East Lancashire Hospitals
NHS Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

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East Lancashire Hospitals NHS Trust

TRUST BOARD MEETING (OPEN SESSION)

13 NOVEMBER 2019, 13.00

SEMINAR ROOM 4, ROYAL BLACKBURN HOSPITAL

AGENDA

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

OPENING MATTERS				
TB/2019/134	**Chairman's Welcome**	Chairman	v	
TB/2019/135	**Open Forum** To consider questions from the public	Chairman	v	
TB/2019/136	**Apologies** To note apologies.	Chairman	v	
TB/2019/137	**Declaration of Interest** To note the directors register of interests and note any new declarations from Directors.	Chairman	d	
TB/2019/138	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 11 September 2019.	Chairman	d✓	Approval
TB/2019/139	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2019/140	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2019/141	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2019/142	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information
QUALITY AND SAFETY				
TB/2019/143	**Patient/Staff Story** To receive and consider the learning from a patient story.	Executive Director of Nursing	p	Information/ Assurance
TB/2019/144	**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.	Director of Clinical Strategy on behalf of Acting Executive Medical Director	d✓	Assurance/ Approval
TB/2019/145	**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.	Director of Clinical Strategy on behalf of Acting Executive Medical Director	d✓	Assurance/ Approval

TB/2019/146	**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.	Director of Clinical Strategy on behalf of Acting Executive Medical Director	d✓	Information/ Assurance
ACCOUNTABILITY AND PERFORMANCE				
TB/2019/147	**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, with items being raised by exception: • Introduction (Acting Chief Executive) • Safe (Executive Director of Nursing and Director of Clinical Strategy on behalf of Acting Executive Medical Director) • Caring (Executive Director of Nursing) • Effective (Director of Clinical Strategy on behalf of Acting Executive Medical Director) • Responsive (Director of Operations) • Well-Led (Executive Director of HR and OD and Executive Director of Finance)	Executive Directors	d✓	Information/ Assurance
TB/2019/148	**Emergency Preparedness and Resilience Statement Update**	Executive Director of Service Development	d✓	Information/ Assurance
TB/2019/149	**Flu Vaccination Programme**	Executive Director of HR and OD	d✓	Information
GOVERNANCE				
TB/2019/150	**Audit Committee Update Report** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information/ Assurance
TB/2019/151	**Finance and Performance Committee Update Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information/ Assurance/ Approval
TB/2019/152	**Quality Committee Update Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information/ Assurance/ Approval
TB/2019/153	**Remuneration Committee Information Report and Terms of Reference** To note the matters considered by the Committee in discharging its duties	Chairman	d✓	Information

TB/2019/154	**Trust Board Part Two Information Report** To note the matters considered by the Committee in discharging its duties	Chairman	d✓	Information
FOR INFORMATION				
TB/2019/155	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2019/156	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2019/157	**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? • Does the Board take into account the collaboration agenda when setting its strategy? • To what extent have we made collaboration and system working part of our business as usual?	Chairman	v	
TB/2019/158	**Date and Time of Next Meeting** Wednesday 15 January 2020, 1.00pm, Seminar Room 4, Learning Centre, Royal Blackburn Teaching Hospital.	Chairman	v	

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 137

13 November 2019

Purpose Information
Approval

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

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

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

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 Partnership (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	Yes	Financial	No
Equality	No	Confidentiality	No

Directors Register of Interests

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

Name and Title	Interest Declared	Date last updated
Professor Eileen Fairhurst Chairman	• Professor at Salford University (until 21.12.2017). • Trustee, Beth Johnson Foundation (until 31.03.2017). • Chairman of Bury Hospice (from 23.01.2017 until 19.06.2018) • Member of the Learning, Training & Education (LTE) Group and Higher Education Board (until 12.3.2017). • Chairman of the NHS England Performers Lists Decision making Panel (PDLP) (until November 2018) • Honorary Doctorate UCLan awarded 2018 • Visiting Professor, Chester University	09.05.2019

Name and Title	Interest Declared	Date last updated
Kevin McGee Joint Chief Executive Officer and Accountable Officer for East Lancashire Hospitals NHS Trust (ELHT) and Blackpool Teaching Hospitals NHS Foundation Trust (BFWH) (From 01.10.2019)	• Spouse is the Director of Finance and Commercial Development at Warrington and Halton Hospitals NHS Foundation Trust • Honorary Fellow at University of Central Lancashire • Interim Chief Executive, Blackpool Teaching Hospitals NHS Foundation Trust (from 01.05.2019), this became a permanent appointment across both Trust's on 01.10.2019.	23.10.2019
Patricia Anderson Non-Executive Director (Mrs Anderson took a leave of absence from the Trust from 01.05.2019 to 03.10.2019)	• Accountable Officer at Wigan Borough CCG (until 31.05.2018). • Public Sector Director on One Partnership (LIFTCO) (January 2015 until 31.05.2018) • Spouse is a recently retired Consultant Psychiatrist formerly employed at Mersey Care NHS Trust • Assignment with Knowsley Clinical Commissioning Group, supporting the Accountable Officer for a period of six months (10.05.2019 to 01.10.2019). During this time Mrs Anderson took a leave of absence from the Trust Board at ELHT.	03.10.2019
Stephen Barnes Non-Executive Director	• Chair of Nelson and Colne College. • Member of the National Board of the Association of Colleges (from 02.03.2017). • Vice Chair of the National Council of Governors of the Association of Colleges (from 02.03.2017).	09.01.2019

Name and Title	Interest Declared	Date last updated
Michelle Brown Executive Director of Finance (Commenced 01.08.2019)	• Vice Chair of Board of Governors and Chair of the Finance and Resources Committee of St Catherine's Catholic Primary School, Leyland. (No known association with ELHT). • Spouse works for the North West Ambulance Service as an Emergency Technician.	19.04.2018
Harry Catherall Associate Non-Executive Director (Commenced 01.07.2019)	• Member STAR Multi Academy Trust former Tauheedul Academy Trust • Former Chief Executive Blackburn with Darwen Council. • Interim Chief Executive at St Helens Council (from 07.10.2019)	06.11.2019
Martin Hodgson Executive Director of Service Development /Deputy Chief Executive Officer	• Partner is the Chief Operating Officer at Aintree University Hospital NHS Foundation Trust.	23.10.2019
Christine Hughes Executive Director of Communications and Engagement	• Currently lending strategic communications advice to a neighbouring Trust (Lancashire and South Cumbria Care NHS Foundation Trust) on a temporary basis that will finish no later than 31.12.2019. • Provide advice, guidance and support to Blackpool Teaching Hospitals NHS Foundation Trust (BFWH) as part of the ongoing collaboration between the two Trusts (from 01.11.2019).	06.11.2019
Naseem Malik Non-Executive Director	• Independent Assessor- Student Loans Company- Department for Education - Public Appointment. • Fitness to Practice, Panel Chair: Health & Care Professions Tribunal Service (HCPTS) -	04.09.2019

Name and Title	Interest Declared	Date last updated
	Independent Contractor. • Investigations Committee Panel Chair at Nursing & Midwifery Council (NMC) - Independent Contractor. • Non-Executive Director and Senior Independent Director (SID) at Lancashire Care NHS Foundation Trust (until 29.07.2016). • Worked for Blackburn Borough Council (now Blackburn with Darwen Borough Council) in 1995/6. • Non-Executive Director at Blackburn with Darwen Primary Care Trust (from 2004 until 2010). • Relative (first cousin) is a GP in the NHS (GP Practice). • Relative (brother-in-law) is a registered nurse employed by Lancashire and South Cumbria Care NHS Foundation Trust.	
Kevin Moynes Executive Director of Human Resources & Organisational Development	• Spouse is a very senior manager at Health Education England (from 02.10.2017) • Governor of Nelson and Colne College (until 01.02.2018). • Joint Appointment as Executive Director of HR and OD at East Lancashire Hospitals NHS Trust and Blackpool Teaching Hospitals NHS Foundation Trust (10.10.2018)	13.09.2019

Name and Title	Interest Declared	Date last updated
Feroza Patel Associate Non-Executive Director (Commenced 01.04.2019)	• Positive Nil Declaration	25.10.2019
Christine Pearson Executive Director of Nursing	• Spouse is the Head of Medicines Optimisation, at Heywood, Middleton & Rochdale Clinical Commissioning Group	20.05.2019
Richard Smyth Non-Executive Director	• Consultant Solicitor with DLA Piper UK LLP Law Firm. DLA Piper undertakes work for the NHS. • Spouse is a Lay Member of Calderdale CCG (until 31.01.2019). • Spouse is a Patient & Public Involvement and Engagement Lay Leader for the Yorkshire and Humber Patient Safety Translational Research Centre, based at Bradford Institute for Health Research, Bradford Royal Infirmary. • Sister is an advanced clinical nurse practitioner with Pennine Acute Hospitals Trust based at the Royal Oldham hospital. • Member of the Law Society. • Spouse is a Non-Executive Director at Lancashire Teachings Hospitals Foundation Trust as from 04.02.2019.	21.03.2019

Name and Title	Interest Declared	Date last updated
Professor Michael Thomas Associate Non-Executive Director	• Vice-Chancellor of UCLAN (to 30.11.2018). • Brother-in-Law is senior manager within Lancashire and South Cumbria Care NHS Foundation Trust. • Sister-in-Law works within Lancashire Education and Social Services. • Self Employed (Thomas and Drake Consultancy) from 01.04.2019	08.05.2019
Michael Wedgeworth Associate Non-Executive Director	• Positive Nil Declaration.	12.09.2019
David Wharfe Non-Executive Director	• Trustee of Pendleside Hospice (from June 2018)	09.01.2019

The individuals included below have been members of the Trust Board, but have either left the Trust or stepped down from their posts since the last time the report was provided to the Trust Board.

Name and Title	Interest Declared	Date last updated
Jonathan Wood Executive Director of Finance (until 31.07.2019)	• Spouse is the Director of Finance at the Oldham Care Group Hospital, part of Pennine Acute Hospitals NHS Trust. Pennine Acute Hospitals currently form part of the 'hospital chain' with Salford Royal Hospitals Foundation Trust (replaced by declaration below number 1133) – removed from register on 26.04.2019)	01.04.2019

Name and Title	Interest Declared	Date last updated
	• Chair of Blackburn Cathedral Finance Committee • Spouse is Director of Finance at North West Ambulance Service • Non-Executive of the East Lancashire Financial Service (hosted by Salford Royal Foundation Trust).	
Damian Riley Acting Chief Executive Officer and Executive Medical Director (until 31.10.2019)	• Member of British Medical Association Registered with General Medical Council. • Spouse is a locum GP and may undertake work in local GP practices. There is potential for bias affecting relationships and interactions with CCGs and commissioners of primary care. • Spouse may undertake work in PWE practices, and ELHT has a financial commitment to PWE consortium.	23.10.2019
Ian Stanley Acting Executive Medical Director (until 31.10.2019)	• Working for Facing Africa (Charity) in Ethiopia (two weeks per year)	25.10.2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 138

13 November 2019

Purpose Action

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

Summary: The minutes of the previous Trust Board meeting held on 11 September 2019 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

(138) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 1.00PM, 11 SEPTEMBER 2019

MINUTES

PRESENT

Professor E Fairhurst	Chairman	Chairman
Mr K McGee	Chief Executive/Accountable Officer	
Dr D Riley	Acting Chief Executive	
Mr H Catherall	Associate Non-Executive Director	Non-voting
Mr M Hodgson	Executive Director of Service Development	Non-voting
Mrs C Hughes	Executive Director of Communications and Engagement	Non-voting
Miss N Malik	Non-Executive Director	
Mr K Moynes	Director of HR and OD	Non-voting
Mrs F Patel	Associate Non-Executive Director	
Mrs C Pearson	Executive Director of Nursing	
Mr R Smyth	Non-Executive Director	
Dr I Stanley	Acting Executive Medical Director	
Professor M Thomas	Associate Non-Executive Director	Non-voting
Mr M Wedgeworth	Associate Non-Executive Director	Non-voting
Mr J Wood	Executive Director of Finance	

IN ATTENDANCE

Mrs M Almond	Senior Patient Experience Facilitator	For Item TB/2019/089
Mrs A Bosnjak-Szekeres	Associate Director of Corporate Governance/ Company Secretary	
Mrs J Butcher	Freedom to Speak Up Guardian	For Item TB/2019/094
Mr D Byrne	Corporate Governance Officer	Minutes
Mrs EL Cooke	Senior Communications Manager	Observer
Mrs J Gaskill	End of Life Facilitator	For Item TB/2019/089
Mrs S Gilligan	Director of Operations	
Professor D Harrison	Director of Public Health, Blackburn with Darwen Borough Council	
Miss K Ingham	Corporate Governance Manager/Assistant Company Secretary	Minutes

Mrs U Krishnamoorthy	Clinical Director, Medical Director's Office	Observer
Mrs K Quinn	Operational Director of HR and OD	

APOLOGIES

Mr S Barnes	Non-Executive Director
Mr D Wharfe	Non-Executive Director

TB/2019/107 CHAIRMAN'S WELCOME

Professor Fairhurst welcomed the Directors and members of the public to the meeting. Professor Fairhurst extended a warm welcome to Professor Dominic Harrison, Director of Public Health at Blackburn with Darwen Borough Council to the meeting in his capacity of Consultant to the Board on matters relating to public health.

TB/2019/108 OPEN FORUM

A member of the public raised a question in relation to the inability to raise a complaint on behalf of another person. Professor Fairhurst suggested that this issue could possibly be addressed more comprehensively outside the meeting. The member of the public agreed that the third party's confidentiality would not be breached by what he wanted to raise to the attention of the Board. Dr Riley confirmed that he had been in contact with the individual regarding the matter and reiterated that the Trust was in the same position as others in the country in terms of the process for making complaints. He went on to confirm that it was important that issues were raised and that they would be welcomed, however it was not possible for the Trust to provide patient related information to anyone, even family members, without the written consent of the patient. The member of the public provided a general overview of their concerns, including excessive waiting times in the Emergency Department, and medications not being available at the time of discharge, all of which lead to poor patient experience. The individual went on to comment that there had been no concerns about the nursing care received by his relative, but he wanted to put on record his comments and concerns.

Dr Riley thanked the individual for his feedback and comments. He went on to suggest that the issues that had just been raised were recognised by the Trust and work was taking place to address them. He offered to investigate the reasons why only two days' worth of medication were supplied at the point of discharge and agreed to liaise with the individual outside the meeting with a response.

RESOLVED: **Directors noted the issues raised.**

Dr Riley will investigate the reasons why only a short supply of medication was provided at the point of discharge and liaise with the member of the public outside the meeting.

TB/2019/109 APOLOGIES

Apologies were received as recorded above.

TB/2019/110 DECLARATIONS OF INTEREST REPORT

Directors received the report for information.

