. Directors noted that the theme of mental health had run through a number of the items discussed during the course of both the public and private parts of the meeting. Dr Riley suggested that an additional verbal item (Patient Safety) be included on future closed session agendas to give the opportunity for any issues of patient safety to be raised and discussed. He commented that this item was already included on a number of other Board sub-committee and operational meeting agendas within the Trust.

Mr Bannister suggested that soft intelligence was not to be underestimated, particularly in relation to issues such as timely and accurate communication with patients. Mrs Pearson reported that a Patient Participation Panel was in the process of being developed and that the Trust was seeking members of the public to be involved. Members of the public interested in taking part should contact the Patient Experience Team for more details.

R**ESOLVED:** **Directors noted the feedback provided.**

Members of the public interested in taking part should contact the Patient Experience Team for more details.

TB/2018/107 DATE AND TIME OF NEXT MEETING

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

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 104

14 November 2018

Purpose Information

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

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do 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 their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2018/080: Open Forum	Mr Bannister to provide an update on the work being carried out at the Burnley General Teaching Hospital site in relation to improving signage.	Director of Operations	November 2018	Verbal Report
TB/2018/085: Action Matrix	Mrs Pearson will provide an update at the next meeting regarding the work being undertaken with UCLan to review the educational requirements of the potential cohort of nurses from Kosovo.	Director of Nursing	November 2018	Verbal Report
TB/2018/090: Corporate Risk Register	Dr Riley will provide an update in relation to the proposed changes to the Corporate Risk Register following completion of internal risk management processes.	Medical Director	November 2018	Verbal Report
TB/2018/091: Board Assurance Framework	Dr Riley and Mr Hodgson will undertake a refresh of the Clinical Strategy in conjunction with the Clinical Directors under the lens of increased partnership working at ICP level.	Medical Director and Director of Service Development	November 2018	Verbal Report
TB/2018/094: Culture and Leadership	A detailed communications plan to disseminate the learning from phase one of the work to staff will be developed in conjunction with the Trust's Communications Team.	Director of HR and OD and Director of Communications and Engagement	November 2018	Verbal Report

Item Number	Action	Assigned To	Deadline	Status
TB/2018/095: Integrated Performance Report	*Workforce:* The HR team will undertake a review of the staff sickness absence policy, particularly the sections relating to the reporting of sickness.	Director of HR and OD	November 2018	Verbal Report
TB/2018/096: Emergency Preparedness Statement	The Board delegated the authority to the Director of Operations to approve and submit the documents by the prescribed deadline. The documents will be submitted to the Board for information at the November meeting.	Director of Operations Director of Operations	September 2019 November 2018	Verbal Report **Complete** Agenda Item November 2018
TB/2018/106: Board Performance And Reflection	Members of the public interested in taking part should contact the Patient Experience Team for more details.	Director of Nursing	November 2018	Verbal Report

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 106

14 November 2018

Purpose Information

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

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

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

Report linkages

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

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

CEO Report
November 2018

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

One - National Headlines

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

Sale of sugary drinks

Every NHS hospital has pledged to stop or reduce the sale of sugary drinks on site as part of the action to curb rising levels of obesity. Leading national retailers operating from NHS premises, including WH Smiths, have also signed up to the call of action. This leads on from last year's incentive to limit confectionary sold in canteens and vending machines, supporting CQUIN Indicator 1b: Healthy food for NHS staff, visitors and patients 2017/18.

NHS winter campaign

NHS England launched the 'Help Us Help You' brand which brings together a family of campaigns incorporating messages about flu, staying well during winter, NHS 111, pharmacy and extended GP hours. The aim is to help the public navigate NHS services and receive the right help and advice, at the right time, in the right place.

GP funding

NHS England announced the provision of £10m to GPs to support the delivery of additional extended hours, out of hours and unscheduled care sessions over the winter period.

Reinvestment of potential savings

Simon Stevens, NHS England Chief Executive, has asked for NHS hospitals to prepare to reinvest savings resulting from the patent expiration of the NHS's most costly drug; Adlimumab

(brand name Humira). It is expected that the use of biosimilar versions could help save at least £150 million per year by 2021, depending on the price agreed for the drug. More than 46,000 patients are prescribed Adlimumab for hospital treated serious conditions such as rheumatoid arthritis, inflammatory bowel disease and psoriasis.

More support for NHS doctors

National funding has been agreed for a new mental health support scheme which would cover all NHS doctors in England. This scheme builds upon the success of NHS England's programme to support GPs and trainees suffering from mental health issues. It will provide the most comprehensive national mental health support service to doctors across England. Ultimately it will be patients and not just their doctors who will benefit.

Autumn budget

Chancellor Phillip Hammond made a number of announcements in his autumn budget which have an impact on the NHS and its workforce; with particular emphasis on mental health services and support. These are:

- Confirmation of an extra £20.5bn for the NHS over the next five years.
- A minimum extra £2bn a year for mental health services.
- The NHS 10-year plan will include a mental health crisis service in all A&Es, in addition to more mental health ambulances, crisis services in the community and a new 24hr mental health crisis hotline.
- £10m donation to the Armed Forces Covenant Fund Trust to support veterans with mental health needs.
- £650m grant funding for English authorities for social care in 2019/20.
- £10m towards air ambulances.
- Private Finance Initiative (PFI) projects are to be abolished for future projects. The government will continue to honour existing contracts. A centre of excellence will be established to actively manage PFI contracts in the public sector, starting with health.

Staff sickness

The latest figures released by NHS Digital show that the June 2018 monthly NHS staff sickness absence figure was 3.90 per cent; the same as during June 2011. The lowest sickness absence rate by staff group was 1.15 per cent for nursing, midwifery and health visiting learners. The highest at 6.06 per cent was healthcare assistants and other support staff.

Zero tolerance to abuse against staff

Violence against NHS staff has reached its highest level in five years. Figures reveal that one in seven health professionals were attacked in the course of their work last year. Matt Hancock, the health and social care secretary announced plans to better protect NHS staff against deliberate attacks and abuse from patients, their families and the public. The creation of a new partnership between the NHS, police and Crown Prosecution Services will work to reduce assaults and speed up the prosecution of offenders.

Big savings from small changes

Trusts from across England have saved £288m, according to NHS Improvement data, in the last financial year. This was achieved by securing the best deals for everyday essentials, such as syringes and disposable gloves, through negotiations and bulk buying. Online savings were also made through the price comparison tool, allowing Trusts to view the cheapest options for over one million products.

Eliminating the pay gap

A new goal to eliminate the ethnicity pay gap in the NHS has been announced. The aim is for black, Asian and minority ethnic representation at very senior management levels to match the rest of the NHS workforce by 2028. In addition, the creation of the new Race at Work Charter, backed by NHS England, Public Health England and Health Education England, will recognise organisations who sign up to the five calls of actions as outlined in the McGregor-Smith review: One year on.

Two - Pennine Lancashire Headlines

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

CAMHS redesign

Progress is being made on the redesign of child and adolescent mental health services (CAMHS). A report entitled "Thrive: Healthy young minds" has been published, sharing the views of children and young people and their families/carers, about CAMHS in Lancashire and South Cumbria. The report is the result of engagement events held during the summer by local Healthwatch teams. Planning for the next phase of co-production is underway with the aim to build on the good work that has been carried, enhance the service further and looking at better ways to engage with patients for a better-quality experience.

Opening of Ribblemere

The new eight-bed mother and baby unit, Ribblemere, enjoyed a successful opening in October. The inpatient facility will provide care for women experiencing severe mental health problems or who may be at high risk of becoming mentally unwell in the perinatal period, including very serious conditions such as post-partum psychosis. Mothers can access the vital support and treatment they need whilst remaining alongside their babies.

New appointment

We are delighted to announce that Michelle Brown has now been formally appointed to role of Associate Director of Improvement following a rigorous interview process. Michelle will be heavily involved in working on the Pennine Lancashire Integrated Care Partnership.

Our Health Our Care update

After two years of work to develop more services within the community, the Our Health Our Care programme is now focusing on how hospital services are delivered in Central Lancashire. They are calling upon patients, the public and key stakeholders to provide feedback and opinion on the emerging model of care.

Stakeholder briefing

A Lancashire and South Cumbria stakeholder briefing on Primary Care Transformation has been released. It covers topics such as Primary Care Networks, resilience programmes and the GP retention fund.

Top spot for inpatient recommendation

According to the latest data from NHS Friends and Family Test survey, inpatients rated all five of ELHT's hospitals as the best in Lancashire and South Cumbria. In the 12 months to July 2018, 98 per cent of inpatients recommended the treatment and care they received at ELHT. This is highest rating of any NHS Trust in the region, and among the highest in England. ELHT's impressive ratings were the opinion of 28,364 people who stayed in one of our hospitals for at least one night between August 2017 and July 2018.

Three - ELHT Headlines

Important news and information from around the Trust which supports our vision, values and objects.

Use of the Trust Seal

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

- On 25 September 2018 the seal was applied to a Licence to Assign the Lease of Land and Building in the High Street in Rishton, between Hyndburn Borough Council, ELHT and Gorgemead Ltd in relation to the sale of Rishton Health Centre.
  The Chief Executive and the Director of Finance/Deputy Chief Executive signed the document.
- On 10 October 2018 the seal was applied to the Transfer of Title related to the sale of the Rishton Clinic, High Street, Rishton BB1 4LA.
  The transfer document was signed by the Medical Director/Deputy Chief Executive and the Director of Service Development/Deputy Chief Executive.
- On 5 November 2018 – the seal was applied to the Lease relating to the Retinal Services Unit at the Holden centre, Gisburn Road, Barrowford, Nelson, Lancashire, BB9 8NF, between ELHT and Medical Imaging UK Ltd.
  The document was signed by the Medical Director/Deputy Chief Executive and the Director of Service Development/Deputy Chief Executive.

Forget Me Not

NICU on our Burnley site has put a lot of time and thought into how we can help and support newly bereaved parents. The new Forget Me Not suite is a beautiful, serene area which provides families with the opportunity to spend precious time with their baby and prepare to say goodbye. It offers a peaceful, homely, private surrounding where families can make special memories and be supported by NICU experts. The suite was made possible through the hard work of NICU staff, the Estates and Facilities team, and ELHT&Me.

Ambulatory Emergency Care Unit

It was an exciting day when the new Ambulatory Emergency Care Unit at the Royal Blackburn Teaching Hospital opened. The unit is for adult patients who arrive at the Emergency Department or Urgent Care Centres with a range of conditions. These include patients with low risk chest pain and suspected pulmonary embolisms. There is a lot of confidence that the new

Unit will relieve pressure on our Emergency and Urgent Care services, reducing waiting times and providing our patients with a much better environment and experience.

Outstanding contribution

During Black History month the Royal College of Nursing held a conference celebrating and honouring the BAME contribution to health and social care of the last 70 years. Awards were presented and ELHT's Workforce Project Manager, Sufiya Rasul received the 'Outstanding Contribution to Equality and Inclusion in Health and Social Care' award. It recognised the tireless work of Sufiya and her colleagues to engage with local schools and our wider community.

Kate Granger Award

A multi-disciplinary team of obstetricians, midwives, theatre staff and anaesthetists who introduced 'skin-to-skin' caesarean births received a coveted NHS award recently. For the second time in three years ELHT was awarded the NHS Kate Granger Award for Compassionate Care. Since introducing the 'skin-to-skin' caesarean option, maternity staff have seen an increase in mothers-to-be requesting early skin-to-skin contact.

Honorary titles

Twenty-two ELHT consultants received honorary titles from the University of Central Lancashire. Six clinicians received Honorary Professorships and a further sixteen received Honorary Senior Clinical Lecturers. The awards strengthen ELHT's reputation as the region's leading NHS Teaching institution and acknowledges the significant contribution made by our clinical staff to educating and training the local NHS workforce.

See something, say something

In October we showed our support to Speak Up Month, a national campaign which calls on NHS organisation to increase awareness of how staff can raise concerns at work. We are very proud to have Jane Butcher as Staff Guardian who provides a safe environment for staff to voice their concerns or anxieties. The Board receives regular updates, giving a clear picture on all matter concerning the freedom to speak up.

Grade A service

Not so long ago, we were a low performing Trust and rated Grade E in the independent SSNAP Audit. Thanks to the hard work and dedication of many staff, fantastic improvements have taken

place, resulting in the service achieving Grade A in our most recent audit (Dec - March 2018).

National recognition for local initiative

Well placed congratulations are in order for the ’10,000 Feet’ theatre safety initiative, led by Rob Tomlinson. The project recently received a national Patient Safety Award, under the category "Improving the environment in which staff are able to raise and address safety concerns". This very simple communications tool has been developed from a concept in the aviation world, where the need for focused attention is essential. Calling 10,000 feet in the theatre signals the need for a quiet environment and to direct absolute concentration to the task at hand.

Four – Communications and Engagement

A summary of the external communications and engagement activity.

Communications and Engagement
Monthly Media Update

During October ELHT has…

- Supported National AHP day
- New Ambulatory Emergency Care Unit
- Hosted a visit from Sir Keith Pearson
- Opened the 'Forget-me-not ' Suite
- Promoted Breast Screening Month
- Celebrated Older Peoples Day
- First to use new Ultrasound technology

Sufiya Rasul has been honoured with a special award sponsored by the Royal College of Nursing

Press and Media Relations

30 ↑	14 ↑	6 ↓	90% ↑
Mentions in all media	Media enquiries handled	Media releases issued this month	Of stories were positive or neutral

Top Stories

- Trust first to benefit from latest ultrasound technology
- NICU receives generous EG Group donation
- Makeup workshops for cancer sufferers
- Re-use walking aids plea

The monthly media net score (positive minus negative) **+10**

Website

Our website got **78,436** page views by **63,245** people

The most viewed webpage was – Visiting Times

Social media and digital

Followers on social media

8,907

5,391

634

7475
Avg Daily Facebook Reach

132,000
Twitter Impressions

90%
Facebook page responsiveness

777
Twitter mentions

The most talked about issues on out social networks

- AHP day
- Forget-me-not suite
- Have you seen our new Instagram page?
- Trainee Nursing Associates

- Alison Turner appointment
- AHP Day
- Freedom to speak up
- Employee of the Month

Posts of the month

Forget-me-not suite

17,263
People reached

7,070
Engagements

Speak Up

2 18 28

Facebook review rating

4.5

Other activity

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

Safe | Personal | Effective

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

Five - Chief Executive's Meetings

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

October 2018 Meetings

Date	Meeting
1 October	Research Collaboration Meeting
2 October	Executive Meeting
2 October	Ambulatory Emergency Care Unit Opening Event
3 October	Integrated Care System Board Meeting
3 October	Burnley, Pendle and Rossendale Council for Voluntary Services AGM
3 October	ELHT Long Service Awards
4 October	A&E Delivery Board
4 & 5 October	Chief Executive Development Network event
8 October	HSJ Awards Judging Panel
9 & 10 October	NHS Providers Conference 2018
11 October	Mick Forrest, interim CEO Northwest Ambulance
11 October	Partnership Delivery Group
12 October	Meeting with Harry Catherall, CEO of BwD Council
12 October	Introductory meeting with Dr Habib Naqvi, NHS England's Equality Lead
15 October	Making it Happen – Partnership Delivery Group
16 October	Rakehead Neuro-Rehabilitation Open Day
17 October	AOs, CEOs and Exec STP Execs
17 October	NHS England UEC Strategic Oversight Meeting
17 October	Accountable Health and Care Partnership Leaders' Forum
22 October	NHS England Long Term Pan Engagement
23 October	Executive Meeting
23 October	Making it Happen – Partnership Delivery Group
24 October	Presentation - Stoptober certificates
24 October	Employee of the Month
24 October	BwD Healthwatch AGM

November 2018 Meetings

Date	Meeting
5 November	Making it Happen – Partnership Delivery Group
5 November	Meeting with Chairman, Professor Eileen Fairhurst
6 November	Board Strategy Session
6 November	Health Education England Postgraduate Visit
12 November	Invitation: Chairman and CEO of Virginia Mason Health System UK visit, London
13 November	Executive Meeting
13 November	Estates Strategy meeting
13 November	Public Heath Meeting
13 November	Meeting with Chairman, Professor Eileen Fairhurst
14 November	Trust Board
15 November	NW Leadership Academy Board Meeting
15 November	Invitation to High Sheriff and the Dean's Banquet
16 November	NHS Lean Programme Report Session
20 November	Pennine Lancashire Middle Management Briefing Session
20 November	Meeting Chairs/CEOs ELHT and ELCCG
20 November	Meeting with Chairman, Professor Eileen Fairhurst
21 November	HSJ Awards
23 November	Deputy Director of Finance interviews
26 November	Finance and Performance Meeting
26 November	Meeting re Northern Lincolnshire and Goole NHS Foundation Trust
27 & 28 November	CQC Executive Reviewer Inspection
29 November	Vital Signs Guiding Board – London
30 November	Phase 8 site visit

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 108

14 November 2018

Purpose Information

Title	Corporate Risk Register Report
Author	Mr D Tita, Risk Manager
Executive sponsor	Dr D Riley, Medical Director /Deputy Chief Executive

Summary: The report presents an overview of the Corporate Risk Register (CRR) and risks which have been recommended by Divisions/Corporate areas to the RAM for approval and inclusion onto the CRR.

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do 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 their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a

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

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Introduction

1. The Risk Assurance Meeting (RAM) has delegated responsibility for verifying, reviewing, scrutinising, monitoring and approving the Corporate Risk Register (CRR) as well as the Trust-wide Risk Register (TWRR). The changes recommended by the RAM and Patient Safety Risk Assurance Committee (PSRAC) to the CRR are set out in this report. Directors have also reviewed their risks to reflect any changes in the current risk profile. The main thrust of this report is to provide information and assurance that there are effective processes, systems, mechanisms and governance arrangements in place to robustly manage the Trust`s Corporate and Trust-wide risk registers.
2. There are currently 9 live risks on the CRR which are as follows:

Risk	Title	Current Score
7010	Aggregated Risk - Failure to meet internal & external financial targets in year will adversely impact the continuity of service Risk Rating	20
7583	Loss of facility for Level 3 Containment in pathology	15
7529	Risk of not attaining the CQUIN for Hepatitis C treatment pathways through the Operational Delivery Network hub based at ELHT	15
1810	Failure to adequately manage emergency capacity flow system.	15
7008	Failure to comply with the 62 day cancer waiting time.	15
5790	Aggregated risk – Failure to adequately recruit to substantive medical posts may adversely impact on patient care and finance.	15
5791	Aggregated Risk - Failure to adequately recruit to substantive nursing & midwifery posts may adversely impact on patient care and finance.	15
7513	Aggregated Risk - Radiology capacity issues would impact on inpatient flow, Referral to Treatment (RTT) and Patient Experience'.	15
7067	Aggregated Risk - Failure to obtain timely MH treatment impacts adversely on patient care & safety and quality	15

3. The following new risks were discussed at the last RAM meeting on 12th October 2018 with the view of approving them for inclusion onto the CRR:
   a) Risk 755: **PACS Downtime.** This risk was represented at the RAM by the handler who stated that PACS is still posing a challenge and causing delays at the

moment, the new system will only be up and running in February 2019. The issues identified regarding PACS is leading to delays with some patients waiting for up to 30mins, poor patient experience and some procedures being cancelled in theatre. The Chair advised that this risk should be reviewed, updated to clearly describe and reflect the current concerns and current risk score then circulated to the Chair`s for approval.

b) Risk 1810: The Chair suggested that this risk regarding Trust capacity should be disaggregated and split into capacity issues in radiology, cancer treatment – compliance with the 62 days cancer performance and issues with Emergency capacity system. The rationale here is to ensure that the specificity of each risk and the actions required to mitigate them are robustly and clearly articulated and implemented. It was agreed by members of the meeting to have the following risks as stand-alone risks on the CRR.

i. Risk ID 1810 - **Failure to adequately manage emergency capacity flow system.**

ii. Risk ID 7008 - **Failure to comply with the 62 day cancer waiting time.**

iii. Risk ID 7513 – **Aggregated Risk** - **Radiology capacity issues would impact on inpatient flow, Referral to Treatment (RTT) and Patient Experience'.**

Risks discussed for de-escalation from the Corporate Risk Register:

4. No risks were discussed for de-escalation from the CRR.

New Risks reviewed for inclusion onto the Corporate Risk Register:

5. The following risks were presented for review and discussion at the RAM and approved for inclusion onto the CRR:

a) Risk ID 7513 - **Radiology capacity issues would impact on inpatient flow, Referral to Treatment (RTT) and Patient Experience'.** This risk relates to delays in both reporting and reading scans/images which could lead to poor patient experience, delays in the RRT pathway/cancer pathways with financial and performance targets implications for the Trust.

b) Risk ID 7008 - **Failure to comply with the 62 day cancer waiting time.** This risk has now been added onto the CRR as a stand-alone risk due to emerging concerns around the Trusts cancer waiting times which constitute a key

performance indicator for the Trust. This will engineer greater visibility, scrutiny and support in mitigating this risk.

c) Risk ID 1810 - **Failure to adequately manage emergency capacity flow system.** This risk has been updated to concentrate on capacity issues with flow and the inability to timely treat emergency patients in ED.

Risks being presented for approval for closure

6. No risks were presented for approval for closure.

Corporate Risk Register (Appendix 1):

7. Details of the current Corporate Risk Register can be found in appendix 1, whilst appendix 2 provides a one page representation of all risks on the CRR by showing their current score.

Conclusion

8. Members are asked to gain confidence and note the assurance provided in relation to the ongoing management of the risks on the Corporate Risk Register and to approve this report.

David Tita, Trust Risk Manager, October 2018

Appendix 1: The Corporate Risk Register – Current Risks					
Title:	Aggregated Risk - Failure to provide timely Mental Health treatment impacts adversely on patient care & safety and quality				
Trust-wide/ Divisional	Trust-wide (More than one Division)				
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:	Jonathan Smith	Risk Owner:	John Bannister	Linked to Risks:	2161 - Failure to provide sufficient skilled staffing for the needs of Tier 4 patients on the Paediatrics Ward will adversely continue - (12) 7582 -Inability to meet the needs of high risk mental health patients on in patient wards within ICG - (8) (5083 – Linked to 7582 - Failure to have a robust system to assess and manage patients with mental health needs - 15).
What is the Hazard:	ELHT is not a specialist provider or equipped to provide inpatient mental health services. However, patients with mental health need do present to the Trust and they may require both physical and mental health assessments, treatment and referral to specialist services. Due to lack of specialist knowledge, this may cause deterioration of the patient. Staff generally do not have training in physical interventions and restraint.		What are the risks associated with the Hazard:	• Breach of statutory targets • Impact on other patient care due to resource use and patients and/or carers perceptions • Risk of harm to other patients • Impact on staffing (medical and nursing) to monitor/ manage patients with MH needs • Patient deterioration, or failure to Safeguard • Risk of patient harm to themselves	
What controls are in place:	• Frequent meetings to minimise risk between senior LCFT managers, specialist and urgent care commissioners and Senior		Where are the gaps in control:	• Unplanned demand • ELCAS only commissioned to provide weekday service • Limited appropriately trained agency staff available	

	ELHT managers to discuss issues and develop pathways to mitigate risk including; Mental Health Shared Care policy, OOH Escalation pathway for Mental health patients, Instigation of 24hrs a day Band 3 MH Observation staff. Ring fenced assessment beds within LCFT bed base (x1Male, x1Female). In Family Care ongoing liaison with ELCAS and Commissioners • Monthly performance monitoring • Monitoring through Pennine Lancashire Improvement pathway • Monitoring by Lancashire and Cumbria Mental Health Group • Twice weekly review of performance at Executive Team teleconference • Discussion and review at four times daily clinical flow meeting • Introduction of mental health triage service within ED		
What assurances are in place:	• Appropriate management structures in place to monitor and manage performance • Appropriate monitoring and escalation processes in place to highlight and mitigate risks • Ongoing monitoring of patient feedback through a variety of sources • Escalation of adverse incidents through internal and external governance processes • Review of performance by Executive Team members on a weekly basis	What are the gaps in assurance:	Other agency capacity and availability of s136 facilities

	• Monthly Performance Report to Trust Board • Appropriate escalation and management policies and procedures are in place and regularly reviewed • Joint working with external partners on pathways and design improvements • 12 hour breach monitoring • Cluster reviews of 12 hour breaches undertaken. Presented at A and E Delivery board and SIRI (if required) • Every 12 hour breach is incident reported and has a timeline undertaken to identify themes for shared learning • Themes from timelines/cluster reviews are discussed weekly with commissioners, NHS England and LCFT • SOP in place for management of high risk patients (recently reviewed and up-dated)		
Actions to be carried out			
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.			

Title:	Failure to adequately manage emergency capacity flow system.				
Trust-wide/ Divisional	Trust-wide				
ID	1810	Current Status	Live Risk Register – all risks accepted	Opened	05/07/13
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 3 Total: 9
Risk Handler:	Tony McDonald	Risk Owner:	John Bannister	Linked to Risks:	3835 - Failure to appoint to vacant oncologist posts is impacting on service delivery and provision of safe, personal, effective care (16), 7587 - (There is a risk that patient's in ED at RBH are not always receiving optimal care due to a lack of embedded clinical systems- 12) 7108 - Extreme escalation areas open in response to capacity issues in ICG - (15)
What is the Hazard:	• Lack of bed capacity across the Trust can lead to extreme pressure resulting in a delayed delivery of the optimal standard of care across departments. • At times of extreme pressure this increase in the numbers of patients within the emergency pathway makes medical/nursing care difficult and impacts on clinical flow		What are the risks associated with the Hazard:	• Patients being managed on trolleys in the corridor areas of the emergency /urgent care departments impacting on privacy and dignity. • Delay in administration of non-critical medication. • Delays in time critical patient targets (four hour standard, stroke target) • Delay in patient assessment • Potential complaints and litigation. • Potential for increase in staff sickness and turnover. • Increase in use of bank and agency staff to backfill. • Lack of capacity to meet unexpected demands. • Delays in safe and timely transfer of patients	
What controls are in place:	• Daily staff capacity assessment • Daily Consultant ward rounds • Opening of Ambulatory Emergency Care Unit for Acute Medicine. • Review of Ambulatory Emergency Care for Surgery		Where are the gaps in control:	Trust has no control over the number of attendees accessing ED/UCC services	

	in progress. • Pennine Lancashire and ELHT Winter Plans approved by Pennine Lancashire A&E Delivery Board and ELHT Operational Delivery Board to support safety and timely care and movement of patients. • Introduction of ED & UCC Trigger Tools and Escalation arrangements including actions cards for relevant roles and services linked to Trust Resilience and Escalation Policy and Procedures. • Establishment of specialised flow team • Bed management teams • Delayed discharge teams • Ongoing recruitment • Ongoing discussion with commissioners for health economy solutions • ED/UCC/AMU will take stable assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley • ED/UCC/AMU will take stable assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley • Introduction of Full Capacity Protocol • Refined 2 hourly patient flow meetings		
What assurances are in place:	• Regular reports to a variety of specialist and Trust wide committees • Consultant recruitment action plan • Escalation policy and process • Monthly reporting as part of Integrated Performance Report • Weekly reporting at Exec Team • System Oversight by Pennine Lancashire A+E Delivery Board	What are the gaps in assurance:	None identified

Actions to be carried out
Numerous actions are incorporated within the Emergency Care Pathway Redesign Programme which forms part of the Trust's Transformation Programme Review the impact of the newly introduced Full Capacity Protocol and refined patient flow meetings Development of Ambulatory and Emergency Care Unit and new pathways
Notes: Mitigating actions are deployed on a daily basis at an operational level to reduce the risk to patient care.

Title:	Aggregated risk – Failure to adequately recruit to substantive medical posts may adversely impact on patient care and Finance.				
Trust-wide/ Divisional	Trust-wide				
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:	4488 - Inadequate Senior Doctor Cover for MFOP - (12), 7268 - Clinical, financial and organisational risks of (SOS) and T&O short and long term rota gaps – (9), 5557 - (Adequate Medical Staffing - 12) 3835 - Failure to appoint to vacant oncologist posts is impacting on service delivery and provision of safe, personal, effective care - (16), 7401- There is a risk that patients may not receive timely clinical care due to a lack of junior doctor cover on medical wards in ICG - (10)
What is the Hazard:	Gaps in medical rotas require the use of locums to meet service needs at a premium cost to the Trust		What are the risks associated with the Hazard:	• Escalating costs for locums • Breach of agency cap • Unplanned expenditure • Need to find savings from elsewhere in budgets	
What controls are in place:	Divisional Director sign off for locum usage Ongoing advertisement of medical vacancies Consultant cross cover at times of need		Where are the gaps in control:	Reduction in agency staffing costs form previous year has already been demonstrated, however, the availability of medical staff to fill permanent posts continues in some areas, linked to regional or national shortages in some specialties	
What assurances	Directorate action plans to recruit to		What are the gaps	None identified.	

are in place:	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 Analysis of detailed monthly report through AMG (Agency Monitoring Group). Areas for targeted action understood	in assurance:	
Actions to be carried out			
Per individual linked risks Ongoing recruitment and innovative packages offered Workforce transformation and new models of skill mix On-going pressure to reduce locum rates			
All requests to exceed capped rates to be approved by medical directorate on a case by case basis.			

Title:	Aggregated risk – Failure to adequately recruit to substantive nursing and midwifery posts may adversely impact on patient care and finance.				
Trust-wide/ Divisional	Trust-wide				
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 - Failure to recruit and retain nursing staff across inpatient wards and departments may result in inadequate nurse staffing - (12) 7496 - There is a risk of failing to deliver financial balance against the ICG nursing budget - (12)
What is the Hazard:	Use of agency staff is costly in terms of finance and levels of care provided to patients		What are the risks associated with the Hazard:	• Breach of agency cap • Agency costs jeopardising budget management	
What controls are in place:	• Daily staff teleconference • Reallocation of staff to address deficits in skills/numbers • Ongoing reviews of ward staffing levels and numbers at a corporate level • 6 monthly audit of acuity and dependency to staffing levels • Recording and reporting of planned to actual staffing levels • E-rostering • Ongoing recruitment campaigns • Overseas recruitment as appropriate • Establishment of internal staff bank arrangements • Senior nursing staff authorisation of agency usage		Where are the gaps in control:	• Unplanned short notice leave • Non elective activity impacting on associated staffing • Break downs in discharge planning • Individuals acting outside control environment	

	• Monthly financial reporting		
What assurances are in place:	• 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			
All current planned actions completed as shown in “what controls are in place” Non-Medical Bank and Agency Group			
Risk mitigation action plans are appended to each of the linked risks and are reviewed by the Divisions on an on-going basis with assurances being provided to Divisional meetings.			

Title:	Aggregated Risk – Failure to meet internal and external financial targets in year will adversely impact the Continuity of Service Risk Rating				
Trust-wide/ Divisional	Trust-wide				
ID	7010	Current Status	Live Risk Register – all risks accepted	Opened	25/08/16
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 5 Consequence: 4 Total: 20	Target Rating:	Likelihood: 4 Consequence: 3 Total: 12
Risk Handler:	Allen Graves	Risk Owner:	Jonathan Wood	Linked to Risks:	1487 - Failure to deliver the SRCP- (12) 1489 - Failure to meet the activity and income targets - (12) 6692 - Risk to safe, personal and effective service delivery due to lack of quality information from Community IT systems (EMIS) - (15)
What is the Hazard:	Failure to meet the targets will result in the Trust having an unsustainable financial position going forward and the likely imposition of special measures		What are the risks associated with the Hazard:	• If Divisions deliver their SRCP and meet their Divisional financial plans the Trust will achieve its agreed control total. • Breach of control totals will likely result in special measures for the Trust, adverse impact on reputation and loss of autonomy for the Trust • Sustainability and Transformational funding would not be available to the Trust • Cash position would be severely compromised	
What controls are in place:	• Standing Orders • Standing Financial Instructions • Procurement standard operating practice and procedures • Delegated authority limits at appropriate levels • Training for budget holders • Availability of guidance and policies on Trust intranet • Monthly reconciliation		Where are the gaps in control:	Individual acting outside control environment in place	

	• Daily review of cash balances • Finance department standard operating procedures and segregation of duties		
What assurances are in place:	• Variety of financial monitoring reports produced to support planning and performance • Monthly budget variance undertaken and reported widely • External audit reports on financial systems and their operation • Monthly budget variance undertaken by Directorate and reported at Divisional Meeting • Monthly budget variance report produced and considered by corporate and Trust Board meetings • internal audit reports on financial system and their operation	What are the gaps in assurance:	
Actions to be carried out			
Per individual linked risks			
Notes: Risk mitigation action plans are appended to each of the linked risks and are reviewed by the Divisions on an on-going basis with assurances being provided to Divisional meetings.			

Title:	Aggregated Risk - Radiology capacity issues would impact on inpatient flow, Referral to Treatment (RTT), Cancer and Patient Experience				
Trust-wide/ Divisional	Divisional				
ID	7513	Current Status	Live Risk Register – all risks accepted	Opened	30/08/17
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: Total: 15	Target Rating:	Likelihood: 5 Consequence: 2 Total: 10
`Risk Handler:	Moira Rawcliffe	Risk Owner:	John Bannister	Linked to Risks:	2310 - Failure to deliver 18 week Referral to treatment waiting times has an adverse impact on staff and patients (12),
What is the Hazard:	• Increased Radiology report turnaround times.		What are the risks associated with the Hazard:	Due to delayed reporting of scans/ images this is having a negative impact on the following for SAS Division: • 1. Patient experience • 2.Delays in the RTT pathway • 3.Financial risk • 4.Delays to Cancer Pathway • 5.Impact on Performance targets	
What controls are in place:	1. Weekly Performance meetings to review report turnaround times. 2. Daily PTL statistics to all modality leads to target long waiters. 3. Capacity Lists offered for reporting when required. 4. Outsourcing of reporting. 5. Locum Radiologists recruited. 6. Actively recruiting to the Radiology vacancies. 7. Training of chest reporting radiographers. 8. Training of MSK reporting radiographers 9. Training of CT Reporting radiographers.		Where are the gaps in control:	None identified	
What assurances	• None identified		What are the gaps in	None identified	

are in place:		assurance:	
Actions to be carried out			
Ongoing discussions with supplier being led by Director of Finance			

Title:	Loss of facility for Level 3 Containment in pathology				
Trust-wide/ Divisional	Divisional				
ID	7583	Current Status	Live Risk Register – all risks accepted	Opened	26/11/17
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 1 Consequence: 3 Total: 3
Risk Handler:	Pamela Henderson	Risk Owner:	Johnathon Wood	Linked to Risks:	N/A
What is the Hazard:	• Changes to air pressure to resolve the air pressure fault (risk 7342) have caused rips and bubbling of the vinyl wall covering from the wall. If the wall covering integrity is damaged beyond immediate repair the CL3 facility will be put out of use. The vinyl has split on many occasions and continues to be an ongoing hazard.		What are the risks associated with the Hazard:	• If the vinyl wall covering is damaged, the containment properties of the facility are compromised and therefore it cannot be used. • Crowthorn Ltd has reassessed the remedial action undertaken by Engie Raised concern about the ongoing viability of the repairs as vinyl has ripped repeatedly and been repaired on multiple occasions and is likely to continue being breached until fully refurbished.	
What controls are in place:	• The contractor, Atlas, has been appointed by Consort and plans will be finalised between all Consort, Atlas and the Trust next week commencing 15th Oct 2018. The plan then needs approval by HSE. All things being equal the contractor should be on site in November. The works programme will take up to 50 weeks. Monitoring remains in place. The back stop date for the completion of the works will be November 2019. Once completed the facility will be brought up to the correct prevailing standards.		Where are the gaps in control:	None identified	

	• The vinyl wall covering is checked every morning before processing is started and findings recorded on a worksheet. If tears are found, Engie is informed immediately and work does not start until they have filled the breach with silicon sealant. This will only be effective as long as the breaches are small. • Current safe procedures for working in CL3 to be adhered to as per policy • Visual inspection of vinyl wall covering recorded daily and repairs conducted before any processing can begin. • Consort to repair/refurbished wall covering to repair damage.		
What assurances are in place:	• Completed worksheets available demonstrating checks are conducted daily. • Risk assessment and actions reviewed at departmental quality meetings and CLM governance meetings. • Refurbishment plan available from Consort (timeline TBA).	What are the gaps in assurance:	None identified
Actions to be carried out			
Discussion with PFI partners and specialists progressing to remedy issues. Consort have taken on the proposed refurbishment and plans are going out to tender in the near future. Consort to repair/refurbish wall covering to repair damage.			