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

TB/2019/111 MINUTES OF THE PREVIOUS MEETING

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

RESOLVED: **The minutes of the meeting held on 10 July 2019 were approved as a true and accurate record.**

TB/2019/112 MATTERS ARISING

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

TB/2019/113 ACTION MATRIX

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

TB/2019/081: Open Forum – Dr Riley confirmed that a response had been provided to Mr Todd regarding the matter he raised at the previous meeting.

TB/2019/088: Chief Executive's Report - Mrs Hughes confirmed that the Trust was currently in the process of extending the Trust website to include a virtual trophy cabinet.

TB/2019/089: Patient Story – Mrs Pearson confirmed that she was working with Mrs Quinn to incorporate effective communication skills in the overarching People Strategy.

TB/2019/090: Corporate Risk Register – Dr Riley reported that the Executive Directors had spent some time at a recent Operational Executive Briefing session discussing the development of the Corporate Risk Register and its links to the Board Assurance

Framework. He confirmed that the Executive Directors welcomed feedback from Non-Executive Board members on the document and that he was keen to ensure that the document presented the right information in a way that was easy to understand and was useful to the Board.

TB/2019/091: Board Assurance Framework – Mrs Quinn confirmed that national guidance on the pensions related issues was still being awaited following the national level consultation that had taken place. She went on to report that the Trust continued to work with Trusts and regulators at local, regional and national level on the matter. A further update is expected on or around 16 September 2019.

TB/2019/093: Integrated Performance Report – Mrs Gilligan confirmed that she and her fellow Directors of Operations would be pleased to provide any information or training to Non-Executive Board members on the revised format of the Integrated Performance Report.

TB/2019/094: Raising Concerns Annual Report – Mrs Quinn reported that the Trust was working with the Advisory, Conciliation and Arbitration Service (ACAS) and academics to scope future work on the early resolution approach. She went on to confirm that the Trust had been in discussions with the CQC in relation to how they may utilise the Trust's approach to raising concerns and early resolution.

TB/2019/094: Raising Concerns Annual Report – Mrs Hughes reported that she and Mrs Butcher had met to discuss the development of a Raising Concerns Summary Report and had agreed that they would work together to produce the 2019/20 report.

RESOLVED: The position of the action matrix was noted.

TB/2019/114 CHAIRMAN'S REPORT

Professor Fairhurst reported that, since the last meeting, the recruitment process for a new Non-Executive Director had commenced and the position was currently advertised on both the Trust and NHS Improvement websites. Directors noted that the interviews would take place on 19 November 2019.

RESOLVED: Directors received and noted the update provided.

TB/2019/115 CHIEF EXECUTIVE'S REPORT

Mr McGee confirmed that he would present sections one and two of the report, whilst Dr Riley would present the remainder of the report. He confirmed that Ms Pritchard had been appointed as the Chief Operating Officer for NHS Improvement/England. This was viewed as a good appointment across the sector, as Ms Pritchard has an excellent understanding of

operational pressures across the NHS.

Mr McGee went on to highlight the new Oversight Framework that had been published and confirmed that rather than individual Trusts being held to account, the new documentation was clear that systems would be held to account in the future, which was perhaps the most significant change to its previous iterations.

Directors noted the ongoing issues in relation to the national pension taxation changes and the approach being taken across the organisations within the ICS.

Mr McGee referred Directors to the section of his report which focused on the national preparations for Brexit and guidance that had been issued to Trusts to mitigate any risks associated with the UK's exit from the European Union later in the year. Mr Hodgson confirmed that, since Mr Wood's departure from the Trust, he had taken over the Executive responsibility for Brexit preparations, with Mr Tony McDonald being responsible for the Trust's operational planning for Brexit along with Mrs Alison Whitehead, Emergency Planning Officer for the Trust.

Directors noted the work being undertaken in relation to new models of care, population health management and health inequalities at ICS level. Mr McGee commented that the work being undertaken was set against a backdrop of financial difficulty across the ICS and as a result, Trusts were looking at ways of working together to make the best use of the available funds.

Dr Riley referred Directors to the section of the report detailing local activities, including the formal announcement of Mr Catherall joining the Board as an Associate Non-Executive Director. He went on to report that Keelie Barrett has been confirmed as the first ever Maternity Support Worker to be elected to the Board of the Royal College of Midwives (RCM). Mrs Sue Elliston, Directorate Manager for Outpatient Services and colleagues collected the 'Best Use of a Digital Solution' award at the national Public Sector Paperless Awards 2019 in recognition of the Trust's successful introduction of new Patient Portal technology.

Dr Riley confirmed that the Trust had developed a private space for staff working in the Emergency Department at Royal Blackburn Hospital to use to reflect and gather their thoughts following traumatic situations or difficult circumstances.

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

TB/2019/116 **PATIENT/STAFF STORY**

Mrs Pearson introduced Mrs Louise Bardon, Bereavement Care Midwife and explained that

she would be sharing her experience of providing care and advice to a lady who had lost a baby many years ago.

Mrs Bardon reported that she was contacted in 2017 by a former patient who had used the Trust's maternity services in 1993. The contact came about as a result of the patient speaking with another service user who had informed her that the Trust had a bereavement midwife, and she may be able to access support. The patient informed Mrs Bardon that at the time when she was a patient in the maternity service, she had been extremely resistant to support following the loss of her child. After the elapse of such a significant time period, the patient had very few details about her child, and due to recent events in her life, she was currently feeling an element of emotional and psychological impact due to her having a number of unanswered questions. Mrs Bardon reported that she was able to access the archived maternity notes and share with the patient her child's accurate date and time of birth and a range of other information, such as birth weight, length, and head circumference, in addition to information that helped to clarify the events that had occurred during the episode of care.

Mrs Bardon was also able to share information regarding 'what happened to babies' following a pregnancy loss in the early 1990s. Directors noted that whilst this kind of information can be upsetting for parents, the patient was comforted to know that practises have changed and that hospital funerals were now undertaken more sensitively via the local cemetery.

Mrs Bardon shared that she was aware that there had been an active Stillbirth and Neonatal Death (SaNDs) support group within the Burnley area and that they had funded a baby memorial book. She shared with the patient that the book was no longer kept within the hospital, but she was able to locate the book and arrange for it to be brought to the hospital where she met with the patient who was able to view the entry for her baby, which her father had written at the time. She was also able to offer a memory box, which she had put together with some tangible items such as baby wrist bands and a card containing her child's clinical details. In addition, Mrs Bardon gave the patient the opportunity to have an entry made within one of the baby memorial books held within the Trust's Spiritual Centre.

Since the original meeting, the patient has accessed support from SaNDs, and had ordered a granite memorial stone for her child and on 6 September 2018 a private baby memorial service was held in remembrance of her baby boy born sleeping in 1993.

Mrs Bardon passed round a number of items that are provided to parents or available for them to access following the death of their baby, including memory boxes and miscarriage

keepsakes which help, as they provide tangible memories of their babies. She went on to confirm that a range of reading materials are also available for parents to access, in a range of languages, to help them heal.

Mrs Pearson confirmed that since this particular case, the Trust has opened two suites which are available to bereaved parents to spend some time with their baby after they have died. She also confirmed that, with the passage of time, the things that happened to the patient's baby in terms of disposal have changed for the better.

Mr McGee commented that the Board needed to recognise the outstanding mother and baby services that the Trust provides and asked Mrs Bardon whether she thought that there would be an increase in the numbers of women contacting the Trust regarding similar issues. Mrs Bardon confirmed that a number of women have accessed the service and they usually find out about the service after speaking to patients who have had similar experiences recently.

Professor Fairhurst thanked Mrs Bardon for her efforts in this case and commented that it demonstrates in a tangible way how compassionate care permeates throughout the whole organisation.

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

TB/2019/117 **CORPORATE RISK REGISTER (CRR)**

Dr Stanley presented the report and confirmed that it had been produced following the Risk Assurance Meeting (RAM) that had taken place in August 2019. He advised that the report format had been revised in order to enable Directors to track the progress of actions and the inclusion of new actions to mitigate and address risks.

Directors noted that two new risks had been discussed at the RAM and subsequently at the Operational Executive Briefing session, prior to being recommended for inclusion on the CRR. The two risks were noted to be Risk ID 6654: Use of surgical day-case unit for escalation when demands increase within the Trust and Risk ID 8160: There is a potential to compromise the quality of care due to poor synchronization and connectivity. In addition, Directors were asked to consider the recommendation to increase the risk score for Risk ID 8126: Potential Delay in the implementation of the Electronic Patient Record (EPR) system from 15 to 20, based on an increase to the consequence score (from 3 to 4) related to the number of risks and incidents aggregated within this particular risk and also the scoring against the 'Descriptors of Consequence' within the Trust Risk Management Strategy.

Mr Smyth commented that the revised format was helpful, particularly the heat map, as it provided a clear view of the risks.

Directors agreed that there would be a benefit to reviewing the EPR related risk in depth at its next Strategy Session and asked that this be added to the agenda.

Miss Malik commented that there had been a lengthy discussion about Risk ID 8061: Management of Holding Lists at the last Quality Committee meeting and the Committee were sufficiently assured that the appropriate work was being undertaken to manage the risk.

Directors approved the inclusion of the risks as per the recommendations set out in the report.

RESOLVED: **Directors approved the proposed revisions to the register.**
Risk ID 8126 (EPR) will be added to the next Board Strategy Session agenda for detailed discussion.

TB/2019/118 BOARD ASSURANCE FRAMEWORK

Dr Stanley referred Directors to the previously circulated report and provided an overview of the various revisions that had been proposed to the Directors for approval.

He highlighted the recommendation to reduce the risk score of BAF Risk 1 (Transformation schemes) from 20 to 16 based on the embedding of the 'Vital Signs' and improvement methodologies. Directors approved this request. Professor Fairhurst highlighted the importance of showing the internal and external sources of assurance clearly in the document, particularly as there is a move towards system working.

In relation to BAF risk 3 (partnership working) Directors spent some time discussing the revised governance structure at ICS level and noted that the Trust and the Pennine Lancashire ICP were well represented.

Professor Fairhurst invited Professor Harrison to share his views in relation to BAF risk 3. He commented that the ICS Board was seen as a leader across a range of aspects, particularly in relation to population health.

In response to Mr Wedgeworth's question regarding cyber security, Dr Stanley confirmed that whilst the risks around cyber security as a whole remained, the Trust was taking action to identify and manage/eliminate any potential threats to its IMT systems. Hence the risk score remained under the threshold for inclusion on the CRR or BAF.

Mrs Bosnjak-Szekeres asked that the current arrangements that were in place for the review of the document by Directors and Sub-Committees of the Board remain in place for the 2019/20 – 2020/21 year. Directors approved the continuation of the current arrangements for the review of the BAF.

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

Directors approved the continuation of the current review method for the BAF.

TB/2019/119 SERIOUS INCIDENTS REQUIRING INVESTIGATION REPORT

Dr Stanley referred Director to the previously circulated report and confirmed that there had been 23 incidents reported to the Strategic Executive Information System (StEIS) since the last meeting and a further 9 incidents which were reported, but did not meet the criteria for reporting through the StEIS route. Consequently, they are being investigated at a Divisional level.

Directors noted that for the previous reporting year (2018/19) 45 of the 111 serious incidents reported had been de-escalated by the Clinical Commissioning Group (CCG) following a full review of the incidents.

Dr Stanley confirmed that the highest reporting categories remained consistent with previous reports: pressure ulcers; slips, trips and falls; and diagnosis problems/failures. He went on to confirm that there were programmes of work being undertaken around these areas to address the issues, for example, the implementation of a falls collaborative and the work undertaken as part of the pressure ulcer collaborative. Directors noted that the findings of the thematic analysis around diagnosis problems/failures had been included in the report for information.

Dr Stanley confirmed that there had been one Never Event reported in the time period covered by the report, and provided a brief overview of the incident. He confirmed that no harm had been caused to the patient and a full Root Cause Analysis (RCA) has been undertaken. Directors noted that the Trust practice had been revised as a consequence of the findings of the RCA and the national guidance may also be reviewed as a result of the Never Event and the learning from it.

Dr Stanley reported that there was one incident which was overdue by 96 days and confirmed that this was due to the ongoing investigation by the Healthcare Investigation Board (HIB). This was having an adverse effect on the timescale of the incident review.

Dr Stanley proposed that rather than submit a complete list of StEIS reported incidents (Appendix A) to future Board meetings, a table be submitted that showed the themes of incidents and the actions being undertaken to address them. Directors agreed that this was a sensible proposal.

Directors agreed that the Board had been able to gain sufficient assurance that when an incident happens it is reported and investigated appropriately. Professor Fairhurst noted the open reporting culture of the Trust and its willingness to over-report incidents in order to maximise learning and improve patient care as much as possible.

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

Future reports will include a table showing the themes of incidents and the actions being undertaken to address them rather than a full list of StEIS reported incidents.

TB/2019/120 INTEGRATED PERFORMANCE REPORT

Dr Riley introduced the report to the Directors and confirmed that the report related to the period covering July 2019. He explained that the Trust's performance had been mixed, relative to both its performance earlier in the year and to the performance of other organisations in the region. Significant improvements were reported in the emergency care pathway, particularly the reduction in ambulance handover times, but other areas, such as RTT and cancer encountered struggles in the efforts to meet the national standards. Dr Riley explained there were a number of contributing factors to this drop in performance, the biggest being a reduction in clinical capacity caused by the ongoing pension dispute, but stressed that the Trust was still performing better than the national average for cancer waiting times.

a) Safe

Mrs Pearson reported that July had continued to be a challenging month from a safe nursing and midwifery perspective, caused in part by an increase in the use of escalation areas and general pressures in the emergency department. The fill rate for nursing staff had increased to 92% with a number of red flag incidents reported, although Mrs Pearson stressed no patients had come to harm. She requested that the Board take note of the range of actions being carried out to mitigate any risks associated with nurse staffing levels.

Mr Catherall enquired, given the pressures on the workforce, if the Trust was doing everything in its power to promote healthcare and job opportunities in the NHS in order to attract younger people to the sector. Mrs Pearson confirmed that a considerable amount of work was underway in this area, and explained a new Ambassador Scheme had recently been started by the Chief Nursing Officer for England in order to promote closer relationships with local schools. She also explained that a dedicated recruitment group met

on a regular basis and its members were looking at ways to get the Trust more involved in external exhibitions. Mrs Quinn concurred with Mrs Pearson's points and advised that similar work was underway in the HR team to secure a future supply of staff into the Trust. This included the imminent launch of a new Care Academy scheme, specifically intended to get more 16-18 year olds interested in a career in health or social care. Mrs Quinn also advised the Trust had been in conversation with an organisation called 'Be Ready', which had offered to assist with promoting ELHT careers on college websites. Dr Stanley highlighted that the Trust's work experience programme had massively expanded over the previous 18 months and was now looking to attract wider participation from areas not typically considered when seeking medical students.

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

Mrs Quinn to provide an update about the new care academy scheme and the promotion of ELHT careers on college websites.

b) Caring

Mrs Pearson reported that concerted efforts had been made to improve the response rate to the Friends and Family test and confirmed there had been an increase in the amount of data collected. She explained that the guidance around the test would be changing from September onwards in an effort to remove some of the anomalies in results. Mrs Pearson reported that recent results from the patient experience survey were extremely positive and continued to be actively monitored via the Patient Experience Committee.