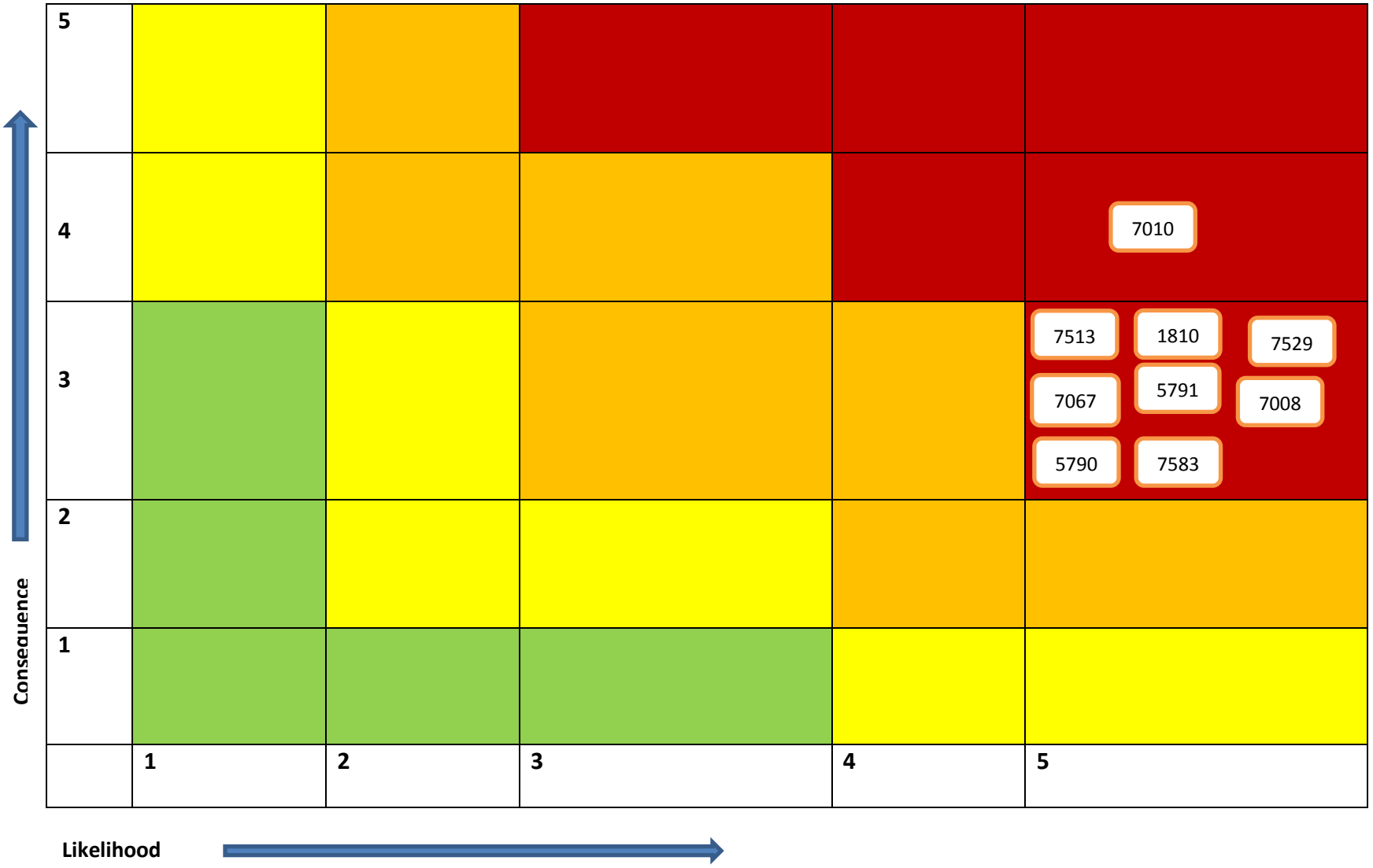
Title:	Risk of not attaining the CQUIN for Hepatitis C treatment pathways through the Operational Delivery Network hub based at ELHT				
Trust-wide/ Divisional	Divisional				
ID	7529	Current Status	Live Risk Register – all risks accepted	Opened	17/10/2017
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 3 Consequence: 5 Total: 15	Target Rating:	Likelihood: 2 Consequence: 3 Total: 6
Risk Handler:	Matt Sutcliffe	Risk Owner:	John Bannister	Linked to Risks:	N/A
What is the Hazard:	Financial risk due to CQUIN contract for HCV ODN delivery of pathways. Updated triggers for CQUIN received in October 2017 with measure and payments that require strategic involvement across the network. Quarter 3 and Trigger B2 of the CQUIN for 2017/2018 failed due to not achieving the run rate and cost of treatments issued.		What are the risks associated with the Hazard:	Financial - Penalty for not achieving the CQUIN, loss of incentive (partnership working and governance, plus 1.6% of overall CQUIN) Financial - lack of treatment may incur increased incidence of liver disease and the effects. Clinical - lack of HCV antiviral provision for patients with HCV across the network - having to give slots away to other ODN's. Reputation - ELHT is the hub for the ODN and failure to achieve the CQUIN may result in the ODN being lost to a larger Trust.	
What controls are in place:	ODN set up with weekly meetings for approval of treatments across Lancashire networks. Minute meetings and clinical treatment decisions for all organisations.		Where are the gaps in control:	Workforces gaps, project manager, case finder/band 3 further nursing support – No funding secured for posts Strategic support for Triggers required	

	Clinical registry of patients initiated and live. Run rate divided across network according to population served. Specialist pharmacist Medical support with deputy and 24 hour support. Experienced specialist nurses across the network. Temporary post of MDT-ODN co-ordinator for help with collation of statistics.		across the network with other partners. Memorandum of Understanding requires partnership sign-off, signed by ELHT Partnership organisations not hitting the run rates Letter received from NHSE identified insufficient staffing and lack of robust memorandum of understanding Hepatology nurse of long term sick
What assurances are in place:	PSRAC Reporting	What are the gaps in assurance:	
Actions to be carried out			
Ongoing discussions with partner organisations. Work towards completion of Peer review Action Plan Work towards completion of Peer review Action Plan			

Title	Failure to comply with the 62 day cancer waiting time				
Trust-wide/ Divisional	Trust-wide				
ID	7008	Current Status	Live Risk Register – All risks accepted	Opened	01/08/2018
Initial Rating	Likelihood: 3 Consequence: 3 Total: 9	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 2 Total: 6
Risk Handler:	David OBrien	Risk Owner:	John Bannister	Linked to Risks:	N/A
What is the Hazard:	Cancer treatment delayed. Potential to cause clinical harm to a patient if the treatment is delayed.		What are the risks associated with the Hazard:	Trust fails to achieve compliance with the 85% national standard for the cancer 62 day waiting time target. The Trust is performance managed for failure to comply with cancer waiting time targets - the cancer waiting times are key performance indicators for all NHS providers. Potential to cause clinical harm to a patient if the treatment is delayed. There is also a risk to the patient experience and risk of adverse publicity/reputation to the Trust	
What controls are in place:	Immediate ongoing actions to improve performance a) CNS engagement with virtual PTL b) Cancer escalation process modified and re-issued c) Cancer Hot List issued twice weekly d) Additional theatre capacity e) Daily prioritisation of elective and cancer activity by clinical and pathway urgency. f) Additional Alliance funding provided to		Where are the gaps in control:		

	Radiology for in-house Cancer Reporting in March g) Re-validate previous months (review all treatments capture, all breaches and re-allocations) h) Continued micro-management of all patients at risk on hot list i) Senior Directorate Managers to attend all PTLs in coming weeks to gain assurance of efficient and appropriate process. j) Weekly performance forecast issued to Cancer Management Team and DGMs. k) Ongoing Breach analysis		
What assurances are in place:		What are the gaps in assurance:	
Actions to be carried out			
Ongoing actions to improve performance a) Patient education b) Collaborative working with Primary Care c) Recruitment to vacancies within Clinical service d) Capacity review e) Pathway review – New alliance pathway for Prostate, Upper GI, Colorectal and Lung f) Investment of Alliance Funding in pathways to improve processes g) Establishment of Template Biopsy Service at ELHT for Urology h) Additional Capacity lists being undertaken i) Outsourced Radiology Scanning and Reporting j) 62 Day Cancer Recovery Action Plan k) Liaise with CCG colleagues including reporting and monitoring to the Pennine Tactical Group			

Appendix 2: One page representation of the Corporate Risk Register as at 30th October 2018 showing risk IDs and their current scores: (9 Risks in total)



East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 109

14 November 2018

Purpose Approval

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

Summary: The Executive Directors have revised the BAF and examined the controls and assurances, together with any gaps, to establish whether they have changed. Since the last report to the Board, the BAF risks have been cross-referenced with the risks on the Corporate Risk Register (CRR) and this is indicated in the CRR report to the Board.

The Audit Committee carried out an in-depth review of risks 2 and 5 as part of its annual review of the BAF. The Finance and Performance Committee received the BAF and revised the risks within its remit at its meeting held on the 29 October 2018. The Quality Committee will review the BAF risks on the 21 November 2018.

Recommendation: The Board is asked to discuss the revised BAF, including the controls, potential sources of assurance, gaps and actions to address and mitigate these and approve the document.

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

Quality Committee (September 2018)

Audit Committee, Executive Directors (October 2018)

Finance and Performance Committee (October 2018)

Operational Delivery Board (October 2018)

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

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.

5. There is a **proposed decrease to the risk score**, from 20 **to 16** based on the reduced likelihood of the risk materialising (likelihood **4** x consequence **4**), due to the strengthening and developing of the Vital Signs (Lean) Programme and the developments related to the Pennine Lancashire Way improvement methodology.
6. The following key controls have been included:
   a) There are a number of delivery steering groups covering the transformation themes, which monitor delivery, consider risks/mitigation and set direction. This programme is now evolving as a result of the Trust and the system developing its Pennine Lancashire Way improvement methodology, resulting from being a part of the NHS Improvement (NHSI) Vital Signs programme. The initial phase of this programme is covering the frailty pathway (whole system working), Theatres improvement and a HR/workforce development piece. The impact in each of these areas is reported through the Operational Delivery Board and the Finance

and Performance Committee. We are also developing an executive overview group; due to start November 2018. All schemes are aligned to the Trust's clinical, financial and operational strategies.

7. Potential sources of assurance have been updated and the following information has been included:
   a) Monthly performance and safely releasing cost report which reports to the Operational Delivery Board, Finance and Performance Committee and the Trust Board and associated information papers and minutes.
   b) Care Professionals Board workshop with a wider audience held in August 2018 resulted in the creation of Pennine Lancashire Professional Leadership Committee, bringing together relevant professionals to support the Pennine Lancashire transformation. Several senior ELHT clinicians attending and actively participating in the Professional Leadership Committee Care and associated workshops.
   c) Finance and Performance Committee agreed process for the review of tenders and service implementation 12 months after the tender bid.
   d) Model Hospital and GIRFT (Speciality benchmarked performance and efficiency data) reviewed at Clinical Effectiveness Committee.
   e) Performance monitoring in all areas covering quality, delivery, finance and people (staff/patients)
      i. Monthly performance report
      ii. Incident reporting
      iii. Complaints data
      iv. ICO breaches
      v. WRES reporting
      vi. Number of disciplinaries/grievances
      vii. Patient stories
      viii. Staff survey
      ix. Friends and families tests

8. The following information in the potential sources of assurance column has been removed as the updated section describes the assurances in a more detailed way:
   a) Trust SRCP and transformation plans for 2018-19 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.

9. Gaps in control have been updated and the following two items have been removed as they are covered in the section below (points 10 and 11):
   a) Capacity for delivery of transformation programme.
   b) Workforce issues/senior clinical and managerial staff ability to balance the operational and strategic requirements/demands.

10. Risk that through the transition from the original transformation plan to the Pennine Lancashire Way programme that delivery of the aims of the original programme may not be achieved or are delayed.

11. Gaps in control in respect of the following and their impact on the transformation programme:
   i. Workforce improvement capacity
   ii. Workforce capability
   iii. Competing priorities
   iv. Dependency on stakeholders to deliver key pieces of transformation
   v. System wide working and no one 'true north' as a system
   vi. Financial constraints
   vii. Short term regulatory targets detracting from the delivery of short to medium term objectives of the transformation programme.

12. The actions planned and updates have been revised to include:
   a) The transformation programme is working with the Pennine Lancashire Partnership Delivery Group to agree the strategic goals for the system to ensure that transformation plans are aligned to these in future and to ensure that ELHT business plans are also aligned. The business planning round for 2019-20 will be improved in respect of alignment and prioritisation. The first event will be held on 4 December 2018.
   b) A system wide value stream analysis for the frailty pathway took place in August 2018. This identified an agreed 'future state' for frailty. The programme will now ensure the delivery of this programme over the coming 12 months. This pick up some of the improvement work of the original transformation plan. In addition, the Pennine Lancashire Way is also planning events in respect of a HR/workforce development and assisting in the theatres improvement journey. Regular reporting on progress through the Finance and Performance Committee.

c) Executive Overview Group for monitoring the progress and deliverables of the Pennine Lancashire Way improvement methodology due to be set up from November 2018.

13. Revised Performance Assurance Framework presented to the Finance and Performance Committee on 29 October 2018 and to the Operational Delivery Board on 31 October. Final version will be presented to the Finance and Performance Committee on 26 November 2018.

14. The following action has been completed and moved to the potential sources of assurance column (see point 7b):

a) Care Professional Board workshop with a wider audience held in August 2018 resulted in the creation of Pennine Lancashire Professional Leadership Committee, bringing together relevant professionals to support the Pennine Lancashire transformation.

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

15. The **risk score remains 12** (likelihood 3 x consequence 4).

16. The consequences of the risk materialising have been updated to include:

a) 3. Inability to staff escalation areas
b) 4. Inability to create an integrated workforce
c) 5. Unable to recruit a representative workforce
d) 6. Inability to release staff for training and appraisal

17. The following key controls have been included:

a) Pennine Lancashire Workforce Transformation Group
b) Divisional finance and performance meetings

18. The potential sources of assurance have been updated to include:

a) Workforce Dashboard reporting key performance indicators within division on a monthly basis
b) Agency staffing group monitoring the use of agency spend
c) Implementation of Allocate rostering
d) Uptake of flu vaccine across the workforce
e) Completion rates of the annual staff survey and low rates of turnover
f) Integrated performance report
g) Friends and family test

19. Gaps in control now include:
    a) Varying incentive schemes/packages across provider sector.
    b) Integrated workforce assurance group
    c) Broader equality and diversity group
20. Actions and updates have been updated to include:
    a) E&D Action Plan
    b) Establishment of an equality and diversity group by January 2019
    c) 10 WRAPT (workforce planning projects underway across the organisation)
    d) Health Education England (HEE) funding secured to develop clinical leadership for workforce transformation through the WRAPT process
    e) Establishment of a Care Academy for Pennine Lancashire to secure a talent pipeline locally
    f) Development of a Recruitment and Retention Strategy to reflect emerging labour market and to sell ELHT and Pennine Lancashire as employer of choice.

Risk 3: Lack of effective engagement within the partnership organisations (ICS and ICP) results in failure to work together causing a detrimental effect on the health and wellbeing of our communities.

21. The **risk score remains 12** (likelihood 3 x consequence 4).
22. There is a proposal to slightly revise the wording of the strategic risk to the following: **Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities.**
23. The potential sources of assurance have been reviewed and the following points have been included:
    a) The ICP and ICS Cases for Change have been published.
    b) Cultural development programme for system level leadership established with involvement of all senior leaders across the ICP.
    c) Mitigation in place for creating single teams across the system, e.g, 'one workforce' with timelines for implementation. Progress covered under BAF risk 2
    d) Strengthening the relationship with primary care networks' leadership. Associate Medical Director for Service Improvement appointed, increasing our capacity for clinical leadership in relation to service improvements.

24. The actions planned and updates section had been reviewed and now includes the following updates:
    a) Prioritisation of diagnostics, pathology and cancer work streams agreed. Next steps in a process to be agreed. Update in Quarter 4.
    b) The following items have been moved to the Potential Sources of Assurance column:
        i. Pennine Lancashire project solution design phase completed and case for change published.
        ii. Regular ICS Programme Board happening with CEO attendance.
        iii. Mitigation in place for creating single teams across the system, e.g, 'one workforce' with timelines for implementation.

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

25. The **risk score remains at 20** (likelihood 5 x consequence 4).
26. The potential sources of assurance section now includes:
    a) Using the Performance Accountability Framework (PAF) to provide assurance that action is taken to help ensure the delivery of objectives.
    b) Use of data sources (e.g. Model Hospital data.) to drive improvement and mitigate deterioration. Evidencing the routine use of benchmarking data to drive positive change.
    c) External audit view on value for money.
27. The gaps in assurance have been updated:
    a) The following item moved to the Potential Sources of Assurance column:
        i. External audit view on value for money.
    b) The following item moved to the Actions/Update column:
        i. The Performance and Accountability Framework will require review and approval in 2018.
28. The actions section has been updated to include:
    a) Revised Performance Accountability Framework presented to the Finance and Performance Committee on 29 October 2018 and to the Operational Delivery Board on the 31 October 2018, with final approval by the Finance and Performance Committee at the end of November.

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

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

30. Key controls have been updated to include:

    a) Quality and safety compliance assessed by each division and assurance through the Divisional Quality and Safety Boards (DQSB) reporting into the Quality Committee Sub-Committees.

    b) Nursing Assessment Performance Framework reporting through to the Quality Committee and involvement of NEDs on the SPEC Panels and Board approval for the award of SPEC awards.

    c) A&E Delivery Board with Emergency Care Pathway assurance feeding into it.

    d) System-wide Scheduled Care Board with elective pathway assurance feeding into it.

    e) Weekly Medical Staffing Review - Nursing and Midwifery staffing review feeding into the annual professional judgement review for all wards.

31. Potential sources of assurance have been updated to include:

    a) Reduction on overall number of complaints, 50+ and 40+ days continues with regular reporting at operational and Board level.

    b) Action plan for 62 day cancer standard in place, emergency care pathway action plan in place, both monitored through the Finance and Performance Committee, and at operational level through the Operational Delivery Board and the Executive.

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

    a) The action related to the continued reduction of the overall number of complaints have move to the Potential Sources of Assurance.

    b) Plans for staffing and estates challenges have progressed as follows:

        i. Emergency care pathway action plan in place and is monitored monthly through the ECP Programme Board. Redesign emergency care workforce plan carried out as planned and agreed with NHSI, awaiting response.

        ii. Ambulatory Care Emergency Unit opened as planned on 14 September 2018. Fortnightly service reviews carried out.

        iii. Business case approved by the Trust Board and submitted to NHSI in July 2018 for the extended acute medical facility. Awaiting response from NHSI.

        iv. Frailty Assessment Unit due to open in January 2019.

c) Develop escalation facilities in Victoria wing at BGTH by October 2018, convert ward C3 to allow use as a decant ward in the next financial year (after Easter 2019). Escalation ward in Victoria wing in Burnley due to open on 15 November 2018.

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance, 7 November 2018.

Our Strategic Objectives

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

Reference Number: BAF/01

Responsible Director(s): Director of Finance and Medical Director

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

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

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

Key Controls *What controls/ systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**				**Gaps in Control** *Where we are failing to put controls/ systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/ systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	**Q2**	**Q3**	**Q4**			
The transformation programme has been set for 2018-19 for the Trust, covering following themes: 1. Emergency care pathway 2. Model ward 3. Productivity & Efficiency 4. Community 5. Support services The Trust is working across the Pennine Lancashire footprint a single transformation plan. 'the Pennine Way'. This will offer benefits in terms of sharing resources and joint savings and quality plans. The programme is monitored through the Improvement Practice Office who report to the Operational Delivery Board and the Finance and Performance Committee. All schemes are aligned to our clinical, financial and operational strategy. Trust has been selected to be in the 1st cohort of the new NHSI Lean programme and are working with the NHSI Lean team to develop a single improvement methodology across Pennine Lancashire. There are a number of delivery steering groups covering the transformation themes, which monitor delivery, consider risks/mitigation and set direction. This programme is now evolving as a result of the Trust and the system developing its Pennine Lancashire Way improvement methodology, resulting from being a part of the NHSI Vital Signs programme. The initial phase of this programme is covering the frailty pathway (whole system working), Theatres improvement and a HR/workforce development piece. The impact in each of these areas is reported through the Operational Delivery Board and the Finance and Performance committee. We are also developing an executive overview group, due to start November 2018.	Monthly performance and Safely releasing cost report which reports to the Operational Delivery Board, Finance and Performance Committee and the Trust Board and associated information papers and minutes. Performance monitoring in all areas covering quality, delivery, finance and people (staff/patients) a. Monthly performance report b. Incident reporting c. Complaints data d. ICO breaches e. WRES reporting f. Number of disciplinaries/grievances g. Patient stories h. Staff survey i. Friends and families tests System-wide reporting is currently being developed through the Pennine Lancs Business Intelligence group and the Pennine Lancs Way programme. 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 Agreed transition to one Pennine Lancs team, one transformation plan and one improvement methodology - allowing all schemes to gain traction and improve delivery. LDP system level aiming to prioritise health improvements that can deliver beneficial outcomes more quickly. Care Professional Board workshop with a wider audience held in August 2018 resulted in the creation of Pennine Lancashire Professional Leadership Committee, bringing together relevant professionals to support the Pennine Lancashire transformation.Several senior ELHT clinicians attending and actively participating in the Professional Leadership Committee and associated workshops Medial Director of the Trust appointed as the Professional Lead for the Pennine Lancashire ICP influencing the collaborative work on transformation. Good track record of successfully bidding for tenders in the last 12 months. Finance and Performance Committee agreed process for the review of tenders and service implementation 12 months after the tender bid. Emergency care pathway good example of collaborative working used as a blueprint for other system working moving away from organisational boundaries. Model Hospital and GIRFT (Speciality benchmarked performance and efficiency data) reviewed at Clinical Effectiveness Committee.	15	10	16	4x4	16	20	16		Capacity and resilience building in relation to the service redesign is in early phase. Risk that through the transition from the original transformation plan to the Pennine Lancashire Way programme that delivery of the aims of the original programme may not be achieved or are delayed. Gaps in control in respect of the following and their impact on the transformation programme: • Workforce improvement capacity • Workforce capability • Competing priorities • Dependency on stakeholders to deliver key pieces of transformation • System wide working and no one 'true north' as a system • Financial constraints • Short term regulatory targets detracting from the delivery of short to medium term objectives of the transformation programme. Opportunities to link transformation objectives to appraisals.	Assurance in place about the process, but assurance about the delivery and benefits is still work in progress at this stage. Dependency on stakeholders to deliver key pieces of transformation. Linking between clinical effectiveness and the transformation programme needs to be developed. The need to explore the interdependencies between BAF risks 1 and 3 and the system transformation in areas such as community services and the emergency care pathway. Exploring the opportunities in a changing leadership at collaborative level and linking into the new system executive roles. Winning tenders creates a risk of reaching a point where services cannot be maintained due to the lack of relevant/appropriate infrastructure. This has the potential to affect all risks identified in the BAF. Practical application and delivery of the transformation plan together with resourcing needs to be addressed in the near future . Model Hospital and associated processes still developing. Early planning of improvement events and flexible approach to enable the release of clinicians for improvement activities. Not delivering the percentage increase regarding the productivity and Efficiency transformation that we aspire to. Internal changes are needed, external efficiencies require Pennine Lancashire whole system working. Risks associated with the high concentration of efficiency schemes being scheduled to release savings in the second half of the year, the potential impact which winter pressures may have on this work and the number of non-recurrent schemes in the plan.	Using the Financial Assurance Board meetings and our membership of Pennine Lancashire to influence delivery of transformation. The transformation programme is working with the Pennine Lancashire Partnership Delivery Group to agree the strategic goals for the system to ensure that transformation plans are aligned to these in future and to ensure that ELHT business plans are also aligned. The business planning round for 2019-20 will be improved in respect of alignment and prioritisation. The first event will be held on 4 December 2018. A system wide value stream analysis for the frailty pathway took place in August 2018. This identified an agreed 'future state' for frailty. The programme will now ensure the delivery of this programme over the coming 12 months. This pick up some of the improvement work of the original transformation plan. In addition the Pennine Lancs Way is also planning events in respect of a HR/workforce development and assisting in the theatres improvement journey. Regular reporting on progress through the Finance and Performance Committee Executive Overview Group for monitoring the progress and deliverables of the Pennine Lancashire Way improvement methodology due to be set up from November 2018. Revised Performance Assurance Framework presented to the Finance and Performance Committee on 29 October 2018 and to the Operational Delivery Board on 31 October. Final version will be presented to the Finance and Performance Committee on 26 November 2018. Divisions attending Finance and Performance Committee from September 2018 onwards to provide assurance on the delivery of SRCP.

Reference Number: BAF/02

Responsible Director(s): Director of HR and OD

Aligned to Strategic Objectives: 2, 3 and 4.

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

Consequences of the Risk Materialising:

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

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**				**Gaps in Control** *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	Q2	Q3	Q4			
Workforce Transformation strategy in place and associated Divisional and Trust-wide plans monitored through the Workforce Transformation Board. Divisional Workforce Plans aligned to Business & Financial Plans Divisional Performance Meetings Reports to Finance & Performance Committee Recruitment strategy and plans linked to Workforce Plans. Trust Workforce Controls group in place to review all vacancies and support the Workforce Transformation strategy. One Workforce Planning Methodology across Pennine Lancashire Workforce planning at STP level, e.g. Apprenticeships, recruitment and retention initiatives, collaborative medical banks and talent management. Pennine Lancashire Workforce Transformation Group Divisional finance and performance meetings	On-going monitoring of vacancies and bank/agency usage at Trust Operational Delivery Board via Trust performance report. Performance measures, time limited focus groups with action plans, board and committee reports, regulatory and inspection agencies, stakeholders, internal audit. WRES action plan with timelines in place. Regular reporting to the Board on progress. Work with the Fanshawe Report. Ongoing monitoring of workforce diversity through the re-establishment of the Diversity and Inclusion Steering Group and Trust Operational Delivery Board. Workforce Control Group regularly reports to the Executive on workforce control measures and indicators. Dashboard developed. Annual report to the Quality Committee. Medical and Non-Medical Agency Group in place. Dashboard giving overview of bank/agency usage presented to the Executive team meeting monthly. The Performance Assurance Framework Lean Programme (Vital Signs) overall linking into workforce transformation. Workforce Dashboard reporting key performance indicators within division on a monthly basis Agency staffing group monitoring the use of agency spend Implementation of Allocate rostering Uptake of flu vaccine across the workforce Completion rates of the annual staff survey and low rates of turnover Integrated performance report Friends and family test	16	10	12	3x4	12	12	12		National recruitment shortages, capacity for delivery of transformation programmes, financial restrictions. Reduction of CPD monies from HEE (could be off-set by the apprenticeship levy). Varying incentive schemes/packages across provider sector. Implications of Brexit on the workforce - uncertainty/ workforce are yet to be determined. Integrated workforce assurance group Broader equality and diversity group	Inability to control external factors (Brexit, visas etc).	Currently there are a further 126 external nurses in the recruitment pipeline due to start with the Trust been now and March 2019. 23 nurses have been sourced via the global learners programme. A large scale HCA recruitment exercise is complete resulting in over 100 appointments. HCA bank shift requests have reduced by 1500 per month as a result. Adding further stability and flexibility to our support workforce. A Senior Medical Staffing Performance Review Group has now been established and will take responsibility for reviewing all consultant job plans, consultant vacancies etc. adding further rigor on our appropriate use of resource. E&D Action Plan The Culture and Leadership programme update report was presented at Trust board in March and a Culture and Leadership Programme presentation took place at the Pennine Lancashire Workforce Group in April. The Culture and Leadership Change Team have met on a number of occasions and stage 1 (diagnostics) of the programme is due to close in September with a presentation to Board on the 12 September. Significant progress made with WRES action plan. The NHS National Workforce Race Equality Standard (WRES) 2017 data analysis report December 2017 demonstrated continued improvement and ELHT are highlighted as better than average in Indicator 6: a decrease in the overall percentage of staff experiencing harassment, bullying or abuse from other colleagues. Review of internal data in January demonstrates further improvements in WRES indicators 1, 2 and 3. Work continues with Diversity by Design to pilot joint selection process. 2018/19 plan to review the Trust Equality and Diversity Strategy and to develop plans to address issues related to all protected characteristics. The national WRES lead is visiting the Trust on the 8th October and arrangements are being made for this equality and diversity event. The Workforce Transformation Strategy addresses the future workforce supply pipeline, opportunities to up skill current staff, introducing new competencies, e.g. Physicians Associates and Associate Nurses and establishing new ways of working. The 2018-19 Business Planning approach includes a Workforce Planning and Transformation return from each Division which will inform the Trusts and Pennine Lancashire Transformation and Workforce priorities. We are now working with ICP partners to undertake systematic and integrated workforce transformation linked to the NHSi LEAN improvement programme. We are working across the ICS to develop a mobility agreement to assist with the movement of staff across the region. A Recruitment and Selection Strategy is being developed to underpin a system wide approach to recruitment. The 12 hour shift project is now complete, reducing the number of nursing shift patterns to fewer than 10 (from 250+) allowing for greater resource flexibility to cover gaps and reduce agency usage. Establishment of an equality and diversity group by January 2019 10 WRAPT (workforce planning projects underway across the organisation) HEE funding secured to develop clinical leadership for workforce transformation through the WRAPT process Establishment of a Care Academy for Pennine Lancashire to secure a talent pipeline locally Development of a Recruitment and Retention strategy to reflect emerging labour market and to sell ELHT and Pennine Lancashire as employer of choice

Reference Number: BAF/03

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

Aligned to Strategic Objectives: 3 and 4

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

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

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**				**Gaps in Control** *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	Q2	Q3	Q4			
Pennine Lancashire System Leaders' Forum meets to discuss strategy. Engagement by senior leaders in wider transformation programmes. Regular Board updates and decisions on key actions. At Pennine Lancashire level health improvement priorities agreed (HIMPs). HIMPs reporting to the Professional Leadership Commitee (PLC) Number of senior clinicians involved with ICS work groups. Professional Leadership Commitee (PLC) has ELHT representation. ICS Finance Group and ICP Finance and Investment Group with ELHT senior representation . The ELHT Chief Executive is the senior responsible officer (SRO) for the Pennine Lancashire Transformation Programme, sits on the System Leaders Forum and on the Integrated Care System for Lancashire and South Cumbria (ICS) Programme Board. The Trust's Medical Director is the professional lead for the Pennine Lancashire ICP. Vital Signs Programme ensures the ICP as a system is having a significant participation as part of the transformation programme.	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 generation of ideas and options with external stakeholders. The Pennine Lancashire and ICS Cases for Change have been published. Pennine Lancashire resource in post working on developing models of care against specific improvement priorities (paediatrics, respiratory and frailty). Health and Wellbeing Improvement Partnerships (HIMPs) at Pennine Lancashire level reviewed around the health improvement priorities and the majority are relatively well established with minor changes needed to link into the new structures. ICS governance oversight forms part of the Audit Committee standing agenda for 2018/19. Fostering good relationships with GP practices and Federations e.g. service pilots and as a result of tenders and general dialogue. Pennine Lancashire ICP Memorandum of Understanding agreed by stakeholders. ELHT Chief Executive chairing the ICS Providers' Forum. ELHT hosting the Providers Programme Director for the ICS Provider Board who reports to the Chief Executive of ELHT. Director of Service Development leading on the construction of the work programme with the Directors of Strategy from all the providers. Component business cases at Pennine Lancashire level forming a draft overarching ICP plan. Plan on a page for the ICP, connecting to the Plan on a page for ELHT completed and shared with the Commissioners. CEO of ELHT and Accountable Officer of East Lancashire CCG jointly chairing the Pennine Lancashire ICP Programme. Posts for Portfolio Holders at ICP level are in development. Cultural development programme for system level leadership established with involvement of all senior leaders across the ICP. Potential gains in strengthened reputation with regulators and across the ICS footprint with regular reporting to the Board via the Finance and Performance Committee on progress, milestones and risks linked to the gateway process. ICS architecture on clinical services is developing (eg pathology, stroke and frailty). Positive feedback from service reviews (stroke and endoscopy). Structures in place for the Out of Hospital stream with the Trust significantly contributing to the workstream. Mitigation in place for creating single teams across the system, e.g, 'one workforce' with timelines for implementation. Progress covered under BAF risk 2. Clinical leadership through the Professional Leadership Committee (PLC) at Pennine Lancashire ICP level giving consistent message about the importance of working as a system. Strengthening the relationship with primary care networks' leadership. Associate Medical Director for Service Improvement appointed, increasing our capacity for clinical leadership in relation to service improvements. Pennine Lancashire Delivery Group has ELHT representation and is chaired by the Trust's Chief Executive. A&E Delivey Board meets monhtly, chaired by teh ELHT Chief Executive. Progress on collaborative efforts in relation to the emargency pathway covered under BAF risk 5. Vital Signs is a system wide transforamtion programme across the Pennine Lancashire ICP. Patient experience strategy envisages good patient and public involvement to support the collaborative transoformation. Progress with work covered under BAF risk 1.	16	12	12	3x4	12	12	12		System leaders agreed a process to develop the governance system across Pennine Lancashire; however this is still in development ICS System Management model is in early stages of development. Decision making process for Pennine Lancashire system will need agreement. Priorities of the individual organisations and those of the system not being aligned/agreed. There is a need for consistent leadership across the system. Building trust and confidence and agreeing collaborative approaches to service provision	Timeline for consultation with public - uncertainty about the detail of the consultation for the component business case at ICP level. Lack of unified approach in relation to procurement by Commissioners. Priorities of CCGs starting to be aligned with priorities for pathway redesign (e.g. stroke) but this work is still in the early phases. Future role of NHSE/NHSI merged teams to be determined. Creation of single teams for care functions to deliver the transformation agenda at system level. Ensuring consistent capacity to work externally as well as internally by building system collaboration into the leadership roles and having good joined leadership programmes. Adequate assurance mechanism that the service integration plans are on track together with the rigour of governance arrangements/lack of delegation from the sovereign bodies to the system. it is unclear what the impact of the changes in senior leadership in partner organisations will be.	Regular updates provided to Board and the Audit Committee. Standing agenda item at Execs and Trust Board. Across the ICS footprint the Medical Directors of the four Trusts agreed to focus on urology, vascular services, stroke, emergency department, interventional radiology and gastrointestinal bleed, and neonatology. At ICS level all providers met to formulate work programme - 3 categories of services agreed a) services that are fragile now b) services where there is no immediate risk but possible in the not too distant future c) services that need to be managed across the whole footprint. Agreement on the way of taking this forward to be agreed. Prioritisation of diagnostics, pathology and cancer work streams agreed. Next steps in a process to be agreed. Update in Quarter 4. Pennine Lancashire ICP component business case prepared and consultation in progress. Focus on developing at LDP level wider deliverables. East Lancashire CCG extended the Community Services contract by 12 months allowing for the principles of the new clinical model at ICP level to be developed. Good co-production on developing clinical model across the ICS for CAMHS services was presented to the Commissioners on 6 August, outcome awaited.

Reference Number: BAF/04

Responsible Director(s): Director of Finance

Aligned to Strategic Objectives: 3 and 4.

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

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

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**				**Gaps in Control** *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	Q2	Q3	Q4			
Budgetary controls (income & expenditure) in place including virement authorisation, workforce control, monthly performance meetings and variance analysis. Measures to mitigate financial risk overseen by Finance and Performance Committee.	Monthly reporting to Finance and Performance reports and the Board to reflect financial position. Separate reporting available to support assurances on the transformation programme. Regular Performance Review meetings between Executives and Divisions. Using the Performance Accountability Framework (PAF) to provide assurance that action is taken to help ensure the delivery of objectives. Financial objective included in individual appraisals. Setting of financial objectives in senior management appraisals. Budget setting Financial Forecasts Briefings on risk Pipeline of schemes to reduce cost. Use of data sources (e.g. Model hospital data.) to drive improvement and mitigate deterioration. Evidencing the routine use of benchmarking data to drive positive change. External audit view on value for money.	16	12	20	5x4	20	20	20		Additional workforce controls to remain in place. Policies and procedures may require amendments where they are no longer fit for purpose. Controls around transformation schemes and SRCP to be monitored by the PMO and the Finance Department with Division to be held to account via the PMO. Gaps in control regarding funding for A&E and STF funding - recovery plan underway. Lack of standardisation in applying rostering controls. Weaknesses in discretionary non-pay spend Deterioration in the underlying financial position requiring additional transformation schemes in 2018/19. SRCP being delivered non-recurrently. Officers operating outside the scheme of delegation. Inadequate funding assumptions applied by external bodies (pay awards) Hidden costs of additional regulatory requirements - highlighted with NHSI	Utilise the internal audit programme to test for assurance on core controls, SRCP and transformation plans. Review of divisional governance processes. Understanding the changes in income services (NHS and private). Weaknesses in appraisals and accountability framework.	Regular updates to Board and Finance and Performance Committee Actions and risk relating to the achievement of 'incentivised funding' (e.g. Provider Sustainability Funding) will be routinely reviewed. Risks in relation to the impact of the changes to CQUIN and Provider Sustainability Funding arrangements to the end of 2018/19 are being managed and reporting to the Quality Committee and Finance and Performance Committee. Revised Performance Accountability Framework presented to the Finance and Performance Committee on 29 October 2018 and to the Operational Delivery Board on the 31 October 2018, with final approval by the Finance and Performance Committee at the end of November.
										Cost shunting of public sector partners increasingly managed through ICS and ICP Failure to meet Provider Sustainability Fund requirements Agency and locum sign off with escalation of cost		Agency and locum sign off with escalation of cost, total hours booked and average per hour will be reported to the Finance and Performance Committee from September 2018 as part of the Financial Performance Report.

Reference Number: BAF/05

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

Aligned to Strategic Objectives: 1, 3 and 4.