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

c) Effective

Dr Stanley explained significant efforts had been made to improve the Trust's position around mortality and that the graphs for both SHMI and HSMR both clearly showed data that was well within expected limits. He went on to explain that the other key focus was on ensuring the Trust as a whole learned from instances where patients have died and that the Structured Judgement Reviews (SJRs), introduced two years previously, had been critical in facilitating this. Dr Stanley reported there had been a significant improvement in the numbers of SJRs being undertaken every year and that this clearly demonstrated the Trust was committed to learning when things did not go to plan and to taking action to avoid repetition.

He advised that the Trust was involved in five national CQUIN projects related to mortality and that its compliance with these schemes was actively monitored via the Clinical Effectiveness Committee (CEC).

Professor Harrison congratulated Dr Stanley on these improvements, noting that hospital mortality had been a key area of challenge for many years. He enquired why the HSMR performance had been labelled as deteriorating in the report despite the positive results; Dr Riley explained that, as the graph showed a slight rise in mortality earlier in the year, it had been classed as a deteriorating position, despite still being well under the national average.

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

d) Responsive

Mrs Gilligan reported that, despite the current difficulties in achieving the national RTT standard, the Trust had still managed to avoid any 52 week breaches. She advised that there had been an increase in the number of patients waiting over 40 weeks, but provided assurances that these were being micromanaged at a directorate level and at the weekly operational meetings. Mrs Gilligan reiterated that there had been an improvement in ambulance handover times and reported that the Trust had achieved its six week diagnostic standard, with 99.3% of patients receiving tests within this period.

Mrs Gilligan reported that the Trust had failed to achieve both the national target and its own trajectory targets for the emergency four hour standard in July, due to both a spike in patient attendance and a drop in staffing levels. She advised that this positon had improved in August, with an improvement of 5% over the previous year, and reported that September performance at the time of the meeting was at 91%. 13 breaches of the 12 hour trolley wait were reported in July; Mrs Gilligan explained these were entirely due to long waits for mental health beds and noted that this was an improvement from the 33 breaches reported at the same time the previous year. She provided assurances that the cancer standard was being actively managed and that patients requiring urgent treatment were being prioritised as required. Mrs Gilligan concluded her update by reporting an increase in delayed discharged, up to 4.3% in July and advised an internal workshop had been scheduled to drill down into the reasons behind this to determine if anything could have been done differently.

Following an invitation from Professor Fairhurst for comments or questions from members, Miss Malik enquired what the longest wait for a mental health bed had been. Mrs Gilligan clarified the longest wait had been around three days and advised waits tended to be much

worse over weekends. Mrs Gilligan added the matter had been escalated to the A&E Delivery Board, in addition to colleagues from LCFT and advised that the situation did seem to be improving, as waiting times had been closer to 4-5 days during the previous year.

Mr McGee stated that he felt that the performance in A&E was to be commended. He requested clarification on whether any work was being done to understand the reasons behind the high numbers of ambulance conveyances and whether any work was underway with North West Ambulance Service (NWAS) to better manage them. Mrs Gilligan explained work was underway with CCG colleagues to monitor demand and ensure patients were going to the best possible place for treatment.

Professor Fairhurst praised the improvements that had taken place in emergency care over the preceding 12 months. Directors noted that the improvements have allowed the Trust to provide the local population with better patient experience in more appropriate care settings.

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

Mrs Gilligan will provide an update will be provided about the internal workshop in relation to the increase in delayed discharges during the summer months and the learning from this exercise.

e) Well-Led

Mrs Brown reported the financial position of the Trust as a £3.8m deficit, in line with the overall plan for the year. She explained the key risks to the Trust achieving its control total were the use of agency staffing, which had started to increase due to the issues caused by the ongoing pension dispute, its ability to achieve its savings programme and the increase in spending in security staff following a rise in assaults on staff. Despite these risks, Mrs Brown provided assurances that the Trust's cash balances were relatively good and reported it was working well with CGGs to ensure suppliers were paid on schedule.

Mrs Quinn reported that sickness and absence levels in the Trust had begun to stabilise and that this would likely continue to improve once the new sickness team was in place. She explained a new 'EASE' approach, intended to increase the speed of referrals which would be rolled out by the occupational health team from October onwards and was also expected to significantly improve sickness rates. Mrs Quinn reported that the main area of challenge continued to be bank and agency spending, which had again started to increase since the dispute over pensions began, and advised she and her colleagues were working closely with

finance colleagues around appropriate control mechanisms. She stated that the imminent rollout of the e-roster and allocate systems would also help to reduce costs going forward. Mrs Quinn added that vacancies continued to be a challenge and confirmed a range of ideas were being explored to offer more flexible careers to attract candidates.

Mr Catherall advised that a documentary had recently aired that had detailed the efforts by Royal Derby Hospital to lunch a new pilot scheme to enable volunteers to work on wards with clinical staff and enquired if the Trust was pursuing any similar schemes. Mrs Quinn pointed out that the Trust had a robust supply of bank staff and had worked closely with the Lancashire Volunteer Partnership, but agreed that it could probably do more.

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

Mrs Quinn will provide an update on the EASE approach at the January 2020 Board meeting.

Mrs Quinn will update the November Board about the offer of more flexible careers and sharing of best practice to enable volunteers to work on wards with clinical staff.

TB/2019/121 DOCTORS' APPRAISAL AND REVALIDATION ANNUAL REPORT

Dr Stanley presented the latest Doctors' Appraisal and Revalidation report to members, and advised that the Trust was required to submit it on an annual basis to provide assurance that it was fully compliant with the GMC and NHS England standards. Dr Stanley explained that the report covered several domains and that it clearly demonstrated that the Trust was compliant with the requirements for each. He requested that the Board give its approval for the report to be signed off for submission to NHSE.

Dr Riley extended his thanks to the revalidation team for their efforts in delivering such positive results, noting the achieved score of 97% was significantly above the national average of 89%. Professor Fairhurst concurred, explaining the report was an important source of assurance to the local population that the Trust took seriously its duty to ensure its clinical staff were fit to practice.

Members gave their approval for the report to be signed off and submitted to NHSE as per Dr Stanley's request.

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

TB/2019/122 EMERGENCY PREPAREDNESS AND RESILIENCE REPORT

Mr Hodgson advised that the Trust was required to report its positon against a range of emergency planning core standards to East Lancashire CGG by the end of the month and clarified that it was a requirement for all Trusts to provide these reports to their lead CCG on an annual basis. Mr Hodgson explained that he was seeking delegated authority from the Board to submit the full report and to bring it to the next meeting for assurance. He confirmed that the Trust was compliant with 59 of the 62 core standards and that only a handful of minor changes had been made from the previous year, mainly in relation to decontamination processes.

In response to a request from Professor Fairhurst, Mrs Hodgson clarified he was requesting for authority to be delegated to the Executive Directors. Members confirmed they were comfortable with this approach.

RESOLVED: Directors received the report and noted its contents.

The Board agreed to delegate to the Executive Directors the authority to submit the annual statement.

The statement will be presented to the November Board for assurance.

TB/2019/123 INTEGRATION AND INTERMEDIATE CARE (PENNINE LANCASHIRE UPDATE)

Dr Riley informed members that his presentation was a formalised version of the discussions that had taken place at a recent workshop, and concerned closer integration between organisations across Pennine Lancashire and the many challenges involved. He began by explaining that all hospitals across the region would need to work differently with other organisations across the ICS to promote closer integration, as the current environment was heavily fragmented, with different providers providing services under different contractual mechanisms. Dr Riley added that it would also be vital for hospitals to develop more robust assessment functions and for more specialist services to be provided at community sites. He advised there were currently 13 Primary Care Networks (PCNs) spread across the Pennine Lancashire region and that each of them were due to become self-autonomous bodies, responsible for electing their own leadership. Dr Riley explained the Trust's wider role would be to fill the gap between primary and secondary care, which would also require a range of key changes, including maturing the urgent primary care offering. Dr Riley advised that work was also underway to enable therapy teams to provide a primary care response service,

giving the example of therapy staff visiting patients in their homes to assess them and avoid having to send them to A&E. Dr Riley explained outpatient services would also be key to avoiding unnecessary A&E attendances and that the ultimate aim would be to move all of them out to community areas. He advised that the development of assessment units on hospital sites would also be crucial, as it would help to move away from the default of keeping patients in overnight. He explained that the main areas of challenge would be fitting together the different strategies for PCNs, Community Services, Intermediate Care and Acute Care and the remodelling of step up and step down care. Dr Riley concluded by informing members that a formal Pennine Lancashire Intermediate Care Strategy, incorporating all of these elements, would be released in the near future.

Mr Wedgeworth thanked Dr Riley for his presentation and enquired whether he agreed with the statements made elsewhere that digital links would be critical to this and other schemes succeeding. Dr Riley agreed that the ability to share information would be key and explained that it would be vital to ensure that any new systems developed could integrate with existing systems in community areas.

Professor Harrison also extended his thanks to Dr Riley and stated that he felt that this new strategy would enable hospitals to move back towards their original purpose of treating immediate life threatening illness, as patients requiring long term care for less serious conditions could be managed in the community.

Mr Catherall advised that that PCNs were already pushing themselves to understand the issues facing families that ultimately lead to A&E attendances and that the changes described by Dr Riley were an ideal opportunity to link agendas. He stated that the proposition to have more specialised resources available in neighbourhoods would be well received.

Professor Fairhurst stated it would be vital for the messaging around these new developments to be sent out as far as possible and suggested that Dr Riley could provide a similar presentation at a future meeting of the tripartite steering group. Dr Riley advised he was already planning to add more information to his presentation for use at other venues.

RESOLVED: **Directors received the report and gave their support to the recommendations contained within it.**

Dr Riley will share the formal Pennine Lancashire Intermediate Care Strategy when available.

Dr Riley to provide a presentation to a future meeting of the Tripartite Steering Group.

TB/2019/124 AUDIT COMMITTEE UPDATE REPORT

Mr Smyth presented the report to Directors for information and highlighted the discussions which had taken place at the last meetings, particularly the discussions around the limited assurance report pertaining to Legal Service (Claims) department and the steps that have been taken to address the recommendations in the internal audit report. He went on to confirm that he had undertaken a number of additional meetings to gain a better understanding of the issues. Directors noted that a full management response would be provided at the next meeting of the Committee in October 2019.

RESOLVED: Directors received the report and noted its content.

TB/2019/125 FINANCE AND PERFORMANCE COMMITTEE UPDATE REPORT

Mrs Brown referred Directors to the previously circulated report and highlighted the discussions which had taken place at the last meetings, particularly those pertaining to the development of the People Strategy and financial position. She went on to confirm that the meeting that is due to take place later in the month would receive a detailed review of the Trust's financial position and consider a range of actions to improve the financial performance for the remainder of the 2019/20 year.

RESOLVED: Directors received the report and noted its content.

TB/2019/126 QUALITY COMMITTEE UPDATE REPORT

Miss Malik referred Directors to the previously circulated report and highlighted the discussion that had taken place, particularly those relating to the holding lists, the Board Assurance Framework and the Corporate Mortality Report.

RESOLVED: Directors received the report and noted its contents.

TB/2019/127 TRUST CHARITABLE FUNDS COMMITTEE UPDATE REPORT

Mrs Bosnjak-Szekeres presented the report on behalf of Mr Barnes and drew Directors attention to the discussion that had taken place around a suitable and workable process for the approval of expenditure over £20,000. In addition she highlighted the continued positive efforts of the charity in raising awareness and funds, including the work being carried out the secure a number of charity partnerships with local businesses.

Mrs Hughes added that ELHT&Me had also introduced a mascot for the charity in order to raise the profile of the charity further.

RESOLVED: Directors received the report and noted its contents.

TB/2019/128 REMUNERATION COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2019/129 TRUST BOARD (CLOSED SESSION) INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2019/130 ANY OTHER BUSINESS

Professor Fairhurst confirmed that the Trust would be holding its Annual General Meeting on Wednesday 25 September 2019, 12.00 noon – 2.00 pm and encouraged members of the public and staff to attend.

TB/2019/131 OPEN FORUM

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

TB/2019/132 BOARD PERFORMANCE AND REFLECTION

Professor Fairhurst sought the views of the Board members in relation to the meeting. Directors commented that the collaboration between Trusts at ICP and ICS level was increasing and could be best demonstrated by the presentation that Dr Riley had given earlier in the meeting.

Professor Thomas suggested that collaboration would become an even more important part of the Trust working in the coming years and the work being undertaken at the moment was a good indicator of the leadership that the Trust was willing and able to provide.

Dr Stanley highlighted the healthy culture that had been developed for reporting incidents and being an open and honest organisation.

Professor Harrison suggested that there were opportunities to showcase the positive work that the Trust was undertaking and suggested that the presentation given by Dr Riley could be reworked and made available through the Trust's social media accounts.

RESOLVED: Directors noted the feedback provided.

The presentation given by Dr Riley will be considered for reworking and made available through the Trust's social media accounts.

TB/2019/133 DATE AND TIME OF NEXT MEETING

The next Trust Board meeting will take place on Wednesday 13 November 2019, 13:00, Seminar Room 4, Learning Centre, Royal Blackburn Teaching Hospital.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 140

13 November 2019

Purpose Information

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

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

Report linkages

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

East Lancashire Hospitals NHS Trust

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2019/096: People Strategy/ Creating Supportive Staff Culture	A report will be provided to the next available Board meeting about the resources needed to implement the strategy.	Executive Director of HR and OD	January 2020	Agenda Item: January 2020
TB/2019/108: Open Forum	Dr Riley will investigate the reasons why only a short supply of medication was provided at the point of discharge and liaise with the member of the public outside the meeting.	Director of Clinical Strategy	November 2019	**Complete:** following discussions outside the meeting, Dr Riley was able to ascertain the reasons why only a short supply of medication was given to the patient at the point of discharge and provided an explanation to the individual who raised the query.
TB/2019/117: Corporate Risk Register (CRR)	Risk ID 8126 will be added to the next Board Strategy Session agenda for detailed discussion.	Associate Director of Corporate Governance	November 2019	**Complete:** the item was included on the agenda for discussion at the Board Strategy Session that took place on 4 October 2019.
TB/2019/119: Serious Incidents Requiring Investigation Report	Future reports will include a table showing the themes of incidents and the actions being undertaken to address them rather	Acting Executive Medical Director	November 2019	**Complete:** the table has been included in the report submitted to the Board.

Item Number	Action	Assigned To	Deadline	Status
	than a full list of StEIS reported incidents.			
TB/2019/120: Integrated Performance Report	*Safe:* Mrs Quinn to provide an update about the new care academy scheme and the promotion of ELHT careers on college websites.	Operational Director of HR and OD	November 2019	**Update:** the Care Academy website has been developed and work is ongoing to launch the site with Communications colleagues. In relation to the work being undertaken with Be Ready to promote careers within ELHT, the Education Directorate within the Trust had linked in with the organisation and plans are being developed.
	Responsive: an update will be provided about the internal workshop in relation to the increase in delayed discharges during the summer months and the learning from this exercise.	Director of Operations	November 2019	**Complete:** as a result of the workshop the Trust has changed its management of patients with a long length of stay. A Multi-Disciplinary Team have been developed which includes nurses, doctors, therapists and managers who review all patients with a length of stay in excess of 21 days to ensure a plan is in

Item Number	Action	Assigned To	Deadline	Status
				place. Any patients who have a length of stay in excess of 40 days are escalated to the Executive Triumvirate (Medical Director, Director of Nursing and Director of Operations) by the Divisional Triumvirate. If there are any patients with a length of stay in excess of 80 days, the Divisional Triumvirate are required to present the patient's management plan to the Executive Triumvirate for review.
	Mrs Quinn will provide an update on the EASE approach at the January 2020 Board meeting.	Operational Director of HR and OD	January 2020	Due in January 2020
	Mrs Quinn will update the November Board about the offer of more flexible careers and sharing of best practice to enable volunteers to work on wards with clinical staff.	Operational Director of HR and OD	November 2019	**Update:** The Trust has been in contact with the Royal Derby Hospital and have obtained information about the flexible working arrangements. The Trust in the process of developing its own Flexible

Item Number	Action	Assigned To	Deadline	Status
				Career Strategy. The Trust has also established contact with the Head of Resources at Salford Royal to share best practice.
TB/2019/122: Emergency Preparedness and Resilience Report	The statement will be presented to the November Board for assurance.	Executive Director of Service Development	November 2019	Agenda Item: November 2019 **Update:** the statement has been submitted to the CCG within the required timeframe.
TB/2019/123: Integration and Intermediate Care (Pennine Lancashire Update)	Dr Riley will share the formal Pennine Lancashire Intermediate Care Strategy when available. Dr Riley to provide a presentation on integration and intermediate care to a future meeting of the Tripartite Steering Group.	Director of Clinical Strategy Director of Clinical Strategy	November 2019 November 2019	A verbal update will be provided to the November 2019 Trust Board meeting. A verbal update will be provided to the November 2019 Trust Board meeting.
TB/2019/132: Board Performance and Reflection	The presentation given by Dr Riley on integration will be considered for reworking and made available through the Trust's social media accounts.	Director of Clinical Strategy	November 2019	A verbal update will be provided to the November 2019 Trust Board meeting.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 142

13 November 2019

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 2019

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

One - National Headlines

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

£210 million funding boost for frontline NHS staff announced

This funding will support the drive to make the NHS the best place to work, retain nursing workforce by supporting long-term career progression, and improve patient care.

Funding includes a £1,000 personal development budget for every nurse, midwife and allied health professional to support their personal learning and development needs over three years. Wider education and training budgets will also get a funding boost.

Dr Nikki Kanani appointed as England's top family doctor

GP Dr Nikki Kanani has been appointed Medical Director for Primary Care in England. Prior to joining NHS England, she was Chief Clinical Officer of NHS Bexley Clinical Commissioning Group (CCG). Dr Kanani, continues to work as a GP in Bexley, south-east London.

High street heart checks on the NHS

Pharmacists now offer rapid detection and help for killer conditions like heart disease as part of a major revamp of high street pharmacy services. Implemented on 1 October 2019 as part of a new £13 billion five-year contract, community pharmacists have begun to develop and test an early detection service to identify people who may have undiagnosed high-risk conditions like high blood pressure for referral for further testing and treatment. If successful, this could be rolled out to all community pharmacies in 2021-22.

The high street heart checks are part of an ambitious target the NHS in England has set itself as part of its Long Term Plan to prevent tens of thousands of strokes and heart attacks over the next ten years.

On the lookout for 'social media influencers'

The search is on to find 10 passionate NHS ambassadors including nurses, midwives, allied health professionals and doctors to promote the use of the new NHS App. The free app (available on Google Play and Apple app stores) will be key to transforming people's experience of services as well as helping them to take back control of their own health.

Ambassadors for the app will be drawn from a range of different backgrounds, locations and clinical roles. They will play a critical role in the wide promotion of the NHS App by encouraging downloads and talking about the benefits, especially for those with long-term health conditions and pregnant women.

'NHS Passport' to support flexible working

Following the successful pilot projects, Prerana Issar, Chief People Officer for NHSE/I took the opportunity at the Health and Care Innovation Expo to urge all hospitals in England to sign-up to passporting agreements. The scheme is part of a package of measures to build a workforce to deliver the Long Term Plan.

The 'NHS Passports' will cut the need for up to two-day inductions and other administration when staff move between organisations. Supporting flexible working for staff is seen as a cornerstone of helping to improve retention rates as outlined in the NHS Long Term Plan and interim People Plan. A toolkit has been created to help Trusts set up workforce sharing agreements.

NHS taskforce to drive improvements in young people's care

NHS chief Simon Stevens announced a new taskforce will be set up to improve current specialist children and young people's inpatient mental health, autism and learning disability services in England. An independent oversight board, chaired by Anne Longfield OBE, Children's Commissioner for England, will also be set up to scrutinise and support the work of the taskforce.

The establishment of the taskforce and oversight board comes as part of a package of measures in the NHS Long Term Plan. They will ensure that the NHS services operate at safe and effective levels, as well as immediately injecting a boost in care quality.

Computer gaming addiction support available

The country's first specialist clinic to treat children and young adults who are addicted to playing computer games such as Fortnite, Candy Crush and Call of Duty has been opened. This follows the World Health Organization recently classifing Gaming Disorder as a mental health condition for the first time.

NHS staff will help those aged 13 to 25 whose lives are being debilitated by spending countless hours playing games. GPs and other health professionals in England can refer addicts to the service. It has been set up because of concern about the growing number of children and young people whose heavy use of computer games is causing problems for them, especially with their mental health. The clinic will be part of the National Centre for Behavioural Addictions in London. Patients referred to it will be able to attend in person or have an online consultation using Skype.

Call to cut catering plastics from hospitals

The NHS will slash the use of plastic in hospital canteens as part of its drive to reduce waste and make hospitals healthier for patients and staff. If the NHS cut its use of catering plastic in half it could mean over 100 million fewer items each year end up polluting the oceans or in landfill.

Retailers operating in hospitals, including Marks & Spencer and WH Smith, are backing the call by committing to cut the use of avoidable plastics starting with straws and stirrers from April with cutlery, plates and cups phased out over the following 12 months. Simon Stevens has urged hospital Trusts with in-house catering to step up and match stores' commitment by signing a pledge to support the reduction campaign.

Life changing news for cystic fibrosis patients

NHS England has announced an agreement with Vertex Pharmaceuticals to make available all three of their UK-licensed cystic fibrosis medicines.

This means NHS patients will now have full access to Orkambi, Symkevi and Kalydeco, and around 5,000 people may now take up these treatments. There is no cap on patient numbers, and each and every patient in England who might benefit can now get these treatments, free on the NHS. Clinicians will be able to begin prescribing these drugs from the end of November.

Public backing for new rapid care measure plans

A national survey commissioned by Healthwatch England found that an overwhelming majority of people placed a high priority on early initial assessment on arrival at A&E for everyone, allowing staff to prioritise those patients with the greatest need, and ensuring that patients with critical conditions get the right standard of care quickly.

These priorities are mirrored in new standards now being trialled across the NHS, as part of a review led by NHS National Medical Director, Professor Stephen Powis, supported by leading staff and patient groups. They include a rapid assessment measure for all patients arriving at A&E, coupled with measuring how quickly life-saving treatment – or Critical Time Standards – is delivered for those with the most serious conditions, such as heart attacks, sepsis, stroke and severe asthma attacks.

Drive to increase lifesaving vaccines uptake

An NHS review has stated more lifesaving vaccines should be provided in convenient locations for parents to drive uptake. Analysis shows that one in seven children aged five had not had both doses of essential measles jabs, with vaccination rates dropping in each of the past five years. Vaccination rates for measles, mumps and rubella (MMR) are currently at 91.2%; below the recommended 95%.

The new review of immunisations in general practice says that the introduction of new 'primary care networks' nationwide, could mean more access to evening and weekend appointments, to offer more convenient access for parents.

Support increased for survivors of female genital mutilation

Hundreds of survivors of female genital mutilation (FGM) will be able to access expert care, support and treatment earlier thanks to a new network of NHS 'one stop shop' clinics.

The new network of FGM support clinics will be led by specialist doctors, midwives and nurses, and provide access to specially trained counsellors for emotional support, as well as FGM Health Advocates for advice on accessing other services locally.

Two - Pennine Lancashire Headlines

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

Together a Healthier Future update

Pennine Lancashire Integrated Care Partnership Strategy Development

The Pennine Lancashire Integrated Care Partnership has released their 2018/2019 Annual report. There have been a number of excellent achievements this year and this report shines a light on key achievements from our health and care improvement areas including Prevention and Social Prescribing, Neighbourhoods and Community Health Services, Intermediate Care, Regulated Care, Urgent and Emergency Care and Digital Health as well as Workforce, Estates and Volunteering.

Some of the achievements highlighted for 2018/2019 include the Home First programme supporting over 3000 patients a year, a reduction of the number of care home residents needing to be taken to the hospital, improvements in mental wellbeing for clients attending the Blackburn with Darwen Wellbeing Service and the new GP extended access scheme.

ICS/ICP Strategy Development Update

An approach is now underway with the Lancashire and South Cumbria Integrated Care System to respond to the national planning requirements. In support of this the ICP Partnership Leaders' Forum has endorsed the Strategic Narrative for the ICP, which was submitted as part of ICS planning approach. The narrative outlines the delivery priorities of the ICP and sets out how partners in the ICP will work together to deliver improvements to health and care in Pennine Lancashire.

Partnership Leaders also considered an initial draft Five Year Pipeline of potential deliverables for the Integrated Health and Care Partnership; this outlines some of the strategic developments that are likely to require Partnership consideration over the next twelve months. The pipeline will allow the ICP, with its constituent organisations, to make informed judgements regarding transformation priorities for the next five years and in turn, the alignment of system capacity and capability to deliver the required change.

A proposition has been put forward regarding future developments for Intermediate Care in Pennine Lancashire. The Draft Intermediate Care Strategy outlines potential actions to assist patients stepping up and stepping down from the system, supporting people to stay out of

hospital and helping to reduce pressures on the system and on our staff by shifting activity into the community and providing a broader discipline model. Working is ongoing to develop implementation timelines and impact assessment for the draft Strategy.

Another proposition endorsed by the Partnership Leaders is the Neighbourhood Integration Accelerator. The Accelerator will follow a public health management approach to develop new pathways and ways of working in Neighbourhoods and PCNs that focuses on person centred care. The key points of the approach are:

- The patients who are most in need will be identified and worked with to understand their challenges and goals; interventions will be decided with the patient and effectiveness will be monitored. This will lead to a system being designed with patient involvement
- A quantitative, qualitative and economic evaluation will be in operation with metrics to reflect patient and staff outcomes
- An alliance approach will be adopted which will maximise the chances of success

PCNs will be invited to submit expressions of interest to take part in the first wave of the Accelerator programme.

Health improvement efforts shortlisted for national award

The collective efforts of six GP practices to improve the health and wellbeing of local residents has been shortlisted for a prominent national award. The Chorley Central Primary Care Network was put forward for the 'Primary Care Network of the Year' at the 2019 General Practice Awards - the most prestigious awards for primary care professionals.

The Chorley Central network has been at the forefront of delivering key benefits for patients which are linked to the NHS Long Term Plan. Through the development of the Chorley Central network, local GP practices have been working with partners at Chorley Council, Lancashire County Council's public health team and others, including the third and voluntary sector to improve local people's health in new ways.

Innovative digital health project receives national award

The Digital Discharge programme helps health organisations and councils across the region to share patient information more seamlessly and deliver a more efficient discharge process to both the NHS and social care. Led by Lancashire and South Cumbria Integrated Care System (ICS) and in place between Lancashire County Council and Lancashire Teaching Hospitals NHS Foundation Trust the programme has been named Best Communication Solution at the

2019 Health Tech Digital Awards. The Health Tech Digital Awards recognise the best technologies across the UK.

An integral part of the Digital Discharge pathway is the Local Person Record Exchange Service. It provides health and care professionals instant access to shared health and care records across Lancashire and South Cumbria.

Top Public Health official visits Blackburn with Darwen

Chief Executive of Public Health England, Duncan Selbie, was recently welcomed at Blackburn with Darwen Borough Council (BwD). The visit was a part of a series of weekly meetings that Mr Selbie holds across England that allow him to sit down with local government, NHS and, where possible, the Volunteer, Community, Faith and Social Sectors to discuss their work and share learning.

Mr Selbie was keen to learn more about the work that BwD Borough Council has been doing as part of the Pennine Lancashire Integrated Care Partnership (ICP). In his national blog he noted that BwD has been, "an outstanding example of modern local government underpinned by an unwavering commitment to their communities and outcomes."

Digital technologies help local people to live well at home

The Lancashire and Cumbria Innovation Alliance Test Bed programme was a collaborative study which tested a combination of innovative technologies and practices to determine if they could improve services and patient experiences.

The project was funded by NHS England and hosted by Lancashire and South Cumbria NHS Foundation Trust (previously Lancashire Care) and ran for two years. Each person participating received a 'digital' solution from a range of equipment to trial at home. The equipment, (blood pressure recorders, oxygen monitoring finger probes and tablet computers), held technology designed to help measure vital signs at home. These were monitored remotely by clinicians which helped healthcare teams understand how they may be able to support patients manage their condition from home with the re-assurance to a patient that they were still being monitored by a healthcare professional.

The project was aimed at supporting people aged 55 and over living with long term conditions (such as heart failure, Chronic Obstructive Pulmonary Disease and/or dementia) to remain well in the community, avoiding unnecessary hospital admissions where possible.

Morecambe Bay NHS FT joint top for dementia screening

The Trust has achieved joint top of a national 'leader-board' for screening for undiagnosed dementia in people admitted to hospital through the Emergency Department. For the last few years, all NHS Trusts in England have been required to achieve a national financially-led CQUIN (Commission for Quality and Improvement) target for the screening of possible dementia in patients.

The CQUIN target requires 90 per cent compliance and UHMBT has achieved this target for the last six years. UHMBT is joint top out of 87 health organisations that have been required to meet the target. This means patients and families affected by dementia are able to get support and advice sooner thanks to the earlier detection.

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 not been applied since the last report to the Board.

Executive Appointments

Trust Reappoints Chairman

NHS Improvement confirmed the reappointment of Professor Eileen Fairhurst as the chairman of ELHT for a further 12 month period. Professor Fairhurst has been in post since February 2014. During that time, she has overseen the Trust improvement journey from 'special measures' to 'GOOD' with areas of 'OUTSTANDING'. The Trust is delighted that the Chairman will continue her work with colleagues across the health care economy to improve the health and wellbeing of all who live and work in Pennine Lancashire.