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

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

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**				**Gaps in Control** *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
						Q1	Q2	Q3	Q4			
Monthly divisional performance meetings feeding into the ODB and Finance and Performance Committee and weekly operational performance meeting covering RTT, cancer, 4 hour performance and holding list management monitoring delivery against the divisional business plans and the operational delivery standard. Engagement meetings with CQC and CQC Steering Group in place monitoring performance against the CQC standards. Quality and safety compliance assessed by each division and assurance through the Divisional Quality and Safety Boards (DQSB) reporting into the Quality Committee Sub-Committees. Divisional assurance boards feeding into the operational sub-committees and the Quality Committee. Nursing Assessment Performance Framework reporting through to the Quality Committee and involvement of NEDs on the SPEC Panels and Board approval for the award of SPEC awards. A&E Delivery Board with Emergency Care Pathway assurance feeding into it. System-wide Scheduled Care Board with elective pathway assurance feeding into it. Daily nurse staffing review using safe care/allocate Nursing and Midwifery. Weekly Medical Staffing Review - Nursing and Midwifery staffing review feeding into the annual professional judgement review for all wards. Operational flow meetings at 08.30, 12.30, 15.30, 18.00 and 19.30	IPR reporting to the ODB and at Board/Committee level. Regular deep dive into the IPR through Finance and Performance Committee. System wide approach to Emergency Care Pathway, as part of monthly A&E Delivery Board supported operationally by the A&E Delivery Group Regular reporting from the divisions into the operational sub-committees and the Quality Committee. Alignment with national priorities through the quality and safety governance mechanisms. Trust rated 'Good' by CQC in 2006. ED performance and four hour improvement action plan aligned with the NHSI Rapid Improvement Collaborative and agreed by NHS England. Performance monitoring provided through the Emergency Care Pathway Programme Board (progress reporting) as part of the transformation programme governance. Silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments continues. Eight Silver Accreditation of a ward approved by the Trust Board with further three awaiting approval. Increased number of assessments under the framework planned all inpatient wards completed in ICG and SAS. Work started on Family Care and Community Services and a plan is in place for 2018/19. Significant reduction in the number of complaints upheld by the Ombudsman. Comprehensive system for addressing complaints. Reduction on overall number of complaints, 50+ and 40+ days continues with regular reporting at operational and Board level. PLACE assessments - percentage improved in all areas and monitoring continues. Annual PLACE report presented to the Quality Committee for assurance. Nursing and Midwifery Leaders' Forum also monitor. Patient Experience Committee receive minutes of the PLACE Steering Group. NAPF Team also monitors environmental issues linking to PLACE Assessments. Positive responses to Friends and Family Test and patient surveys with improvement areas identified. Monitoring at ward level, local divisions prepare monthly patient experience action plans that feed into the Patient Experience Committee that reports to the Quality Committee. Monitoring monthly by the Nursing and Midwifery Leaders' Forum. CQC Steering Group meets regularly and is chaired by the Director of Nursing and includes representation by all the Clinical Divisions. Mini mock-CQC visits regularly carried out and focussing on all areas with regular reporting back to the Quality Committee. Reduction in use of nursing bank and agency staff continues, revisiting the specialing policy with further reduction in spend. Delivery of RTT and most cancer standards, action plan for 62 day cancer standard in place, emergency care pathway action plan in place, both monitored through the Finance and Performance Committee, and at operational level through the Operational Delivery Board and Executive. Staffing escalation process for nursing including forecast gaps in staffing and senior decision making. Standard Operating Procedure (SOP) developed and monitoring through Nursing and Midwifery Leaders' Forum. Patient Safety Walkrounds Delayed Transfers of Care have been reduced to below 3% and target achieved in the last quarter. Positive response and results from the most recent National Staff Survey. The Performance Assurance Framework System-wide approach to elective care pathway through the System Scheduled Care Board, supported operationally by the Access and Choice Committee . Recovery plans in relation to the risks around some of the national trajectories addressed through the Emergency Care Pathway Transformation programme, Scheduled Care Programme, Cancer Improvement Action Plan. Regular monitoring by Execuive Team and ODB. Weekly monitoring of complaints and reporting to the Patient Experience Committee and End of Life Care Group Nurse staffing review as part of the IPR. Staff Care Allocate and daily monitoring of allocation for staff and three times daily matrons meetings to monitor. Audit carried out by MIAA for nurse staffing received significant assurance. NAPF - operational monitoring through the Nursing and Midwifery Leaders' Forum monthly, recieving assurance from the Assistant Director of Nursing and NAPF team and monitoring by matrons at ward level where they carry out mini-NAPFs on a weekly basis to keep up the improvement work.	15	9	12	4x4	12	16	16		Restrictions in the supply of medical, nursing, midwifery and other staff groups to meet demand. Refrence in BAF risk 2. Risk of mental health providers not being able to ensure sufficient assessment and treatment capacity. Restrictions in the primary care system to ensure sufficient capacity. Insufficient capacity to deliver comprehensive seven day services across all areas.	Staffing gaps on rotas. Gaps in assurance from the medical staffing perspective. E-Rostering inability to fill all vacant shifts/short term sickness or non-attendance. Challenges to the delivery of the four hour standard and the delivery of the 62 day cancer standard Extended waiting times for mental health patients. Continued non-elective activity is placing pressure on the elective care and the RTT standard. Wards and departments overdue for refurbishment due to the lack of decant facilities. Nursing Assessment Performance Framework post funded for a further 12 months and will need to be re-considered for permanent funding.	Review of the complaints element of the Patient Experience Strategy has been launched and a user friendly version developed and presetned to the Patient Experience Committee on 22 October 2018. The Trust is developing a full business case regarding the emergency care pathway and is anticipated to be ready for presentation and sign off in late 2018. Plans for staffing and estates challenges have progressed as follows: 1. Emergency care pathway action plan in place and is monitored monthly through the ECP Programme Board. Redesign emergency care workforce plan carried out as planned and agreed with NHSI, awaiting response. 2. Ambulatory Care Emergency Unit opened as planned on 14 September 2018. Fortnightly service reviews carried out. 3. Business case approved by the Trust Board and submitted to NHSI in July 2018 for the extended acute medical facility. Awaiting response from NHSI. 4. Frailty Assessment Unit due to open in January 2019. Board receives regular SRCP and transformation updates. Nursing Assessment and Performance Framework (NAPF) assessments are continuing. Nine Silver Accreditation of wards approved by the Trust Board. Further inspections planned for a number of wards awaiting third assessment following two green assessments. Work is planned within the NAPF team to develop the process to incorporate non-nursing areas, such as pharmacy. Objective is for a 50% reduction in all red wards by the end of March 2019. Core 24 (Lancashire Care Foundation Trust mentnal health programme) implementation commenced in April 2018 and will run until March 2019. Development of mental health decision unit planned by July 2018 had been delayed by external partners. Unit has opened in August 2018. The Trust continues to work with external partners to enable delivery and further update by November 2018. Performance Assurance Framework - Revised document presented to the Finance and Performance Committee and Operational Delivery Board at the end of October, with final approval at the end of November. Develop escalation facilities in Victoria wing at BGTH by October 2018, convert ward C3 to allow use as a decant ward in the next financial year (after Easter 2019). Escalation ward in Victoria wing in Burnley due to open on 15 November 2018.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 110

14 November 2018

Purpose Information Assurance

Title	Serious Incidents Requiring Investigation Report
Author	Mrs R Jones , Patient Safety Manager Mrs J Hardacre, Assistant Director of Safety and Risk
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 August and September 2018

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	Recruitment and workforce planning fail to deliver the Trust objectives The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

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

(110) Serious Incidents Requiring Investigation Report

Contents:

Executive Summary

Trust has reported 15 strategic executive information system incidents in August and September 2018:

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

Trust has requested 10 internal root cause analysis investigations within the Divisions:

- All duty of candours have been served in appropriate cases
- Root cause analysis investigations are in progress

The report provides an overview of work which has been completed by the Falls Collaborative group on falls leading to fracture neck of femurs and what are the next steps going forward.

An overview has been provided of the main findings and recommendations from the independent level 3 investigation which was commissioned into a death of a patient in 2015.

Part 1: Overview of Serious Incidents Requiring Investigations (SIRI) reported since last Board report

Strategic executive information system* (STEIS) – *SIRIs reported in August and September 2018

1. There have been 15 serious incidents requiring investigation which have been reported through Strategic Executive Information System (STEIS). Each incident has had a rapid review undertaken and a copy has been sent to the commissioner and regulatory bodies. The Assistant Director of Quality and Safety has commissioned a root cause analysis investigation for each incident and on completion these will be presented to the serious investigation requiring investigation (SIRI) panel. The table on the following pages provides details of these incidents:

	eIR1	Division	Incident reported	Category/Allegation	Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of harm	Next steps
1	eIR1150759	ICG	22/08/18	Pressure ulcer	Y	Y	Encouraged to use pressure relieving devices	Moderate	RCA to SIRI
2	eIR1148274	ICG	09/07/18	Mental Health Breach	N	Y	Close liaison with LCFT / CCG re 12 hour breaches	No harm - Impact not prevented	RCA to SIRI
3	eIR1150260	ICG	14/08/18	Slips Trips Falls	Y	Y	Post falls check / x-ray /surgery	Severe / Major	RCA to SIRI
4	eIR1149606	SAS	02/08/18	Sub optimal care of deteriorating patient (SJR2)	Y	Y	RCA completed due to structured judgement review outcome	Moderate	RCA to SIRI
5	eIR1149411	ICG	30/07/18	Maternity/Obstetric (baby only)	Y	Y	Awareness in ED around DVT vs Pre-eclampsia	Severe / Major	RCA to SIRI

	eIR1	Division	Incident reported	Category/Allegation	Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of harm	Next steps
6	eIR1151807	ICG	10/09/18	Slips Trips Falls	**Y**	Y	Post falls check / x-ray /surgery	Severe / Major	RCA to SIRI
7	eIR1152616	ICG	25/09/18	Slips Trips Falls	Y	Y	Post falls check / x-ray /surgery	Severe / Major	RCA to SIRI
8	eIR1150739	ICG	22/08/18	Pressure Ulcer - Grade 4 Community Acquired	Y	Y	Police / safeguarding investigation	Severe / Major	RCA to SIRI
9	eIR1150941	FC	26/08/18	Maternity / Obstetric: Baby only	Y	Y	Awareness of appropriate referral to midwife sonographer and consultant unit	Moderate	RCA to SIRI
10	eIR1151405	ICG	04/09/18	Sub optimal care of the deteriorating patient (SJR2)	Y	Y	RCA completed due to structured judgement review outcome	Moderate	RCA to SIRI
11	eIR1149563	ICG	01/08/18	Sub optimal care of deteriorating patient (SJR2)	Y	Y	RCA completed due to structured judgement review outcome	Moderate	RCA to SIRI
12	eIR1150780	FC	23/08/18	Maternity incident - baby only	Y	Y	No immediate changes identified	Moderate	RCA to SIRI
13	eIR1151153	ICG	30/08/18	Actual / alleged abuse	Y	Y	Asked for de-escalation, patient has withdrawn allegation	No Harm (was severe / major)	Awaiting feedback from CCG

	eIR1	Division	Incident reported	Category/Allegation	Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of harm	Next steps
14	eIR1149264	SAS	26/07/18	Sub optimal care of deteriorating patient (SJR2)	N	Y	RCA completed due to structured judgement review outcome	Low / Minor	RCA to SIRI
15	eIR1150412	ICG	16/08/18	Sub optimal care of deteriorating patient (SJR2)	Y	Y	RCA completed due to structured judgement review outcome	Moderate	RCA to SIRI

Part 2: **Overview of Divisional Serious Incident Reporting Groups (DSIRG) reported since last Board report**

Non-strategic executive information system – serious incidents requiring investigations reported in August and September 2018

2. There were 10 non-strategic executive information system incidents deemed to be serious incidents requiring investigation. A rapid review has been undertaken where further information was required and duty of candour completed on all moderate and above incidents in line with trust policy. A full root cause analysis investigations have been requested and once complete will be presented to each divisional serious investigation review group (DSIRG) panel.

	eIR1	Division	Incident reported	Category/Allegation	Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of Harm	Next steps
1	eIR1134665	SAS	24/10/17	Extravasation injury	Y	N	No – known risk and complication	Moderate	RCA to DSIRG

	eIR1	Division	Incident reported	Category/Allegation	Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of Harm	Next steps
							(patient consented for)		
2	eIR1151792	SAS	10/09/18	Delay in treatment via complaint process	Y	N	Investigation initiated	Moderate	RCA to DSIRG
3	eIR1149437	FC	30/07/18	Information Governance Breach	N	N	Awareness of information governance / GDPR to staff	No harm - Impact not prevented	RCA to DSIRG
4	eIR1148961	FC	21/07/18	Unexpected transfer to NICU	N	Y	No immediate changes initiated	No harm - Impact not prevented	RCA to DSIRG
5	eIR1150446	ICG	17/08/18	Self-harm	N	Y	Risk assessments carried out for quiet rooms – to ensure unlockable from both sides	No harm - Impact not prevented	RCA to DSIRG
6	eIR1151969	FC	13/09/18	Unexpected transfer to NICU	Y	Y	No immediate changes initiated	Moderate	RCA to DSIRG
7	eIR1148721	ICG	17/07/18	Delay in treatment	Y	Y	Training for triage nurses about RCEM Quality Standards	Moderate	RCA to DSIRG
8	eIR1147952	FC	03/07/18	Unexpected transfer to NICU	N	N	No immediate changes initiated	No harm - Impact not prevented	RCA to DSIRG
9	eIR1149015	SAS	22/07/18	Unexpected deterioration	Y	Y	No immediate changes initiated	No Harm (was moderate)	Discussed at DSIRG – no lessons learned identified due to existing comorbidities

	eIR1	Division	Incident reported	Category/Allegation	Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of Harm	Next steps
10	eIR1152798	SAS	28/09/18	Consent issues	N	N		No harm - Impact not prevented	RCA to DSIRG

Duty of Candour

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

4. Of the above reported incidents Duty of candour has been delivered where applicable.

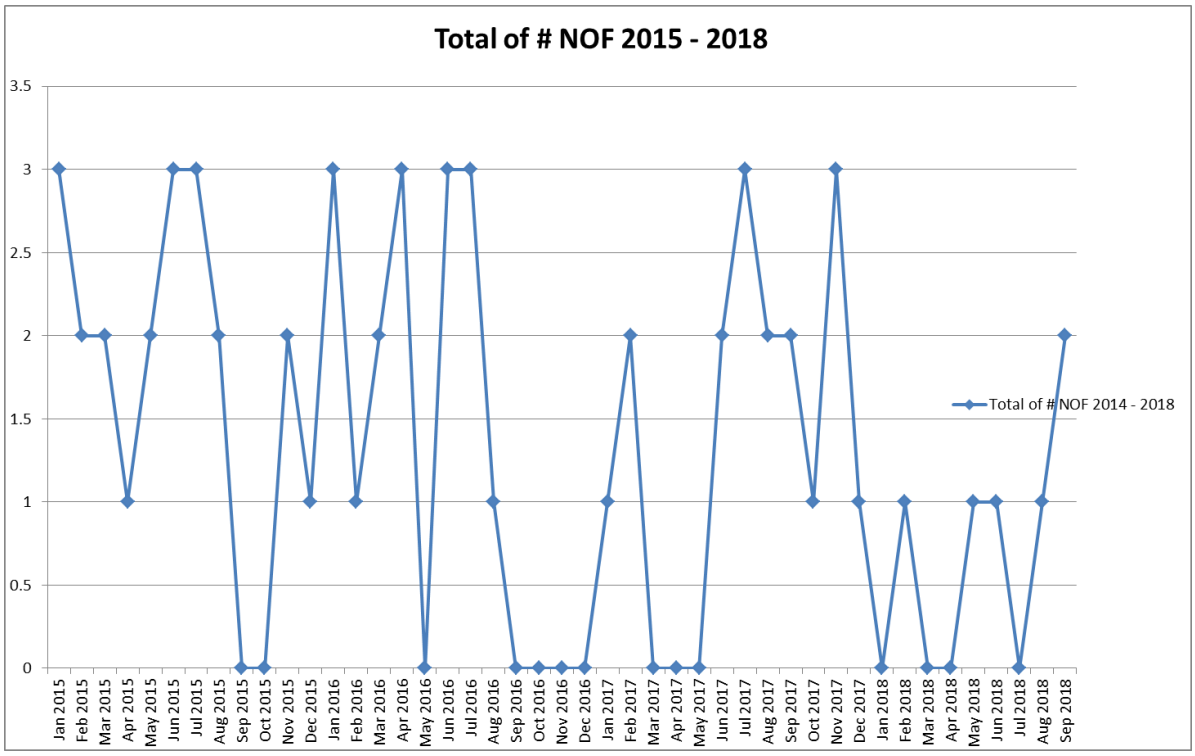
Part 3a – Overview of fracture neck of femur incidents – Falls Collaborative

Background of Falls collaborative 2015:

5. Patient falls are one of the most common patient safety incidents reported across the NHS. Within ELHT's 2014 Quality Strategy, reducing patient falls resulting in harm was identified as a specific harm reduction area with a goal of achieving a 15% reduction. This coincided with the direction of the Nice Clinical Guidance 161 that Falls are the most common and serious problem for older people. The estimated cost to the NHS of falls is approximately £2.3 billion per year and therefore it has a significant impact on quality of life, health and healthcare costs.

6. In July 2015 ELHT's Patient Safety & Risk Assurance Committee approved the Project Initiation of the Falls Collaborative. The Quality Improvement project methodology used was the Model for Improvement with the aim to reduce the number of inpatient falls across all inpatient areas at East Lancashire Hospitals NHS Trust by 15% by August 2017, which was achieved.

Comparison of data year on year



7. A full root cause analysis (RCA) is conducted for falls that have caused moderate and above harm. Fracture neck of femur incidents are graded as severe / major harm within Datix and above is a table summarising these incidents since 2015.

8. Each fracture neck of femur RCA have individual action plans which are monitored and evidence gathered for assurance by divisions. The divisions then provide assurance at the SIRI panel on a monthly basis around the completion of action plans. The average number of falls sustaining fracture neck of femur is 1 incident per month.

What next Falls Steering Group

9. When the falls collaborative ended a falls steering group was initiated and a new aim was agreed: **reduction of falls by 20% by year 2020**. The falls steering group meet bimonthly to review falls on all wards with all levels of harm. Trust wide falls audit was conducted between early June and July 2018 to measure compliance with Trust's falls change package, and to try and establish baseline in accordance with National Inpatient Falls Audit Data. A quarterly falls audit is to be rolled out from October/November once the audit pro forma has been modified.

Part 3b - Overview of External Level 3 Investigation Report for incident eIR198516

Background

10. The Trust has received the 2018 independent investigation report into the death of a patient in 2015. Whilst the patient details remain a matter of confidentiality, the Board is asked to receive this update in order to acknowledge the 2018 investigation findings, and that the investigators recognised the learning and improvements that have taken place since and also that there are final recommendations for actions to be undertaken.
11. The 2018 investigating team were independently commissioned to carry out this investigation by a clinical commissioning group. The Investigators produced their findings in two separate reports, one detailing the investigation of the case, and another describing the improvements already made by the Trust.
12. The patient presented with acute abdominal difficulties and had a number of other medical conditions, including autism and mild learning disability. The patient had initially been under the care of another hospital where several admissions and operations had taken place.
13. In 2015, the patient was admitted as an emergency to the Trust. The surgeons considered the patient to be high risk because of adhesions from his previous operation and inflammation from the pancreas. As an alternative to invasive surgery, the option of a biodegradable stent was considered.
14. The stent had to be obtained as it was not in stock. The patient deteriorated significantly overnight. Emergency theatre was being arranged the following morning. The clinical team thought that this would be the best option given his deterioration. He had a cardiac arrest and died before the operation took place.
15. The death was referred to the Coroner although a post-mortem was not carried out. As a result, the cause of the patient's cause of death is not known. The Trust undertook an internal investigation and as part of this, the Trust commissioned an independent expert in 2016 to offer opinion on the case. The Trust's internal investigations concluded in 2017. Updates were given to Quality Committee and Board.
16. The Trust set up a task and finish group to take forward the actions identified by our internal investigation. The teams involved have implemented many actions since Patient's death to improve patient safety. These have been recognised in the 2018 Independent report.

Summary of Outcome of Findings

17. The 2018 independent report stated that the Trust did not provide the patient with a consistently high standard of care and treatment and that there were weaknesses in aspects of both his nursing and medical care. This is in line with our own internal investigation findings, as previously reported to Board.
18. Within the 2018 report it is stated that the reasons for patient's death were multifaceted, but the death may have been avoidable.
19. The report identifies lapses in care in terms of some aspects nursing and medical assessment, leadership, record keeping, communication and protocols that were in existence in 2015.
20. The investigators report that the Trust, in their view, endeavoured to be open and honest and to share as much information as possible.
21. The CCG asked the 2018 independent investigation team to write a separate report describing what improvements the Trust had already made. The investigators have taken these improvements into account and, therefore, have only made additional recommendations where they think that there needs to be further action.
22. The 2018 independent report makes the recommendation that the Medical Director from ELHT should reconvene the task and finish group to oversee and manage the additional new recommendations from this 2018 report.

ELHT Actions and Next Steps

23. The Trust has reconvened the task and finish group, having had the first meeting on the 4th October 2018.
24. Each of the recommendations have been reviewed and discussed.
25. Actions have been agreed and are under development, with a process for collating the necessary evidence of completion of actions.
26. The Task and Finish Group will meet again regularly over the coming year to review and monitor actions, and progress will be reported via the Quality Committee.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 111

14 November 2018

Purpose Information Assurance

Title	Flu Vaccination Programme 2018/19
Author	Mr P Denney, Head of Occupational Health & Wellbeing
Executive sponsor	Mr K Moynes, Director of Human Resources and Organisational Development

Summary: The board are asked to note the success of the previous year's Seasonal Influenza (Flu) campaign at ELHT and note the measures taken in the 2018/19 campaign aimed at exceeding last year's achievement of 92.3%.

Members are asked to support the ongoing Flu campaign and encourage colleagues at every level of the organisation to receive their Flu vaccination.

Report linkages

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

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Executive summary

1. On the 7th September 2018 the 'Annual Flu Letter' titled Health care worker Flu vaccination was sent to all Chief Executives of NHS Trusts.
2. In order to ensure organisations are doing everything possible as an employer to protect patients and staff from seasonal Flu, Trusts were asked to provide an update for public assurance via Trust board by December 2018. This paper details East Lancashire Hospitals NHS Trust's (ELHT) plan for the 2018/19 Flu season.
3. The Annual Flu Letter can be viewed here.

Introduction

4. ELHTs 2018/2019 Seasonal Influenza (Flu) Plan sets out a coordinated and evidence-based approach to planning for and responding to the demands of Seasonal Flu across the organisation taking account of lessons learnt during previous Flu seasons and provides assurance to the Board that those recommendations made in Appendix 1 of the Annual Flu Letter are being met.
5. The plan provides an overview of the coordination and the preparation for the Flu season and signposting to further guidance and information. The Seasonal Flu Plan 2018 can be viewed here.
6. During the 2017/18 Flu season the uptake of the Flu vaccine in healthcare workers nationally was 68.7%. Within ELHT the uptake was 92.3% during the 2017/18 season. This represents the highest uptake nationally for vaccination of frontline healthcare workers (HCW).

Our key activities for the 2018/19 campaign

7. The 2018/19 campaign is aimed at exceeding last year's achievement. A range of interventions have been employed to ensure ELHT are successful with this year's Flu campaign already 8.2% ahead of schedule at week 4. The following summary of the measures taken in this year's Flu campaign have been provided below:
   a) The quadrivalent (QIV) vaccine has been provided for healthcare workers.
   b) All high risk areas of the hospital have been contacted and visited for their Flu vaccinations in haematology, neonatal intensive care and specialist paediatric units, Coronary Care, Emergency Department and ITU and visits are on-going throughout the campaign.

c) An agreed board champion has been assigned in Kevin Moynes, Director of Human Resources & Organisational Development with the board and senior managers being vaccinated and publicised.

d) Corporate induction continues to be visited to offer vaccinations.

e) The Flu Team has scheduled walk rounds and further drop in clinics at our 5 main hospital sites as well as those peripheral community sites. Additional Flu sessions have been scheduled out of hours at night and over weekends to allow for easy access for clinics. These continue to be advertised using a wide range of communication mechanisms.

f) Students, trainees and volunteers who are working with patients will also be included in the vaccination programme.

g) Weekly feedback has been provided via a Flu trajectory with the aim of vaccinating at least 95% of ELHT employees.

Recommendations

8. It is recommended that the board note the actions in place for the 2018/19 Flu campaign and continue to support the implementation of the plan across the organisation.

9. By February 2019 it is expected that each Trust will use its public board papers to locally report their performance on overall vaccination uptake rates and numbers of staff declining the vaccinations, therefore it is recommended a further report summarising the outcome of the 2018/19 Flu campaign is scheduled for the February 2019 Trust board meeting.

Conclusion

10. All necessary measures are being taken to ensure the 2018/19 campaign exceeds last year's achievement of 92.3%. The current uptake for flu vaccination is **43.2%** at week 4 this is **8.2%** ahead of target.

Next steps

11. Further report to be provided at the February 2019 Trust board meeting.

Phil Denney, Head of Occupational Health & Wellbeing

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 112

14 November 2018

Purpose Discussion

Title	Lancashire and South Cumbria Integrated Care System (ICS) Memorandum of Understanding (MoU)
Executive sponsor	Mr K McGee, Chief Executive

Recommendation: The Board is asked to receive the MoU for the ICS and support the document.

Report linkages

Related strategic aim and corporate objective	Work with key stakeholders to develop effective partnerships

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

Memorandum of understanding for Integrated Care Systems

Dear Amanda,

We are writing to confirm Lancashire & South Cumbria's status as an Integrated Care System (ICS), subject to collective agreement of all the leaders in your system), and to describe the terms of this relationship with the national leadership bodies.

In order to enable the further development of the ICS approach in 2018/19, this document sets out the national expectations of ICSs, the freedoms and flexibilities that these systems will gain in return and how we will work to support system leaders and their teams.

1. Objectives

ICSs are systems in which NHS commissioners and providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they use their collective resources to improve quality of care and health outcomes. They are expected to make faster progress than other health systems in transforming the way care is delivered, to the benefit of the population they serve.

ICSs will:

- re-design and integrate clinical and care pathways to better meet the needs of the local population, incorporating use of prevention and self-care where appropriate;
- develop population health management approaches that facilitate the integration of services focused, in the first instance, on populations that are most at risk of developing acute illness and hospitalisation;
- work with key system partners and stakeholders including patients and residents and their democratic representatives, health and care staff, local government and the voluntary sector;
- take collective responsibility for managing financial and operational performance, quality of care (including patient/user experience) and health and care outcomes;
- implement new methods of payment that support integration of services and population health management approaches, whilst enabling delivery of a shared system control total;
- create more robust cross-organisational arrangements to tackle the systemic challenges that the health and care system is facing;
- act as a leadership cohort, demonstrating what can be achieved with strong local leadership, operating with increased freedoms and flexibilities; and

- commit to developing and disseminating learning, together with the national bodies, so that other systems can develop ICSs.

2. National NHS priorities and deliverables

The NHS guidance for refreshing 2018/19 plans confirmed the priorities set out in *Next Steps on the Five Year Forward View*. These include to:

- improve investment in, access to and the quality of mental health services as defined in *Implementing the Five Year Forward View for Mental Health* and the planning round refresh;
- promote better prevention and earlier diagnosis of cancer, as well as increasing access to innovative and timely treatments that improve survival, quality of life and patient experience;
- stabilise general practice, ensuring measures are in place to maximise GP retention and recruitment, and support the development of primary care networks that improve access and share assets and workforce. In time these networks will collaborate to expand the range of services available in the community, including proactive services aimed at keeping people well and/or prevent acute deterioration;
- redesign and strengthen the urgent and emergency care system through successful implementation of the UEC transformation programme. This includes delivering national operational standards, the 2018/19 ambitions on "Reducing long stays in hospital - to reduce patient harm and bed occupancy" and urgent and emergency mental health care for people of all ages;
- transform the treatment, care and support available to people of all ages with a learning disability, autism or both so that they can lead longer, happier, healthier lives in homes not hospitals; and
- continue to make maternity services in England safer and more personal through the implementation of the Better Births.

The deliverables that underpin these priorities are set out in Annex 1 of this document for ease of reference.

We are also expecting ICSs to go further than other systems in driving improvement across the clinical priority areas including:

- reaching 100% coverage of self-identified primary care networks (PCNs) by the end of 2018/19. We expect PCNs to be: functionally sharing assets and workforce and consistently delivering care through integrated teams to high risk groups; making use of data to understand their populations, identifying variation in resource use and outcomes, and guiding clinical decision making; acting as core partner in system decision making. We will work with each ICS in July and August to agree the level of primary care network maturity that systems expect

to achieve by March 2019, and that would represent a step change in the delivery of integrated primary care during 2018-19. We will also co-produce with ICSs appropriate measures to assess progress and impact, aligned with the national Primary Care Network Programme;

- enhancing resilience of systems before next winter, for example by improving system-level working across urgent and emergency care and improving resilience in care homes through implementation of the Enhanced Health in Care Homes framework;
- working in partnership with the National Mental Health Team to develop and implement actions to improve system-level working across all local partners for Mental Health delivery in 2018/19. This includes an ICS system-wide mental health investment strategy, and credible mental health workforce plan;
- working through, and as an active member of your Cancer Alliance, and in partnership with the National Cancer Programme, to implement the National Cancer Taskforce's recommendations[1].

3. Integrating care

In addition to making progress on these core priorities, ICSs will lead the way in integrating health and care services at the population and person level, including in the following ways.

- Analysing patterns of need, health and care utilisation, cost and other metrics by population segment. These analyses should help ICSs identify population groups that should receive proactive care with the objective of preventing illness or hospitalisation and reducing inequalities. Nationally we will work with ICSs to design a mechanism that can provide a common and consistent source of data to support benchmarking, peer learning and improvement.
- Using these analyses to redesign care with a view to providing proactive services to at-risk population groups and coordinating different services for them. We will support ICSs with practical learning derived from the new care models programme as well as other models used internationally.
- As population analytical methods will initially be snapshots, ICSs will increasingly need to build the digital infrastructure that allows for real-time analyses, patient 'tracking' and actionable insight. We will provide ICSs with advice on interoperability, information governance and, where necessary and appropriate investment.
- With support from the national team, ICSs will be required to make significant progress towards full maturity of the three population health management

[1] http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

capabilities and develop a system-wide plan setting out locally determined population health priorities.

4. Local priorities and deliverables

The ICS leadership commits to delivering the following high priority deliverables in 2018/19:

Urgent & Emergency Care:

- provide system wide leadership and oversight of the UEC system across L&SC;
- identify opportunities to 'do things once' and provide a system wide response to UEC;
- bring together interdependent organisations across the Lancashire and South Cumbria system; and
- agree an escalation process and determine how ICPs will support each other through mutual aid during pressurised periods.

MH and LD:

- implement agreed remedial short, medium and long-term actions as per local plans to reduce the impact of MH demand on UEC services by increasing MH capacity across the L&SC system; and
- develop and implement revised clinical models for community and hospital service support to people with LD and/or autism as per local plans

Acute care:

- continue to design the reconfiguration of acute services, vertically integrating local hospital care within developing ICPs and horizontally integrating across L&SC acute providers the more specialised or clinically fragile services;
- design the implementation of hyper-acute stroke units; and
- align consultation processes for local and L&SC-wide reconfigurations under a single consultation framework to ensure consistency of public messages.

Integrated care:

- work with ICPs to ensure consistency and accelerate the development of integrated models of population health, prevention, primary care, community care and social care on a neighbourhood level. Neighbourhoods will have accurate information as to the resources they are utilising in taking care of their population and that incentives and or gain share arrangements are in place or in development in order to promote the management of more people out of hospital where that is safe and effective.

Financial strategy:

- To develop and agree a collective approach to system financial management across partners and make significant progress towards a system control total. This will include implementing a blended payment model by 1 April 2019 and working closely with the national teams on a formative evaluation of the blended model to inform future ICS payment approaches, dedicating sufficient local resource to progress this work and the requisite enablers.

Governance:

- implement the agreed ICS strategic framework, which sets out those actions across ICS responsibilities (assurance; sustainability; transformation; and ICS/ICP design) that will be undertaken once at a L&SC level, and those that will be undertaken at ICP level to the same blueprint.
- implement the defined ICS/ICP shift of commissioning responsibilities for MH, LD, children's, UEC, CHC, Out of Hospital and Cancer services as agreed under the commissioning development framework

5. Transformation funding

ICSs have been given transformation funding delegated to a host CCG on behalf of an ICS to support the implementation of integrated care and the local priorities set out above. This transformation funding package is set out in Annex 2. We will also be taking steps where possible to increase the flexibility of transformation funding streams dedicated to specific priorities from 2019/20 and beyond.

Financial governance arrangements

Definitive allocations are subject to NHS England and NHS Improvement approval for ICSs to go live. Prior to the release of any of the additional devolved funding included in this package each ICS will need to demonstrate:

- Governance and accountability arrangements so it is clear how decisions are made and who is accountable for delivering value for money from the expenditure.
- A value based allocation process for determining the use of the funding.
- Arrangements for oversight and reporting of expenditure and tracking of benefits realisation.

6. Managing collective resources

i) Shared system control total

As a shadow ICS you are required to work towards managing a system control total for 2019/20. Being able to manage a system control total is a key deliverable for your system for 2019/20.

For 2018/19, the tables in Annex 3 set out the organisation control totals and Provider Sustainability Funding allocations for your system.

As a shadow ICS, Provider Sustainability Funding will be paid in line with the rules for non-ICSs.

ii) Single system operating plan

We expect you to put plans in place to allow the system to manage its combined income and expenditure across commissioners and providers, with a view to submitting a single system operating plan as part of the 2019/20 planning process.

iii) Capital and estates

As for STPs, you should develop a system-wide estates and capital plan by July. This should include sufficient focus on out-of-hospital schemes. This STP capital process is the main channel for access to strategic capital in 2018/19.

7. Oversight

We will progressively look to systems to manage and improve their own performance, as well as transforming services to ensure they are clinically and financially sustainable.

We will develop an oversight model that empowers your system to take a shared or leading role in decisions about oversight of trusts and CCGs, supported as necessary by NHS England and NHS Improvement, and with a commitment to minimising the administrative burden placed upon systems.

Regional teams will agree with ICSs how this oversight model will operate, taking into account the maturity of system working, including governance and financial management. This will include:

- establishing a single governance forum, the L&SC ICS Board, (led and hosted by the ICS, but with input from regional teams) to review both system performance and the performance of individual providers and CCGs.
- agreeing an accountability framework setting out how oversight will work in practice.
- agreeing a work programme and timetable which identifies specific and tangible changes that will be made to the relationship between NHS England, NHS Improvement, the ICS and local trusts and CCGs.

General principles

In order to support system working and as the oversight model develops, all parties agree to work by the following principles:

- The ICS will interact with a single regional director, acting on behalf of both NHS Improvement and NHS England. We are working towards having fully integrated regional teams, as part of our wider plans for joint working.
- Where underperformance is identified, the ICS will generally be responsible in the first instance for working with local organisations to address the issue. Any NHS England or NHS Improvement intervention required will, wherever possible, be identified in consultation with and agreed with the ICS.
- Any regulatory decisions e.g. to put a trust or CCG into special measures, will, as now, be made by NHS England and NHS Improvement, but wherever possible in consultation with and taking into account the views of the ICS.
- NHS England/NHS Improvement will not generally engage with individual providers or CCGs without the knowledge of the system and an invitation to participate in the discussion.
- National programmes will, wherever possible, work through and with the ICS to ensure that challenge and support is in line with the needs of the system. Where there are national support offers focussed on systems, these offers will be agreed with the ICS.

- NHS England/Improvement will minimise ad hoc data and information requests. Where additional data or information is sought, the ICS will be consulted before the request is issued. Where additional data or information is being sought from CCGs or trusts, we will, wherever possible, agree whether the request should come from NHS England/NHS Improvement or the ICS.
- These principles support a single route of communication, seek to enable the system to focus on improving and transforming quality and efficiency of care and reduce duplication of effort across our organisations.

Specific additional agreements made between the region and the ICS

In addition to abiding by the above general principles, the regional team and the ICS also commit to the following specific actions:

- The North HR framework will be used to consolidate HR and OD models for embedded NHS England staff and to further develop the relationship and integration of NHS Improvement staff.

8. National support

NHS Improvement and NHS England will continue to support ICSs. We will:

Facilitate learning between systems including convening a regular ICS leads development day. We will also continue to convene learning groups on specific topics such as primary care development, population health and communications and engagement. In addition, in 2018/19 we intend to start convening other professional groups such as ICS programme directors.

Dedicate a senior 'sponsor' from the national team to support the regional team in working with the ICS to help source national expertise and help coordinate and control the demands placed on local systems. This sponsor will also be able to provide hands-on help in solving problems or removing barriers that inhibit ICS development.

Provide bespoke support to leadership teams drawing on the King's Fund, NHS Confederation and others. In addition to re-procuring leadership support similar to that which we provided last year, we will expand our development offer in 2018/19 to provide, for example, clinical leadership teams with a facilitated programme that builds on Surrey Heartland's Clinical Academy and Frimley's 2020 programme.

Mobilise teams with specific expertise or tasked with solving common problems faced by ICSs and other systems. For example, we already have teams assisting many systems with the rollout of primary care networks. In 2018/19, we will provide hands-on expertise around population health management approaches, engagement and communication, and system financial management. Other workstreams will be developed in consultation with ICS leaders.

Continue to develop national strategy and policy with ICSs. The ICS community provides an invaluable source of expertise on which we will draw in developing policy, for instance on national financial architecture and incentives, the operating model for integrated regional teams, and how national bodies should oversee and support systems as they mature.

Promote a collaborative and open approach, working with the ICS community to collectively solve problems and set future direction for the NHS. We commit to communicating openly with you, providing support where we can and doing so at a pace that supports the development of ICSs.

Signature

Amanda Doyle confirms collective agreement of Lancashire and South Cumbria system leaders

Matthew Swindells on behalf of NHS England and Ben Dyson on behalf of NHS Improvement

Annex 1: 2018/19 Deliverables

Reminder of 2018/19 deliverables – drawn from 'Next Steps on the NHS Five Year Forward View' published in March 2017

The NHS already has two-year priorities, set out in last year's Planning Guidance and the March 2017 publication of the *Next Steps on the NHS Five Year Forward View.* This Annex confirms these deliverables for 2018/19.

For national targets we will, where appropriate, provide disaggregated STP and CCG-level improvement targets and templates to ensure plans are completed on a consistent basis.