Greater collaboration for two North West Trusts

Kevin McGee has been appointed Chief Executive and Accountable Officer of East Lancashire Hospitals NHS Trust (ELHT) and Blackpool Teaching Hospitals NHS Foundation Trust (BTHFT). This strategy of collaboration follows extensive discussions with Board members of both organisations, the Governors at Blackpool FT, governance advisors and regulators and will see both Trusts benefit form sharing good practice and experience.

Non-Executive Director returns to role

Trish Anderson has returned to the post as Non-Executive Director following a six-month leave of absence. Trish re-joined the Board in October following the completion of the assignment she was undertaking at Knowsley NHS Clinical Commissioning Group. There she supported the Chief Executive Officer in the development of the 'Local Place Plan' in response to the NHS Long Term Plan and Eastern Sector Cancer Alliance.

NHS' Chief Midwife visits Lancashire birth centres

NHS England's new Chief Midwifery Officer, Professor Jacqueline Dunkley-Bent, gave East Lancashire the honour of being one of her first official visits.

Professor Dunkley-Bent became the country's senior midwife earlier this year and immediately accepted an invitation to visit the Lancashire Women's and Newborn Centre. During the visit the Chief Midwifery Officer witnessed how staff in the Trust's Maternity Services provide award winning care for parents and babies. The Centre was the first in the UK to receive the UNICEF Baby Friendly Gold Accreditation in 2018, maintaining the standard in 2019. Staff involved in achieving the accreditation presented the programme of work to Professor Dunkley-Bent and her colleagues.

Official opening of the Fairhurst Building

After over two years in the planning, the £15M development was officially opened at Burnley General Teaching Hospital, by Chairman Professor Eileen Fairhurst.

The state-of-the-art Fairhurst Building, completed ahead of schedule and within budget, provides patients and staff with high quality facilities for outpatient appointments, ophthalmology and maxillo facial treatment, in bigger and better surroundings that meet increasing demands.

A ribbon cutting ceremony and tours were conducted, providing local officials and key dignitaries the opportunity to see the new ground-breaking facilities for themselves.

Presidential position for ELHT Clinical Psychologist

Dr Andrew Beck, Clinical Psychologist, has been elected President of the British Association of Cognitive and Behavioural Psychotherapists (BABCP).

The BABCP is the lead organisation for Cognitive Behaviour Therapists in the UK, representing 12,000 members nationally. The organisation is the lead advocate for the national development of Cognitive Behavioural Therapy, and lead organisation for accrediting therapists who work using the therapy.

Taking up this role enables Dr Beck to further promote his recent work developing a national framework for the NHS, providing the best possible mental health care to BAME communities. The work has resulted in the production of a guidance document, the Improving Access to Psychological Therapies BAME Positive Practice Guide.

Hats off to Assistant Practitioner graduates

The Trust celebrated the success of five therapy staff who recently graduated from the University of Central Lancashire's Burnley campus. All five graduates began their studies as Trainee Assistant Practitioners in 2017, successfully completing the Assistant Practitioner degree course this summer.

With an ageing population and increasing demands on the NHS, Assistant Practitioners and other support workers represent more than one in three NHS staff who assist doctors, nurses and registered therapists in delivering face-to-face patient care.

Digital health pioneers awarded by NHS Innovation Agency

Clinical coding specialists at ELHT have been rewarded for their outstanding performance by winning a prestigious award presented by the Innovation Agency.

The Trust was among the winners at the North West Skills Development Network's Informatics Awards, part of the Connect 2019 conference showcasing pioneering work in digital health. ELHT's Clinical Coding Team were named Team of the Year in recognition of a number of achievements, including five members of the team achieving their National Clinical Coding Qualification, with one coder achieving a double distinction.

Inclusivity project opens doors for potential doctors

It is hoped an 'Inclusivity Project', born out of a workshop headed by Professor Damien Lynch at the Annual ELHT and UCLan Medical Education Conference, will encourage and support more people to train as doctors.

Many young people have the academic capability and the ambition to train to become a doctor but for a number of reasons are put off applying to medical school. This could be due to the demands and complexity of the application process, the finances involved as well as challenges of living away from home.

This project is a package that will provide insight into what it takes to be a medical student mixed with help to develop life skills to support independent living.

Walking Morecambe Bay sands for ELHT&Me

There was a fantastic turnout – over a hundred supporters – for the second ELHT&Me Morecambe Bay charity walk. Charity supporters of mainly Trust staff, walked approximately eight miles in glorious sunshine, from Arnside to Kent's Bank. The group was led by the newly

appointed Queen's official guide, Michael Wilson.

The walk raised over £3,000 through registration and sponsorship of the event.

New service specialist service launched

The new Rainbow Pregnancy Clinic provides specialist clinical and holistic care for women who fall pregnant following late miscarriage, stillbirth and early neonatal death – a 'rainbow' pregnancy.

The specialist multi-disciplinary team approach of the clinic enables continuity of care for parents expecting a rainbow baby. This bespoke antenatal clinic is led by consultants, with additional midwifery support and shared care with other relevant services. Expectant parents are able to use a separate waiting area when visiting the clinic, and can attend more regular 'reassurance scans' to ensure the health of the unborn baby.

National accreditation for specialist service

ELHT has been accredited by the British Society for Gynaecological Endoscopy (BGSE) as a national centre for Endometriosis.

The Trust's Lancashire Women and Newborn Centre at Burnley General Teaching Hospital is one of only three in the region providing a specialised service for patients with endometriosis and the BSGE accreditation cements the position of ELHT as a leading centre in this area of gynaecological care.

To become an accredited centre, a hospital must meet stringent criteria regarding the service it provides to patients. Requirements include a dedicated, consultant-led endometriosis service run within a specialist outpatient clinic and access to a multidisciplinary team including two colorectal surgeons, urologist, pain management specialists and two Endometriosis Nurse Specialists.

More hospital opportunities for local unemployed

A further 12 local people have gained a national qualification and relevant work experience by taking part in ELHT's **Step Into ELHT** pre-employment initiative.

In partnership with the Department of Work and Pensions (DWP) and Blackburn College, 12 men and women aged 20-55 recently completed the programme which began with a 3-week course at Blackburn College studying for a Level 1 City and Guilds in 'Employability Skills in the Adult and Child Care Sector'. This was followed by a three-week work placement at either

Burnley or Royal Blackburn hospital in departments including patient services, health records, laundry and business administration.

Donation is music to the ears!

Blackburn birth Centre will be able to provide the music of choice for mothers in labour thanks to a generous donation of four Panasonic Audio units. Zoe Cook, midwife at the Centre, and her husband delivered the new sound systems as a charitable donation to the delight of the staff and expectant mums. The gift was made possible through raising funds at a charity boxing match.

Speech and language therapy equipment donated

The Issa Family, founders of the international company EG Group, generously donated funds to ELHT&Me, to purchase Fibreoptic Endoscopic Evaluation of Swallowing (FEES) equipment.

Mr Issa, father of the company's CEOs Mohsin and Zuber Issa, personally chose the Speech and Language Therapy department to receive the donation.

The equipment can be used to assess a patient's swallow, their voice, and the structures of the throat, secretions and sensation. It can help to make decisions on whether a patient is safe to eat and drink, to facilitate voice assessment and accurate care planning.

East Lancashire Hospitals
NHS Trust

Four – Communications and Engagement

A summary of the external communications and engagement activity.

September 2019

Communications and Engagement

Monthly Media Update

Top Stories...

- Essential works in Urgent Care and Emergency Departments
- Hospital experts demonstrate state-of-the-art eye testing to opticians
- Join us for our annual listening event and AGM!
- NHS' Chief Midwife visits Lancashire Birth Centres

- £15 million Fairhurst Building opens at Burnley General Teaching Hospital

Press and Media Relations...

35 Mentions in all media

10 Media enquiries handled

4 Media releases issued this month

75% of stories were positive or neutral

+28 The monthly media net score (positive minus negative

Projects the Communications Department has supported...

- TOGETHER a healthier future
- Well Service events
- NHS Big Tea Parties
- AGM
- Phase 6
- Phase 8
- PLACE
- Dementia Strategy

Website...

Our website got **103,120** page views by **34,728** people .

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

Social media and digital...

Followers on social media:

10,881

6,588

1,428

38,966

Avg Weekly Facebook Reach

255,000

Twitter Impressions

73%

Facebook page responsiveness

619

Twitter mentions

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

- A&E is Busy Alert Messages
- Debbie Vaughan and her shopping trolley
- Jasper the Therapy Dog wants to meet staff!
- Nurse Recruitment Event

Posts of the month...

Facebook review rating:

4.5 out of 5

Routine activity:

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

Safe | Personal | Effective

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

Communications and Engagement

Monthly Media Update

Top Stories...

- AHP Day 14 October 2019
- Inclusivity project
- Digital health pioneers awarded by NHS Innovation Agency
- East Lancashire Clinical Psychologist to be next President of the British Association of Cognitive and Behavioural Psychotherapists (BABCP)
- More hospital opportunities for local unemployed

- First patients welcomed into new Fairhurst building

Press and Media Relations...

40 Mentions in all media ↑

8 Media enquiries handled ↓

16 Media releases issued this month ↑

99% of stories were positive or neutral ↓

+39 The monthly media net score (positive minus negative)

Projects the Communications Department has supported...

- TOGETHER a healthier future
- Well Service events
- Ophthalmology service engagement
- AHP Day
- Menopause awareness
- Pefect Week preparation
- Staff Flu Vaccinations
- MEC transformation

Website...

Our website got **111,134** page views by **38,919** people.

The most viewed webpage was – **Shuttle Bus times**

NHS

East Lancashire Hospitals

Social media and digital...

Followers on social media:

10,916

6,920

1,482

41,115

Avg Weekly Facebook Reach

215,000

Twitter Impressions

88%

Facebook page responsiveness

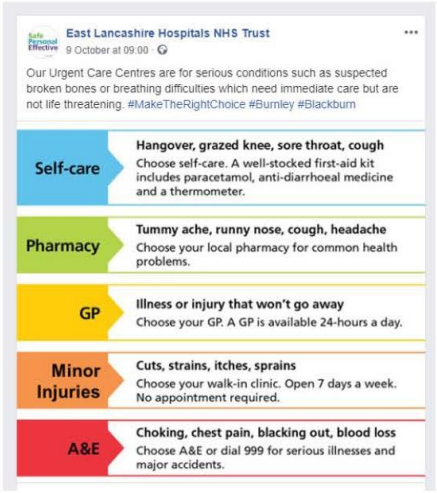
638

Twitter mentions

The most talked about issues on our social networks..

- Urgent Care and #MakeTheRightChoice
- Suicide Awareness
- Staff Nurse Vacancy Ward C8
- Fairhurst Building

Posts of the month...



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

Safe | Personal | Effective

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

Five - Chief Executive's Meetings

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

October 2019 Meetings

Date	Meeting
1 October	Pennine Lancashire Assurance Meeting
1 October	CQC Engagement Meeting
2 October	Team Brief Blackburn and Burnley
2 October	Filming Team Brief
3 October	A&E Delivery Board workshop
4 October	Board Strategy Session
7 October	Corporate Induction
8 October	Clinical Strategic Executive/Operational Executive Briefing
15 October	Clinical Strategic Executive/Operational Executive Briefing
15 October	Employee of the Month
15 October	Royal College of Physicians
16 October	Lancashire and South Cumbria Integrated Care System Leaders Executive
16 October	Partnership Leaders
17 October	Financial Assurance Board
17 October	Pathology Meeting
21 October	Financial Sustainability Meeting
21 October	Meeting with Chief Officer, NHS Chorley and South Ribble CCG
22 October	Clinical Strategic Executive/Operational Executive Briefing
23 October	NHS Providers and NHSE/I roundtable winter performance telecom
24 October	CQC NHS external coproduction group - London
28 October	UCLan research telecom
29 October	Chairman update
31 October	Medical Director Interviews

November 2019 Meetings

Date	Meeting
4 November	PL Chief Officers Meeting
5 November	Clinical Strategic Executive/Operational Executive Briefing
6 November	Lancashire and South Cumbria Integrated Care System Board Meeting
6 November	HSJ Awards – London
7 November	STP and ICS Leaders' Development Day – London
7 November	Perfect Week Briefing
11 November	Finance and Performance
12 November	Chairman update
12 November	Long Service Awards Evening
13 November	Trust Board
19 November	Clinical Strategic Executive/Operational Executive Briefing
19 November	Shadow Board Presentation
19 November	Chairman update
20 November	Extraordinary Lancashire and South Cumbria Provider Board
20 November	ICS System Leaders Executive meeting
20 November	Collaborative Working Meeting
20 November	Chief Officers meeting
20 November	Partnership Leaders Forum
21/22 November	Board Development
26 November	Clinical Strategic Executive/Operational Executive Briefing
26 November	Tri-partite Purpose and Vision Task and Finish Group
26 November	Chairman update
27 November	Pendle Hospital Christmas Fayre
27 November	Monthly Tripartite Task and Finish Group
29 November	Lancashire and South Cumbria NHS FT meeting

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 144

13 November 2019

Purpose Monitoring

Title	Corporate Risk Register
Author	Mr M Stephen, Head of Safety & Risk
Executive sponsor	Dr D Riley, Director of Clinical Strategy (on behalf of the Acting Executive Medical Director)

Summary: This report presents an overview of the Corporate Risk Register (CRR) as of the 15/10/2019 these risks which were reviewed at the Risk Assurance Meeting (RAM) on the 11/10/2019 by the Divisions and Corporate services for review, scrutiny, assurance.