1. Mental Health

<table>
<tr><td colspan="2">Overall Goals for 2017-2019
We published Implementing the Mental Health Forward View in July 2016 to set out clear deliverables for putting the recommendations of the independent Mental Health Taskforce Report into action by 2020/21. The publication of Stepping Forward to 2020/21[5] in July 2017 provides a roadmap to increase the mental health workforce needed to deliver this. Making parity a reality will take time, but this a major step on the journey towards providing equal status for mental and physical health. These ambitions are underpinned by significant additional funding for mental health care, which should not be used to supplant existing spend or balance reductions elsewhere.</td></tr>
<tr><td>Progress in 2017/18
• On track to ensure an extra 35,000 children and young people are able to access services this year.
• 70 new or extended community eating disorder services funded and commissioned.
• 81 new beds for Children and Adolescent Mental Health Services (Tier 4) and at least another 50 beds will open by</td><td>Deliverables for 2018/19
Additional funding has now been built into CCG 2018/19 allocations to support the expansion of services outlined in this planning guidance and the specific trajectories set for 2018/19 to deliver the Five Year Forward View for Mental Health. Progress to be made against all deliverables in the Next Steps on the NHS Five Year Forward View and the Implementing the Mental</td></tr>
</table>

[5] Stepping Forward to 2020/21: Mental Health Workforce Plan for England (Health Education England).

end of March 2018. • Expanded **specialist perinatal care** with over 5,000 additional women accessing these services between April and December 2017. Contracts awarded for four new Mother and Baby Units. • Continued to meet the waiting time standard for **early intervention in psychosis.** • **Physical health checks and interventions** for patients with severe mental illness in secondary care, with 60% of people in inpatient settings and 42% in community mental health teams receiving this to date. • Health Education England (HEE) expects to provide over 600 training places for Improving Access to Psychological Therapies (IAPT) practitioners. At least **800 practitioners in primary care** settings by March 2018. • 10 mental health **new care models** up and running and an additional 7 go live by April 2018. • CCGs have continued to meet the **dementia diagnosis standard**, which was at 68.3% by December 2017. • Seven **Global Digital Exemplar** Mental Health Trusts, funded to identify trusts which they will partner with as 'fast followers'.	*Health Forward View* in 2018/19 with all CCGs and STPs required to: • Each CCG must meet the **Mental Health Investment Standard** (MHIS) by which their 2018/19 investment in mental health rises at a faster rate than their overall programme funding. CCGs' auditors will be required to validate their 2018/19 year-end position on meeting the MHIS. • Ensure that an additional 49,000 **children and young people** receive treatment from NHS-commissioned community services (32% above the 2014/15 baseline) nationally, towards the 2020/21 objective of an additional 70,000 additional children and young people. Ensure evidence of local progress to transform children and young people's mental health services is published in refreshed joint agency Local Transformation Plans aligned to STPs. • Make further progress towards delivering the 2020/21 waiting time standards for **children and young people's eating disorder services** of 95% of patient receiving first definitive treatment within four weeks for routine cases and within one week for urgent cases. • Deliver against regional implementation plans to ensure that by 2020/21, **inpatient stays for children and young people** will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements, within a context of 150-180 additional beds. • Continue to increase access to **specialist perinatal mental health services,** ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%.

	• Continue to improve access to **psychology therapies** (IAPT) services with, maintaining the increase of 60,000 people accessing treatment achieved in 2017/18 and increase by a further 140,000 delivering a national access rate of 19% for people with common mental health conditions. Do so by supporting HEE's commissioning of 1,000 replacement practitioners and a further 1,000 trainees to expand services. This will release 1,500 mental health therapists to work in primary care. Approximately two-thirds of the increase to psychological therapies should be in new integrated services focused on people with co-morbid **long term physical health conditions** and/or medically unexplained symptoms, delivered in primary care. Continue to ensure that access, waiting time and recovery standards are met. • Continue to work towards the 2020/21 ambition of all acute hospitals having **mental health crisis and liaison services** that can meet the specific needs of people of all ages including children and young people and older adults; and deliver Core 24 mental health liaison standards for adults in 50% of acute hospitals subject to hospitals being able to successfully recruit. • Ensure that 53% of patients requiring **early intervention for psychosis** receive NICE concordant care within two weeks. • Support delivery of STP-level plans to reduce all inappropriate adult acute **out of area placements** by 2020/21, including increasing investment for Crisis Resolution Home Treatment Teams (CRHTTs) to meet the ambition of all areas providing CRHTTs resourced to operate in line with recognised best practice by 2020/21. Review all patients who are placed out of area to ensure that have appropriate packages of care.

	• Deliver annual **physical health checks** and interventions, in line with guidance, to at least 280,000 people with a severe mental health illness. • Provide a 25% increase nationally on 2017/18 baseline in access to **Individual Placement and Support** services. • Maintain the **dementia** diagnosis rate of two thirds (66.7%) of prevalence and improve post diagnostic care. • Deliver their contribution to the **mental health workforce** expansion as set out in the HEE workforce plan, supported by STP-level plans. At national level, this should also specifically include an increase of 1,500 mental health therapists in primary care in 2018/19 and an expansion in the capacity and capability of the children and young people's workforce building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence based interventions by 2020/21. • Deliver against multi-agency **suicide prevention** plans, working towards a national 10% reduction in suicide rate by 2020/21. • Deliver **liaison and diversion** services to 83% of the population. • Ensure all commissioned activity is recorded and reported through the Mental Health Services **Dataset**.

2. Cancer

Overall Goals for 2017-2019 Advance delivery of the National Cancer Strategy to promote better prevention and earlier diagnosis and deliver innovative and timely treatments to improve survival, quality of life and patient experience by 2020/21.

Progress in 2017/18	Deliverables for 2018/19
• **Cancer survival** at its highest ever with latest figures showing that one-year cancer survival is up by over 2,000 people a year. • 95.1% of people seen by a specialist **within two weeks** of an urgent GP referral for suspected cancer, with 5.1% more patients being seen in the 12 months to November 2017 than in the previous 12 months. • Ten **multidisciplinary rapid diagnostic and assessment centres** in place across the country by March 2018, supporting patients with complex symptoms through to diagnosis. • We are on track to deliver the **largest radiotherapy upgrade programme in 15 years modern radiotherapy** have now funded 26 new machines in 21 trusts in 2017/18. • Half of the country's Cancer Alliances have begun to roll out **personalised follow-up** after cancer treatment. • Added 22 more drugs to the Cancer Drugs Fund, which have benefitted nearly 7,500 more patients, taking the total since the reformed CDF launched in July 2016 to 15,700 patients having benefited from 52 drugs treating 81 different cancers.	• Ensure all **eight waiting time standards** for cancer are met, including the 62 day referral-to-treatment cancer standard. The '10 high impact actions' for meeting the 62 day standard should be implemented in all trusts, with oversight and coordination by Cancer Alliances. The release of cancer transformation funding in 2018/19 will continue to be linked to delivery of the 62 day cancer standard. • Support the implementation of the new **radiotherapy** service specification, ensuring that the latest technologies, including the new and upgraded machines being funded through the £130 million Radiotherapy Modernisation Fund, are available for all patients across the country. • Ensure implementation of the nationally agreed **rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers**, ensuring that patients get timely access to the latest diagnosis and treatment. Accelerating the adoption of these innovations helps meet the 62 days standard ahead of the introduction of **the 28 day Faster Diagnosis Standard** in April 2020. • Progress towards the 2020/21 ambition for **62% of cancer patients to be diagnosed at stage 1 or 2**, and reduce the proportion of cancers diagnosed following an emergency admission. • Support the rollout of FIT in the **bowel cancer screening** programme during 2018/19 in line with the agreed national timescales following PHE's procurement of new FIT kit, ensuring that at least 10% of all bowel cancers diagnosed through the screening programme are detected at an early stage, increasing to 12% in 2019/20. • Participate in pilot programmes offering low dose CT scanning based on an assessment of lung cancer risk in

	CCGs with lowest **lung cancer** survival rates. • Progress towards the 2020/21 ambition for **all breast cancer patients to move to a stratified follow-up pathway** after treatment. Around two-thirds of patients should be on a supported self-management pathway, freeing up clinical capacity to see new patients and those with the most complex needs. All Cancer Alliances should have in place clinically agreed protocols for stratifying breast cancer patients and a system for remote monitoring by the end of 2018/19. • Ensure implementation of the **new cancer waiting times system** in April 2018 and begin data collection in preparation for the introduction of the new 28 day Faster Diagnosis standard by 2020.

3. Primary Care

Overall Goals for 2017-2019 Stabilise general practice today and support the transformation of primary care and for tomorrow, by delivering *General Practice Forward View* and *Next Steps on the NHS Five Year Forward View*.	

Progress in 2017/18
• 52% of the country now benefitting from **extended access** including appointments on evenings and weekends, beating the target of 40% for 2017/18.
• **Primary care workforce**:
  ○ Over 770 additional GP trainees started specialist training since 2015 baseline (3,157 in total in 2017/18);
  ○ Begun GP international recruitment, with the first 100 GPs being recruited;
	Deliverables for 2018/19
	Progress against all *Next Steps on the NHS Five Year Forward View* and *General Practice Forward View* commitments. This includes all CCGs:
	• Providing **extended access** to GP services, including at evenings and weekends, for 100% of their population by 1 October 2018. This must include ensuring access is available during peak times of demand, including bank holidays and across the Easter, Christmas and New Year periods.
	• Delivering their contribution to the **workforce commitment**

○ Launched the GP Retention Scheme; ○ Recruitment of an additional 505 clinical pharmacists, in addition to the 494 already in post. • **Investment in general practice** continues to increase on track to deliver the pledged additional £2.4 billion by 2021. • CCGs investing in line with expectations set out in the 2017/18 NHS's Planning Guidance, for **additional primary care transformation investment (£3/head)** over two years. • Invested in **upgrading primary care facilities**, with 844 schemes completed and a further 868 schemes in development.	to have an extra 5,000 doctors and 5,000 other staff working in primary care. CCGs will work with their local NHS England teams to agree their individual contribution and wider workforce planning targets for 2018/19. At national aggregate level we are expecting the following for 2018/19: ○ CCGs to recruit and retain their share of additional doctors via all available national and local initiatives; ○ 600 additional doctors recruited from overseas to work in general practice; ○ 500 additional clinical pharmacists recruited to work in general practice (CCGs whose bids have been successful will be expected to contribute to this increase); ○ An increase in physician associates, contributing to the target of an additional 1000 to be trained by March 2020 (supported by HEE); ○ Deliver increase to 1,500 mental health therapists working in primary care. • I**nvesting** the balance of the £3/head investment for general practice transformation support. • Actively encourage every practice to be part of a local **primary care network**, so that there is complete geographically contiguous population coverage of primary care networks as far as possible by the end of 2018/19, serving populations of at least 30,000 to 50,000. • Investing in upgrading primary care facilities, ensuring completion of the pipeline of **Estates and Technology Transformation schemes**, and that the schemes are delivered within the timescales set out for each project. • Ensuring that 75% of 2018/19 **sustainability and resilience funding** allocated is spent by December 2018, with 100% of the allocation spent by March 2019.

	• Ensuring every practice implements at least two of the **high impact 'time to care' actions**. • In all practices, delivering primary care **provider development initiatives** for which CCGs will receive delegated budgets, including online consultations. • Where primary care commissioning has been **delegated**, providing assurance that statutory primary medical services functions are being discharged effectively. • Lead CCGs expected to commission, with support from NHS England Regional Independent Care Sector Programme Management Offices, **medicines optimisation** for care home residents with the deployment of 180 pharmacists and 60 pharmacy technician posts funded by the Pharmacy Integration Fund for two years.

4. Urgent and Emergency Care

Overall Goals for 2017-2019 Redesign and strengthen the urgent and emergency care system to ensure that patients receive the right care in the right place, first time.	
Progress in 2017/18 • More patients able to **speak to a clinician** about their urgent and emergency care needs when calling NHS 111 – 40% of answered calls now receive clinical input, up from 22% last year. • Piloted and evaluated **NHS 111 Online** in a number of areas, with 27% of the population now able to access urgent and emergency care advice through this online portal.	**Deliverables for 2018/19** • Ensure that **aggregate performance against the four-hour A&E standard** is at or above 90% in September 2018, that the majority of providers are achieving the 95% standard for the month of March 2019. Also Trusts are expected to improve on their performance each quarter compared to their performance in the same quarter the prior year in order to qualify for STF payments.

• 110 **Urgent Treatment Centres (UTCs)** designated according to the revised standard specification. • **Ambulance Response Programme** implemented in all English mainland ambulance trusts. • 105 Trusts received capital funding of £96.7 million to implement **front-door clinical streaming**. Over 90% of Trusts now have this in place. • **1,491 beds have been freed up** as a result of **reducing delayed transfers of care (DTOC)**. • £30 million awarded to 74 areas to increase number of acute hospitals meeting the **'Core 24' standard for 24/7 mental health liaison teams**. • 97% of A&Es, 98% of the initial cohort of UTCs and 96% of e-prescribing pharmacies now have **access to primary care records** through either summary care records or local record sharing portals.	• Implementation of the **NHS 111 Online** service to 100% of the population by December 2018. • Access to enhanced **NHS 111** services to 100% of the population, with more than half of callers to NHS 111 receiving clinical input during their call. Every part of the country should be covered by an integrated urgent care Clinical Assessment Service (IUC CAS), bringing together 111 and GP out of hours service provision. This will include direct booking from NHS 111 to other urgent care services. • By March 2019, CCGs should ensure technology is enabled and then ensure that **direct booking from IUC CAS into local GP systems** is delivered wherever technology allows. • Designate remaining **UTCs** in 2018/19 to meet the new standards and operate as part of an integrated approach to urgent and primary care. • Work with local Ambulance Trusts to ensure that the new **ambulance response time standards** that were introduced in 2017/18 are met by September 2018. Handovers between ambulances and hospital A&Es should not exceed 30 minutes. • Deliver a **safe reduction in ambulance conveyance** to emergency departments. • Continue to make progress on **reducing delayed transfers of care** (DTOC), reducing DTOC delayed days to around 4,000 during 2018/19, with the reduction to be split equally between health and social care. • Continue to improve patient flow inside hospitals through implementing the "Improving Patient Flow" guidance[6]. Focus specifically on **reducing inappropriate length of stay for admissions**, including specific attention on 'stranded' and

[6] https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow/

	‘super stranded’ patients who have been in hospital for over 7 days and over 21 days respectively. • Continue to work towards the 2020/21 deliverable of all acute hospitals having **mental health crisis and liaison services** that can meet the specific needs of people of all ages including children and young people and older adults; and deliver **Core 24 mental health liaison standards for adults** in 50% of acute hospitals, subject to hospitals being able to successfully recruit. • Ensure that fewer than 15% of NHS **continuing healthcare full assessments** take place in an acute setting. • Continue to progress **implementation of the Emergency Care Data Set** in all A&Es (Type 1 and Type 2 by June 2018; and Type 3 by the end of 2018/19). • Increase the number of patients who have consented to share their additional information through the **extended summary care record** to 15% and improve the functionality of e-SCR by December 2018. • Implement a **proprietary appointment booking system** at particular GP practices, 50% of integrated urgent care services and 50% of UTCs by May 2018, supported by improved technology and clear appointment booking standards issued by December 2018. • Continue to rollout the **seven-day services four priority clinical standards to five specialist services** (major trauma, heart attack, paediatric intensive care, vascular and stroke) and the **seven-day services four priority clinical standards in hospitals** to 50% of the population.

5. Transforming Care for People with Learning Disabilities

Overall Goals for 2017-2019

Our goal is to transform the treatment, care and support available to people of all ages with a learning disability, autism or both so that they can lead longer, happier, healthier lives in homes not hospitals.

Progress in 2017/18

- 22% increase in the number of **annual health checks** delivered by GPs to improve access to community alternatives to hospital and tackle premature mortality.
- New and expanded **community teams** to support people with a learning disability at risk of admission to hospital, backed by £10 million transformation funding.
- **6% reduction in inappropriate hospitalisation** of people with a learning disability, autism or both, between March and November 2017, totalling a 14% reduction since March 2015. In addition, over 100 people previously in hospital for 5 years or more were discharged between March and November 2017.
- Tackling **premature mortality** by beginning to systematically review and learn from deaths of patients with learning disabilities by March 2018.

Deliverables for 2018/19

All Transforming Care Partnerships (TCPs), CCGs and STPs are expected to:

- Continue to **reduce inappropriate hospitalisation** of people with a learning disability, autism or both, so that the number in hospital reduces at a national aggregate level by 35% to 50% from March 2015 by March 2019. As part of achieving that reduction we expect CCGs and TCPs to place a particular emphasis on making a substantial reduction in the number of long-stay (5 year+ inpatients).
- Continue to improve access to healthcare for people with a learning disability, so that the number of people receiving an **annual health check** from their GP is 64% higher than in 2016/17. CCGs should achieve this by both increasing the number of people with a learning disability recorded on the GP Learning Disability Register, and by improving the proportion of people on that register receiving a health check.
- Make further investment in **community teams** to avoid hospitalisation, including through use of the £10 million transformation fund.
- Ensure more **children with a learning disability**, autism or both get a community Care, Education and Treatment Review (CETR) to consider other options before they are admitted to hospital, such that 75% of under 18s admitted to hospital have either had a pre-admission CETR or a CETR immediately post admission.

	• Continue the work on tackling **premature mortality** by supporting the review of deaths of patients with learning disabilities, as outlined in the National Quality Board 2017 guidance.

6. Maternity

Overall Goals for 2017-2019 Continue to make maternity services in England safer and more personal through the implementation of the *Better Births.*	
Progress in 2017/18 • Continuing the year on year **safety improvements** to maternity services including, since 2010, a 16% reduction in stillbirths, 10% reduction in neonatal mortality and 20% reduction in maternal deaths. • Seven maternity 'early adopters' established covering 125,000 births a year to implement specific elements of *Better Births* and service improvements. Pilots of **continuity of carer** established to over 3,000 women. • 44 **Local Maternity Systems** established bringing together commissioners, providers and service users to lead and deliver transformation of maternity services in every part of the country. • We will exceed the planned goal of 2,000 more women receiving **specialist perinatal care** in 2017/18, with over 5,000 additional women accessing these services between April and December 2017. Four new mother and baby units also funded.	**Deliverables for 2018/19** • Deliver improvements in **safety** towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025, including full implementation of the Saving Babies Lives Care Bundle by March 2019. • Increase the number of women receiving **continuity** of the person caring for them during pregnancy, birth and postnatally, so that by March 2019, 20% of women booking receive continuity. • Continue to increase access to **specialist perinatal mental health services,** ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%. • By June 2018, agree trajectories to improve the **safety, choice and personalisation** of maternity.

N.B. This is not a comprehensive list of ‘Next Steps’ deliverables for 2018/19, simply an ‘aide memoire’ covering these service improvement areas. CCGs and STPs should also continue to work to reduce inequalities in access to services and in people’s experiences of care.

Annex 2: Transformation Funding Package

Lancashire and South Cumbria		
INDICATIVE FIGURES (£m's)		
ICS Transformation Funding	**2018/19**	**Requirements/notes**
1. Committed programme transformation funds		
General Practice Forward View		
- Access	8.37	Delivery of GPFV Access requirements
- Training Care Navigators	0.30	Funded from core Primary Care allocations for 2018/19 only
- Online Consultations	0.58	Funded from core Primary Care allocations for 2018/19 only
- Practice Resilience	0.24	Based on a Fair share % per registered patient applied as per the Primary Care team guidance
- Clinical Pharmacists 2	0.34	Delivery of GPFV requirements
- ETTF	2.05	Capital and revenue funds
Other Programmes		
Mental Health	2.04	Tied to delivery of mental health requirements on IPS, Suicide, Perinatal, Liaison and CYP
Diabetes	1.28	Diabetes Next Steps FYFV objectives
Cancer	3.25	Indicative value for the ICS (from Cancer Alliance funds) to deliver the Cancer strategy
Maternity	0.62	Maternity Next Steps FYFV objectives
UEC	0.57	Indicative figures to be confirmed by the UEC team
STP infrastructure	0.31	STP infrastructure support - only applicable to ICS areas co-terminus with STPs
Sub Total	**19.95**	
2. Uncommitted funds		
Uncommitted Funds	6.44	Released on acceptance of governance information and subject to acceptance of the incentive option. Used to deliver national priorities £1 per head population notionally allocated to primary care network development.
TOTAL	**26.39**	

Annex 3: Organisation control total and Provider Sustainability Funding agreement for 2018/19

Lancashire and South Cumbria
Shadow

Table 1: Organisation control total and Provider Sustainability Funding allocations

Org Name	Included in SCT	Control Total (excl. PSF) (£000s)	PSF Allocation (£1.8bn) (£000s)	PSF Allocation (£650m) (£000s)	Total PSF Allocation (£000s)
NHS Blackburn with Darwen CCG	100%	0	-	-	-
NHS Blackpool CCG	100%	0	-	-	-
NHS Chorley & South Ribble CCG	100%	0	-	-	-
NHS East Lancashire CCG	100%	(1,380)	-	-	-
NHS Fylde & Wyre CCG	100%	0	-	-	-
NHS Greater Preston CCG	100%	0	-	-	-
NHS Morecombe Bay CCG*	100%	(4,000)	-	-	-
NHS West Lancashire CCG	100%	0	-	-	-
CCG Subtotal		**(5,380)**	**0**	**0**	**0**
Blackpool Teaching Hospitals NHS Foundation Trust	100%	(10,541)	4,675	1,900	6,575
East Lancashire Hospitals NHS Trust	100%	(15,798)	5,725	2,325	8,050
Lancashire Care NHS Foundation Trust	100%	(3,879)	1,564	635	2,199
Lancashire Teaching Hospitals NHS Foundation Trust	100%	(16,916)	11,292	4,587	15,879
North West Ambulance Service NHS Trust	26%	(152)	448	182	630
University Hospitals of Morecambe Bay NHS Foundation Trust	100%	(48,423)	8,834	3,589	12,423
Provider Subtotal		**(95,709)**	**32,538**	**13,218**	**45,756**

**CCG eligible for CSF*

Table 2: Quarterly phasing of the control total and Provider Sustainability Funding by type for each organisation

Org Name		Q1 (£000s)	Q2 (£000s)	Q3 (£000s)	Q4 (£000s)	2018/19 Total (£000s)
Blackpool Teaching Hospitals NHS Foundation Trust	CT	(6,495)	(3,173)	(1,181)	308	**(10,541)**
	Trust A&E PSF	296	395	592	690	**1,973**
	Trust Finance PSF	690	921	1,381	1,611	**4,603**
	Total PSF	**986**	**1,315**	**1,973**	**2,301**	**6,575**
East Lancashire Hospitals NHS Trust	CT	(4,843)	(2,981)	(3,786)	(4,188)	**(15,798)**
	Trust A&E PSF	362	483	725	845	**2,415**
	Trust Finance PSF	845	1,127	1,691	1,972	**5,635**
	Total PSF	**1,208**	**1,610**	**2,415**	**2,818**	**8,050**
Lancashire Care NHS Foundation Trust	CT	(2,355)	(896)	(504)	(125)	**(3,879)**
	Trust Finance PSF	330	440	660	770	**2,199**
	Total PSF	**330**	**440**	**660**	**770**	**2,199**
Lancashire Teaching Hospitals NHS Foundation Trust	CT	(6,616)	(5,131)	(1,113)	(4,056)	**(16,916)**
	Trust A&E PSF	715	953	1,429	1,667	**4,764**
	Trust Finance PSF	1,667	2,223	3,335	3,890	**11,115**
	Total PSF	**2,382**	**3,176**	**4,764**	**5,558**	**15,879**
North West Ambulance Service NHS Trust	CT	84	(5)	(124)	(107)	**(152)**
	Trust Finance PSF	94	126	189	220	**630**
	Total PSF	**94**	**126**	**189**	**220**	**630**
University Hospitals of Morecambe Bay NHS Foundation Trust	CT	(11,192)	(11,526)	(11,819)	(13,886)	**(48,423)**
	Trust A&E PSF	559	745	1,118	1,304	**3,727**
	Trust Finance PSF	1,304	1,739	2,609	3,044	**8,696**
	Total PSF	**1,863**	**2,485**	**3,727**	**4,348**	**12,423**

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 113

14 November 2018

Purpose Information Assurance

Title	Integrated Performance Report
Author	Mr M Johnson, Associate Director of Performance and Informatics
	Mr J Bannister, Director of Operations
Executive sponsor	

Summary: This paper presents the corporate performance data at September 2018

Recommendation: Members of Finance are Performance Committee are requested to note the attached report for assurance.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do 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 their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework.

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

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: Finance and Performance Committee (October 2018)

Board of Directors, Update

Corporate Report

Executive Overview Summary

No never events were reported during September 2018. A total of six incidents were reported to StEIS during the period.

One clostridium difficile infection was detected during September, which is below trajectory for the month. No MRSA during September.

Nursing and midwifery staffing in September 2018 continued to be a challenge, although slightly improved on last month. 11 areas fell below an 80% average fill rate for registered nurses on day shifts.

HSMR remains 'better than expected' and the SHMI is 'as expected'.

The Emergency Care 4 hour standard remains below the 95% threshold at 81.2%.

The proportion of delayed discharges has increased to 3.9% and remains above the 3.5% threshold.

The number of ambulance handovers over 30 minutes decreased during September, despite an increase in average handover time. The HAS compliance remained above the threshold.

There were 19 mental health breaches of the 12 hour trolley wait standard in September, all as a result of waits for mental health beds within Lancashire Care Foundation Trust.

The 6wk diagnostic target was met in September at 0.9%

The number of operations cancelled on the day increased in September, however there were no breaches of the 28 day standard. 2 breaches were reported for August.

The Referral to Treatment (RTT) target was again achieved at 92.1% above the 92% standard.

There were no breaches of the 52wk standard at the end of September.

The cancer 62 day target was not met during August at 82.4% and the breast symptomatic 2 week standard was below target at 86.8%, however the GP 2 week and 31 day standards were achieved.

Sickness rates are above threshold (5.0%) and remain higher than last year (4.6%)

The vacancy rate reduced to 7.8% in September and remains above threshold and above

last year (7.1%).

Compliance against the Information Governance Toolkit remains below threshold as well as Trust appraisal rates (AFC staff). All other areas of core skills training are above threshold.

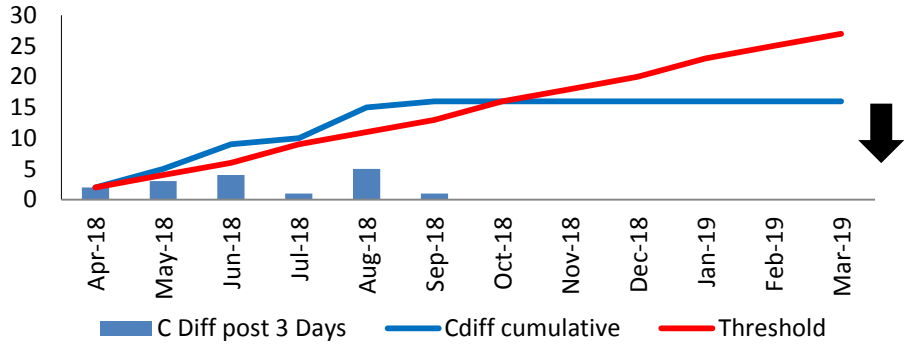
The revised 2018/19 underlying control total for the Trust of a £15.798million deficit has been met for the first six months of 2018/19, with a deficit of £7.823million reported, and a £5.852million deficit after Provider Sustainability Funding (PSF) of £1.971million.

Introduction

This report presents an update on the performance for April - September 2018 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.

SAFE

C Difficile

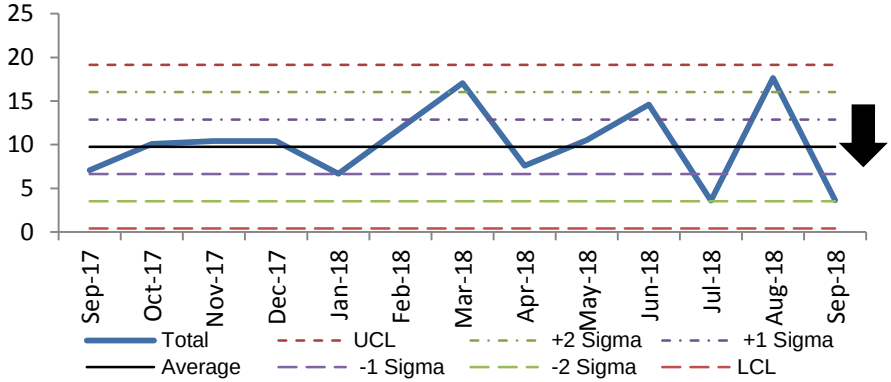


There were no post 2 day MRSA infections reported in September. Year to date there has been 1 case attributed to ELHT.

There was one Clostridium difficile toxin positive isolates identified in the laboratory in September which was post 3 days of admission.

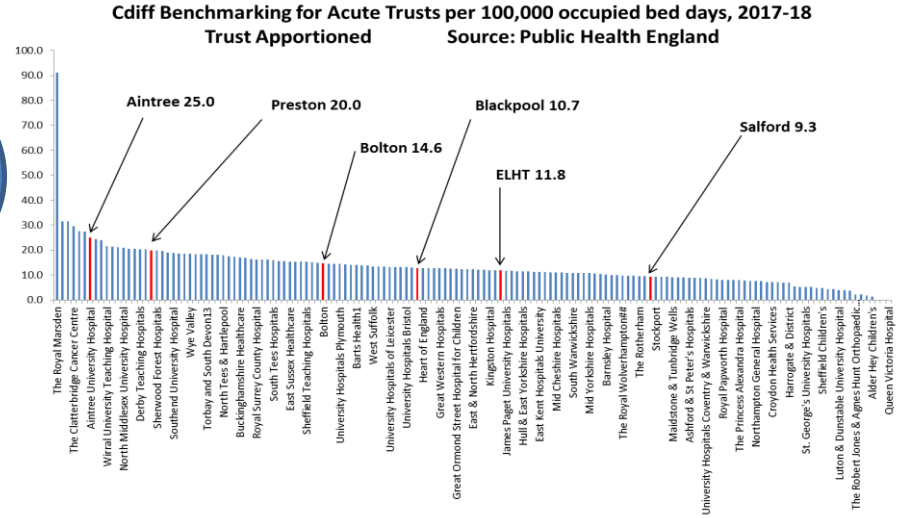
The year to date cumulative figure is 16 against the trust target of 27. The detailed infection control report will be reviewed through the Quality Committee.

C Difficile per 100,000 occupied bed days



The rate of infection per 100,000 bed days decreased in September to 3.6, below average.

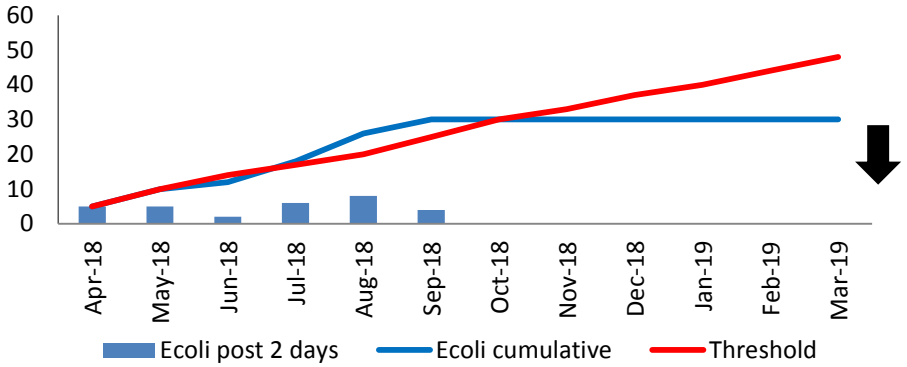
C Difficile benchmarking



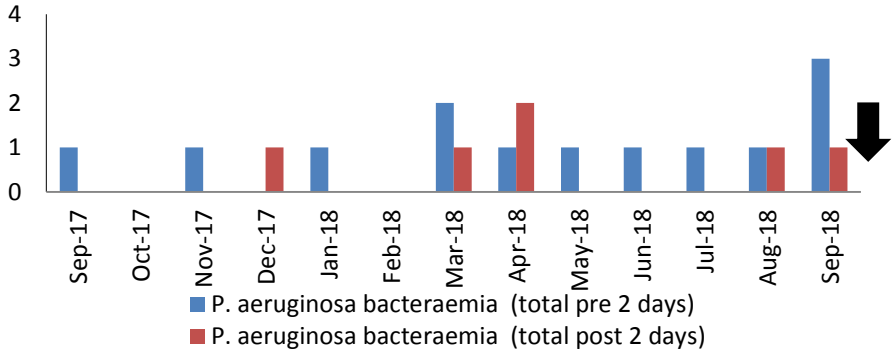
ELHT ranked 71st out of 151 trusts in 2017-18 with 11.8 clostridium infections per 100,000 bed days. The best performing trust had 0 and the worst performer had 91 infections per 100,000 bed days.

SAFE

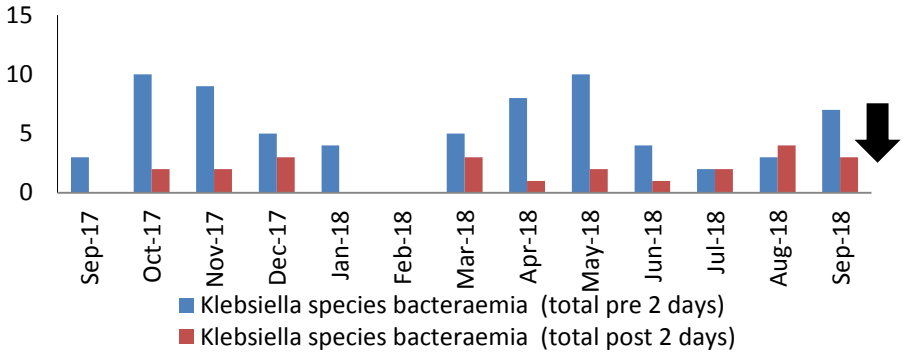
E. Coli



P.aeruginosa



Klebsiella



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

One of the first priorities is reducing E.coli BSI which account for 55% of all BSI nationally. In 2017/18, the Trust achieved the target 10% reduction.

This year we should have no more than 48 E. coli bacteraemia.

There were four E.coli bacteraemia detected in September, which is below the monthly threshold.

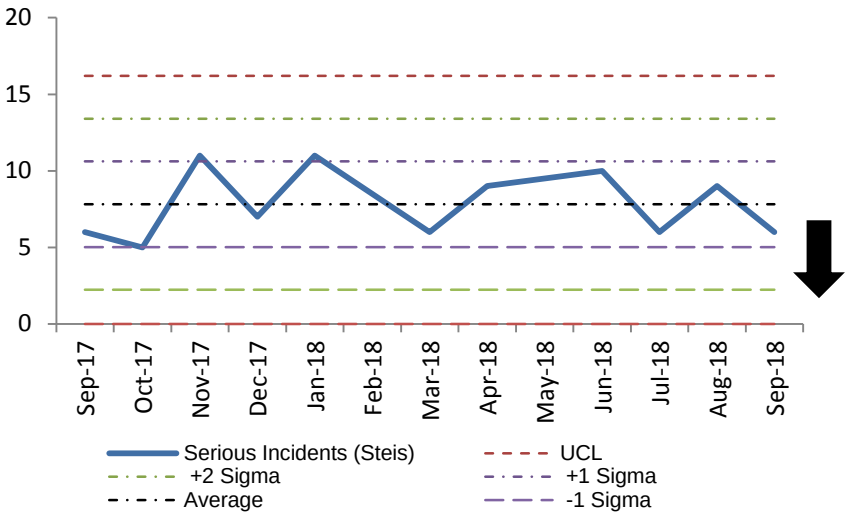
From April 2017, NHS Trusts must report cases of bloodstream infections due to *Klebsiella species* and *Pseudomonas aeruginosa* to Public Health England.

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

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

SAFE

Serious Incidents

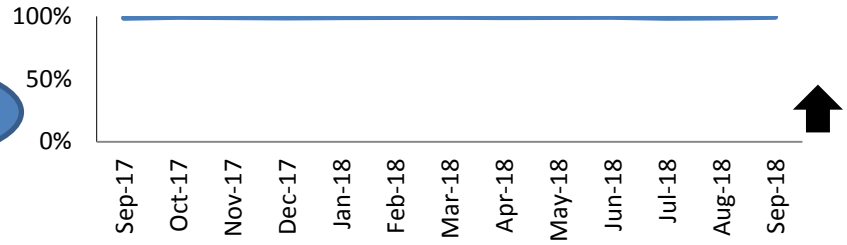


There were no never events reported in September.

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

StEIS Category	No. Incidents
Sub optimal care of deteriorating patient	3
Slips Trips Falls	2
Maternity/ Obstetrics	1

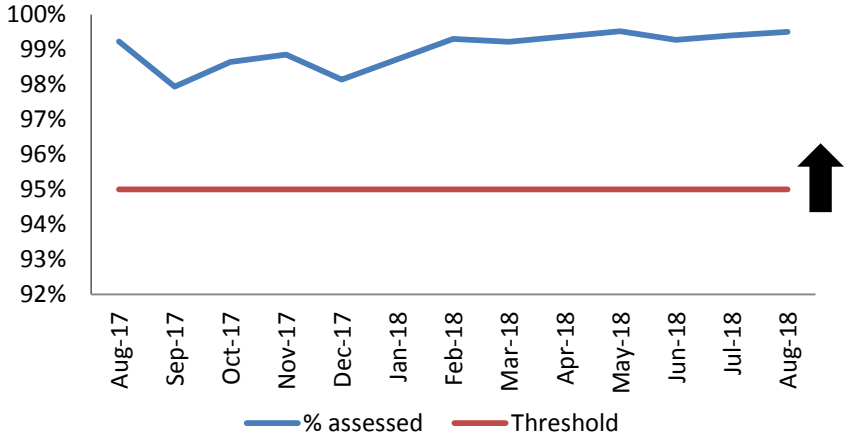
% Harm Free



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

The Trust remains consistent with the percentage of patients with harm free care at 99.6% for September using the National safety thermometer tool.