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

Report linkages

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

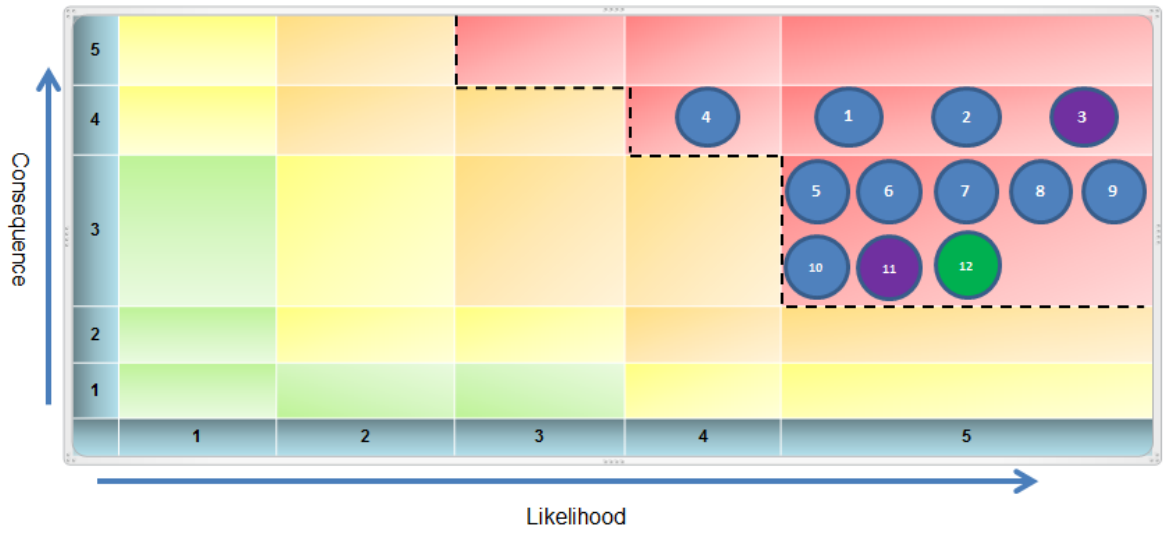
Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Table 1: The Corporate Risk Register (CRR) as of 18/10/2019

No	Risk	Title	Current Score	Actions	Date last reviewed	Risk Movement
1	7010	**Aggregated Risk** - Failure to meet internal and external financial targets in year will adversely impact the continuity of service	**20**	All actions complete **(New actions under review)**	13/09/2019	
2	8126	**Aggregated Risk** - Potential delay in the implementation of Electronic Patient Record (EPR) System	**20**	**2** actions on-going	30/09/2019	
3	7762	**Newly added to report -** Risks associated with providing HDU (High Dependency Unit) care in DGH with no funding for HDU provision	**20**	**2** actions on-going	15/10/2019	
4	8061	**Aggregated Risk** - Management of Holding List	**16**	**2** actions on-going	04/09/2019	
5	7067	**Aggregated Risk** - Failure to obtain timely mental health (MH) treatment impacts adversely on patient care, safety and quality	**15**	**1** action on-going	11/09/2019	
6	1810	**Aggregated Risk** - Failure to adequately manage the Emergency Capacity and Flow system.	**15**	**2** actions on-going	19/09/2019	
7	5791	**Aggregated Risk** - Failure to adequately recruit to substantive nursing and midwifery posts may adversely impact on patient care and finance.	**15**	**4** actions on-going	07/10/2019	
8	5790	**Aggregated risk** – Failure to adequately recruit to substantive medical posts may adversely impact on patient care and finance.	**15**	**4** action on-going	18/10/2019	
9	7008	Failure to comply with the 62 day cancer waiting time.	**15**	**5** actions on-going	30/09/2019	
10	7552	Risk that PACS downtime occurs and brings delay to patient pathways or delays in operating theatre activity.	**15**	**1** action on-going	11/10/2019	
11	8184	**Newly added to report -** Inability to meet the set Numerators in the falls CQUIN	**15**	New risk, actions being identified	15/10/2019	
12	8060	**De-escalating from the CRR-** Potential to compromise patient care/deliver sub-optimal care on the elective centre & infusion suite	**12**	All actions complete **(Risk under review)**	24/09/2019	

Table 2: CRR Risk Heat map



Change in Risk Template

1. The risk register template has been amended to capture more information which will support the assurance provided to board.
   a) A new table has been added to show the movement of risks, the arrows within the 'Risk Movement' column show the direction of the risk score going up or down and staying the same as reported the previous month.
   b) The heat map has been updated. Numbers in green reflect the 'de-escalation of a risk'. Numbers in purple reflect a new risk being added to the register.

Risks recommended for inclusion on the (CRR) since the last Trust Board in August.

No	Risk	Title	Score at escalation	Added to Corporate Risk Register?
1	7762	Risks associated with providing HDU care in DGH with no funding for HDU provision	20	YES
2	8184	Inability to meet the set Numerators in the falls CQUIN	15	YES
3	8207	failure to deliver cystoscopy/urodynamic service	15	NO
4	1489	Failure to meet the activity and income targets	15	NO

Table 3: items recommended for the (CRR) in September and October.

2. **Risk 7762 –** This risk was escalated to RAM in October and reviewed by the meeting attendees. This risk centres the provision of HDU (High Dependency Unit) service within family care which no funding is provided for. It was escalated to Operation Executive Briefing and agreed at a score of **(20)** and added to the CRR.
3. **Risk 8184 –** This risk was escalated to RAM in September and was reviewed by the meeting attendees. The current risk highlights the issue of not meeting our CQUIN target for the end of the year which was valued at a loss of £250,000 per quarter should we not achieve this target. It was escalated to Operation Executive Briefing and agreed at a score of **(15)** and added to the CRR.
4. **Risk 8207 –** This was escalated to RAM in September and reviewed by the meeting attendees and it was agreed to aggregate this risk into the CRR risk (7008- *Failure to comply with the 62 day cancer waiting time*). This is because of the similar activities underway within the linked risks. The service has slightly improved because of improvements made by the supplier but this is currently under monitoring.
5. **Risk 1489 –** This was escalated to RAM in September and reviewed by the meeting attendees and was agreed to be escalated to the Operational Executive Briefing. This was reviewed by the Executive Team and agreement was made for this not to be added to the CRR but linked up to the overall financial risk already on the CRR (**7010-** *Failure to meet internal and external financial targets in year will adversely impact the continuity of service*).

De-escalated risks from the Corporate Risk Register

No	Risk	Title	Previous Score	New score
1	8060	Potential to compromise patient care/deliver sub-optimal care on the elective centre & infusion suite	**15**	**12**

6. Significant work has been completed across the divisions to reduce the scoring of this risk. The risk has been reviewed and the actions to reduce this risk have now been completed with no incidents reported over the last few months due to the actions taken. The following actions have reduced the scoring of the risk.
   a) Governance structure has been strengthened.
   b) RMO contract has been changed to cover the infusion suite.

Corporate Risk Register (Appendix 1):

7. Details of the current Corporate Risk Register can be found in appendix 1, including the management of actions and controls within the risk. This has been updated with the latest information following the RAM meeting on the 11th October. Outstanding actions have been chased with the relevant handler and controls have been reviewed. There are 12 risks on the CRR with 1 risk being de-escalated from the register.

Conclusion

8. Members are requested to:
   a) Gain assurance that risks on the CRR are being robustly managed in line with best practice and the Trust Risk Management Strategy.
   b) Support the ongoing management of Corporate Risk Register risks within respected functions/divisions throughout the Trust.

Appendix 1: The Corporate Risk Register – Current Risks
RAG Key:

	Outstanding/Overdue		In progress & on track

East Lancashire Hospitals NHS Trust

Title	**Aggregated Risk: Failure to meet internal and external financial targets in year will adversely impact the Continuity of Service Risk Rating**				
Risk ID	7010		Date opened	25/08/2016	
Risk Handler	Allen Graves		Exec Director/Risk Lead	Charlotte Henson	
Identified in BAF Risk ID	BAF/04: The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework.				
Linked to Risks:	1487 - Failure to deliver the SRCP- (15) 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) - (10)				
Initial Rating	**Likelihood: 3 Consequence: 5 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 4 Total: 20**	Target Rating:	**Likelihood: 3 Consequence: 4 Total: 12**
What is the Hazard	• Failure to meet the targets will result in the Trust having an unsustainable financial position going forward and the likely imposition of special measures		What are the risks associated with the hazard	• If Divisions deliver their SRCP and meet their Divisional financial plans the Trust will achieve its agreed control total. • 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 throughout the organisation • Training for budget holders • Availability of guidance on Trust intranet • Monthly reconciliation • Daily review of cash balances • Finance department standard operating procedures and		What are the gaps in controls	• Pay rises (junior medics) • HEE and any other levies changes • External tariff changes • Changes in income from changes in referral patterns and activity due to cancelling ops • Unexpected backlog maintenance and emergency repairs to estate of equipment	

	Outstanding/Overdue		In progress & on track

	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	• None identified.

Actions to be carried out in mitigating this risk

	No	Action	Action Lead	Due date	Expected Completion date	RAG Rating

East Lancashire Hospitals NHS Trust

Title	**Aggregated Risk: Potential delay in the implementation of Electronic Patient Record (EPR) System**				
Risk ID	8126		Date opened	02/05/2019	
Risk handler	Mark Johnson		Exec Director/Risk Lead	Mark Johnson	
Identified in BAF Risk ID	BAF 5: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).				
Linked to Risks:	8165- Current IT systems do not support the collection of the Emergency Care Data Set (15) Linked to possible 327 incidents (Please see the start of this report for info)				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 4 Total: 20**	Target Rating:	**Likelihood: 2 Consequence: 3 Total: 6**
What is the Hazard	• The absence of a Trust Wide Electronic Patient System, the reliance on paper case notes, assessments, prescriptions and the multiple minimally interconnected electronic systems in the Trust. • This risk supersedes previous system specific risks.		What are the risks associated with the hazard	• Inability to effectively share a persons medical record with the treatment and support teams. • Potential increase in prescribing errors due to the absence of a ePMA system. • Inability to effectively monitor patient flow and patient care. • Inability to capture required patient and statutory data sets with contingent solutions causing disruptions to patient care. • Loss of income due to poor capture of patient activity. • Inability for patients to contribute and be informed of their care. • Increased risk of harm due to manual transcription of results and observations. • Reduced clinical decision making and excessive tests due to lack of effective decision support systems. • Significant costs to the organisation due to the storage and retrieval of paper case notes. • Increased costs to the organisation due to the inability to comply with regulatory and dataset requirements (eg	

			CNST). • Increased costs to the organisation due to ineffective monitoring of key clinical conditions and treatments (eg sepsis, pressure ulcers, VTE, infection). • Excessive variation in clinical practice leading to sub optimal outcomes for patients due to the inability to monitor practice and effectively implement care pathways. • Poor clinical care coordination across specialties, primary and secondary care and other outside agencies. • Poor patient outcomes due to ineffective referrals and discharge systems due to paper based systems. • Poor data quality due to transcription errors between clinical systems both internally and externally. • Inability to undertake detailed review of patient care due to paper based data collection systems. • Increased patient risk due to inability to capture certain data sets (such as MSDS). • Inability to integrate with Trusts within and outside of the organisation. • Inability to attract senior clinical and operational leaders due to the Trust using ineffective and aged systems. • Poor practice may not be picked up due to inability to measure outcomes consistently. • Patient may become 'lost in the system' due to inability to track them through the stages of care effectively. • Significant reputational damage due to clinical, operational and financial limitations.
What controls are in place	• Stable PAS system (albeit 25+ years old) • Extramed patient flow system, including capture of nursing docs • ICE system • EMIS system • Winscribe digital dictation system • Windip scanning solution	What are the gaps in controls	• Windip scanning solution not across all specialties and casenote groups. • EMIS system only supports community activity, no significant system in acute setting. • Not all systems are registered (or known about). • Contracts for current systems being 'rolled over' annually cannot identify specific 'switch over' dates.

	• Orion Portal • 24/7 system support services • Large medical record department • paper contingencies for data capture • Additional administrative staff as required • All critical systems managed by informatics or services with direct links to Informatics. • Register of non-core systems capturing patient information (feral systems) in place. • Improved infrastructure (including storage) to maintain and manage existing systems.		• Inability to rapidly flex the current system to emerging demands from NHSI / D for additional information. • Limited capital budget to invest in additional hardware / software as clinical requirements develop.
What assurances are in place	• Consistent monitoring of current clinical systems and support via helpdesks and informatics services. • Significant amount of Business Intelligence system data quality and usage reports.	What are the gaps in assurance	• Whilst many reports may be produced the Trust does not always have enough admin or clinical resource to action. • Unable to plan infrastructure as new technologies and clinical techniques develop in isolation from the main ePR.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	RAG Rating
1	ICS support and approval for ELHT ePR route	Mark Johnson	31/08/2019	31/08/2019	Overdue
2	Submission of FBC for approval	Mark Johnson	27/09/2019	05/11/2019 (Still awaiting feedback from National Team. Updated date to reflect this.)	On track

East Lancashire Hospitals NHS Trust

Title	**Risks associated with providing HDU (High Dependency Unit) care in DGH with no funding for HDU provision**				
Risk ID	7762		Date opened	31/05/2018	
Risk handler	Helen Campbell		Exec Director/Risk Lead	Neil Berry	
Identified in BAF Risk ID	**BAF/04:** The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework.] **BAF/03:** Lack of effective engagement within partnership organisations (ICS and ICP) results in failure to work together causing detrimental effect on the health and wellbeing of our communities.				
Linked to Risks:	Linked to **5** incidents raised on Datix, dated between 2015 and 2016.				
Initial Rating	**Likelihood: 5 Consequence: 4 Total: 20**	Current Rating:	**Likelihood: 5 Consequence: 4 Total: 20**	Target Rating:	**Likelihood: 2 Consequence: 4 Total: 8**
What is the Hazard	• ELHT provides HDU (High Dependency Unit) care as does most District General Hospitals with the tertiary centres providing formal HDU In recent years with increasing demand and limited tertiary capacity the provision for HDU care is increasing. We have received no funding to manage this provision and yet provide an estimated 1404 HDU days per year (70 % being Level 2 HDU). This presents a series of risks		What are the risks associated with the hazard	• Clinician and safety risk - not fully staffed as per PCC (Primary care Commissioning) standards for HDU care. Not able to meet HDU standards at present time. • Financial risk - pressure on budgets from managing acuity on ward on daily basis particularly in winter. Loss of income for service provided for free despite significant cost in budgets to provide service. • Reputational risk - not meeting HDU standards of care.	
What controls are in place	• Safer staffing is reviewed for nursing on a daily basis at Matron and Trust Director of nursing level. Staffing is managed according to acuity and therefore managed in a safe manner. • Medical staffing actions have been taken to mitigate risk of medical cover to HDU activity in winter months -specific winter planning takes place. • HDU competencies and training completed and co-ordinated in the Directorate to ensure suitable skills. • Safer staffing for nursing completed on a daily basis and acuity of patients managed at Matron/Trust level. • Medical staffing support monitored and winter planning		What are the gaps in controls	• Unable to meet HDU standards with no additional funding. • Nursing budget/WTE does not meet HDU required activity. • Medical rota is struggling to cope with HDU care on top of general emergency role. • No income or specified funding for HDU activity completed - lost income	

	actions put in place to support increased HDU activity. • Local actions taken in line with SIRIs to improve safety of HDU care. • Paper identifying risks and issues highlighted to DMB (Divisional Management Board) (July 17 and June 18)		
What assurances are in place	• Reviewed at Family Care DMB June 18. • Risk assessment live and monitored at Child Health QSB and General Paediatrics Spec Board. • Present to RAM May 2019. • Incidents in relation to HDU are reviewed through Child Health QSB (Quality& Safety Board) and escalated as per policy. • HDU is being reviewed at ICS (Integrated Care Systems) through the Womens and Children's / Acute Care Stream with all DGHs in Lancashire & South Cumbria ICS. • Meetings have been held with commissioners and spec commissioners by Exec Leads to flag the issue of HDU care. • 15/7/19 Reviewed at Child Health Risk Management Group.	What are the gaps in assurance	There has been limited resolution following meetings with commissioners and spec commissioners - this issue is still outstanding. Whilst the risks are managed on a day to day basis to ensure patient safety, longer term operational plans are limited by limitations in funding to support further investment in HDU care.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	RAG Rating
1	Review of funding in light of CCG funding 18/19	Catherine Vozzolo	02/12/2019	02/12/2019	On track
2	STP leading review of DGH HDU care	Dr Vanessa Holme	06/12/2019	06/12/2019	On track

East Lancashire Hospitals NHS Trust

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

What controls are in place	The following controls have been put into place: • Meeting held between the Divisional Triad and the Ophthalmology Triad to discuss the current risk and agree next steps (Friday 19th Jan). • Escalated concerns to the Executive Team through Exec Part 2 Meeting (Tuesday 23rd Jan). • Request sent to all Directorates requesting all patients on holding lists who expected their appointment before the end of January who do not have a booked appointment to be initially assessed for any potential harm that could have been caused due to the delay to being seen. Suitable RAG ratings need to be applied to all these patients (Wednesday 6th February). Information to be collected in a standardised format. • RAG status for each patient to be added to the comments field on the patient record in OWL to capture current RAG status. This will allow future automated reports to be produced (starting weekend 2nd and 3rd Feb). • Meeting held with the Directorate Managers from all Divisions to understand the position of all Directorate holding lists (Wednesday 30th January and weekly thereafter). • All patients where harm is indicated or flagged Red to be actioned immediately. Directorates to agree plans to manage these patients depending on numbers. • A process has been agreed to ensure all follow up patients in the future are assigned a RAG rating at time of putting them on the holding list. Rolling out new process from 6th February across the Trust. • An automated reporting system is in development to ensure oversight of the risk stratified lists by speciality. • Underlying demand and capacity gaps must be quantified and plans put in place to support these specialities in improving the current position and reduce the reliance on holding lists in the future. • Report being provided weekly to the Executive Team.	What are the gaps in controls	• Patients currently booked into appointments that are not RAG rated will drop into the Holding List if appointments are cancelled and will not have a RAG rating identified. • Patients that are added to the holding list from other sources such as theatres Wards and Med Sec's will currently not have a RAG identified.
What assurance		What are the gaps in	• Current level of patients without a RAG who are classed as uncoded and unknown on the holding

s are in place		assurance	list. • General lack of capacity across many specialties to reduce the holding list level which leaves larger numbers of patients on the holding list waiting appointments.

Actions to be carried out in mitigating this risk

	No	Action	Action Lead	Due date	Expected Completion date	RAG Rating
	1	Progress Report and Harm assessment to be provided to Trust Quality Committee	Natalie Hudson	30/04/2019	31/12/2019 Original completion date changed from 30/04/2019 as regular updates are being sent to the Executive Team and bi-monthly to the Quality Committee.	On track
	2	Automated holding list report to be integrated in Trust's weekly ops meeting	Natalie Hudson	30/04/2019	31/12/2019 Original completion date changed from 30/04/2019 as new report has been designed and is being circulated weekly to the Directorates.	On track

East Lancashire Hospitals NHS Trust

Title	**Aggregated Risk: Failure to obtain timely Mental Health treatment impacts adversely on patient care, safety and quality.**				
Risk ID	7067	Date opened	06/10/2016		
Risk Handler	Jonathan Smith	Exec Director/Risk Lead	Sharon Gilligan		
Identified in BAF Risk ID	**BAF/03:** Lack of effective engagement within partnership organisations (ICS and ICP) results in failure to work together causing detrimental effect on the health and wellbeing of our communities. **BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).				
Linked to Risks:	2161 - Failure to provide sufficient skilled staffing for the needs of Tier 4 patients on the Paediatrics Ward will adversely continue - (12). 7582 -Inability to meet the needs of high risk mental health patients on in patient wards within ICG - (8) (5083 – Linked to 7582 - Failure to have a robust system to assess and manage patients with mental health needs – (8).				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 4 Consequence: 3 Total: 12**
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 members 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 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		What are the gaps in controls	• Unplanned demand • ELCAS only commissioned to provide weekday service • Limited appropriately trained agency staff available • MHDU service will be decommissioned in October 2019. This will increase risk of mental health patients arriving or having prolonged stays in ELHT, especially ED.	

	• 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 • • Monthly performance monitoring • Monitoring as part of 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 clinical flow meetings four times daily • Introduction of mental health triage service within ED • Development of mental health Clinical Decision Unit on the RBH site • In family care liaison with ELCAS • Frequent meetings to minimise risk between senior LCFT managers and senior ELHT managers to discuss issues and develop pathways to mitigate risk • Mental Health Shared Care Policy • OOH Escalation pathway for mental health patients • 24hour Band 3 mental health observation staff • Ring fenced assessment beds within LCFT bed base • Triage risk assessment tool in place • Shared documentation LCFT and ED • MH triage in place from 5pm to 1am 7 days per week based in department • 2 hourly joint board rounds •		

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 • 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)	What are the gaps in assurance	• The daily system teleconference between health and social partners was stood down from daily to twice weekly w/c 2-7-18.

Actions to be carried out in mitigating this risk

	No	Action	Action Lead	Due date	Expected completion date	RAG Rating
	1	Embed recommendations from NTW work	Jonathan Smith	06/04/2020		On Track

Title	**Aggregated Risk: Failure to adequately manage the Emergency Capacity and Flow system.**				
Risk ID	1810		Date opened	05/07/2013	
Risk Handler	Jonathan Smith		Exec Director/Risk Lead	Sharon Gilligan	
Identified in BAF Risk ID	**BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).				
Linked to Risks:	908 - The inability to provide performance and patient care due to low medical staffing levels within the ED department – (12). 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 - (8).				
Initial Rating	**Likelihood: 5** **Consequence: 3** **Total: 15**	Current Rating:	**Likelihood: 5** **Consequence: 3** **Total: 15**	Target Rating:	**Likelihood: 3** **Consequence: 3** **Total: 9**
What is the Hazard	• Lack of bed capacity across the Trust can lead to extreme pressure resulting in a delayed delivery of the optimal standard of care across departments. • 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, sepsis six, and access to early senior review for trauma patients). • Delay in patient assessment. • Potential complaints and litigation. • Potential for increase in staff sickness and turnover. • Increase in use of bank and agency staff to backfill. • Lack of capacity to meet unexpected demands. • Delays in safe and timely transfer of patients.	
What controls are in place	• Daily staff capacity assessment • Daily Consultant ward rounds • Establishment of specialised flow team • Bed management teams • Delayed discharge teams • Bed meetings x4 daily • Ongoing recruitment		What are the gaps in controls	• Trust has no control over the number of attendees accessing ED/UCC services • Shortage of suitably qualified and experienced staff for recruitment • Delays in transport for patients requiring ambulance discharge / transfer • Social services timescales / delays	

	• Ongoing discussions with commissioners for health economy solutions • ED/UCC/AMU will take stable assessed patients out of the trolley space/bed to facilitate putting the un-assessed patients in to bed/trolley • Two-hourly board rounds in ED (Consultant led) • Streaming pathways increased to AMU/RAT/AECU • Hourly rounding by nursing staff now embedded in ED • Ambulance turnaround times improved (work ongoing to decrease <30mins) • Further in-reach to department to help to decrease admission • Workforce redesign aligned to demands in ED • work with CCG on attendance avoidance • Phase 6 build commenced - completion Nov 2020 • Review of processes across Acute / Emergency medicine in line with Coronial process and incidents.		• SAFER work stream still to be fully embedded • Demand for mental health beds continues to increase impacting upon physical health capacity on RBTH site • Suitably qualified and experienced staff are difficult to recruit • Senior nurse appointed to lead on SAFER roll-out across MEC.
What assurances are in place	• Regular review at 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 • NHSE Fortnightly teleconferences to review performance • Winter Planning agreed with commissioners and funding secured	What are the gaps in assurance	• None identified

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected Completion date	RAG Rating
1	VSA flow work stream action implementation	Joanne Gardiner	17/04/2020		On Track
2	Perfect week initiative planned	Damian Riley	04/11/2019	Due to end on 08/11/2019	On Track

Title	**Aggregated risk: Failure to adequately recruit to substantive nursing posts may adversely impact on patient care and Finance.**				
Risk ID	5791		Date opened	11/09/15	
Risk Handler	Julie Molyneaux		Exec Director/Risk Lead	Christine Pearson	
Identified in BAF Risk ID	**BAF/02:** Recruitment and workforce planning fail to deliver the Trust objectives. **BAF/04:** The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework. **BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations.				
Linked to Risks:	3804 - Failure to recruit and retain nursing staff across inpatient wards and departments may result in inadequate nurse staffing - (12) 7496 - There is a risk of failing to deliver financial balance against the ICG nursing budget - (15)				
Initial Rating	**Likelihood: 5** **Consequence: 3** **Total: 15**	Current Rating:	**Likelihood: 5** **Consequence: 3** **Total: 15**	Target Rating:	**Likelihood: 3** **Consequence: 2** **Total: 6**
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 • Daily review of acuity and dependency to staffing levels • Recording and reporting of planned to actual staffing levels and Care Hours per Patient Day (CHPPD) • E-rostering KPI's • Ongoing recruitment campaigns • Overseas recruitment as appropriate • Establishment of internal staff bank arrangements • Senior nursing staff authorisation of agency usage • Monthly financial reporting		What are the gaps in controls	• Unplanned short notice leave and sickness. • Non elective activity impacting on associated staffing • Break downs in discharge planning • Individuals acting outside control environment	
What assurances are in place	• Daily staffing teleconference with Divisional Director of Nursing • 6 monthly formal audit of staffing needs to acuity of		What are the gaps in assurance	• None identified.	

	patients • Formal review of nursing and midwifery establishments annually more often if required • Exercise of professional judgment on a daily basis to allocate staff appropriately, alongside Safe Care acuity data • Monthly integrated performance report contains staffing data containing planned to actual nurse staffing levels and CHPPD • Active progression of recruitment programmes in identified areas.		

Actions to be carried out in mitigating this risk

	No	Action	Action Lead	Due date	Expected completion date	RAG Rating
	1	Ongoing recruitment, locally, nationally and internationally	Julie Molyneaux	Review monthly	Ongoing review. However will formally review alongside professional judgment review: **28.2.2020**	On track
	2	Workforce transformation: Registered Nurse Associates	Julie Molyneaux	28.2.2020	Ongoing evaluation of programme. Will formally review alongside professional judgment review: **28.2.2020**	On track
	3	Increase to student nurse and midwifery student placements from September 2019	Julie Molyneaux	31.3.2020	Evaluation of increase to student nurses will not be apparent for the next 3 years. However the increase achieved will be assessed: **31.3.2020**	On track
	4	Twice yearly professional judgment review of nurse and midwifery staffing requirements	Julie Molyneaux	28.2.2020	**28.2.2020**	On track

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Title	**Aggregated risk: Failure to adequately recruit to substantive medical posts may adversely impact on patient care and Finance.**				
Risk ID	5790	Date opened	11/09/15		
Risk Handler	Mark Willett	Exec Director/Risk Lead	Damian Riley		
Identified in BAF Risk ID	**BAF/02:** Recruitment and workforce planning fail to deliver the Trust objectives. **BAF/04:** The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework. **BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations.				
Linked to Risks:	7268 - Clinical, financial and organisational risks of (SOS) and T&O short and long term rota gaps – (9). 3835 - Failure to appoint to vacant oncologist posts is impacting on service delivery and provision of safe, personal, effective care - (9). 7401- There is a risk that patients may not receive timely clinical care due to a lack of junior doctor cover on medical wards in ICG - (8). 7816 - Medical (psychiatric) waiting list (15). 4488 -Inadequate Senior Doctor Cover for MFOP (6) 5557-Adequate Medical Staffing (12) 908 – The inability to provide performance and patient care due to low medical staffing levels within the ED department – (12) – is linked but wasn't included within this report.				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 3 Consequence: 3 Total: 9**
What is the Hazard	• Gaps in medical rotas require the use of locums to meet service needs at a premium cost to the Trust. • Difficulties to recruit to some substantive Medical posts e.g. ENT & Ophthalmology.		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. • Impact on staff stress and wellbeing.	
What controls are in place	• Gaps in rota where junior doctors are required have been identified and we are looking to over recruit where possible. • Academic Clinical Fellow post has been recruited to. • To evaluate using an app our internal bank to ensure our rates are competitive.		What are the gaps in controls	• 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.	

	• HR metrics to be reviewed and used in making forward planning for workforce replacement as well as link the metrics to workforce transformation. • Divisional Director signs off for locum usage. • Ongoing advertisement of medical vacancies. • Consultant crosses cover at times of need. • Development of alternate roles. • Offer of OH support if felt needed.		
What assurances are in place	• Directorate action plans to recruit to vacancies. • Reviews of action plans and staffing requirements at Divisional meetings. • Reviews of action plans and staffing requirements at trust Board meetings and Board subcommittees. • Reviews of plans and staffing requirements at performance meetings. • Analysis of detailed monthly report through AMG (Agency Monitoring Group). Areas for targeted action understood.	What are the gaps in assurance	• Unexpected operational pressures could further stress an already stressed system. • Uncertainty about the impact of Pensions/Tax concerns - since this impacts upon the need for additional medical staffing

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	RAG Rating
1	Ongoing recruitment and innovative packages offered.	Simon Hill	31/12/2019	31/03/2020 (updated from the 31/12/2019)	On track
2	Workforce transformation and new models of skill mix.	Simon Hill	31/12/2019	31/03/2020 (updated from the 31/12/2019)	On track
3	On-going pressure to reduce locum rates.	Simon Hill	31/12/2019	31/03/2020 (updated from the 31/12/2019)	On track
4	All requests to exceed capped rates to be approved by medical directorate on a case by case basis.	Simon Hill	31/12/2019	31/03/2020 (updated from the 31/12/2019)	On track

East Lancashire Hospitals NHS Trust

Title	**Failure to comply with the 62 day cancer waiting time.**				
Risk ID	7008		Date opened	01/08/2016	
Risk Handler	William Wood		Exec Director/Risk Lead	Natalie Hudson	
Identified in BAF Risk ID	**BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).				
Linked to Risks:	3835 - Failure to appoint to vacant oncologist posts is impacting on service delivery and provision of safe, personal, effective care (9) 7513 - Radiology capacity issues would impact on inpatient flow, Referral to Treatment (RTT) and Patient Experience. (9)				
Initial Rating	**Likelihood: 3** **Consequence: 3** **Total: 9**	Current Rating:	**Likelihood: 5** **Consequence: 3** **Total: 15**	Target Rating:	**Likelihood: 3** **Consequence: 3** **Total: 9**
What is the Hazard	• Cancer treatment delayed. • Potential to cause clinical harm to a patient if the treatment is delayed. • Damage to Organisational reputation.		What are the risks associated with the hazard	• Trust fails to achieve compliance with the 85% national standard for the cancer 62 day waiting time target. • 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	• ELHT wide Action plan to manage pressures by Specialty Directorate • Weekly PTL meetings in all specialties • Bi weekly 'Hot List' of Cancer Patients at Risk of or already breached is issued to all relevant specialties for review to progress patients where possible. • Weekly Cancer Performance Meeting to review at risk patients and forward plan improvements chaired by exec • Patient Education - use of marketing material to encourage patients to attend		What are the gaps in controls	• Multiple Actions require recruitment of 'difficult to recruit' personnel • Patient choice and compliance is a factor which cannot easily by influenced • ELHT Cancer Action Plan - Issues with ownership in some directorates • Weekly Tumour Site PTL Meetings - Some have better membership than others • Cancer 'Hotlist' - manual record, duplication of day to day tracking, limitations when Data & Performance	