VTE assessment

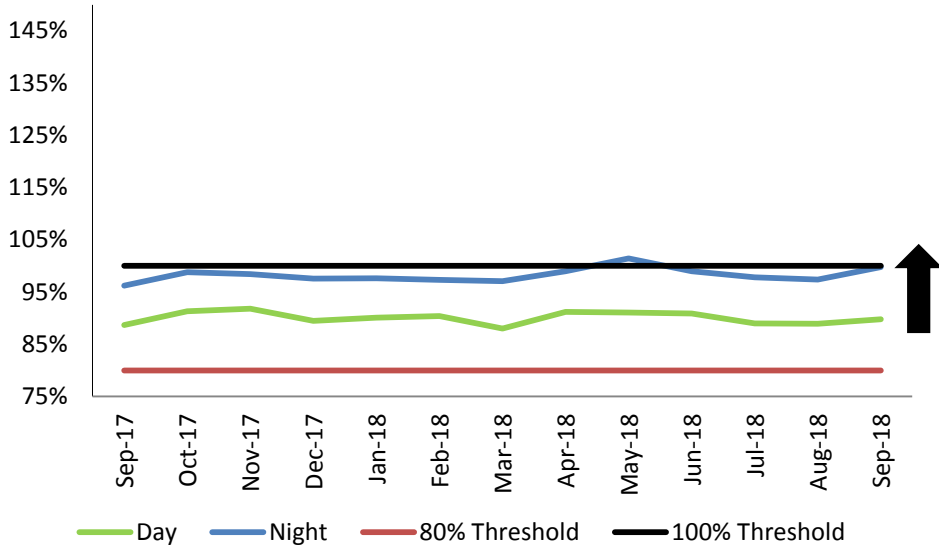


For September we are reporting the current pressure ulcer position, pending investigation, as follows:

Pressure Ulcers	Hospital Aquired	Community Aquired
Grade 2	5	0
Grade 3	3	0
Grade 4	0	0

SAFE

Registered Nurses/ Midwives



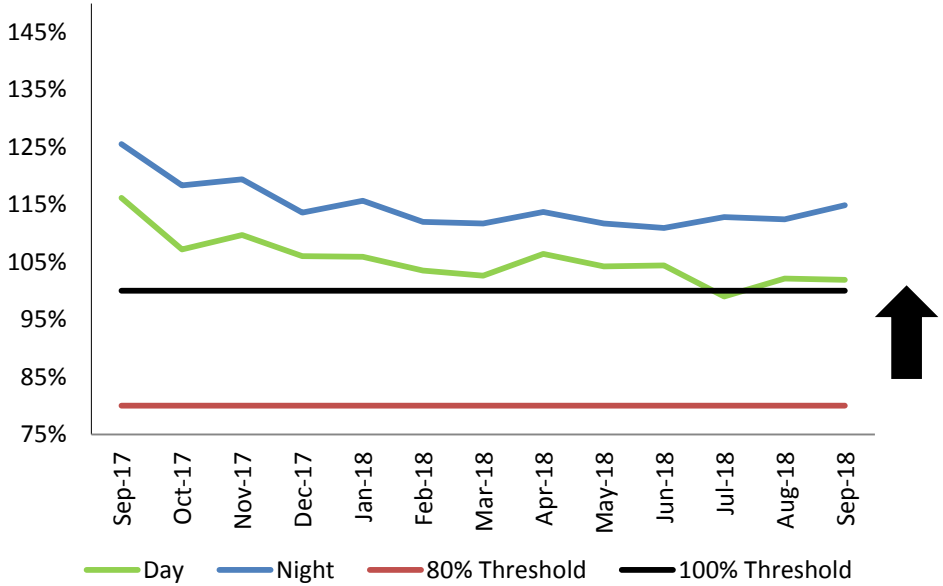
Nursing and midwifery staffing in September 2018 continued to be a challenge. 11 areas fell below an 80% average fill rate for registered nurses on day shifts which is a slight improvement on last month. Within the family care division no wards fell below the 80% threshold for RM's or RN's on day shifts.

The causative factors remain as in previous months, compounded by escalation areas being opened, pressures within the emergency department, vacancies and sickness. Registered nurse allocation on arrival shifts continue to prove challenging to fill for the reasons previously discussed.

Of the 11 areas below the 80% for registered nurses on day shifts, all were due to lack of co-ordinator presence which is above safe staffing levels.

In addition to the above, 2 wards within ICG fell below the 80% threshold for Clinical Support Workers' (C2 & C4) on day shifts and 1 in family care (children ward). However, this risk was mitigated as both wards in ICG are currently hosting trainee nursing associates and the children's ward is constantly risk assessed regarding acuity and bed occupancy.

Care Staff



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

SAFE

Average Fill Rate

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
Month	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff
Sep-18	89.8%	101.9%	99.8%	114.9%	26,649	8.43	11	3	0	0

Red Flag Incidents

There were no red flag incidents reported on the in-patient wards/units in the ICG & SAS division. However, two areas which are classed as outpatient areas for the purpose of this report (ward 6 & respiratory assessment unit) reported a red flag incident each (less than 2 registed nurses on duty). Neither unit reported any associated harms as a result of these red flag incidents.

Actions taken:

- Extra allocation on arrival shifts continue to be booked to meet the demand at the time
- Safe staffing conference at 10 am followed up with meetings through out the day where required to ensure safe staffing, with contingencies agreed for weekends and out of hours.
- Extra health care assistant shifts are utilised to support registered nurse gaps if required
- On going active recruitment.
- The Trust has engaged with Health Education England (HEE) to work collaboratively with the Global Learners Programme. 25 offers of employment have recently been given, with approximately 6 registered nurses due to arrive in the next few months and another 5 awaiting their decision letter from the NMC
- The Trust has agreed to recruit a further 20 trainee nursing associates.
- The staffing templates will change over the coming months to reflect the roll out of the 12 hour shift pattern, some differences may be noticed in respect of actual and planned hours as a consequence, potentially from August/September

Family Care

Maternity

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Staffed to full Establishment	01:29.9	01:28.7	01:30.0	01:29	01:28.7	01:28.6	01:29	01:28.2	01:28.7	01:29.2	01:29	01:27
Excluding mat leave and vacancies	01:31.1	01:30.1	01:31.1	01:30.2	1:29.9 9.21wte on maternity leave	1:29.84	01:30	01:29.3	01:29.9	01:30.8	01:30	01:28.4
With gaps filled through ELHT Midwife staff bank	01:29.8	01:29.2	01:30.1	01:28.3	01:28.7	01:28.5	01:28.4	01:28.5	01:28.8	01:29.4	01:29	01:27
	Bank usage 9.10 WTE		Bank usage 6.43 WTE	Bank usage 10.04 WTE		Bank usage 9.59 WTE	Bank usage 10.4 WTE	Bank usage 6.35 WTE	Bank Usage 7.9 WTE	Bank Usage 9.5 WTE	Bank Usage 9.28 WTE	Bank Usage 9.5 WTE

The staffing figures do not reflect how many women were in labour or acuity of areas.
The midwife to birth ratio should be 1:28

Red Flag Staffing Events
On reviewing Datix 4 incidents were reported overall as Red Flag events in Family Care Division in September
Of the 4 incidents reported 3 of them occurred within Maternity Services and related to staffing issues on Central Birth Suite.
Of these 4 incidents reported 1 has been excluded as it related to medical staffing and an issue with the response to a bleep.
The incidents were reported under the following category and sub-categories:

Maternity Services - 3
• 3 staffing issue – staff shortage midwives. *No harm, impact prevented*.

No harm was caused as a result of these incidents

There was appropriate escalation and implementation of the escalation policy when acuity and activity was high. Workload was prioritised and staff moved to the areas with the highest workload. All area leads, shift co-ordinators were informed of plans and communication was excellent throughout.

Maternity

Where the midwife staffing levels are not at the maximum levels, staff are rotated dependent on acuity and services diverted to other areas of maternity to maintain safety at all times. This is completed formally as part of safety huddles within a 24 hour period with interim or point prevalent huddles if required. Acuity and activity are assessed four times daily with a multi professional team being part of the safety huddles on Central Birth Suite, the huddles assess the whole picture across maternity services at ELHT and staff with relevant skills and competencies are moved accordingly to ensure safe staffing throughout the services.

NICU

Nurse staffing levels for the acuity are monitored throughout the day and if acuity changes shift are put out to bank and agency to fill the gaps to ensure safe staffing and where necessary the unit closed to external admissions to maintain safety. There has been a steady decrease in the amount of agency nurses to cover gaps in staffing.

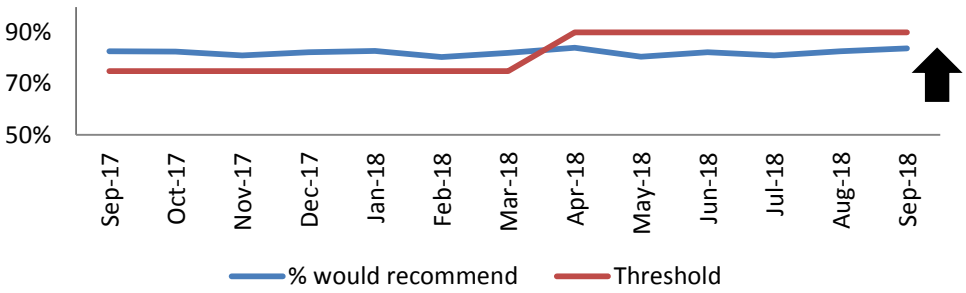
Paediatrics

Activity and acuity are closely monitored and recorded 3 times throughout the day on safe staffing.

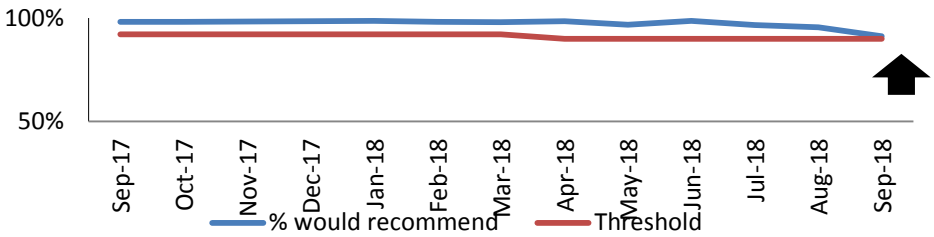
Please see Appendix 2 for UNIFY data and nurse sensitive indicator report

CARING

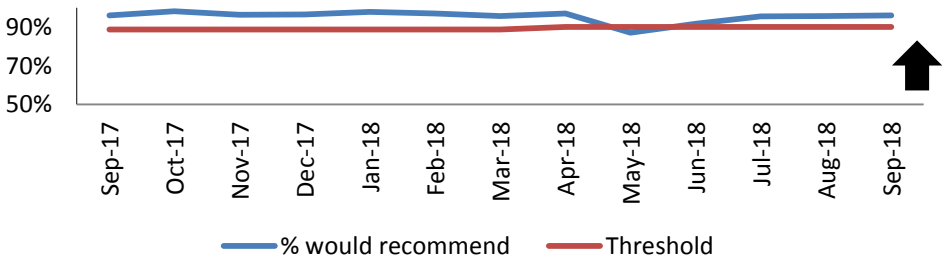
Friends & Family A&E



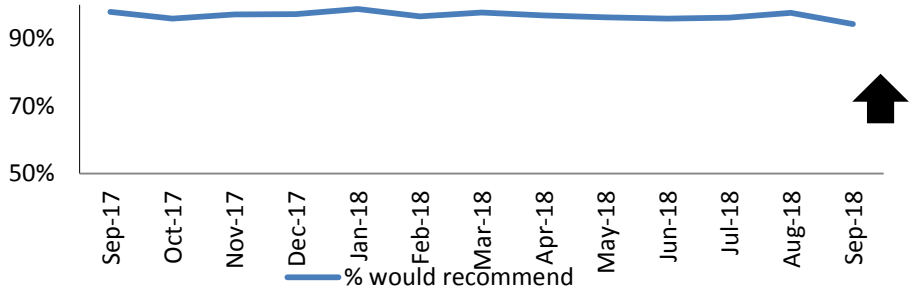
Friends & Family Inpatient



Friends & Family Community



Friends & Family Maternity



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

The proportion that would recommend A&E to friends and family has increased in September to 83.9% with a response rate of 22.9%

The proportion that would recommend inpatient services has decreased but remaina above threshold at 91.2% in September. The response rate was 47.9%

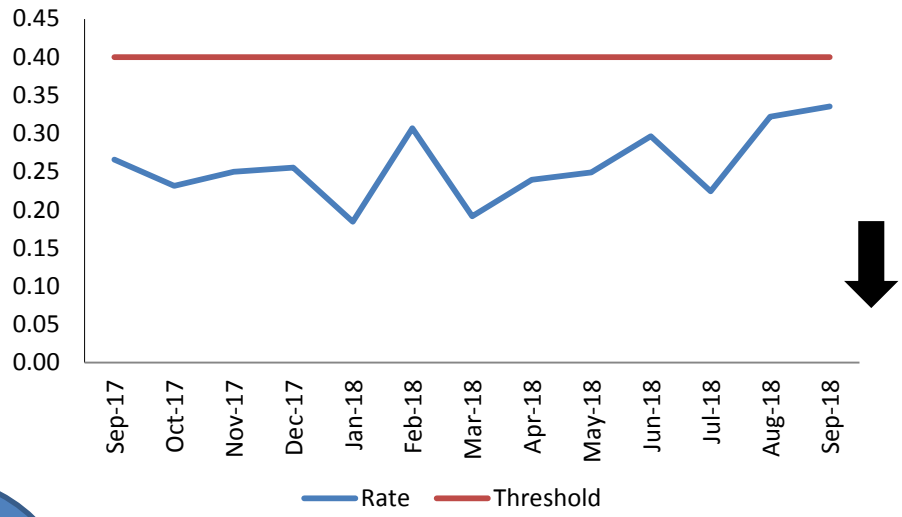
Community services would be recommended by 96.0% in September.

Maternity services would be recommended by 94.3% in September.

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

CARING

Complaints per 1000 contacts



The Trust opened 37 new formal complaints in September. The number of complaints closed was 31.

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

For September the number of complaints received was 0.34 Per 1,000 patient contacts.

Patient Experience

From 1st May 2018 the Trust has been working with Healthcare Communications Envoy to provide the Friends and Family Test (FFT) and survey services via one system.

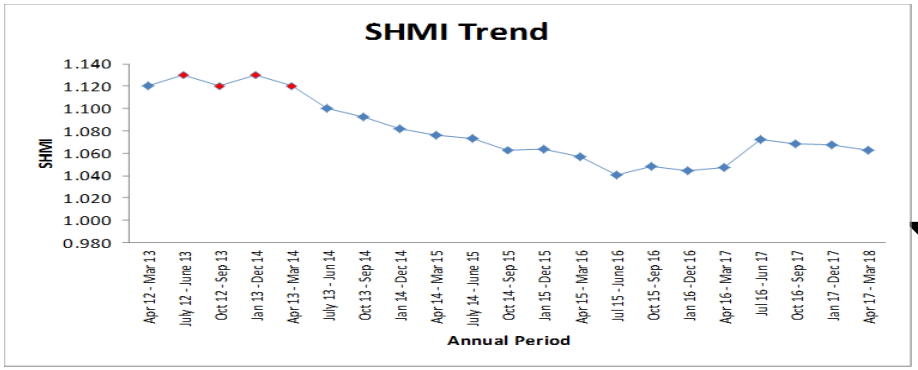
All local surveys have now been created and staff are inputting completed surveys onto the Envoy system.

Competency score performance linked to each survey will require configuration and Envoy have raised a system enhancement request to undertake this task. Until competencies and scoring are added to each survey, competency score data is not available.

Envoy will provide updates on this functionality to the Patient Experience Team.

EFFECTIVE

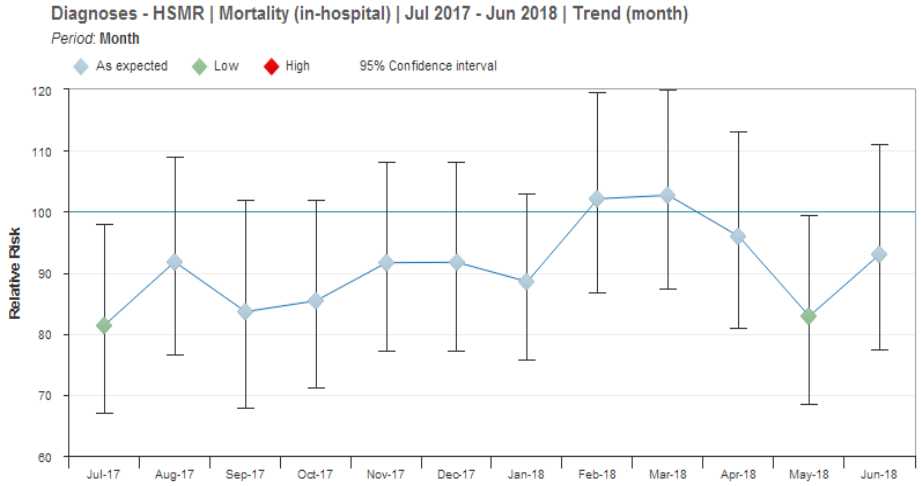
SHMI Published Trend



Dr Foster Indicative HSMR

	DFI Rebased on latest month July 17 – June 18 (Risk model Mar 18)
TOTAL	91.1 (CI 86.7 – 95.7)
Weekday	91.1 (CI 86.0 – 96.4)
Weekend	91.2 (CI 82.6 – 100.5)
Deaths in Low Risk Diagnosis Groups	57.6 (CI 29.8 – 100.7)

Dr. Foster Indicative HSMR monthly Trend



The latest Trust SHMI value as reported by the Health and Social Care Information Centre and Care Quality Commission for the period April 17 to March 18 has improved slightly to 1.063 and is still within expected levels, as published in September 2018.

The latest indicative 12 month rolling HSMR (July 17 – June 18) is reported as 'significantly better than expected' at 91.1 against the monthly rebased risk model.

The weekday and weekend HSMRs are also 'significantly better than expected'

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

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

Two learning disability deaths were reviewed through the Learning Disability Mortality Review Panel in July. All cases have been reported to the LeDeR National Programme. The LDMR Panel continue to meet on a monthly basis as required to review cases.

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

EFFECTIVE

Structured Judgement Review Summary

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

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

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

	Month of Death													
Stage 1	pre Oct 17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	TOTAL
Deaths requiring SJR (Stage 1)	47	50	37	28	34	29	30	30	25	25	27	20	28	410
Allocated for review	42	50	37	27	32	26	22	15	10	5	13	6	0	285
SJR Complete	41	49	32	25	23	18	13	9	6	3	8	0	0	227
1 - Very Poor Care	2	0	0	1	0	0	0	0	0	0	0	0	0	3
2 - Poor Care	7	4	4	3	4	1	0	1	1	2	1	0	0	28
3 - Adequate Care	13	16	8	10	5	7	6	1	0	0	3	0	0	69
4 - Good Care	16	25	18	9	14	10	5	7	4	1	4	0	0	113
5 - Excellent Care	3	4	2	2	0	0	2	0	1	0	0	0	0	14
Stage 2														
Deaths requiring SJR (Stage 2)	9	4	4	4	4	1	0	1	1	2	1	0	0	31
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	0	1	1	0	0	0	0	0	0	0	0	0	5
Allocated for review	5	4	3	3	4	1	0	0	1	2	1	0	0	24
SJR-2 Complete	5	4	3	3	4	0	0	0	0	1	0	0	0	20
1 - Very Poor Care	1	0	0	0	1	0	0	0	0	0	0	0	0	2
2 - Poor Care	3	1	2	1	1	0	0	0	0	0	0	0	0	8
3 - Adequate Care	1	3	1	2	2	0	0	0	0	1	0	0	0	10
4 - Good Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5 - Excellent Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	pre Oct 17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Total
stage 1 requiring allocation	5	0	0	1	2	3	8	15	15	20	14	14	28	125
stage 1 requiring completion	1	1	5	2	9	8	9	6	4	2	5	6	0	58
Backlog	6	1	5	3	11	11	17	21	19	22	19	20	28	183
stage 2 requiring allocation	0	0	0	0	0	0	0	1	0	0	0	0	0	1
stage 2 requiring completion	0	0	0	0	0	1	0	0	1	1	1	0	0	4
Backlog	0	0	0	0	0	1	0	1	1	1	1	0	0	5

Commissioning for Quality and Innovation

EFFECTIVE

in 2018/19 the Trust is participating in the following 5 national CQUIN schemes as agreed with the CSU in 2017/18:

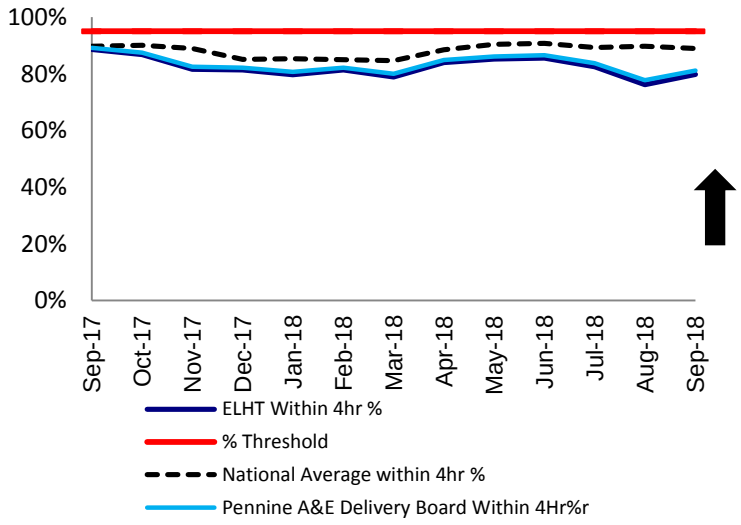
1. NHS Staff Health and Wellbeing
2. Reducing the impact of serious infections
3. Improving services for people with mental health needs who present to A & E
4. Preventing ill health by risky behaviours (2018/2019 only).
5. Personalised care/support planning

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

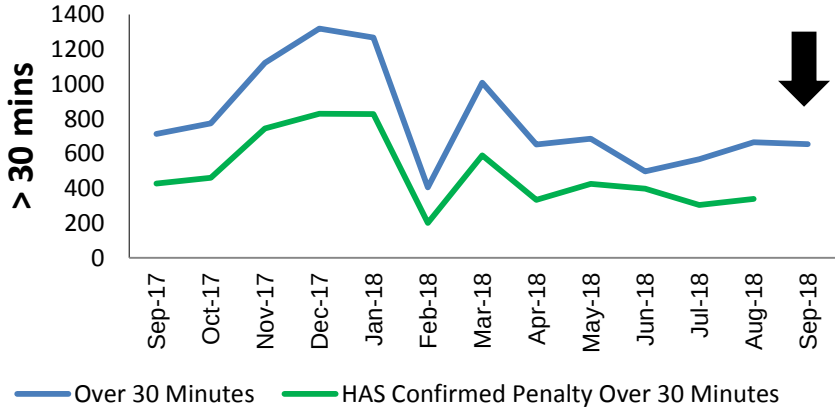
CQUIN Scheme		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Q1	Q2	Q3	Q4
national	**NHS STAFF HEALTH & WELLBEING** - Flu Vaccine Uptake	**75%**																
national	**SEPSIS PART A- IDENTIFICATION**- TOTAL %	**90.0%**	**100.0%**	**100.0%**	**100.0%**										**100%**			
national	**SEPSIS PART B - ANTIBIOTIC ADMINISTRATION - TOTAL %**	**90.0%**	**90.4%**	**93.4%**	**90.6%**										**91.5%**			
national	**SEPSIS PART C - ANTIBIOTIC REVIEW -** % Prescriptions Reviewed within 72 Hrs	**Q1 25% Q2 50% Q3 75% Q4 90%**	**100%**	**100%**	**100%**										**100%**			
national	**REDUCTION IN ANTIBIOTIC CONSUMPTION- PART D**- Total antiobiotic consumption per 1000 admissions	**4845.1**		**5107.3**											5,107			
national	-Antibiotic % Reduction on 2016 baseline	**-2.0%**		**5.4%**											5.4%			
national	- Total consumption of carbapenem per 1000 admissions	**31.9**		**42.1**											42.1			
national	-Carbapenam % Reduction on 2016 baseline	**-3.0%**		**32.2%**											32.20%			
national	- Increase proportion of antiobiotic usage within the Access group of the AWaRe category	***>=55%***		**58.4**											58.4			

RESPONSIVE

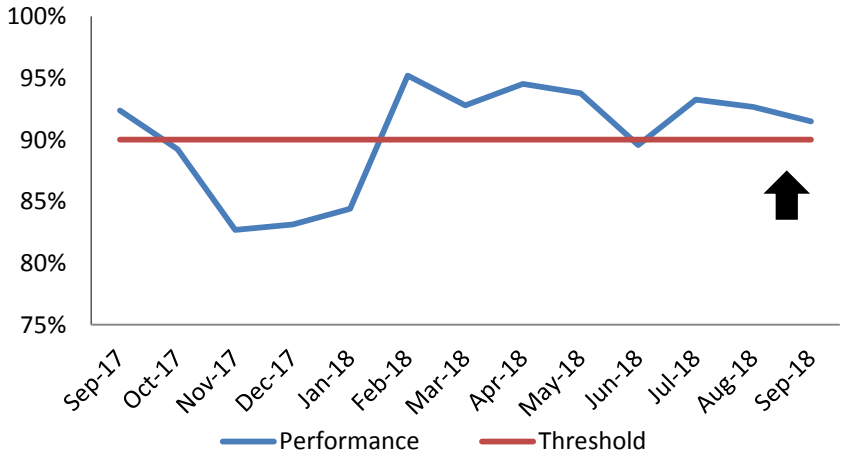
A&E 4 hour standard % performance



Ambulance Handovers



HAS Compliance



Overall performance against the ELHT Accident and Emergency four hour standard improved in September to 79.8%, which remains below the 95% threshold. The performance against the Pennine A&E Delivery Board four hour standard has also improved to 81.2% in September.

The number of attendances during September was 16,088 and of these 13,055 were treated and left the department within 4 hours. (Pennine A&E Delivery Board)

The national performance deteriorated to 88.9% in September (All types) with 18 out of 134 reporting trusts with type 1 departments achieving the 95% standard.

There were 19 reported breaches of the 12 hour trolley wait standard from decision to admit during September. All were mental health breaches. 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 654 for September compared with 665 for August. The average handover time has increased in September to 21:34 minutes from 21:09 minutes in August.

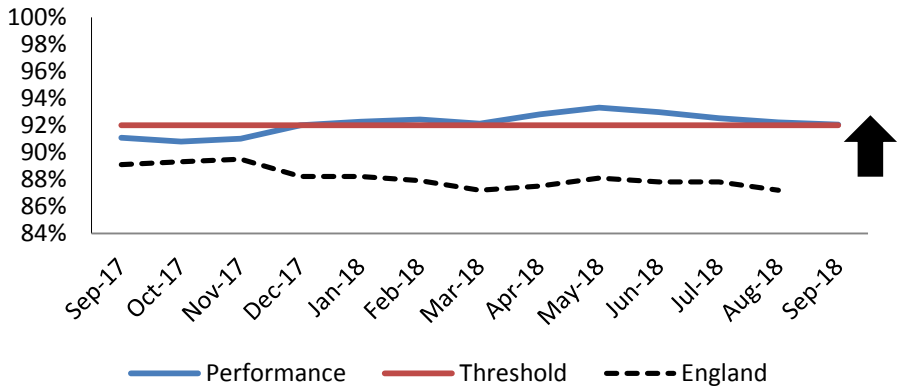
The validated NWAS penalty figures are reported as at August as;- 175 missing timestamps, 286 handover breaches (30-60 mins) and 54 handover breaches (>60 mins).

The ambulance handover compliance indicator measures the compliance with PIN entry on completion of patient handover. This was achieved at 91.5% in September, which is above the 90% threshold.

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

RESPONSIVE

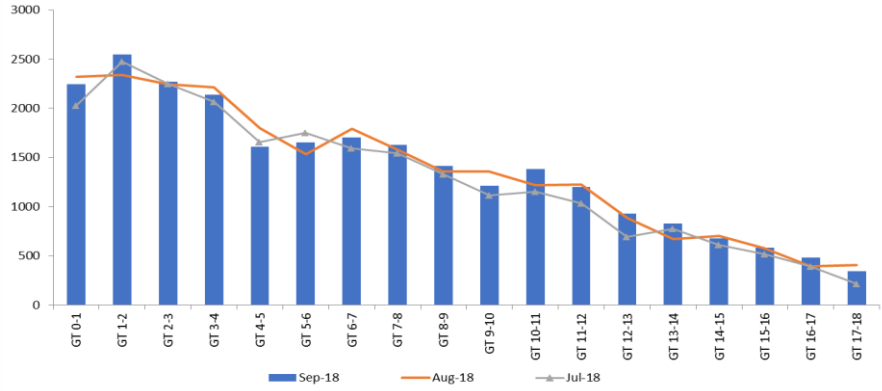
RTT Ongoing



The 18 week referral to treatment (RTT) % ongoing position was achieved in September with 92.1% patients, waiting less than 18 weeks to start treatment at month end.

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

RTT Ongoing 0-18 Weeks



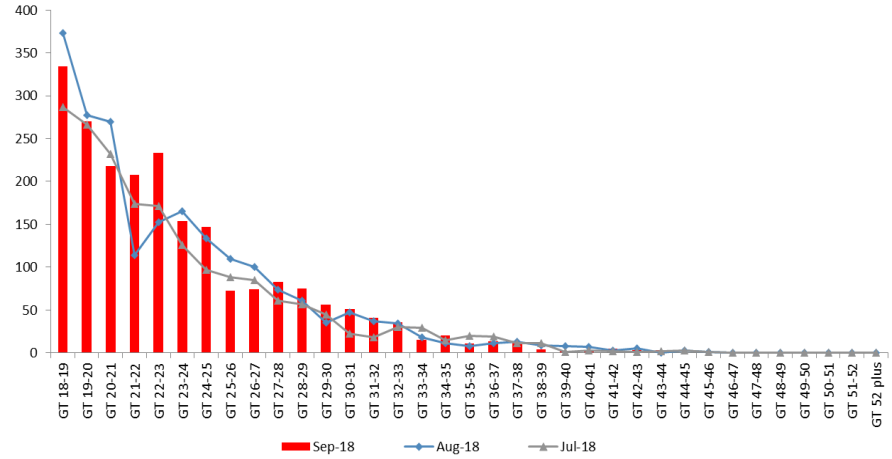
The total number of on-going pathways has increased in September to 26,986 from 26,690 in August.

There has been an increase in patients waiting over 18 weeks at the end of September to 2144 from 2080 in August.

The median wait has increased to 6.8 weeks in September from 6.7 weeks in August.

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

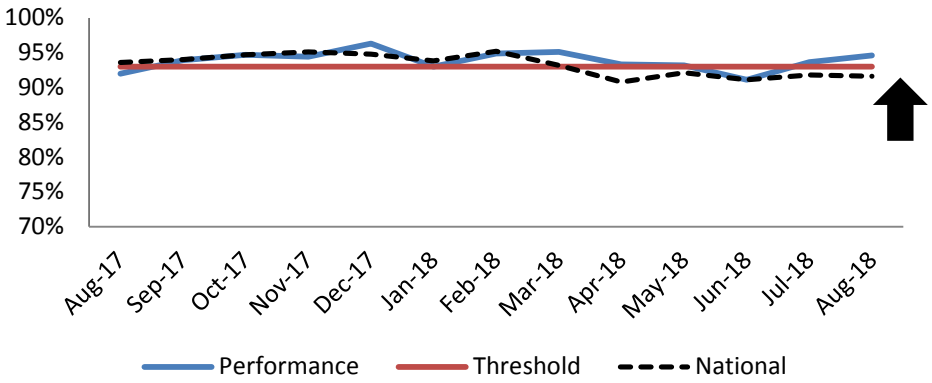
RTT Over 18 weeks



The latest published figures from NHS England show continued failure of the ongoing standard nationally (reported 1 month behind), with 87.2% of patients waiting less than 18 weeks to start treatment in August, compared with 87.8% in July.

RESPONSIVE

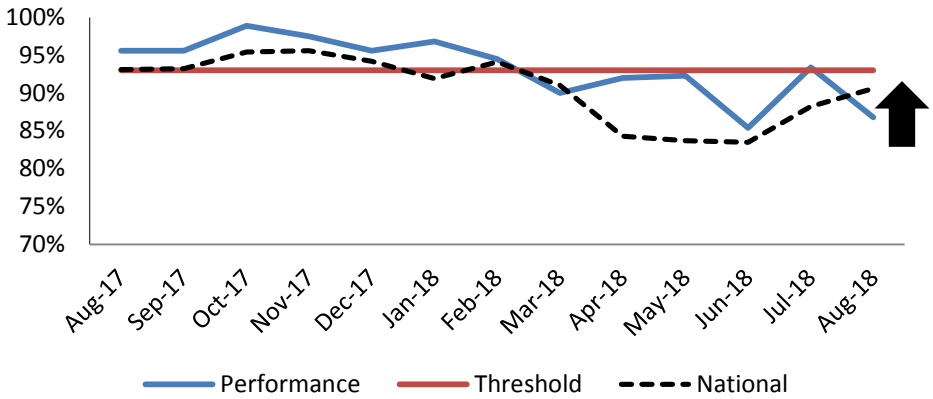
Cancer 2 Week



The cancer 2 week wait for GP referrals standard was achieved in August at 94.6%, above the 93% standard.

National performance remains below the standard in August.

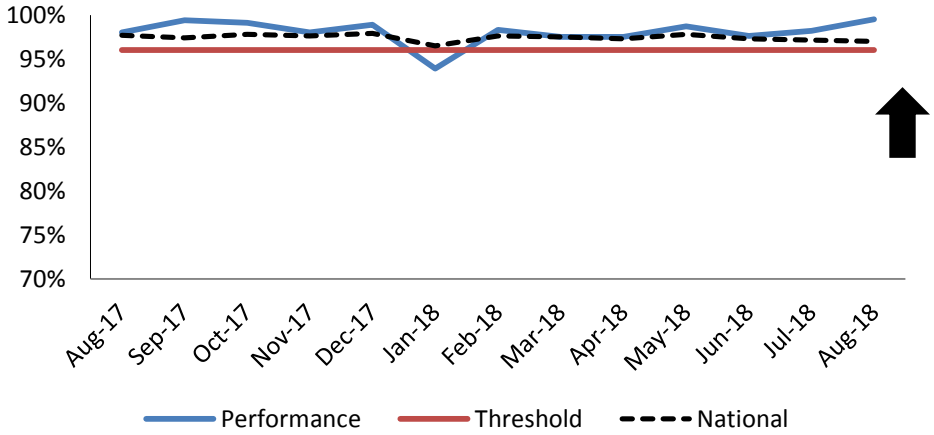
Cancer 2 Week - breast



The 2 week breast symptomatic standard was not achieved in August at 88.6%, below the 93% standard.

National performance remains below the standard in August.

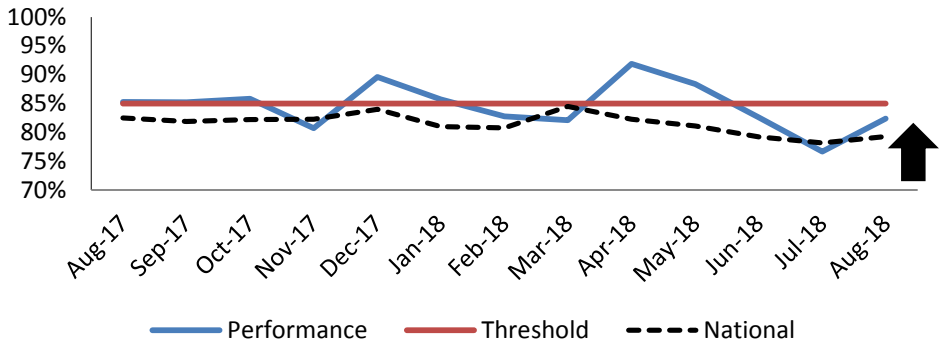
Cancer 31 day



The 31 day target was achieved in August at 99.5%, above the 96% standard.

RESPONSIVE

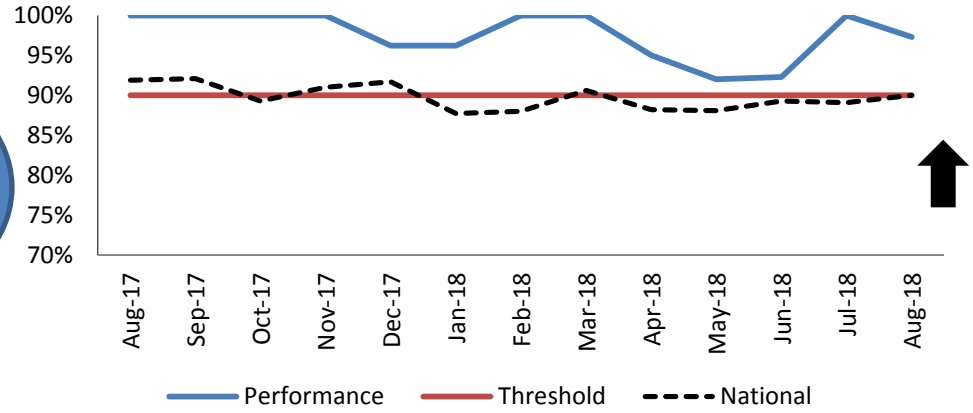
62 Day Cancer



62 day performance was not achieved in August at 82.4%, below the 85% threshold.

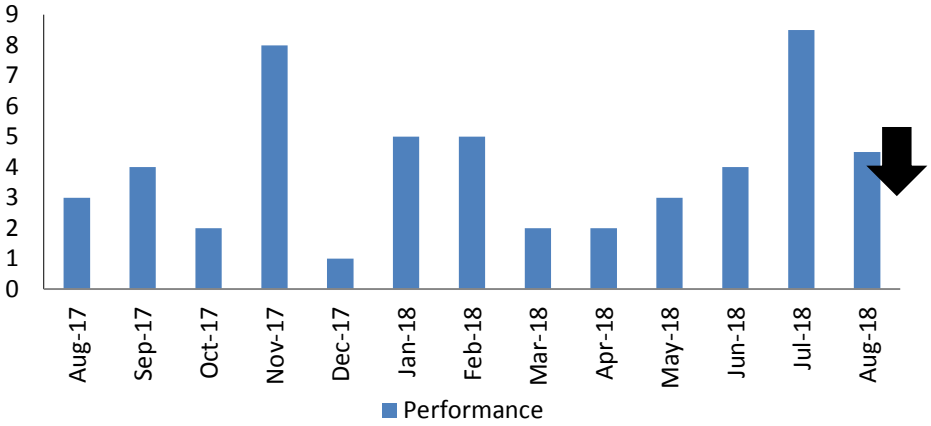
National performance has been consistently below the standard.

62 Day Screening



The 62 day screening standard continued to be achieved in August at 97.3%

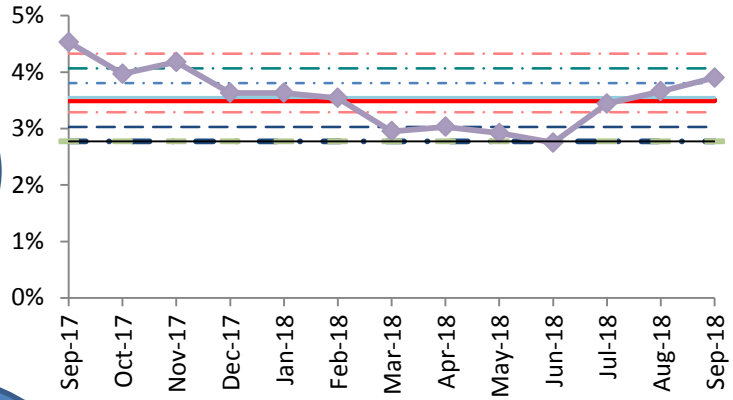
Cancer Patients Treated > Day 104



There were 4.5 breaches allocated to the Trust (7 patients), treated after day 104 in August and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the Consultants involved in the pathway as required.

RESPONSIVE

Delayed Discharges per 1000 bed days

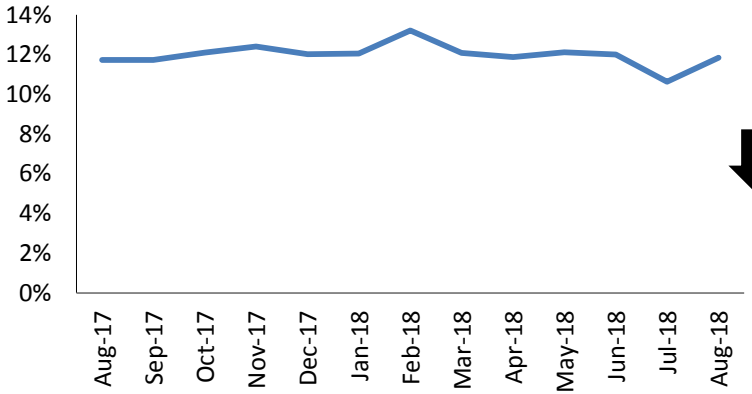


The proportion of delays reported against the delayed transfers of care standard has increased during September to 3.9% which is above the threshold of 3.5%.

This equates to an average of 32 beds lost per day in September. The top three reasons for the bed days lost due to delayed discharge are; 'Awaiting completion of assessment' (28%), 'Awaiting public funding' (23%) 'Patient or Family Choice' (18%). The achievement of this target is multi-factorial, linked to complex discharge processes involving ELHT and partners.

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

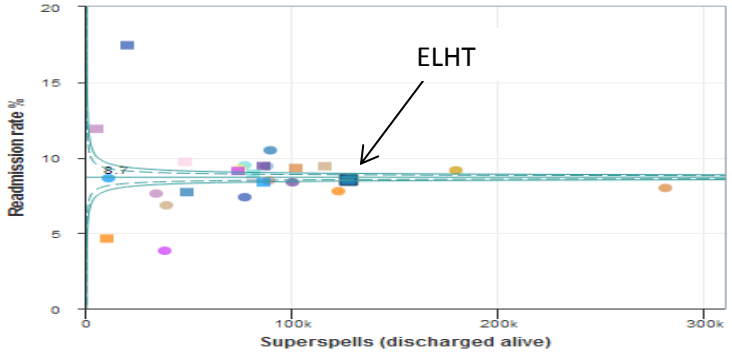
Emergency Readmissions



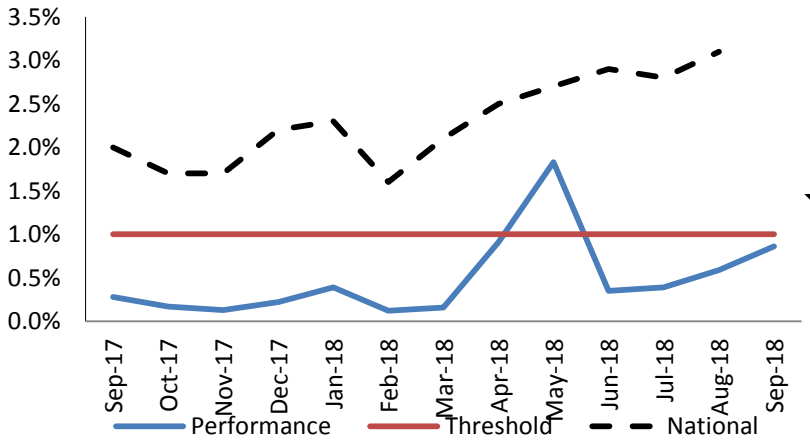
The emergency readmission rate has increased to 11.8% in August 2018 (reported 1 month behind) compared to 11.7% in August 2017.

Dr Foster benchmarking shows the ELHT readmission rate is

Readmissions within 30 days vs North West - Dr Foster
March 2017 - February 2018



Diagnostic Waits



In September 0.9% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is within the 1% threshold. Nationally, the performance is failing the 1% target at 3.1% in August (reported 1 month behind), compared with 2.8% in July.

RESPONSIVE

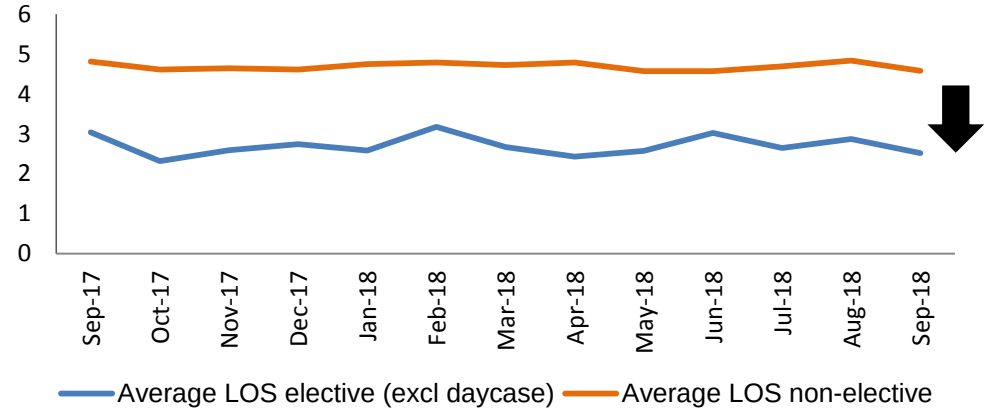
Average Length of Stay Benchmarking

Dr Foster Benchmarking July 17 - June 18

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	61,410	10,037	51,373	3.2	2.6	-0.6
Emergency	54,389	54,389	0	4.5	4.8	0.3
Maternity/ Birth	13,543	13,543	0	2.1	2.4	0.2
Transfer	208	208	0	9.5	26.7	17.1

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

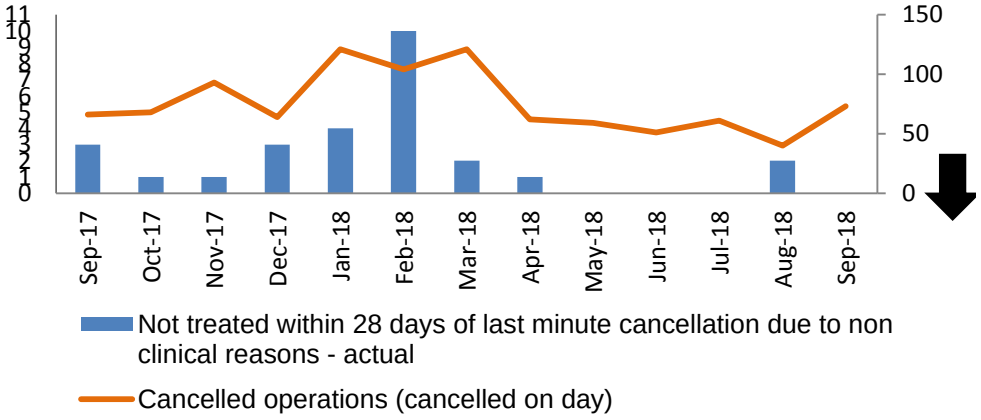
Average Length of Stay



The Trust non elective average length of stay decreased to 4.6 days in September, compared to 4.8 in August.

The elective length of stay (excluding day case) has decreased to 2.5 days in September from 2.9 days in August.

Operations cancelled on day - 28 day standard

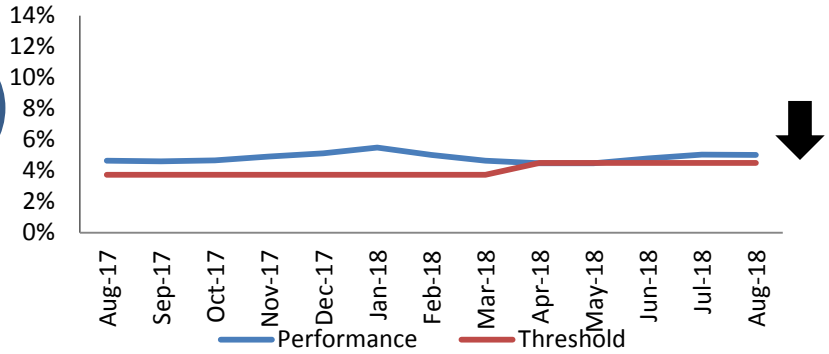


There were 73 operations cancelled on the day of operation in September. There were 0 'on the day' cancelled operations not rebooked within 28 days in September, however there were 2 breaches of the target in August.

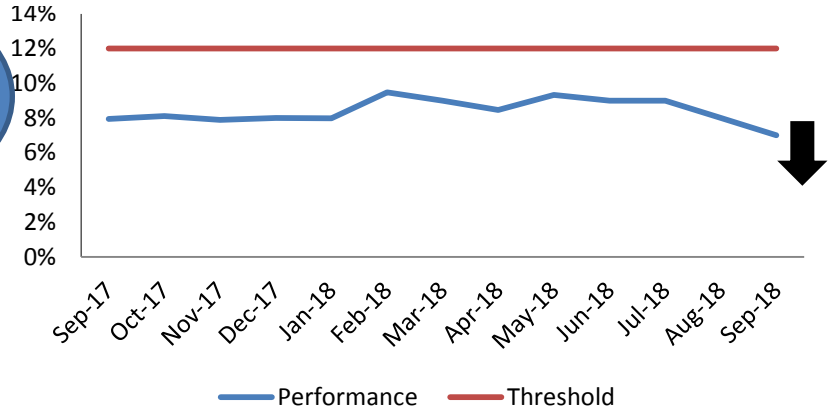
Patients that had procedures cancelled on the day are monitored regularly to ensure dates are offered within the 28 days. Risks are escalated to senior managers and escalated at the weekly operations meeting.

WELL LED

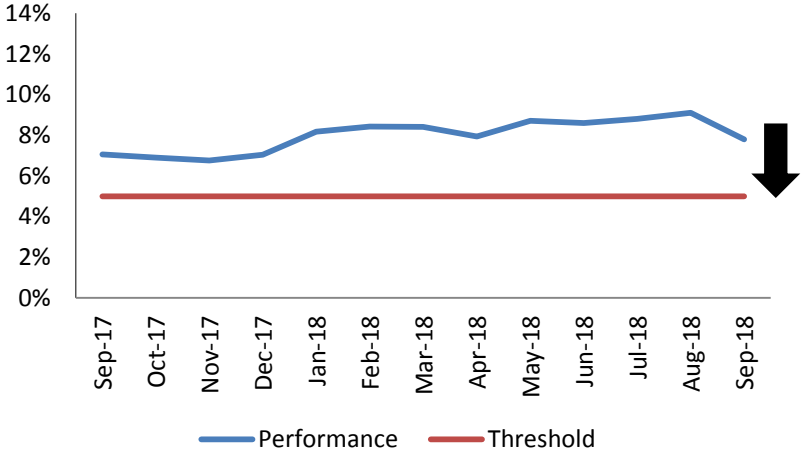
Sickness



Turnover Rate



Vacancy Rate



The sickness absence rate has reduced slightly from 5.05% in July to 5.03% in August 2018. The current rate is higher than the previous year (4.66%).

High sickness rates are a financial risk as bank and agency expenditure increases to cover shifts. Rates are highest in Estates and Facilities and the Integrated Care Group.

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

The trust turnover rate has reduced to 7% in September and the vacancy rate has also reduced to 7.8% in September from 9.1% in August.

Overall the Trust is now employing 7359 FTE staff in total. This is a net increase of 2 FTE from the previous month. The number of nurses in post at September 2018 stood at 2302 FTE which is 43 higher than last month and a net increase of 253 FTE since 1st April 2013.

As at 28 September 2018 as the majority of September newly qualified nurses have now started with the trust we now have 47 external/R&R nurses in the recruitment pipeline, scheduled to start between now and September 2019 and 32 changing posts internally. These figures do not include our overseas nurses through the HEE Global Learners Programme (GLP) of which there is an additional 27 in the pipeline. Out of this 27, we have one nurse starting with us on October 3rd, with another due mid to late October and another 5 mid to late November. The other 20 GLP candidates are currently going through the overseas registration process

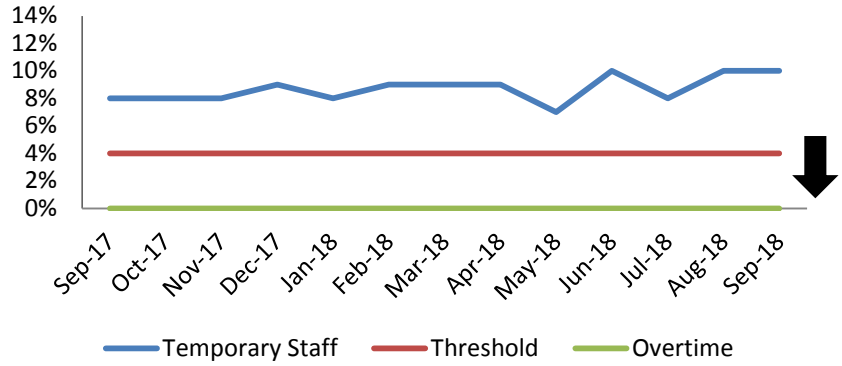
The vacancy rate for nurses now stands at 9.7% (247 FTE)

As of September 2018 there are 87 FTE Medical Posts vacant of which 27 posts have been offered and awaiting pre-employment checks or confirmation of start dates to be agreed.

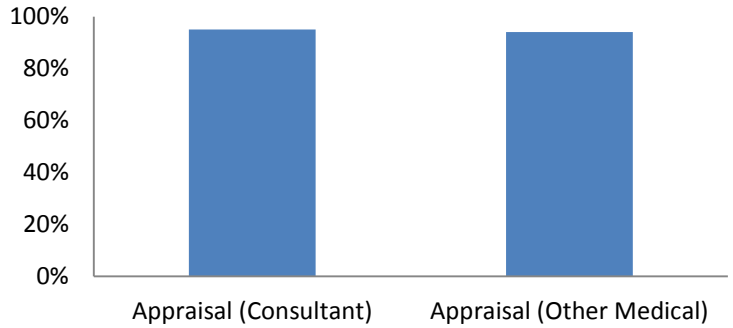
The vacancy rates for doctors now stands at 8.2% (51 FTE).

WELL LED

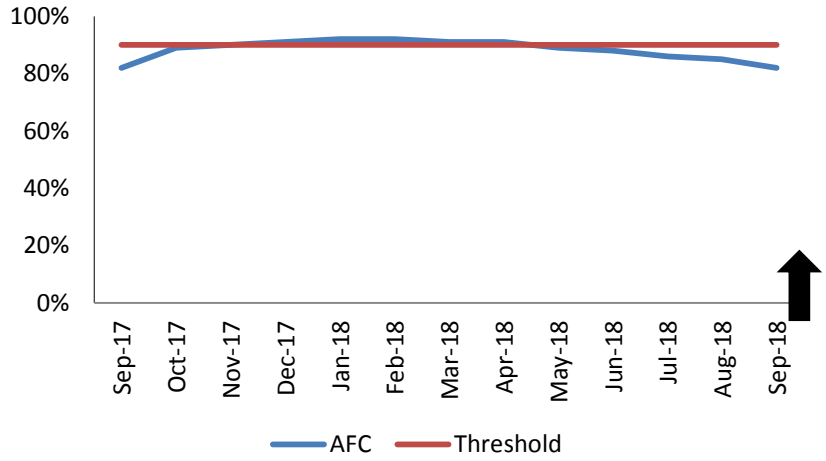
Temporary costs and overtime as % total pay



Appraisals, Consultant & Other Medical



Appraisals AFC



In 2017/18 East Lancashire Hospitals NHS Trust spent £27.4m on temporary staffing for the year. This represented 8% of the overall pay bill. (9% 2016/17;8% 2015/16; 9% 2014/15; 8% 2013/4; 5.5% 2012/13).

For the year ending 2017/18 the Trust spent £27,459,459 (£12,832,971 agency; £14,626,488 bank).

In April to September 2018 £16.1million was spent on temporary staff. £6.6million expenditure on agency staff and £9.5million expenditure on bank staff.

At the 30th September 2018 there are 624 vacancies
Wte staff worked (8,054wte) was 166wte less than is funded substantively (8,220wte).

Pay costs are £3.3million above budgeted establishment primarily due to premium rates paid for agency staff.

The appraisal rates for consultants and career grade doctors are reported cumulative year to date, April – September 2018 and reflect the number of reviews completed that were due in this period.
The consultant and medical staff appraisal rates are above threshold at 95% and 94% respectively.

The AFC appraisal rates continue to be reported as a rolling 12 month figure and remains below threshold at 82% in September.

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

WELL LED

Job Plans

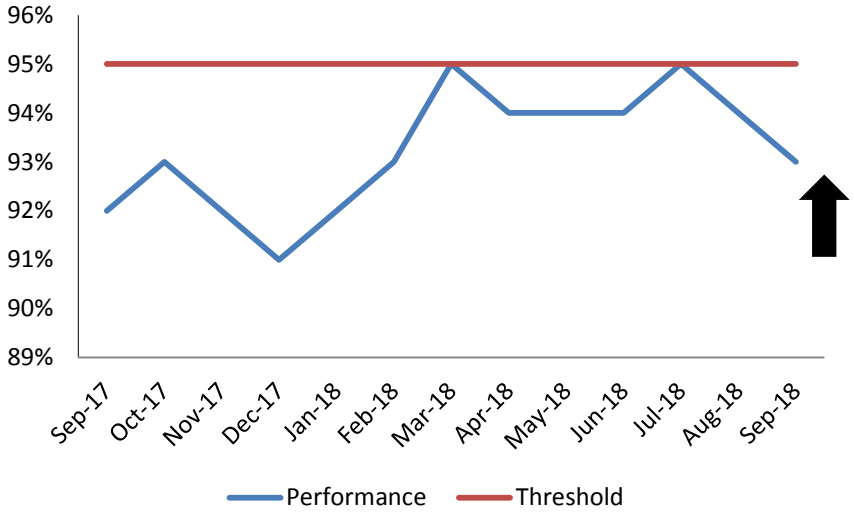
1st Stage Sign off	25	7.9%
2nd Stage Sign Off	216	68.4%
Complete	75	23.7%
TOTAL	316	100.0%

All job plans with the exception of Trauma & Orthopaedics, have been reviewed, at 1st or 2nd sign off stage.

Confirm and Challenge meetings will be held with Divisional Directors during October and November 2018, to sign off job plans within their directorates, chaired by the Deputy Medical Director .

Trauma and Orthopaedics requested an extension to the job plan sign off process, due to undertaking a departmental review and have been granted authorisation to roll over existing job plans from 2017/18.

Information Governance Toolkit



Information governance toolkit compliance has deteriorated to 93% in September, below the 95% threshold.

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

Core Skills Training % Compliance

	Target	Compliance at end September
Basic Life Support	90%	91%
Conflict Resolution Training Level 1	90%	98%
Equality, Diversity and Human Rights	90%	98%
Fire Safety	90%	98%
Health, Safety and Welfare Level 1	90%	99%
Infection Prevention	90%	98%
Information Governance	95%	93%
Prevent Healthwrap	90%	96%
Safeguarding Adults	90%	97%
Safeguarding Children	90%	96%
Safer Handling Theory	90%	97%

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

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

WELL LED

Finance & Use of Resource metrics

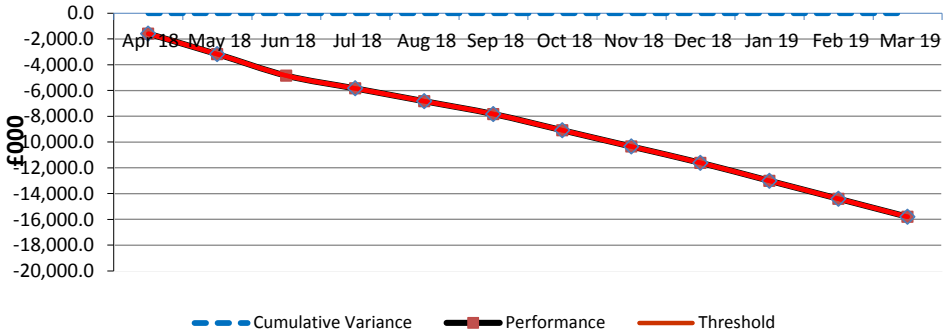
Area	Metric	Actual YTD Performance	Actual YTD Score	Forecast outturn Performance	Forecast outturn Score
Financial sustainability	Capital service capacity	0.6	4	0.8	4
	Liquidity (days)	(9.3)	3	(11.0)	3
Financial efficiency	I&E margin	(2.3%)	4	(1.9%)	4
Financial control	Distance from financial plan	(0.2%)	2	(0.3%)	2
	Agency spend	24.5%	2	35.3%	3
Total			**3**		**3**

The Trust has agreed a revised underlying control total of a £15.798million deficit

The acceptance of the control total allows the Trust access to a Provider Sustainability Fund (PSF) of up to £8.050million, access to which is reliant on 30% achievement of the 4 hour target and 70% achievement of the underlying control total.

At month 6, the Trust is reporting an underlying position of a £7.823million deficit in line with the financial plan, and a £5.852million deficit after Provider Sustainability Funding (PSF) of £1.971million.

Adjusted financial performance (deficit) *



The Safely Releasing Cost Programme (SRCP) is £18.0million for 2018-19. £8.9million has been identified to date, of which £5.1million is recurrent.

The Better Payment Practice Code (BPPC) targets continue to be achieved across all four areas for the year to date.

The 'Finance and use of resources metrics score' remains at 3 for the financial year, with 1 being the best level of performance and 4 being in financial special measures.

The cash balance at 30 September 2018 was £9.0million, an increase of £2.2million in month, largely due to the £2.3million of Public Dividend Capital received for the Burnley Phase 8 capital project.

* - excludes PSF allocation

Efficiency Savings

Division	Target	Green	Amber	Red	Total	(Over) / Under Identified	Total Green Schemes	Non Rec	Rec	Identified
		£000's	£000's	£000's	£000's	£000's	%	£000's	£000's	£000's
Integrated Care Group	3,154	2,084	80	1,874	4,038	(884)	66%	182	1,902	2,084
SAS	3,720	1,906	1,252	108	3,265	455	51%	1,568	338	1,906
Family Care	2,423	490	76	0	565	1,858	20%	378	112	490
DCS	1,103	1,203	302	0	1,504	(401)	109%	38	1,165	1,203
Estates & Facilities	1,440	920	33	0	952	627	64%	60	860	920
Corporate Services	536	388	175	84	646	(79)	72%	16	371	388
Cross divisional	0	0	0	2,909	2,909	(3,081)		0	0	0
Targetted Transformation	5,624	1,946	600	1,573	4,120	1,504	35%	1,528	417	1,946
Total	**18,000**	**8,937**	**2,518**	**6,548**	**18,000**	**0**		3,771	5,165	8,937

APPENDIX 1

Safe

		Threshold 18/19	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Monthly Sparkline
M64	CDIFF	27	2	3	3	3	2	3	5	2	3	4	1	5	1	
M64.1	Cdiff Cumulative from April	27	18	21	24	27	29	32	37	2	5	9	10	15	16	
M65	MRSA	0	0	0	1	0	0	0	0	0	0	1	0	0	0	
M124	E-Coli (post 2 days)	48	4	6	2	3	3	4	3	5	5	2	6	8	4	
M154	P. aeruginosa bacteraemia (total pre 2 days)		1	0	1	0	1	0	2	1	1	1	1	1	3	
M155	P. aeruginosa bacteraemia (total post 2 days)	4	0	0	0	1	0	0	1	2	0	0	0	1	1	
M156	Klebsiella species bacteraemia (total pre 2 days)		3	10	9	5	4	4	5	8	10	4	2	3	7	
M157	Klebsiella species bacteraemia (total post 2 days)	16	0	2	2	3	0	1	3	1	2	1	2	4	3	
M66	Never Event Incidence	0	0	2	0	0	1	0	1	1	0	0	0	0	0	
M67	Medication errors causing serious harm (Steis reported date)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C28	Percentage of Harm Free Care	92%	98.8%	99.5%	99.4%	99.0%	99.3%	99.3%	99.6%	99.3%	99.2%	99.6%	98.9%	98.9%	99.6%	
M68	Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	97.9%	98.6%	98.9%	98.1%	99.1%	99.3%	99.2%	99.4%	99.5%	99.3%	99.4%	99.5%		
M69	Serious Incidents (Steis)		6	5	11	7	11	8	6	9	8	10	6	9	6	
M70	CAS Alerts - non compliance	0	2	0	3	2	2	0	0	2	0	0	0	0	0	
M146	Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80%	89%	91%	92%	90%	90%	90%	88%	91%	91%	91%	89%	89%	90%	
M147	Safer Staffing -Day-Average fill rate - care staff (%)	80%	116%	107%	110%	106%	106%	104%	103%	106%	104%	104%	99%	102%	102%	
M148	Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80%	96%	99%	98%	98%	98%	97%	97%	99%	101%	99%	98%	97%	100%	

M149	Safer Staffing -Night-Average fill rate - care staff (%)	80%	126%	118%	119%	114%	116%	112%	112%	114%	112%	111%	113%	112%	115%	
M150	Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80%	0	4	4	5	12	10	7	12	5	5	8	9	14	11	
M151	Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80%	0	1	1	0	1	0	0	1	0	0	0	1	3	3	
M152	Safer Staffing - Day -Average fill rate - care staff- number of wards <80%	0	0	1	1	1	1	1	1	0	1	1	1	1	0	
M153	Safer Staffing - Night -Average fill rate - care staff- number of wards <80%	0	1	1	1	1	1	1	1	1	1	1	0	0	0	

Caring

		Threshold 18/19	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Monthly Sparkline
C38	Inpatient Friends and Family - % who would recommend	90%	98.2%	98.2%	98.3%	98.5%	98.6%	98.1%	97.9%	98.5%	96.8%	98.7%	96.6%	95.6%	91.2%	
C31	NHS England Inpatients response rate from Friends and Family Test		51.2%	49.8%	47.7%	51.6%	48.6%	45.7%	47.8%	49.3%	36.2%	41.5%	48.6%	50.5%	47.9%	
C40	Maternity Friends and Family - % who would recommend	90%	98.0%	96.0%	97.2%	97.2%	98.8%	96.6%	97.7%	96.8%	96.3%	95.9%	96.2%	97.6%	94.3%	
C42	A&E Friends and Family - % who would recommend	90%	82.7%	82.5%	81.1%	82.3%	82.8%	80.4%	82.1%	84.1%	80.5%	82.3%	81.1%	82.7%	83.9%	
C32	NHS England A&E response rate from Friends and Family Test		15.8%	20.3%	19.5%	20.3%	20.1%	20.9%	22.4%	23.1%	17.1%	20.8%	19.7%	20.0%	22.9%	
C44	Community Friends and Family - % who would recommend	90%	95.9%	98.1%	96.3%	96.4%	97.7%	96.9%	95.6%	97.0%	87.1%	91.7%	95.5%	95.6%	96.0%	
C15	Complaints – rate per 1000 contacts	0.4	0.3	0.2	0.2	0.3	0.2	0.3	0.2	0.2	0.2	0.3	0.2	0.3	0.3	
M52	Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Effective

		Threshold 18/19	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Monthly Sparkline
M73	Deaths in Low Risk Categories - relative risk	Outlier	81.6	67.1	59.1	46.3	47.3	52.4	43.5	51.6	52.0	57.6				
M74	Hospital Standardised Mortality Ratio - Weekday (DFI Indicative)	Outlier	92.0	89.0	89.8	88.8	90.4	88.5	89.8	92.2	91.7	91.1				
M75	Hospital Standardised Mortality Ratio - Weekend (DFI Indicative)	Outlier	95.0	96.2	94.2	93.9	93.2	91.1	91.1	90.3	90.5	91.2				
M54	Hospital Standardised Mortality Ratio (DFI Indicative)	Outlier	92.8	90.8	90.9	90.1	91.1	89.1	90.2	91.7	91.4	91.1				
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Outlier														
M159	Stillbirths	<5	2	2	5	4	3	2	4	3	1	4	2	2	3	
M160	Stillbirths - Improvements in care that impacted on the outcome		0	0	0	0	0	0	1							
M89	CQUIN schemes at risk	0														

Responsive

		Threshold 18/19	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Monthly Sparkline
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95%	88.6%	86.9%	81.6%	81.3%	79.6%	81.4%	78.9%	84.0%	85.3%	85.6%	82.5%	76.1%	79.8%	
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95%	89.2%	87.5%	82.5%	82.1%	80.7%	82.2%	80.1%	84.9%	86.1%	86.6%	83.8%	77.8%	81.2%	
M62	12 hour trolley waits in A&E	0	1	2	4	4	5	12	23	9	3	34	37	34	19	
M81	HAS Compliance	90%	92.37%	89.24%	82.68%	83.12%	84.40%	95.21%	92.79%	94.53%	93.79%	89.57%	93.26%	92.66%	91.49%	
M82	Handovers > 30 mins ALL	0	714	775	1122	1319	1267	405	1008	652	685	497	568	665	654	
M82.6	Handovers > 30 mins ALL (NWAS Confirmed Penalty)	0	428	461	745	829	827	201	589	334	426	399	305	340		
C1	RTT admitted: percentage within 18 weeks	N/A	69.5%	64.8%	65.3%	79.0%	72.2%	72.2%	73.1%	69.7%	71.9%	71.6%	73.0%	72.9%	71.9%	
C3	RTT non- admitted pathways: percentage within 18 weeks	N/A	90.8%	89.4%	89.0%	90.0%	90.7%	92.4%	92.1%	90.6%	93.5%	93.2%	92.4%	90.9%	89.5%	
C4	RTT waiting times Incomplete pathways %	92%	91.1%	90.8%	91.0%	92.0%	92.3%	92.4%	92.1%	92.8%	93.3%	93.0%	92.5%	92.2%	92.1%	

C4.1	RTT waiting times Incomplete pathways Total	<25,920	26,693	25,680	25,340	24,031	22,968	23,006	24,124	23,754	24,320	24,418	25,086	26,690	26,986
C4.2	RTT waiting times Incomplete pathways - over 40 wks		19	14	43	33	34	40	34	25	25	25	9	19	15
C37.1	RTT 52 Weeks (Ongoing)	0	0	1	3	3	0	0	0	0	0	0	0	0	0
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1%	0.3%	0.2%	0.1%	0.2%	0.4%	0.1%	0.2%	0.9%	1.8%	0.4%	0.4%	0.6%	0.9%
C18	Cancer - Treatment within 62 days of referral from GP	85%	85.2%	85.8%	80.7%	89.6%	85.7%	82.8%	82.1%	91.9%	88.4%	82.6%	76.7%	82.4%	
C19	Cancer - Treatment within 62 days of referral from screening	90%	100.0%	100.0%	100.0%	96.2%	96.2%	100.0%	100.0%	95.0%	92.0%	92.3%	100.0%	97.3%	
C20	Cancer - Treatment within 31 days of decision to treat	96%	99.4%	99.1%	98.0%	98.9%	93.9%	98.3%	97.5%	97.5%	98.7%	97.6%	98.2%	99.5%	
C21	Cancer - Subsequent treatment within 31 days (Drug)	98%	100.0%	100.0%	100.0%	98.0%	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94%	97.9%	97.6%	100.0%	95.0%	94.8%	91.2%	96.0%	89.2%	97.5%	92.7%	91.4%	96.0%	
C24	Cancer - seen within 14 days of urgent GP referral	93%	93.9%	94.7%	94.4%	96.3%	93.0%	94.9%	95.1%	93.3%	93.2%	91.1%	93.7%	94.6%	
C25	Cancer - breast symptoms seen within 14 days of GP referral	93%	95.6%	98.9%	97.5%	95.6%	96.8%	94.5%	90.0%	92.0%	92.3%	85.4%	93.4%	86.8%	
C36	Cancer 62 Day Consultant Upgrade	85%	86.4%	93.2%	88.9%	88.5%	89.4%	95.8%	92.3%	90.0%	90.4%	96.3%	90.0%	90.0%	
C25.1	Cancer - Patients treated > day 104		4	2	8	1	5	5	2	2	3	4	9	5	
M9	Urgent operations cancelled for 2nd time	0	0	0	0	0	0	0	0	0	0	0	0	0	0
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	3	1	1	3	4	10	2	1	0	0	0	2	0
M138	Cancelled operations (cancelled on day)		66	68	93	64	121	104	121	62	59	51	61	40	73
M55	Proportion of delayed discharges attributable to the NHS	3.5%	4.5%	4.0%	4.2%	3.6%	3.6%	3.5%	3.0%	3.0%	2.9%	2.8%	3.4%	3.7%	3.9%
C16	Emergency re-admissions within 30 days		11.7%	12.1%	12.4%	12.0%	12.1%	13.2%	12.1%	11.9%	12.1%	12.0%	10.6%	11.8%	13.2%
M90	Average LOS elective (excl daycase)		3.0	2.3	2.6	2.7	2.6	3.2	2.7	2.4	2.6	3.0	2.6	2.9	2.5
M91	Average LOS non-elective		4.8	4.6	4.6	4.6	4.8	4.8	4.7	4.8	4.6	4.6	4.7	4.8	4.6

Well led

		Threshold 18/19	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Monthly Sparkline
M77	Trust turnover rate	12%	8.0%	8.1%	7.9%	8.0%	8.0%	9.5%	9.0%	8.5%	9.3%	9.0%	9.0%	8.0%	7.0%	
M78	Trust level total sickness rate	4.5%	4.6%	4.7%	4.9%	5.1%	5.5%	5.0%	4.6%	4.5%	4.5%	4.8%	5.1%	5.0%		
M79	Total Trust vacancy rate	5%	7.1%	6.9%	6.8%	7.0%	8.2%	8.4%	8.4%	7.9%	8.7%	8.6%	8.8%	9.1%	7.8%	
M80.3	Appraisal (AFC)	90%	82.0%	89.0%	90.0%	91.0%	92.0%	92.0%	91.0%	91.0%	89.0%	88.0%	86.0%	85.0%	82.0%	
M80.3	Appraisal (Consultant)	90%	88.0%	93.0%	94.0%	95.0%	93.0%	95.0%	97.0%	97.0%	97.0%	97.0%	97.0%	90.0%	95.0%	
M80.4	Appraisal (Other Medical)	90%	94.0%	95.0%	95.0%	95.0%	96.0%	95.0%	98.0%	98.0%	98.0%	98.0%	98.0%	85.0%	94.0%	
M80.2	Safeguarding Children	90%	95.0%	95.0%	95.0%	95.0%	95.0%	96.0%	96.0%	96.0%	96.0%	96.0%	97.0%	96.0%	96.0%	
M80.2	Information Governance Toolkit Compliance	95%	92.0%	93.0%	92.0%	91.0%	92.0%	93.0%	95.0%	94.0%	94.0%	94.0%	95.0%	94.0%	93.0%	
F8	Temporary costs as % of total paybill	4%	8%	8%	8%	9%	8%	9%	9%	9%	7%	10%	8%	10%	10%	
F9	Overtime as % of total paybill	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
F1	Adjusted financial performance (deficit) including PSF (£M)	(7.7)	(1.3)	(1.7)	(2.1)	(2.5)	(3.0)	(3.4)	(2.7)	(1.6)	(3.2)	(3.6)	(4.6)	(5.2)	(5.9)	
F1.1	Adjusted financial performance (deficit) excluding PSF (£M)	(15.8)										(4.8)	(5.8)	(6.8)	(7.8)	
F2	SRCP Achieved % (green schemes only)	100.0%	46%	53%	54%	77%	79%	80%	107%	8%	17%	18%	29%	32%	50%	
F3	Liquidity days	>(14.0)	(7.5)	(7.8)	(8.8)	(9.2)	(9.6)	(10.0)	(10.5)	(5.4)	(9.4)	(5.7)	(8.4)	(10.0)	(9.3)	
F4	Capital spend v plan	85%	55%	57%	68%	77%	88%	73%	95%	38%	81%	67%	61%	80%	82%	
F16	Finance & Use of Resources (UoR) metric - overall	3	3	3	3	3	3	3	3	3	3	2	3	3	3	
F17	Finance and UoR metric - liquidity	4	3	3	3	3	3	3	3	4	4	2	3	3	3	
F18	Finance and UoR metric - capital service capacity	4	3	3	3	3	3	3	3	2	3	4	4	4	4	
F19	Finance and UoR metric - I&E margin	4	3	3	3	3	3	3	3	4	4	4	4	4	4	
F20	Finance and UoR metric - distance from financial plan	4	2	2	2	2	2	2	2	4	1	1	2	2	2	

F21 Finance and UoR metric - agency spend	1	2	2	2	2	2	2	2	2	1	1	2	2	2	
F12 BPPC Non NHS No of Invoices	95%	95.8%	96.0%	95.5%	95.7%	95.3%	95.4%	95.0%	95.2%	96.3%	96.5%	96.2%	95.9%	95.7%	
F13 BPPC Non NHS Value of Invoices	95%	95.2%	95.4%	95.3%	95.4%	94.9%	95.1%	95.1%	96.9%	95.6%	96.1%	96.5%	96.7%	97.0%	
F14 BPPC NHS No of Invoices	95%	95.0%	95.0%	95.1%	95.3%	94.0%	92.4%	95.6%	96.6%	97.3%	97.8%	98.1%	97.7%	96.7%	
F15 BPPC NHS Value of Invoices	95%	97.9%	97.9%	98.0%	98.0%	97.7%	97.5%	98.2%	99.3%	99.5%	99.4%	99.3%	98.9%	98.6%	

Safe Staffing (Rota Fill Rates and CHPPD) Collection

Organisation : RXR East Lancashire Hospitals Trust
Month : Aug-18

Trust Website where staffing information is available

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

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
					midwives/nurses		Care Staff		midwives/nurses		Care Staff									
Site code	Hospital Site name	Ward Name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Nurses & Midwives	Care staff	Overall
RXR60	ACCRINGTON VICTORIA HOSPITAL - RXR60	Ward 2	314 - REHABILITATION		1,116	846	744	1,110	744	744	744	756	75.8%	149.2%	100.0%	101.6%	516	3.08	3.62	6.70
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Acute Stroke Unit (ASU)	300 - GENERAL MEDICINE		2,325	1,838	1,628	1,920	977	977	977	977	79.0%	118.0%	100.0%	100.0%	655	4.30	4.42	8.72
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B18	320 - CARDIOLOGY		1,860	1,476	1,116	1,140	744	1,068	744	804	79.4%	102.2%	143.5%	108.1%	745	3.41	2.61	6.02
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B20	100 - GENERAL SURGERY		1,612	1,463	806	1,274	682	682	682	1,089	90.7%	158.1%	100.0%	159.7%	535	4.01	4.42	8.43
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B22	110 - TRAUMA & ORTHOPAEDICS		1,612	1,385	2,418	2,243	682	682	1,705	1,573	85.9%	92.7%	100.0%	92.3%	647	3.19	5.90	9.09
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B24	110 - TRAUMA & ORTHOPAEDICS		1,612	1,391	1,209	1,229	682	682	682	726	86.3%	101.6%	100.0%	106.5%	648	3.20	3.02	6.22
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B4	430 - GERIATRIC MEDICINE		1,488	1,212	2,232	2,124	744	756	1,488	1,476	81.5%	95.2%	101.6%	99.2%	734	2.68	4.90	7.59
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Blackburn Birth Centre	501 - OBSTETRICS		980	880	495	428	1,008	667	333	333	89.8%	86.4%	66.2%	100.0%	24	64.43	31.71	96.14
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C1	300 - GENERAL MEDICINE		1,488	1,194	1,488	1,176	744	744	1,116	1,128	80.2%	79.0%	100.0%	101.1%	604	3.21	3.81	7.02
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C10	300 - GENERAL MEDICINE		1,488	1,158	1,488	1,470	744	780	1,116	1,140	77.8%	98.8%	104.8%	102.2%	680	2.85	3.84	6.69
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C11	300 - GENERAL MEDICINE		1,488	1,200	1,488	1,512	744	744	744	1,104	80.6%	101.6%	100.0%	148.4%	671	2.90	3.90	6.80
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14A	100 - GENERAL SURGERY		1,860	1,806	1,116	1,146	744	744	372	576	97.1%	102.7%	100.0%	154.8%	514	4.96	3.35	8.31
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14B	100 - GENERAL SURGERY		1,860	1,800	1,116	1,152	744	744	372	480	96.8%	103.2%	100.0%	129.0%	504	5.05	3.24	8.29
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18A	100 - GENERAL SURGERY		1,860	1,842	1,116	1,176	744	744	372	540	99.0%	105.4%	100.0%	145.2%	527	4.91	3.26	8.16
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18B	100 - GENERAL SURGERY		1,860	1,812	1,116	1,386	744	756	372	576	97.4%	124.2%	101.6%	154.8%	528	4.86	3.72	8.58
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C2	301 - GASTROENTEROLOGY	MEDICINE	1,488	1,182	1,488	1,284	1,116	1,116	1,116	1,176	79.4%	86.3%	100.0%	105.4%	705	3.26	3.49	6.75
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C22	101 - UROLOGY	120 - ENT	2,418	2,288	1,612	2,197	1,023	1,177	1,364	1,397	94.6%	136.3%	115.1%	102.4%	993	3.49	3.62	7.11
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C3	300 - GENERAL MEDICINE		1,518	1,326	1,488	1,392	972	1,092	1,116	1,452	87.4%	93.5%	112.3%	130.1%	760	3.18	3.74	6.92
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C4	301 - GASTROENTEROLOGY	MEDICINE	1,488	1,092	1,488	1,164	1,116	1,092	1,116	1,152	73.4%	78.2%	97.8%	103.2%	727	3.00	3.19	6.19
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C5	430 - GERIATRIC MEDICINE		1,116	786	1,488	1,362	744	744	1,116	1,152	70.4%	91.5%	100.0%	103.2%	429	3.57	5.86	9.43
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C6	340 - RESPIRATORY MEDICINE	MEDICINE	1,488	1,182	1,116	1,092	1,116	1,056	744	792	79.4%	97.8%	94.6%	106.5%	747	3.00	2.52	5.52
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C7	340 - RESPIRATORY MEDICINE	MEDICINE	1,488	1,158	1,116	1,206	744	804	744	960	77.8%	108.1%	108.1%	129.0%	652	3.01	3.32	6.33
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C8	340 - RESPIRATORY MEDICINE	MEDICINE	1,860	1,494	1,116	1,296	1,116	1,116	744	756	80.3%	116.1%	100.0%	101.6%	562	4.64	3.65	8.30
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C9	300 - GENERAL MEDICINE		1,488	1,170	1,488	1,566	744	756	744	1,152	78.6%	105.2%	101.6%	154.8%	687	2.80	3.96	6.76
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Children's Unit	420 - PAEDIATRICS		4,650	3,810	1,116	690	3,581	3,266	326	315	81.9%	61.8%	91.2%	96.8%	561	12.61	1.79	14.40
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Coronary Care Unit (CCU)	320 - CARDIOLOGY		1,488	1,302	744	744	1,116	1,116	-	-	87.5%	100.0%	100.0%	0.0%	249	9.71	2.99	12.70
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Critical Care Unit	192 - CRITICAL CARE MEDICINE		6,643	6,617	858	780	5,599	5,379	154	154	99.6%	90.9%	96.1%	100.0%	584	20.54	1.60	22.14
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D1	300 - GENERAL MEDICINE		1,482	1,194	1,116	1,140	744	756	744	900	80.6%	102.2%	101.6%	121.0%	619	3.15	3.30	6.45
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D3	300 - GENERAL MEDICINE		1,488	1,200	1,116	1,176	744	780	744	1,092	80.6%	105.4%	104.8%	146.8%	610	3.25	3.72	6.96
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUA)	300 - GENERAL MEDICINE		3,600	3,492	2,160	2,124	3,240	3,072	1,440	1,356	97.0%	98.3%	94.8%	94.2%	1186	5.53	2.93	8.47
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUB)	300 - GENERAL MEDICINE		3,720	3,492	2,232	2,124	3,348	3,072	1,488	1,356	93.9%	95.2%	91.8%	91.1%	1140	5.76	3.05	8.81
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Neonatal Intensive Care Unit	420 - PAEDIATRICS		4,836	4,848	372	393	4,464	4,020	-	168	100.2%	105.6%	90.1%	16800.0%	757	11.71	0.74	12.46
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Surgical Triage Unit	100 - GENERAL SURGERY		1,612	1,599	1,125	1,008	1,221	1,001	682	671	99.2%	89.6%	82.0%	98.4%	524	4.96	3.20	8.17
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Antenatal Ward	501 - OBSTETRICS		1,488	1,483	744	720	1,116	1,032	744	720	99.7%	96.8%	92.5%	96.8%	125	20.12	11.52	31.64
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Burnley Birth Centre	501 - OBSTETRICS		1,395	1,304	372	369	1,116	1,104	372	360	93.4%	99.2%	98.9%	96.8%	51	47.21	14.29	61.50
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Central Birth Suite	501 - OBSTETRICS		3,720	3,722	744	768	3,720	3,600	744	744	100.1%	103.2%	96.8%	100.0%	221	33.13	6.84	39.97
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Gynaecology and Breast Care Ward	502 - GYNAECOLOGY		1,068	1,068	564	564	801	801	326	326	100.0%	100.0%	100.0%	100.0%	216	8.65	4.12	12.77
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Postnatal Ward	501 - OBSTETRICS		2,412	2,478	1,254	1,272	2,232	2,208	1,488	1,482	102.7%	101.4%	98.9%	99.6%	808	5.80	3.41	9.21
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Rakehead	314 - REHABILITATION		1,116	852	1,860	1,884	744	744	744	1,212	76.3%	101.3%	100.0%	162.9%	415	3.85	7.46	11.31
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 15	110 - TRAUMA & ORTHOPAEDICS		1,112	1,105	839	826	682	682	539	517	99.4%	98.4%	100.0%	95.9%	363	4.92	3.70	8.62
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 16	300 - GENERAL MEDICINE		1,860	1,398	1,488	1,824	744	744	1,116	1,812	75.2%	122.6%	100.0%	162.4%	797	2.69	4.56	7.25
RXR70	CLITHEROE COMMUNITY HOSPITAL - RXR70	Ribblesdale	314 - REHABILITATION		1,860	1,560	1,488	1,506	1,116	1,116	1,488	1,476	83.9%	101.2%	100.0%	99.2%	951	2.81	3.14	5.95
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Hartley	314 - REHABILITATION		1,488	1,164	1,116	1,326	744	744	744	864	78.2%	118.8%	100.0%	116.1%	688	2.77	3.18	5.96
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Marsden	314 - REHABILITATION		1,488	1,200	1,860	1,860	744	744	744	756	80.6%	100.0%	100.0%	101.6%	715	2.72	3.66	6.38
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Reedyford	314 - REHABILITATION		1,488	1,164	1,116	1,290	744	744	744	924	78.2%	115.6%	100.0%	124.2%	685	2.79	3.23	6.02
		Total			88,874	79,031	56,259	57,431	58,720	57,190	35,993	40,471	88.92%	102.08%	97.39%	112.44%	27059	5.03	3.62	8.65

Ward Staff Summary - Aug 2018

Executed on: 26/09/2018 at: 11:09:16 AM

Division: All 3 Available Divisions Selected
Directorate: All 17 Available Directorates Selected
Site: All 5 Available Hospital Sites Selected
This report is based on the 45 wards which submitted data for the monthly Safer Staffing return

R: ≥ ±10% | A: ≥ ±5% | G: < ±5% | R: > 0 | G: = 0 | R:≥ 5% | G:< 5% | R:≥ 3.75% | G:< 3.75%

Site	Cost Centre Code	Ward	Day Shift						Night Shift						Pressure Ulcers Acquired			Falls with Harm (Mod & Above)	Infections Acquired		Vacancies WTE (RegN/M + HCA)*		Sickness/Absence RegN/M + HCA)*	
			Registered Nurses / Midwives			Care Staff			Registered Nurses / Midwives			Care Staff												
			Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	G2	G3	G4		C Diff	MRSA	WTE Vacant	% Vacant	WTE Days	% Abs Rate
EC: Surgical & Anaes Services																								
EC02: General Surg Services																								
RBH	5142	Ward C14A	1,860	1,806	97.10%	1,116	1,146	102.69%	744	744	100.00%	372	576	154.84%	0	0	0	0	0	0	3.23	13.49%	37.80	5.88%
	5143	Ward C18A	1,860	1,842	99.03%	1,116	1,176	105.38%	744	744	100.00%	372	540	145.16%	0	0	0	0	0	0	1.85	7.69%	57.40	8.45%
	5144	Surgical Triage Unit	1,612.00	1,599	99.19%	1,124.50	1,007.50	89.60%	1,221.00	1,001.00	81.98%	682.00	671.00	98.39%	0	0	0	0	0	0	10.26	27.66%	88.80	10.55%
	5145	Ward C14B	1,860	1,800	96.77%	1,116	1,152	103.23%	744	744	100.00%	372	480	129.03%	0	0	0	0	0	0	4.56	19.04%	42.80	7.12%
	5146	Ward C18B	1,860	1,812	97.42%	1,116	1,386	124.19%	744	756	101.61%	372	576	154.84%	0	0	0	0	0	0	3.71	15.39%	5.96	0.99%
EC03: Urology																								
RBH	5128	Ward C22	2,418	2,288	94.62%	1,612.00	2,197	136.29%	1,023	1,177	115.05%	1,364.00	1,397	102.42%	0	0	0	0	0	0	-2.44	-11.15%	91.00	12.07%
EC04: Orthopaedic Services																								
BGH	4393	Ward 15	1,111.50	1,105.00	99.42%	838.50	825.50	98.45%	682.00	682.00	100.00%	539	517	95.92%	0	0	0	0	0	0	2.22	6.38%	99.10	9.80%
RBH	5366	Ward B24	1,612.00	1,391.00	86.29%	1,209	1,228.50	101.61%	682.00	682.00	100.00%	682.00	726.00	106.45%	0	0	0	0	0	0	6.70	21.43%	94.00	12.33%
	5367	Ward B22	1,612.00	1,384.50	85.89%	2,418	2,242.50	92.74%	682.00	682.00	100.00%	1,705.00	1,573.00	92.26%	0	0	0	0	0	0	6.23	13.35%	71.12	5.68%
EC05: Head & Neck																								
RBH	5119	Ward B20 Max Fac	1,612.00	1,462.50	90.73%	806.00	1,274.00	158.06%	682.00	682.00	100.00%	682.00	1,089.00	159.68%	0	0	0	0	0	0	1.58	5.74%	7.00	0.86%
EC09: Anaesth & Critical Care																								
RBH	5362	Elht Critical Care	6,643.00	6,617	99.61%	858.00	780.00	90.91%	5,599	5,379.00	96.07%	154.00	154.00	100.00%	0	0	0	0	0	0	15.31	12.39%	203.49	6.03%
ED: Family Care																								
ED07: General Paediatrics																								
RBH	5210	Inpatient	4,650	3,810	81.94%	1,116	690	61.83%	3,580.50	3,265.50	91.20%	325.50	315	96.77%	0	0	0	0	0	0	4.72	5.73%	64.12	2.67%
ED08: Gynae Nursing																								
BGH	4169	Gynae And Breast Care Ward	1,068	1,068	100.00%	564	564	100.00%	800.50	800.50	100.00%	325.50	325.50	100.00%	0	0	0	0	0	0	3.84	13.20%	18.60	2.38%
ED09: Obstetrics																								
BGH	4165	Birth Suite	3,720	3,722	100.05%	744	768	103.23%	3,720	3,600	96.77%	744	744	100.00%	0	0	0	0	0	0	-1.49	-2.17%	94.08	4.33%
	4192	Burnley Birth Centre	1,395	1,303.50	93.44%	372	369	99.19%	1,116	1,104	98.92%	372	360	96.77%	0	0	0	0	0	0	3.13	7.01%	19.52	1.52%
	4200	Antenatal Ward 12	1,488	1,483	99.66%	744	720	96.77%	1,116	1,032	92.47%	744	720	96.77%	0	0	0	0	0	0	-0.44	-1.42%	68.44	6.91%
	4203	Postnatal Ward 10	2,412	2,478	102.74%	1,254	1,272	101.44%	2,232	2,208	98.92%	1,488	1,482	99.60%	0	0	0	0	0	0	-1.52	-2.69%	147.51	8.31%
RBH	5256	Blackburn Birth Centre	979.50	879.75	89.82%	495	427.75	86.41%	1,007.50	666.50	66.15%	333.25	333.25	100.00%	0	0	0	0	0	0	5.61	11.83%	61.76	4.79%
ED11: Neonates																								
RBH	4215	Nicu	4,836	4,848	100.25%	372	393	105.65%	4,464	4,020	90.05%	0	168	-	0	0	0	0	0	0	1.60	1.91%	61.51	2.40%
EH: Integrated Care Group																								
EH05: Business Support Unit																								
RBH	6078	Ward C3	1,518	1,326	87.35%	1,488	1,392	93.55%	972	1,092	112.35%	1,116	1,452	130.11%	0	0	0	0	0	0	28.78	67.09%	43.28	8.52%

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

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

Ward Staff Summary - Aug 2018

Executed on: 26/09/2018 at: 11:09:16 AM

Division: All 3 Available Divisions Selected
Directorate: All 17 Available Directorates Selected
Site: All 5 Available Hospital Sites Selected
This report is based on the 45 wards which submitted data for the monthly Safer Staffing return

R: ≥ ±10% | A: ≥ ±5% | G: < ±5% | R: > 0 | G: = 0 | R:≥ 5% | G:< 5% | R:≥ 3.75% | G:< 3.75%

Site	Cost Centre Code	Ward	Day Shift						Night Shift						Pressure Ulcers Acquired			Falls with Harm (Mod & Above)	Infections Acquired		Vacancies WTE (RegN/M + HCA)*		Sickness/Absence RegN/M + HCA)*	
			Registered Nurses / Midwives			Care Staff			Registered Nurses / Midwives			Care Staff												
			Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	G2	G3	G4		C Diff	MRSA	WTE Vacant	% Vacant	WTE Days	% Abs Rate
EH15: Acute Medicine																								
RBH	5058	AMU A	3,600	3,492	97.00%	2,160	2,124	98.33%	3,240	3,072	94.81%	1,440	1,356	94.17%	0	0	0	0	2	0	9.02	11.01%	121.06	5.39%
	6092	AMU B	3,720	3,492	93.87%	2,232	2,124	95.16%	3,348	3,072	91.76%	1,488	1,356	91.13%	0	0	0	0	1	0	15.64	19.11%	40.88	1.98%
EH20: Respiratory																								
RBH	5063	Ward C6	1,488	1,182	79.44%	1,116	1,092	97.85%	1,116	1,056	94.62%	744	792	106.45%	1	0	0	0	0	0	7.26	22.01%	54.56	6.94%
	5064	Ward C8	1,860	1,494	80.32%	1,116	1,296	116.13%	1,116	1,116	100.00%	744	756	101.61%	0	0	0	0	0	0	7.88	20.56%	18.92	2.01%
	6027	Ward C7	1,488	1,158	77.82%	1,116	1,206	108.06%	744	804	108.06%	744	960	129.03%	0	0	0	1	0	0	3.21	10.18%	78.44	9.73%
EH25: Cardiology																								
RBH	5095	Coronary Care	1,488	1,302	87.50%	744	744	100.00%	1,116	1,116	100.00%	0	0	-	0	0	0	0	0	0	1.47	5.93%	23.08	3.17%
	5097	Ward B18	1,860	1,476	79.35%	1,116	1,140	102.15%	744	1,068	143.55%	744	804	108.06%	0	0	0	0	1	0	-0.50	-1.52%	77.88	7.50%
EH30: Gastroenterlogy																								
RBH	5050	Ward C2	1,488	1,182	79.44%	1,488	1,284	86.29%	1,116	1,116	100.00%	1,116	1,176	105.38%	0	0	0	0	0	0	7.45	20.85%	51.36	6.21%
	5062	Ward C4	1,488	1,092	73.39%	1,488	1,164	78.23%	1,116	1,092	97.85%	1,116	1,152	103.23%	0	0	0	0	0	0	16.42	44.99%	64.20	10.47%
	6103	Ward C11	1,488	1,200	80.65%	1,488	1,512	101.61%	744	744	100.00%	744	1,104	148.39%	0	0	0	0	0	0	3.66	10.24%	35.33	3.63%
	6106	C1 (Gastro)	1,488	1,194	80.24%	1,488	1,176	79.03%	744	744	100.00%	1,116	1,128	101.08%	3	0	0	0	0	0	10.71	32.45%	43.71	6.32%
EH35: Mfop & Complex Needs																								
BGH	4613	Rakehead Nursing Staff	1,116	852	76.34%	1,860	1,884	101.29%	744	744	100.00%	744	1,212	162.90%	0	0	0	0	1	0	4.98	15.10%	33.12	3.86%
	6094	Ward 16 Sept 13	1,860	1,398	75.16%	1,488	1,824	122.58%	744	744	100.00%	1,116	1,812	162.37%	0	0	0	0	1	0	2.79	6.77%	139.92	11.94%
PCH	4581	Marsden Ward	1,488	1,200	80.65%	1,860	1,860	100.00%	744	744	100.00%	744	756	101.61%	0	0	0	0	0	0	6.05	16.93%	37.00	4.02%
	4582	Reedyford Ward	1,488	1,164	78.23%	1,116	1,290	115.59%	744	744	100.00%	744	924	124.19%	0	0	0	0	0	0	2.07	7.08%	30.40	3.65%
	4583	Hartley Ward	1,488	1,164	78.23%	1,116	1,326	118.82%	744	744	100.00%	744	864	116.13%	0	0	0	0	0	0	5.66	18.29%	70.04	9.09%
RBH	5023	Ward D1	1,482	1,194	80.57%	1,116	1,140	102.15%	744	756	101.61%	744	900	120.97%	0	0	0	0	0	0	7.17	23.39%	67.60	9.48%
	5036	Acute Stroke Unit (B2)	2,325	1,837.50	79.03%	1,627.50	1,920	117.97%	976.50	976.50	100.00%	976.50	976.50	100.00%	0	0	0	0	0	0	11.29	24.18%	12.20	1.12%
	5037	Ward B4	1,488	1,212	81.45%	2,232	2,124	95.16%	744	756	101.61%	1,488	1,476	99.19%	0	0	0	0	0	0	8.25	18.78%	147.80	13.84%
	5048	Ward C10	1,488	1,158	77.82%	1,488	1,470	98.79%	744	780	104.84%	1,116	1,140	102.15%	0	0	0	0	0	0	12.78	34.60%	73.88	9.67%
	6096	Ward C5	1,116	786	70.43%	1,488	1,362	91.53%	744	744	100.00%	1,116	1,152	103.23%	0	0	0	0	0	0	8.54	25.89%	13.19	1.79%
	6105	Ward C9	1,488	1,170	78.63%	1,488	1,566	105.24%	744	756	101.61%	744	1,152	154.84%	0	0	0	0	0	0	9.09	25.44%	8.00	0.97%
EH44: Speciality Medicine																								
RBH	5040	Ward D3	1,488	1,200	80.65%	1,116	1,176	105.38%	744	780	104.84%	744	1,092	146.77%	0	0	0	0	0	0	4.93	16.62%	29.12	3.71%
EH70: Comm In Patient Care																								
AVH	R133	Avch Ward 2	1,116	846	75.81%	744	1,110	149.19%	744	744	100.00%	744	756	101.61%	0	0	0	0	0	0	4.29	18.05%	36.00	5.71%
CLI	R141	Ribblesdale Ward	1,860	1,560	83.87%	1,488	1,506	101.21%	1,116	1,116	100.00%	1,488	1,476	99.19%	0	0	0	0	1	0	-0.31	-0.71%	277.03	20.44%
Total for 45 wards shown					**88.92%**			**102.08%**			**97.39%**			**112.44%**	**4**	**0**	**0**	**1**	**7**	**0**	**267.24**	**14.33%**	**2,962.01**	**6.00%**

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD REPORT

14 November 2018

Item 114

Purpose Information

Title	Emergency Preparedness, Resilience and Response (EPRR) Annual Statement
Author	Ms A Whitehead, EPRR Manager
Executive sponsor	Mr J Bannister, Director of Operations

Summary: This paper describes the current position of ELHT with regard to emergency preparedness, resilience and response (EPRR) and outlines the annual work plan for 2018/19.
It includes the Statement of Compliance in relation to the NHS England Core Standards for EPRR, which finds the Trust *Fully Compliant.*

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do 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	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

(114) EPRR Status Report 2018

Impact

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

To be considered by:

Emergency Preparedness and Organisational Resilience Committee, November 2018.

Executive Summary

This paper summarises the current position of the Trust in relation to emergency preparedness and business continuity arrangements based on the completion of the annual EPRR Core Standards Framework.

The EPRR Core Standards Assurance Process for 2018/19 demonstrates a level of Full Compliance, which this Board is asked to ratify (Appendix A).

However, as the Trust is constantly seeking to improve practice, an annual work plan has been developed (Appendix B) to ensure we a) maintain full compliance and b) review a selection of core standards to ensure that what is in place is fit for purpose in light of any local, regional or national incidents, developments and recommended best practice

Trust activity in EPRR over the preceding 12 months

1. In 2017/18, ELHT declared 100% compliance as this has been sustained this year.

2. An overview of the evidence to support this year's Core Standards Assurance Process can be found in Appendix C.

3. An overview of the 'Deep Dive' standards (Incident Co-ordination Centre) and assurance evidence of the Assurance Process can be found at Appendix D.

4. The Trust is undertaking a full and comprehensive review of all departmental business continuity plans providing assurance that they are able to respond effectively to a variety of potential risks including:

- Loss of staff
- Loss of premises / equipment
- Surges in activity
- Fuel shortage
- Loss of IT systems
- Loss of communications (phone / bleep)
- Supply chain failure.

Progress is being made at speed and Clinical Divisions and Corporate Directorates are fully engaged with this process and once complete, this will provide each Clinical Division and Corporate Directorate with a suite of business continuity plans that will provide more robust and resilient services.

5. A Corporate Business Continuity Plan, which outlines the organisation's strategy to respond to large scale business continuity issues, has been developed. From an operational management perspective, this Plan identifies the Trusts priority services based on business impact analysis. This will enhance the Trusts response in the event of a disruptive incident as it will be able to focus resources to the identified 'critical' services, with a phased recovery stage as documented in the Plan.

6. The Switchboard Manager and her team Trust continue to undertake the six monthly communications test named Exercise Starlight. The response rate continues to be at about 90% which provides assurance that in the event of an incident a core group of staff would be contactable.

7. Regular training and testing of the CBRN / HazMat decontamination arrangements continue to be undertaken to ensure that the Trust is able to respond effectively in the unlikely event that a contaminated patient presents at ED.

8. The Trust successfully invoked a Command & Control type system in response to the surge in demand over Christmas and New Year (2017 / 2018) and this will be further utilised over the coming winter as the Trust implements a new Operational Pressures Escalation Plan (OPEL).

9. Since the implementation of the new Patient Flow Model in October 2017, the EPRR Manager now works closely with the Head of Patient Flow and Site Operational Team to provide resilience and joint working to ensure that at times of system and organisational pressures, the Trust can facilitate the implementation of plans to minimise the impact on patients. This could be in response to a critical of major incident, or in response to other triggers such as surges in ED or in the event of an influenza pandemic.

10. There is a new EPRR Manager in post who is a subject matter expert in emergency planning, resilience and business continuity. Since joining the Trust, it has been noted that some support systems have not been kept up to date e.g. OLI, the monitoring and testing of local Business Continuity Plans as there has not been any clerical support in place. The maintenance of these systems is crucial for providing ongoing assurance around preparedness and arrangements are in hand to address this.

Conclusion

11. The Trust has again achieved full compliance with the EPRR core standards.

12. The Trust continues to be able to provide a 24 / 7 incident response and has a cohort of skilled and trained staff available to respond in the event of a major incident (including Senior Managers, Directors / Assistant Directors, Clinicians and a specialist response in ED for CBRN incidents).

13. As noted in the 2017 / 2018 assurance return, the EPPR function requires additional clerical support for the EPRR Manager in order to maintain essential administrative functions such as co-ordinating and quality checking Trust wide business continuity plans, facilitating and monitoring EPRR training e.g. loggist training, mandatory desktop exercises, etc. and keeping OLI and other EPRR / on-call systems up to date.

Recommendations

14. The Board is asked to approve the EPRR Statement of Compliance 2018 / 2019 for signature by the Accountable Emergency Officer which will then be submitted to the lead commissioning CCG.

15. The Board is asked to support the request for essential additional staffing resource, acknowledging that the EPRR portfolio is vast and requires this additional support to maintain full compliance with the core standards moving forward.

Appendices:

Appendix A – Statement of Compliance 2018 - 2019

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2018-19

STATEMENT OF COMPLIANCE

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

Following self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating the following level of compliance against the 2018-19 standards: **Full**

Compliance Level	Criteria
Full	The organisation is **100%** compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position.
Substantial	The organisation is **89-99%** compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is **77-88%** compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation is complaint with **76%** or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plan will be monitored on a quarterly basis to demonstrate progress towards compliance.

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as Red	Standards rated as Amber	Standards rated as Green
64	0	0	64
Acute providers: **64** Specialist providers: **55** Community providers: **54** Mental health providers:**54** CCGs: **43** NWAS: **49/163*** NHS111:**42****			

**NWAS should report two assurance ratings, demonstrating compliance with the core standards for EPRR and interoperable capabilities. ***NHS111 should be reported separately.*

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

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

Signed by the organisation's Accountable Emergency Officer

12/09/2018
Date of board / governing body meeting

07/09/2018
Date signed

Statement of Compliance Version 1 18/07/18

Appendix B - Annual EPRR Workplan (September 2018/ September 2019)

Organisation: East Lancashire Hospitals Trust

Plan owner: Deputy Director of Operations and Trust EPRR Lead

Area	Action required	Who will be involved	Deadline
BCP	All wards and departments are transferring their Business Continuity Plan over a new standard template. These plans will be tested over the next 12 months to ensure that they are fit for purpose.	EPRR Manager All BCP Plan owners	September 2019
Command and Control	The Trust has a cohort of trained loggists but as staff leave the Trust, this number is declining. The EPRR is a 'train the trainer' for loggist training and will therefore undertake both loggist training and 'train the trainer' loggist training to further expand the number of trained loggists available.	EPRR Manager Switchboard Supervisor	September 2019
Command and Control	The number of directors / deputies that have attended strategic training will be reviewed with a view to boosting the numbers over the next 12 months.	EPRR Manager NHSE North	September 2019
Testing and Exercising	The Trust needs to participate in a table top exercise over the next 12 months to test its Plans and response arrangements.	EPRR Manager Deputy Director of Operations	September 2019
Duty to Maintain Plans	As part of a rolling programme to ensure EPRR Plans are up to date and fit for purpose, the Plans relating to pandemic influenza and infectious diseases will be reviewed over the coming 12 months.	EPRR Manager Lead Nurse IPC	September 2019
CBRN	To review CBRN Plans, equipment, training, etc. to ensure that they are fit for purpose and to ensure that the Trust can continue to provide an immediate 24 / 7 response to a contamination incident.	EPRR Lead Consultant EPRR Lead Nurse CBRN Portering Lead EPRR Manager	September 2019
Governance	The EPRR Manager requires further EPRR resources in the form of administrative support. This support will provide essential clerical support to the EPRR function and will also providing resilience in terms of offering advice and support if the EPRR Manager is unavailable.	EPRR Manager Deputy Director of Operations	January 2019
Business Continuity	A selection of 5 suppliers / service providers will be asked to provide evidence of their business continuity plans for assurance purposes.	EPRR Manager Procurement	September 2019

Appendix C - EPRR Core Standards Assurance Compliance Evidence.

Ref	Domain	Standard	Detail	Evidence	RAG
1	Governance	Appointed AEO	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	The Trust has an AEO - Mr John Bannister, Director of Operations NED - Trish Anderson	
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	The Trust has an overarching EPRR Policy Statement in the Major Incident Plan.	
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	An EPRR annual report is presented to the Board and all corporate plans (major incident, BCP) are sent to Board for approval. A six monthly update goes to the Quality and Safety Committee.	
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	An EPPR workplan is produced each year and submitted with the core assurance statement. This is presented to and monitored by the Board.	
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	The Trust has an EPRR manager who reports to the Deputy Director of Operations, both who support the Trust in discharging its EPRR functions. However, additioanl support is needed to maintain administrative functions.	
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Learning is captured at the monthly Operational Planning and Resilience Group which inform the workplan and EPRR arrangements.	

Ref	Domain	Standard	Detail	Evidence	RAG
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	The Trust reviews local risks alongside reviewing regional and national risk registers with the CCG and partner agencies at the LHRP. Local risks are referenced in the Trust BCP.	
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	The organisation has a Risk Management Policy in place and EPRR risks are escalated in line with this Policy.	
Domain 3 - Duty to maintain plans					
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Partner agencies are involved in writing and developing plans as necessary e.g. LMHT, LCFT, LHRP	
	Duty to maintain plans	Planning arrangements:	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the following risks / capabilities:		
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	The Trust has a Major Incident Plan in place which covers critical incidents.	
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	The Trust has Major Incident Plan and divisions have local plans that support this.	
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	The Trust has a Heatwave Plan in place.	
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	The Trust has an Adverse Weather Plan.	
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Policy IC 23	
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	IC 14 Outbreak IC 7 Gastrointestinal outbreak IC8 Avian influenza/SARS/MERS IC22 multi resistant organism IC 21 VHF	
17	Duty to maintain plans	Mass Countermeasures	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, e.g. mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	The Trust has a Vaccination Policy which is reviewed every 12 months in advance of the flu season. ELHT has a suite of vaccination PGDs but does not carry any civil contingency stock. The Trust is not commissioned to carry out public vaccination programmes. However, in the event of needing to action mass prophylaxis / vaccination, the process would be similar to that in the policy but it would be ramped up accordingly as and when needed e.g. time frame and the supporting systems and processes would be defined by NHS E and PHE. ELHT would receive support from the CCG for a health economy wide response e.g. using community facilitites. A command and control structure would be activated accordingly as per existing systems.	
18	Duty to maintain plans	Mass Casualty - surge	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	The Trust has Escalation Policy which covers surge.	

Ref	Domain	Standard	Detail	Evidence	RAG
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	There is a system in A&E that ensures the safe identification of unidentified patients in an emergency incident.	
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	The Trust has evacuation plans in place and these are regularly tested.	
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	The Trust has informal processes in place to lockdown A&E and can and does lockdown entire sites. There is a Lockdown Policy and this needs reviewing once the resources have been agreed to fund a lockable set of doors within A&E to be able to compartmentalise the waiting area to restrict access to the rest of the hospital. A risk assessment is in place and the variation request for the work to be done is complete and a cost has been assigned to it. It will go to the next capital funding meeting early October.	
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	The Trust has a VIP Policy.	
23	Duty to maintain plans	Excess death planning	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	The Trust is now a regional resilience mortuary and has a Policy outlining the process of activating this.	
Domain 4 - Command and control					
24	Command and control	On call mechanism	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	There is a 24 / 7 Clinical Site Manager, SMOC and DOC rota to receive / escalate notification of incidents.	
25	Command and control	Trained on call staff	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	The EPRR Manager provides annual training for all SMOCs / DOCs to ensure they are trained and competent around EPRR and the core competencies. There is an On-Call Policy in place and all SMOCs / DOCs are invited to a monthly On-Call Forum to discuss issues, good practice, share experiences and provide peer support.	
Domain 5 - Training and exercising					
26	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	As part of the EPRR training, competencies are assessed and additional training needs established where appropriate.	

Ref	Domain	Standard	Detail	Evidence	RAG
27	Training and exercising	EPRR exercising and testing programme	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	The Trust was put on stand up to receive patients from Manchester hospitals after the Manchester bombing and therefore this covers the live exercise until at the latest January 2020. This also fulfils the command post exercise. The Trust also responded to the Cyberattack in 2017, testing the Trusts IT BCP. A desktop exercise is planned in the 2018 - 2019 workplan, and A&E continue to undertake regular desktop exercise with the next ones planned for Sept / Oct. Comms tests are undertaken every six months by Switchboard and these are at differing times e.g. out of hours, in hours, weekends. All tests and exercises are reported on in order to capture lessons to be learned and good practice.	
28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	The Deputy and Director of Operations have undertaken strategic level training. However, it would be of benefit to the Trust if further Directors / Deputies undertook this training from a resilience perspective.	
29	Training and exercising	Computer Aided Dispatch	NA		
Domain 6 - Response					
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	There is an Operational Control Centre at RBH that functions 24 / 7 and is one of two ICC on this site. The other is at Trust HQ. There is a fall back incident room at BGH, Trust Offices.	
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Plans are available internally on OLI and version controlled as required. Hard copies of Plans are stored locally as required.	
32	Response	Management of business continuity incidents	The organisations incident response arrangements encompass the management of business continuity incidents.	The Trust has a Corporate Business Continuity Plan in place and departments / wards are in the process of transferring their old BCPs into a new standardised template.	
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	The Trust has access to trained loggist 24 / 7 although does need to enhance the numbers with more training.	
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	There is a system in place to receive and respond to sitreps. These will usually be co-ordinated by EPRR Manager / CSM / Incident Manager.	
35	Response	Access to 'Clinical Guidance for Major Incidents'	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.	The Emergency Department has access to the Clinical Guidance for Major Incidents Handbook.	
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Clinical staff have access to the PHE CBRN Guidance and also have a CBRN Policy in place to reflect the guidance.	

Ref	Domain	Standard	Detail	Evidence	RAG
Domain 7 - Warning and informing					
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	The Trust has a Comms Policy in place and communications are also part of the major incident response.	
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	The Trust has a Comms Policy and comms team in place to support with warning and informing.	
39	Warning and informing	Media strategy	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	The Trust has a media strategy and has a cohort of trained media spokespeople.	
Domain 8 - Cooperation					
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	The Deputy Director of Operations regularly attends the LRHP as the nominated Director level representative for ELHT.	
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	The EPRR Manager attends the LRF to support with EPRR arrangements.	
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource e.g. staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	The Trust has signed off the Lancashire MoU.	
43	Cooperation	Arrangements for multi-region response	NA		
44	Cooperation	Health tripartite working	NA		
45	Cooperation	LHRP	NA		
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	The Trust has policies in place to cover Freedom of Information, Data Protection and the CCA.	
Domain 9 - Business Continuity					
47	Business Continuity	BC policy statement	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	The Corporate BCP outlines the Trusts policy statement of intent.	
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	The scope and objectives of the BCMS are documented in the Corporate BCP.	
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	The impact of disruption to services are documented in local BCPS and also in the Corporate BCP.	
50	Business Continuity	Data Protection and Security Toolkit	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	IM&T are complaint with the Data Protection and Security Toolkit.	
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	All wards / departments have BCPs and are in the process of transferring the information on to a new template that reflects ISO 22301. The Corporate BCP outlines how the Trust will respond to key disruptions including loss of staff, loss of premises, loss of IT and comms, etc. These plans are reviewed at least every 12 months, or more frequent if there is an actual incident.	

Ref	Domain	Standard	Detail	Evidence	RAG
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	The EPRR Manager reviews all BCMs to ensure that they are fit for purpose. Moving forward, these will be tested though desktop exercises (planned for 2018 - 2019) and the outcomes will be reported to the Board.	
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	The Corporate BCP outlines the audit requirements for the testing of it and the reporting process to the Board.	
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	BCPs are reviewed every 12 months as a minimum and regularly tested to take into account any improvements.	
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	The Trust expects suppliers to have BCPs and this is a contractual requirement. However, moving forward, the Trust will be seeking assurance of this directly from the suppliers.	
Domain 10: CBRN					
56	CBRN	Telephony advice for CBRN exposure	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.	Staff are aware of how to access telephone advice for CBRN exposure and this is covered in the training programme.	
57	CBRN	HAZMAT / CBRN planning arrangement	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).	The Trust has a CBRN Policy (C117) outlining its response to a CBRN / HazMat incident. A working group is to be established to co-ordinate the Trust CBRN programme and will include the Deputy Director of Ops, EPRR Manager, CBRN Consultant and Nurse Lead and Portering Supervisor.	
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	These are included in the Decontamination Protocol C117 and competencies are covered in the training package.	
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four per hour), 24 hours a day, 7 days a week.	The A&E Dept has a comprehensive training programme. All Band 7s have been trained and work is ongoing to train the Band 6s. Scenario based exercises will also take place over the next couple of months.	
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	The Trust undertakes a check of CBRN equipment every month and this involves the A&E lead nurse and the portering supervisor.	
61	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	The Trust has 17 live suits available for deployment.	

Ref	Domain	Standard	Detail	Evidence	RAG
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	The Trust undertakes a check of CBRN equipment every month.	
63	CBRN	Equipment PPM	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other equipment	The Trust undertakes a check of CBRN equipment every month which facilitates the PPM.	
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	CBRN equipment is disposed of in line with NHS best practice guidance.	
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training	The A&E CBRN Lead is a trained reservist and appropriately qualified to deliver CBRN training.	
66	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	The training programme is regularly updated and is currently being updated to reflect on recent PHE guidance post-Manchester bombing.	
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	The Trust has several trained CBRN / Hazmat trainers.	
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	All staff in A&E (including reception) are aware of the need to stop a patient requiring decontamination to prevent the spread of the contaminant.	
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.	The Trust has a comprehensive training programme and access to FFP3 in all of the relevant areas.	

Appendix D – Deep Dive Return – Incident Co-ordination Centre

Ref	Domain	Standard	Detail	Evidence - examples listed below	RAG
Deep Dive - Command and control					
Domain: Incident Coordination Centres					
1	**Incident Coordination Centres**	**Communication and IT equipment**	The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance.	The main ICC has access to IP and analogue phones and a satellite phone.	
2	**Incident Coordination Centres**	**Resilience**	The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times.	The ICC is used as an operational co-ordination centre 24/7 and is manned 24/7.	
3	**Incident Coordination Centres**	**Equipment testing**	ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary.	The ICC is regularly tested as it is in use 24/7.	
4	**Incident Coordination Centres**	**Functions**	The organisation has arrangements in place outlining how it's ICC will coordinate it's functions as defined in the EPRR Framework.	The ICC functions are incoporated into the MIP and include: Coordination Operations Information gathering and sharing	
Domain: Command structures					
5	**Command structures**	**Resilience**	The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7.	The command structure is defined in the SMOC / DOC training and in the MIP.	
6	**Command structures**	**Stakeholder interaction**	The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures.	The command structure is defined in the SMOC / DOC training. It is also covered in the MIP	
7	**Command structures**	**Decision making processes**	The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model.	The MIP outlines the decision making process and structure.	
8	**Command structures**	**Recovery planning**	The organisation has a documented process to formally hand over responsibility from response to recovery.	The process of moving to recovery planning is outlined in the MIP	

East Lancashire Hospitals
NHS Trust

TRUST BOARD REPORT

Item 115

14 November 2018

Purpose Information
Assurance

Title	ELHT&Me Update Report
Author	Mrs C Hughes, Director of Communications and Engagement
Executive sponsor	Mrs C Hughes, Director of Communications and Engagement

Summary: ELHT&Me was launched in 2016 and a Fundraising Strategy was agreed which outlined the Charity's aims and objectives. The strategy was updated in 2017, to run until 2019, and this report outlines the progress and challenges to date.

Recommendation: The Trust Board is asked to note progress and agree to act as ambassadors of the charity, ELHT&Me, and its appeals.

The Trust Board, as the Charity Trustee is asked to consider the funding requests and agree to release funding from existing resources to meet those agreed.

The Trust Board, as Charity Trustee is asked to confirm the subject of a major capital appeal early next year.

Report linkages

Related strategic aim and corporate objective	-
Related to key risks identified on assurance framework	-

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: NA

Introduction and background

1. ELHT&Me was launched in 2016 and a Fundraising Strategy was agreed which outlined the Charity's aims and objectives. The strategy was updated in 2017, to run until 2019, and this report outlines the progress and challenges to date.
2. The aims of the strategy were to increase engagement, participation and involvement so that ELHT&Me is well recognised by the people and businesses of East Lancashire as *their local* hospital charity, which will lead to an increase in donations and allow ELHT&Me to better support the trust.
3. The strategy has three specific objectives:
   a) Make it easier to *recognise* the charity;
   b) Make it easier for people to *donate* to the charity: and
   c) Make it easier for people to *fundraise* for the charity.

Objectives

Make it easier to recognise the charity

4. We have refreshed the Charity's branding and have amended the logo to add the words *'your local hospital charity'*. This makes it clear exactly what the charity raises funds for. The new logo is on T-Shirts, collection buckets and tubs, our event marquee and stand, posters, website, social media and all internal and external correspondence. We no longer talk about 'the hospital charity' as it is now becoming widely known and recognised as ELHT&Me.
5. A new, improved website for the Trust has been developed and delivered by the Communications Team. ELHT&Me is now hosted on the home page, with quick links to our charity pages and many ways to donate.
6. ELHT&Me has a large presence in the entrance of the Royal Blackburn Hospital with our promotion stand taking pride of place for everyone to see. Posters are in public spaces and have been distributed, fully branded, to all areas.
7. The increased use of social media and attendance at external events keeps the brand prominent as well as enabling us to easily reach thousands of people.

Make it easier to donate

8. 'Just Giving' is a convenient way for people to both fundraise for various activities and donate direct to the charity. We have increased visibility of and access to 'Just

Giving' through our website. More than £21,000 has been raised in the last year via ELHT&Me Just Giving.

9. We have introduced Text giving and have secured a variety of codes so that we can use different numbers for different appeals. For example, ELHT44 is allocated to our 'million pound appeal' whilst ELHT22 is earmarked for the recently launched 'Endoscopy Appeal'. Our text number is 70070, so one would text *ELHT44* followed by £3, £5 or £10 to 70070 to make a donation for the million pound appeal. This way to give has attracted only a small amount of donations to date, although we expect this to become far more prevalent in the near future.
10. A Gift Aid envelope and information card are now included in bereavement packs. This has proved popular and effective with regular, significant legacy donations and an increasing number of 'in lieu of flowers' collections for ELHT&Me. Online Memory Giving is also used by funeral directors to collect donations. ELHT&Me is registered with this service enabling donations direct to our bank account, reducing the demand on general office from cheque processing.
11. We offer 'appreciation giving' for people who want to acknowledge their positive experience with us, although this is something that needs further development to maximise its potential.
12. Payroll Giving is set up and is ready for business to offer to employee's the launch has had a small response and more work is required.
13. Scores of collection boxes have been distributed both internally and externally resulting in regular donations. We expect this to grown considerably with the appointment of a new community fundraiser role.

Make it easier for people to fundraise for ELHT&Me

14. ELHT&Me can now take signups through Event Bright. This is a cost effective way to sell tickets for various events and activities. This can be hosted on the new website ensuring signing up to participate is available 24/7. The August Morecambe Bay Walk is a great example of how this works well and was a sell out with all 100 places taken, and at least £1,000 raised from entry fees alone.
15. An online form to register events has been added to the new website and this gives ELHT&Me a registered list of all fundraising in aid of the charity. We have created branded sponsorship forms to ensure the charity is recognised and that fundraisers have the correct documentation for them to seek support for their activities.

16. We launched a "70 ways to fundraise" leaflet and this has a list of 70 ideas to encourage and inspire supporters. This is available at all times on the charity's webpage. Fundraising buckets and collection boxes are also available.
17. ELHT&Me now holds a local authorities' licence for raffles which last more than one day. This is a legal requirement and a 'holding a raffle document' is available for guidance.
18. Branded T-Shirts, marquee, banners and posters are all created and available for all events or promotions to ensure the charity is instantly recognisable.

Million Pound Appeal

19. Although ambitious at such an early stage of the charity, we launched an appeal to raise £1million on the 24 February 2018. Seven categories listed in the appeal have been very successful in attracting donors to both general funds, and specific funds where there is a desire to support a particular theme. This gives the Trust a wider appeal to potential donors who may, for example, have selected a children's charity or a woman's health charity in the past. Examples of donations where specific requests for how a donation is used include blood pressure machines, video conferencing equipment for ELCAS, portable sensory equipment for the children's ward, funding of 12 defibrillators, artwork for patient waiting areas, funds for cancer, delivering 10 new therapy chairs, and new facilities for the waiting rooms. Full funding for the development of a children's ward outdoor play area has been pledged.
20. In addition to cash and equipment the appeal has attracted gifts, raffle prizes and cake donations which have all helped the charity raise funds and support events in aid of ELHT&Me.
21. Total income to the charity since the launch of The Million Pound Appeal is over £470,000 with a steady increase in donations and support to the trust.
22. The appeal has received considerable media coverage and support throughout from BBC Radio Lancashire, 2BR – who have nominated ELHT&Me as their charity for 2018 and all local press.

Engaging in our local community

23. The development of the charity has encouraged support and the engagement of our community. For example, raffles being held in aid of ELHT&Me; a golf day which

raised £2,300; church collections; 100 walkers on Morecambe Bay that raised £4,000; 20 Burnley 10k runners who raised over £1,500; two half-marathon runners who raised over £1,000 each; and a growing number of 'in memorium' donors.

24. ELHT&Me has been nominated as the benefitting charity and to switch the charity Christmas lights on at Brierfield, and in Darwen, a family fun day is being held for ELHT&Me.

25. 2018 saw the NHS celebrate 70 years since its inception and this gave the charity huge opportunities to engage with the staff and the local community. **Big7Tea** parties were held throughout the Trust and beyond. Our Director of Nursing's tea party was the subject of a Channel 4 national TV programme and the beneficiary of a large bespoke cake, paying tribute to all NHS staff.

Fundraising Partners

26. We have a positive working relationship with the various hospitals 'Friends' groups who support ELHT&Me for various causes through their own fundraising efforts. We have also entered into an arrangement with CARES, a new local charity dedicated to the early diagnosis of cancer for local people. They have donated £25,000 to start a fundraising appeal for £525,000 to fund a fourth endoscopy suite in Burnley. We continue to work with Rosemere, another cancer charity who donated £100,000 towards the Primrose Suite Burnley.

Legislation and Governance

27. All fundraising activities are now compliant with fundraising legislation and guidelines in order to protect the Trust's reputation. This becomes more important as the charity grows and becomes involved with differing funding streams and projects. ELHT&Me now holds a local authority licence for holding raffles. Raffles that run for more than one day are regulated and must have printed tickets, a financial return on sales report and the winners list is given to the charity and publicised. ELHT&Me is registered with the fundraising regulator. This is promoted in all possible areas of engagement to ensure confidence in the charity.

Future of ELHT&Me

28. It is clear that the charity's performance is effective and progress towards the objectives described is steady. This has involved tremendous effort by a very small

resource. However, a new community fundraiser has now been appointed who will continue with the work already begun.

29. This will enable the Fundraising Manager to considerably step up efforts on securing income from the private and corporate sectors, and to dedicate some time to improving performance from text giving.

30. The Charity Committee members have also agreed that a major capital appeal for a new, much needed MRI Scanner or other significant equipment should be launched soon. They believe this will attract sponsorship and corporate contributions in return for association with the equipment. Developing these relationships is something that will form a considerable part of the Fundraising Manager's role, going forward. However, this new appeal needs to be considered in the context of the Trust's equipment strategy, capital plan and its marketability in terms of fundraising.

31. The ambition of such an appeal, that will run concurrently with the continuation of the Million Pound Appeal and the CARES appeal for endoscopy equipment, should not be underestimated. It will require the support of Trust Board members together with their commitment to help the appeal through their own networks and contacts. Trust Board members are ambassadors for the charity and its appeals

32. The Charitable Funds Committee is keen to learn from other, bigger NHS charities and to this end we are in the process of arranging a visit with the Christie's Charity. In addition, Mr Barnes is arranging for a talk from a leading business figure in the East Lancashire area to talk to the committee to advise on how corporate entities prefer to engage with charities. Both of these measures will inform a refreshed Fundraising Strategy for 2019 and help us maximise income from business.

33. We are already making arrangements for a more prolific presence for the Charity in the main reception of Royal Blackburn Teaching Hospital. Also, the curved wall in the main corridor there will become our 'Supporting Wall', which will feature the logos of companies/organisations who contribute to the future appeal. We will also be looking into a memory tree so that individuals can also be acknowledged, regardless of the size of the donation.

Equipment Requests for funding from Charitable Funds

34. Arif Patel, Head of Medical Engineering gave a presentation to the last Charitable Funds Committee and outlined the need for a strategic approach that recognises technological advances, continuous quality improvement and efficiency and

sustainability. The overall medical equipment allocation this year was £1.36m, but with pre-existing commitments, the total left for planning was £780k against equipment requirements (not including radiology imaging and non-capital equipment) of £2.64m. He has asked for targeted support for equipment not funded from capital; equipment not classed as capital due to its value; and equipment that is innovative and develops a service.

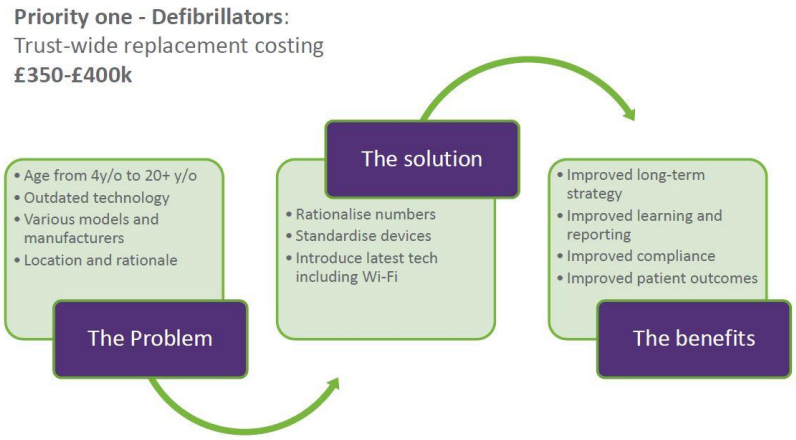
35. Some of the non-funded requirements are shown at Table 1, while Figure 1 details the need for replacement of all Trust defibrillators, in line with the efficiency and sustainability requirement, as a priority.

36. In addition, the Spiritual Care Centre at Burnley is in desperate need of relocation and development at an estimated cost of £300k.

Table 1

EQUIPMENT	RATIONALE	EST. COST
Faxitron	Supports breast cancer treatment, but now end-of-life: failure will significantly impact on service delivery of a high volume breast unit	£76,000
Field analysers	Vital ophthalmology equipment used every day for 20 patients, now obsolete. Failure, subsequently waiting for parts will significantly impact on service delivery.	£66,000
Theatre stack system	Shortages mean one device currently on loan from the company, who could request back at any time, which will reduce capacity	£30,000
Tympanometers	Current pressures mean Audiology desperately need (minimum) one device to support service delivery.	£5,000
Operating Table	Due to breakdown, a device had been loaned for 18-months. Again, company can withdraw at any time resulting in a compromised service.	£18,000

Figure 1



Conclusion

37. In conclusion, you can see that the Charity has had an eventful and successful year to date. A fundraising strategy is in place which identifies clear objectives and steady progress. Income to the charity is substantially increased. The appointment of a Community Fundraiser is expected to have a further positive impact on performance. A major capital appeal to raise funds for a new MRI Scanner or other major equipment is desired by the Charitable Funds Committee and this will be supported by an updated Fundraising Strategy.

Recommendation

38. The Trust Board is asked to note progress and agree to act as ambassadors of the charity, ELHT&Me, and its appeals.
39. The Trust Board, as the Charity Trustee is asked to consider the funding requests and agree to release funding from existing resources to meet those agreed.
40. The Trust Board, as Charity Trustee is asked to confirm the subject of a major capital appeal early next year.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 116

14 November 2018

Purpose Information
Assurance

Title	Audit Committee Update Report
Author	Miss K Ingham, Assistant Company Secretary
Executive sponsor	Mr R Smyth, Non-Executive Director, Committee Chair

Summary: The report sets out the matters discussed and decisions made at the Audit Committee meeting held on 1 October 2018.

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Audit Committee Update

At the meeting of the Audit Committee held on 1 October 2018 members considered the following matters:

1. The internal audit reports listed below were presented to the Committee:
   a) Theatre Stock Management - **Limited Assurance**
   b) Clinical Coding – Substantial Assurance

   Members noted that the management response to the Theatre Stock Management report would be presented to the next meeting of the Committee.
2. The Committee received the management response update in relation to Salary Overpayments. It was noted that the overall responsibility for the Electronic Staff Record (ESR) now sits within the remit of the Finance Team rather than the HR Team. Members received an overview of the actions that had been undertaken to reduce the number of overpayments, including refresher training for managers and the implementation of ESR Go which provides more timely information than the previous version of the system.
3. The Committee received the Information Commissioners Office Audit Action Plan Progress Report which provided an overview of the actions completed to date and progress against the remaining actions. Members noted that the completion report from the Trust to the ICO will be finalised by the end of October 2018 and will be made available to the Committee. In addition members noted that the ICO will carry out a follow-up desktop review of improvements made since the audit in 2017 before the end of the year.
4. The members received an update on the progression of actions relating to the recent audit of Divisional Risk Registers. Members expressed their concerns at the timeline for rollout of the e-learning module and sought clarification around the reasons for delay. Members noted the significant progress made since the last meeting.
5. The Committee received the report from NHS England relating to the Trusts digital maturity assessment and noted the improvements made between 2016 and 2017, particularly in relation to leadership and improved strategic direction. Members commended the team for their efforts and welcomed the positive report.
6. The Committee received the progress report from external auditors and noted that the audit work for 2017/18 was now complete and work would be commencing on the Trust's Charitable Funds annual accounts and report towards the end of the month in preparation for submission in early 2019. Members also noted that planning for the

2018/19 audit work had commenced. A brief overview of the revised methodologies for this work was provided for information.

7. Members received the Anti-Fraud Service Progress Report and noted the progress being made in relation to referrals and investigations. The Committee noted the proactive exercise that had taken place with regard to overseas patients/visitors and the promotion of the anti-fraud service throughout the Trust. Members discussed the practicalities of undertaking witness statements and interviews under caution and sought further assurance that action and reporting is completed within the required timeframes.
8. The Committee also briefly discussed the request of the wider ICS to develop a joint Board Assurance Framework across all ICS organisations and the complexities of this work. In addition the Committee received an update on the new system for declaring any potential and actual conflicts of interest and the minutes of the Information Governance Steering Group.

Prior to the full meeting of the Audit Committee on 1 October 2018, the Committee members met with a number of the Executive Team to review risks two (Workforce) and five (constitutional standards) on the Board Assurance Framework (BAF). The following is a summary of the discussions held:

1. The Committee noted the importance placed on the BAF at the recent Well Led Inspection by the CQC and the way that it drives the Board agenda.
2. Members received an overview of the way that the BAF is revised in preparation for presentation to the Board and its sub-committees.
3. There was an agreement that the BAF could be made more user friendly, including the eradication or explanation of acronyms. This was a particularly pertinent issue as the document is in the public domain.
4. At the previous Well Led inspection there had been criticism of the detail provided in the document regarding actions undertaken and results of them.
5. It was agreed that whilst it is not practical to provide the fine detail of actions and outcomes within the document presented to the Board there is a need to ensure that the information is available should it be required. It was also agreed that there was a need to ensure that once actions have been completed and assurance is gained from the actions the information is recorded in the 'potential sources of assurance' section rather than remain within the 'actions/update' column.

6. Committee members noted that work would be commencing in the coming weeks to look at developing governance across the ICP partners. In addition it was noted that the Trust intends to refresh its Clinical Strategy and will ensure that it aligns to the work of Pennine Lancashire as much as possible.
7. In relation to BAF risk two it was agreed that the information currently available needed to be revised to provide a comprehensive and up to date picture in preparation for the next iteration of the document being presented to the Trust Board.
8. Members discussed the reporting and monitoring/assurance relating to workforce matters and members noted that whilst assurance and reporting around workforce metrics was currently provided through the Quality Committee, it was acknowledged that the required levels of reporting were not always achieved. Members also noted that there some reporting of workforce issues is carried out via the Finance and Performance Committee. Members discussed the possibility of developing a Workforce Group if reporting into the current committee structure did not improve.

Kea Ingham, Assistant Company Secretary, 5 November 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 117

14 November 2018

Purpose Information Assurance

Title	Finance and Performance Committee Update Report
Author	Miss K Ingham, Assistant Company Secretary
Executive sponsor	Mr D Wharfe, Non-Executive Director

Summary: The report sets out the matters discussed and decisions made at the Finance and Performance Committee meeting held on 24 September 2018 and 29 October 2018.

The Board is asked to note the content of the report.

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Finance and Performance Committee Update Report

At the meeting of the Finance and Performance Committee held on 24 September 2018 members considered the following matters:

1. The Committee received the Integrated Performance Report, including an overview of the current financial position to the end of August 2018. The members noted that there had been an increase in the number of patients waiting in excess of 30 minutes to be handed over from the ambulance crew to the Trust, which correlated with the deterioration in performance against the four hour standard. Patients with a length of stay in excess of 21 days also increased in August which also has an impact upon the occupancy and flow of patients through the Trust. Members received an update on performance against the cancer targets and it was agreed that a full improvement plan would be presented to the October Committee meeting.
2. The members received the financial performance report for the month of August and noted that there had been a deterioration of the financial position with the planned overspend being exceeded by £800,000, which was related to the underachievement of Provider Sustainability Funds (PSF).
3. In addition to the standard Sustaining Safe, Personal and Effective Care 2018/19 Report the Committee received a Divisional financial update from the Family Care Division. The Divisional triumvirate attended the meeting and provided a presentation which included an overview of the Family Care Division's financial position to the end of August (month 5); the pressures facing the Division; an overview of the Division's historical successes in delivering SRCP schemes and the actions being undertaken to mitigate risks to the underachievement of SRCP/transformation schemes.
4. The Committee received an update report on tenders; an update on the emergency care pathway; the Committee Specific Board Assurance Framework for review; and the minutes of the Contract and Data Quality Board for information.

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

1. The Committee received the Integrated Performance Report, including an overview of the current financial position to the end of September 2018. The members noted that the two week breast symptomatic standard and 62 day cancer standards were not met in the reporting month. There had been 19 patients who had endured 12

hour breaches, all of which were noted to be patients awaiting assessment or admission by mental health services. Members discussed the ongoing difficulties in achieving satisfactory performance against the four hour standard. Non-Executive members requested that additional assurance be provided at the Board meeting in relation to the anticipated impact of newly implemented schemes/services such as the ambulatory emergency care service on overall four hour performance.

2. Members received the Cancer Performance Improvement Plan and noted the work being undertaken to recover performance against cancer targets. Members also noted that the majority of performance related issues related to the speed at which initial appointments were offered to patients; the mismatch between demand and capacity for diagnostic services; and the timeframe for reporting on diagnostic testing. Monitoring of the improvement plan will continue to take place through the Cancer Board and the Quality Committee.

3. The Committee received a detailed financial performance report for the month of September 2018 and noted that the Trust's financial position remained broadly in line with the overall financial plan. Members noted that the cash position had improved following receipt of £2,000,000 of Public Dividend Capital (PDC) for the phase 8 capital projects at the Burnley General Teaching Hospital site and that income had increased significantly above the planned position due to over performance in clinical services of around £5,600,000. Members were presented with forecast 'best', 'worst' and 'likely' case financial out turn positions and spent some time discussing the risks to the of achievement of the year-end financial control total.

4. In addition to the usual financial performance report the Committee received a deep dive into medical agency costs, with a focus on the Trust's Emergency Department. Members noted that overall medical staffing costs increased by 8% in 2017/18 in comparison to 2016/17 and a further 6% increase in spend was anticipated for the current year. Non-Executive members noted that a number of substantive middle grade appointments had recently been made within the Trust's Emergency Department but expressed their concern around 'double running' in the short to medium term until the individuals are in post and embedded. It was agreed that a further update on medical staffing would be presented to the Committee in April 2019.

5. The Committee received the Sustaining Safe, Personal and Effective Care 2018/19 report and noted the progress being made in relation to the implementation and

embedding of the Lean Pennine Lancs Way. Members also noted that a fully identified change programme was in place to deliver the £18,000,000 required cost savings; however as it stands the RAG analysis of the schemes is showing 64% of schemes classed as green and amber, therefore a significant risk remains to the delivery of the balance of the programme.

6. In addition to the Sustaining Safe, Personal and Effective Care 2018/19 report, the Committee received a presentation from the Surgical and Anaesthetics Service in relation to their financial performance and progress towards achievement of the Division's required efficiency savings and transformation schemes. The presentation covered the Divisional financial position to the end of September 2018 (month 6); and the key challenges within the Division, progress against transformation and SRCP schemes.
7. Members received an update from the Lancashire Procurement Cluster which included the achievements since the last update to the Committee; plans for the future, risks identified and mitigation plans; and an update on the key principles of Brexit preparedness.
8. The Committee briefly discussed the Performance Accountability Framework but due to the time constraints of the meeting it was not possible to give the item the time required, therefore it was agreed that members would submit comments/queries on the document and it would be re-presented to the next Committee.
9. The Committee received an update report on tenders; the Committee Specific Board Assurance Framework for review; an update on the planning guidance for 2019/20; and the minutes of the Contract and Data Quality Board for information.

Kea Ingham, Assistant Company Secretary, 6 November 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 118

14 November 2018

Purpose Information
Assurance

Title	Quality Committee Update Report
Author	Miss K Ingham, Assistant Company Secretary
Executive sponsor	Mrs T Anderson, Committee Chair

Summary: The report sets out the summary of the papers considered and discussions held at its meeting on 19 September 2018. The report also sets out the summary of the Annual Report of the Infection Prevention and Control Committee and the Director of Infection Prevention and Control (DIPC) received by the Quality Committee at its meeting on 25 July 2018.

Recommendation: The Board is asked to note the report.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do 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	Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. 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

Quality Committee Update

At the meeting of the Quality Committee held on 19 September 2018 members considered the following matters:

1. The Committee received an update on the ongoing audit relating to the recent biopsy related never event. It was noted that the Patient Transfer Policy has been updated to reflect the relevant recommendations from the audit the Trust has implemented the 'ID ME' campaign to ensure that staff are aware of the importance of checking patient details prior to commencing any treatment/undertaking patient moves.
2. The Committee received the Serious Investigations Requiring Investigation (SIRI) report that had been presented to the Trust Board in September and discussed the information relating to falls, specifically the number and type of falls (avoidable/unavoidable).
3. Members received an update in relation to the progress of the CQC inspection period. Members noted that the CQC Well-Led inspection would take place during the week commencing 24 September 2018 and that unannounced CQC inspections had taken place throughout the week commencing 17 September 2018. Around six weeks after the conclusion of the inspection process, a report will be drafted and sent to the Trust for accuracy checking. The Trust will have 10 days to submit a response, it is anticipated the final report will be available in early December 2018.
4. The Committee received the annual report from, the Health and Safety Committee and spent some time discussing the incidents of violence, abuse and harassment against staff by patients and visitors and sought clarity on the number that were intentional and unintentional (due to mental health/dementia issues) assaults. In addition the Committee members received some level of assurance concerning the ability to secure or 'lock down' areas to maintain safety of staff and patients in an emergency. Non-Executive Committee members sought further assurance around the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents within the legislative timeframes.
5. The Committee received the quarterly report relating to safe working hours for doctors and dentists in training and noted that there had been no serious concerns raised in the reporting period (February to July 2018). Members noted some issues in ensuring the desired levels of staffing in some areas which can impact on trainees attending training sessions and the actions that were being undertaken to rectify the issues.

6. Committee members received the Lancashire and South Cumbria Hepatitis C ODN full peer review report and noted that the review included a review of investment and recruitment of infrastructure to support the service going forward. A comprehensive action plan was also presented for information and it was noted that a workshop has been set up with all partner organisations to ensure that each issue identified in the report is addressed comprehensively and collaboratively. This matter will be monitored by the Quality Committee on a regular basis to ensure improvements are made in a timely manner.

7. The Committee received the annual report in relation to PLACE assessments 2017 and noted that the Trust performed above the national average and previous year's results in the following three areas: privacy, dignity and wellbeing; dementia friendly; and disability friendly. Cleanliness; food; and condition, appearance and maintenance were noted to have scored below the national average and action plans have been developed to address the issues identified during the assessment.

8. The Committee received the Board Assurance Framework (BAF) for information and noted that it was the same document that had been presented to the Trust Board earlier in the month. Members noted that the Board had asked that the Committee-specific elements of the BAF be reviewed by the committee at each meeting prior to being presented to the Trust Board.

9. Members received the Risk Management Strategy and noted that the document had been developed in-line with the findings of the recent risk management internal audit report

10. Members received the Quality Dashboard and an overview of current quality performance indicators. They were particularly interested in the information presented regarding the compliance with hand hygiene audits across the Trust and the targeted work that was taking place to improve compliance in specific areas. The Committee also received performance exception reports from the following areas:
    a) Hand hygiene audits
    b) MRSA and Clostridium Difficile toxin positive results
    c) Four hour emergency department standard

11. The Committee also received an update on progress towards compliance with the CNST Incentive Scheme for Maternity Services

12. The Committee received the Clinical Audit Annual Report for information; Corporate Risk Register; and Summary Reports from the following Sub-Committee Meetings:

a) Patient Safety and Risk Assurance Committee (June and July 2018)
b) Infection Prevention and Control Committee (July and August 2018)
c) Health and Safety Committee (August 2018)
d) Internal Safeguarding Board (August 2018)
e) Patient Experience Committee (August 2018)
f) Clinical Effectiveness Committee (June and August 2018)

Quality Committee Update from July 2018 - Summary of the Annual Report of the Infection Prevention and Control Committee and the Director of Infection Prevention and Control

1. The Committee received the annual report of the Director of Infection Prevention and Control (DIPC) on behalf of the Trust Board.
2. The report summarised the work of the Infection Prevention and Control Team (IP&CT) during 2017/18, the progress made and the significant infection control and prevention challenges that have been faced by the Trust.
3. The Infection Prevention and Control (IPC) Team took part in the NHS Improvement IPC Collaborative in 2016. A 'Prompt to Protect' Campaign was devised as a quality initiative in order to improve hand hygiene and basic infection prevention practices. A video was produced and is included in the back to basics teaching package. On the wards that have taken part in the campaign to date there has been an average of 29% improvement in hand hygiene.
4. The national target of MRSA screening for all eligible elective and emergency admissions has continued satisfactorily.
5. The trajectory for MRSA blood stream infections for the year 2017/2018 was to have no more than 0 blood stream infections; the year end outturn attributable to the Trust was 2.
6. The post 3 days trajectory target set for *Clostridium difficile* infections for 2017/2018 was 28 cases and the outturn was 37; this included the mandatory inclusion criterion for reporting all diarrhoea samples from patients aged two years and above and also diagnosis of Pseudomembranous colitis (PMC) by CT and endoscopy.
7. From April 2017, NHS Trusts were required to report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa to Public Health England. This is to support the Government ambition to reduce Gram-negative bloodstream infections by 50% by 2021.

8. In the first year from April 2017 the ambition is to reduce E.coli bloodstream infections by 10% across the health economy. East Lancashire Hospitals NHS Trust were one of only 59 Trusts who achieved a >10% reduction in the hospital onset E.coli blood stream infections (based on 2016 data as baseline).
9. There have been a number of outbreaks due to symptoms of Norovirus this year and we have had two outbreaks due to highly resistant organisms. Actions were implemented to prevent further spread and areas opened as soon as possible. This resulted in 102 bed loss days.
10. The Trust continues to work on the implementation of all current national initiatives to control hospital acquired infections. Work has continued to ensure compliance with the Care Quality Commission (CQC) standards and with the Health Act 2008.
11. New starters now have 'essential to role' training such as Aseptic Non-Touch Technique (ANTT) and hand hygiene completed locally in the ward/department.
12. Hand hygiene remains pivotal to good infection control practice and every opportunity has been taken to re-enforce good practice. The "World Hand Hygiene Day" was held at the Royal Blackburn Teaching Hospital and Burnley General Teaching Hospital sites, with stalls at the main entrances, ward visits with Glo-boxes and '5 moments' leaflets given to staff on wards.
13. The Infection Prevention & Control Team (IPCT) have had significant difficulties in recruiting a Consultant Microbiologist over the past two years, but it is pleasing to note that the Trust has successfully appointed to this post and the successful candidate commenced in post in August 2018.
14. The Consultant Microbiologists and the Antibiotic Pharmacist continue to work together reviewing guidelines and embedding the Antimicrobial Formulary across the Trust, with Grand Rounds and FY1/FY2 teaching. The antibiotic audits during increased incidence of C. *difficile* on wards continued. The Trust antimicrobial formulary continues to be reviewed in 2017/18 by the Antimicrobial Stewardship Committee.
15. The ELHT antimicrobial app has been produced and is now available online.
16. The Divisional antimicrobial quarterly audits continued in 2017/18 with audit presentations in Medical Audit meetings and Grand Rounds. This information is disseminated via the Divisional Audit Lead and presented at Infection Prevention Committee.

17. Antibiotic Stewardship Programme continued to be pursued with weekly MDT *C. difficile* ward rounds, antibiotic audit ward rounds, Infection Prevention & Control Nurses (IP&CN) and ward pharmacist notifications.
18. There has been an active audit programme to include monthly commode, hand hygiene, blood culture contamination, MRSA screening, diarrhoea, urinary catheter and mouth care audits. During 2017/18, Infection Control policies have been developed or reviewed to ensure they incorporate current best practices.
19. Cleaning and domestic services continue to deliver a high standard of hospital cleanliness and have received encouraging Patient Led Assessment of the Care Environment (PLACE) inspection reports.

Kea Ingham, Assistant Company Secretary, 1 November 2018

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 119

14 November 2018

Purpose Information

Title	Remuneration Committee Information Report
Author	Miss K Ingham, Assistant Company Secretary
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The list of matters discussed at the Remuneration Committee held on 12 September 2018 are presented for Board members' information.

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

Report linkages

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

Impact

Legal	No	Financial	No

Equality	No	Confidentiality	No

Remuneration Committee Information Report

1. At the meeting of the Remuneration Committee held on 12 September 2018 members considered the following matter:
   a) Director of HR and OD Arrangements
   b) Fit and Proper Person Regulation Annual Report
   c) Committee Terms of Reference Review

Kea Ingham, Assistant Company Secretary, 30 October 2018

East Lancashire Hospitals
NHS Trust

TRUST BOARD REPORT

Item 120

14 November 2018

Purpose Information

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

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 12 September 2018.

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Trust Board Part Two Information Report

1. At the meeting of the Trust Board on 12 September 2018, the following matters were discussed in private:
   a) Round Table Discussion: Update on ICS/ICP Developments
   b) Round Table Discussion: Use of Resources
   c) Sustaining Safe, Personal and Effective Care 2018/19 Update Report
   d) Tender Update
   e) Serious Untoward Incident Report
   f) Doctors with Restrictions
2. The matters discussed were private and confidential and/or identified individuals and/or were commercially sensitive at this time and so the decision was taken that these items should not be discussed in the public domain. As these items progress, reports will be presented to Part 1 of Board Meetings at the appropriate time.

Kea Ingham, Assistant Company Secretary, 30 October 2018