			Manager on leave • Inability to stem rise in urgent 2 week wait referrals
What assurances are in place	• Pennine Lancashire Cancer Tactical Group • Cancer Action Plan • Weekly Cancer Performance Meeting • Cancer Alliance Rapid Recovery Team Meeting	What are the gaps in assurance	• None identified

Actions to be carried out in mitigating this risk

	No	Action	Action Lead	Due date	Expected completion date	RAG Rating
	1	Capacity review.	William Wood	31/07/2019	31/10/2019	On Track
	2	Pathway review – New alliance pathway for Prostate, Upper GI, Colorectal and Lung.	William Wood	30/04/2019	31/03/2020 Original completion date changed from 30/04/2019 as the new Upper GI has only just been published and will take some time and cross organisational work, to complete.	On Track
	3	Investment of Alliance Funding in pathways to improve processes.	William Wood	31/03/2020	31/03/2020	On Track
	5	Capacity & Demand Review	William Wood	28/06/2019	31/03/2020	On Track
	6	To recruit to Oncology Vacancies	William Wood	31/07/2019	12/11/2019	On Track

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Title	**Risk that PACS downtime occurs and brings delay to patient pathways or delays in operating theatre activity.**				
Risk ID	7552	Date opened	25/10/2017		
Risk Handler	Moira Rawcliffe	Exec Director/Risk Lead	Mark Johnson		
Identified in BAF Risk ID	**BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk of safety & poor patient experience).				
Linked to Risks:	7457- Failure to have PACS operating effectively adversely impacts patient care and performance (12)				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 3 Consequence: 3 Total: 9**
What is the Hazard	• Lack of data available while treating patient could cause harm. • The system is periodically failing / turning over so that images are not available as required. This may be due to PACs or networking issues. • The impact of this for the Orthopaedic team is that clinics are delayed/ overrunning and patients are waiting longer than required. • On occasion patients have left having not been able to get the necessary information to talk through their appropriate care. • The impact for theatres is also real and in the past cases have had to be cancelled due to delays and unavailability of appropriate images.	What are the risks associated with the hazard	The risks are: • Trust targets • Delays in patient pathway. • Downtime in clinics and theatres due to periodic system failure. • Poor patient experience having to wait around while backup systems are used. • Some occasions backup systems have failed • Increased complaints. • Concerns re patient in theatre and system going down meaning may have to stop / delay operating. This may cause patient harm. • The impact on the consultants is then the clinic over runs into the afternoon session.		
What controls are in place	• New configuration of PACS allows for significantly more resilience and stability. • New PACS operational board being set up to monitor wider PACs delivery.	What are the gaps in controls	• The above controls can`t stop the system from going down. • The impact of this for the Orthopaedic team is that clinics are delayed or overrunning and patients are waiting longer than required. • On occasion patients have left having not been able to get the necessary information to talk through their appropriate care.		

			• The impact for theatres is also real as cases have had to be cancelled in the past due to delays and unavailability of appropriate images.
What assurances are in place	• Current controls can only reduce the potential impact patients.	What are the gaps in assurance	• Controls are being manually implemented and can`t stop the system from going down.

Actions to be carried out in mitigating this risk

	No	Action	Action Lead	Due date	Expected completion date	RAG Rating
	1	Commission new Sectra PACS system	Tom Newton	31/03/2019	11/11/2019 - Revised go live date 9th November. Don't foresee any delays to this. No major risks remaining on the project plan. No Siemens PACS downtime in the last month. Needs to stay as a risk 15 till after go live due to relatively unstable Siemens PACS	On Track

Title	**Inability to meet the set Numerators in the falls CQUIN**				
Risk ID	8184		Date opened	25/06/2019	
Risk handler	Jarrod Walton-Pollard		Exec Director/Risk Lead	Christine Pearson	
Identified in BAF Risk ID	BAF 5: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).				
Linked to Risks:	N/A				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 3 Consequence: 3 Total: 9**
What is the Hazard	• The trust has not met the requirements in quarter one for the set numerators of the national falls CQUIN (CCG7)'Three high impact actions to prevent Hospital Falls'. Although a series of actions have been taken during Q1 (see below) there is still a significant risk the trust will not meet Q2. This has a high financial penalty if the trust does not meet all of the numerators below:- 1) Lying and standing blood pressure recorded at least once 2) No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented 3) Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required or walking aid provided within 24 hours of admission to inpatient unit. Denominator • Admitted patients aged over 65 years, with length of stay at least 48 hours. Exclusions • 1) Patients who were bedfast and/or hoist dependant		What are the risks associated with the hazard	• The numerators are not necessarily embedded practice within the organisation, in the detail that is required to meet the criteria for achievement within the CQUIN. Success requires 80% achievement in a sample of 100 patients randomly selected in all three numerators. This is worth around £1,000,000 worth of CQUIN money.	

	throughout their stay. • 2) Patients who die during their hospital stay.		
What controls are in place	• 1) The trust standard risk assessments is adequate in some patients. • 2) Email sent to all ward managers to remind them that patients over 65 require lying and standing BP. • 3) Task and finish group set up with key stakeholders to influence practice. • 4) Targeted support to wards via falls specialist nurse which are non-compliant with the set numerators. • 5) CQUIN standards communicated out to staff via message of the day • 6) Standards identified in the CQUIN added to the ward mangers monthly falls audit. This is now embedded as business as usual. • 7) CQUIN standards discussed at the falls steering group to raise awareness (see minutes May and June 2019) • 8) Pharmacist reminded to ensure that all patients on the drugs identified above have rational for instigation and if continued. • 9) Measures identified within the CQUINN are now built into the Mini -Nursing Assessment and Accreditation which is carried out monthly by the matron on every wards.	What are the gaps in controls	• 1) Risk that what is discussed in the falls steering group does not get cascaded down to the clinicians. • 2) The targeted support may be too late in order to achieve the CQUIN • 3) Assurance the ward managers will action the request within the email and message of the day. • 4) Not all staff read message of the day • 5) In order to pass the CQUINN the patients need to have a achieved all three measures.
What assurances are in place	• This will be reviewed at the trusts Clinical Effectiveness Committee	What are the gaps in assurance	

Actions to be carried out in mitigating this risk

	No	Action	Action Lead	Due date	Expected completion date	RAG Rating
	1	Targeted support to wards via falls specialist nurse to areas which are non-compliant with the set numerators. This can be identified in the monthly ward falls audit.	Jed Walton-Pollard	01/01/2020	Action to be continually reviewed as this is an ongoing action.	On Track

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

13 November 2019

Item 145

Purpose Assurance
Approval

Title	Board Assurance Framework (BAF)
Author	Mrs A Bosnjak-Szekeres, Director of Corporate Governance/Company Secretary Miss K Ingham, Corporate Governance Manager/ Assistant Company Secretary

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 September 2019 Trust Board meeting. The Quality Committee received the BAF at its meeting on 30 October. The Finance and Performance Committee will review the BAF at its meeting on the 11 November.

Recommendation: Members are asked to discuss and approve the recommended changes to the BAF.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do 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: Operational Delivery Board (29 October), Quality Committee (30 October).

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. Some of the BAF risks are considered by both the Quality Committee and Finance and Performance Committee (risks 1, 2, 3 and 5) due to their overarching nature, however each Committee only discusses the risk elements under their specific remits and are aligned to their Terms of Reference.

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

5. It is proposed that the risk score remains at **16 (likelihood 4 x consequence 4)**,
6. The key controls section has been updated to include the following:
   a) Participation in the five year planning process which will bring CCG, ICP and Trust processes together (November 2019). This will allow alignment of finances across the ICP area.
7. The internal sources of assurance have been updated to include the following:
   a) NHSI/E Vital Signs Programme Consultant now in place.
8. External sources of assurance have been updated with the following:
   a) Care Professional Board workshop with a wider audience held in Q2 resulted in the creation of Pennine Lancashire Clinical Senate, bringing together relevant professionals to support the Pennine Lancashire transformation. Several senior

ELHT clinicians attending and actively participating in the Clinical Senate and associated workshops.

9. The actions planned/update section has been updated to include the following:
   a) Discussions are ongoing regarding the linking of Quality Improvement (QI) and transformation.
   b) Refocus of the Improvement Guiding Board is almost complete. Completion date has been set for early Q4.

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

10. It is proposed that the **risk score remains at 20 (likelihood 5 x consequence 4).**
11. The key controls section has been updated to include the following:
   a) Development of Inclusion Strategy for presentation to Operational Delivery Board (ODB) in December 2019.
   b) Workforce Solutions Group meeting to target areas of concern.
12. The potential sources of assurance have been updated to include:
   a) Establishment of Pennine Lancashire Workforce Group.
   b) Participation in ICS Bank and Agency Collaborative to manage agency rates across the region.
13. Gaps in assurance have been updated to include the following:
   a) Awaiting national approach to pension issue.
14. Actions and updates have been updated to include the following:
   a) 28 nurses have been sourced and started via the Global Learners Programme with a further 41 in the registration process for the programme, with 11 of them likely to commence employment with the Trust by the end of January 2020.
   b) There are an additional 6 Physician Associates who have commenced in post in September 2019 who work across the ICP as part of the LIFT 2 pilot.
   c) Shadow Board completed its run, with participants being offered Talent Conversations.
   d) Vital Signs improvement programme is underway to improve employee experience from recruitment through to them leaving the organisation. The Hire to Retire Value Stream Analysis (VSA) has now delivered improvements and is now working on refreshing potential improvement opportunities, including the Recruitment Strategy which is being reviewed and developed. The document will go to the Operational Delivery Board (ODB) in January 2020.

e) HEE funding secured to develop clear clinical leadership for workforce transformation through the WRAPT process. Training commenced in Q1 and future funding agreed for next year.

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

15. The **risk score remains 12** (likelihood 3 x consequence 4).
16. Key controls have been updated with the following:
    a) Vital Signs Programme ensures the ICP as a system is having a significant participation as part of the transformation programme. Improvement and transformation programmes reviewed by ICP teams during October 2019.
17. The internal sources of assurance section has been updated to include the following:
    a) First draft of the ICP Five Year Plan has been submitted to the ICS.
    b) Draft Five Year Pipeline included within the Trust's Clinical Strategy.
18. External sources of assurance have been updated with the following:
    a) Pennine Lancashire ICP Programme Co-ordination Group is the engine/delivery room for the ICP. The group has been given delegated authority from the Pennine Lancashire Leaders' Forum and the planning process is driven through this group. The Pennine Lancashire system planning reports into the ICP Programme Co-Ordination Group.
19. The gaps in control section has been updated with the following:
    a) Point being reached relating to ICS workstreams (e.g. Head and Neck services) where dependent on scoring implications there may be an impact on priorities and risks to the Trust.
    b) Case for Early Supported Discharge (EDS) for stroke services, this is critical to the work the Trust is doing to develop a Hyper Acute Stroke service. Funding will be available in the new financial year (2020/21).
    c) Lack of clarity regarding the investment priorities across the ICP have the potential to destabilise acute services.
20. Gaps in assurance have been updated with the following items:
    a) Costs associated with the ICP/ICS 5 year plan may have an effect on Trust finances.

21. The actions planned section has been updated to include the following:
    a) The plans for the submission of the ICS Five Year Plan were presented to and discussed with the Board in September 2019. The draft plan was submitted on 27 September and was well represented at ELHT and ICP level. The final version of the ICP Five Year plan is due for submission on the 15 November.
    b) Event held on 1 October 2019 with senior operational and commissioning managers to discuss the plan.
    c) Executives from the Trust and Local Commissioners are having further meetings during November 2019 to discuss the investment priorities across the ICP.

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

22. The **risk score remains at 20** (likelihood 5 x consequence 4).
23. The key controls section has been updated to include:
    a) Additional financial controls implemented in September 2019 to address significant financial variances for 2019/20.
    b) Financial Assurance Board in operation, a detailed review of all financial positions is ongoing.

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

24. The **risk score** remains at **16** (likelihood **4** x consequences **4**).
25. Key controls have been updated to include the following:
    a) Refreshed the Trust's long length of stay process to provide increased scrutiny at Divisional level. Patients who have a length of stay in excess of 40 days are highlighted to the Divisional Triumvirate who will work to identify any management delays. Any patients with a length of stay in excess of 80 days are highlighted by the Divisional Triumvirate to the Executive Medical Director, Executive Director of Nursing and Director of Operations (the responsible Executive Triumvirate) who will undertake a review.
    b) The Trust has developed the Effective Flow Board to oversee a range of actions to improve patient flow and improve discharges before 1.00pm.
26. Internal sources of assurance have been updated to include:

a) Silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments continues.

b) Reduction in use of nursing agency staff continues. The Trust is also part of the ICS-wide agency staffing collaborative.

27. The joint internal/external sources of assurance section has been updated with the following:

a) 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 receives minutes of the PLACE Steering Group. NAPF Team also monitors environmental issues linking to PLACE Assessments.

28. Gaps in control have been updated with the following:

a) Histopathology pressures affecting cancer performance. Outsourcing in place but external firms are unable to deliver within the required timeframes.

29. The actions have been updated to include the following items:

a) Patient Participation Panel members will commence involvement in the Trust's Vital Signs programmes in Q4.

b) Nursing Assessment and Performance Framework (NAPF) assessments are continuing. 13 Silver Accreditation of wards approved by the Trust Board, with a further two to be presented to the Trust Board in November for approval. 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 and IHSS. Objective is for a 50% reduction in all red wards was achieved by the end of March 2020. As of 30 September 2019 there are no ward areas rated as red.

c) OPRA expansion completed and opened on 3 October 2019. The unit provides additional assessment capacity and support the reduction in the length of stay. The expansion has increased from six beds to nine beds in dedicated accommodation which is supported by the Older Persons Unit and has been achieved by merging wards C1 and C3.

d) Agreement being reached in relation to Histopathology services with University Hospitals Morecambe Bay (UHMB) to support additional capacity. This is expected to commence in November 2019.

e) PLACE assessments for 2019/20 took place throughout the month of October 2019, with data expected to be published in Q4 of 2019/20.

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance and Kea Ingham, Corporate Governance Manager, 6 November 2019

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

Consequences of the Risk Materialising:
1. Ability to deliver against the constitutional standards and organisational delivery would be adversely affected
2. Inability to provide financial assurance to the Board
3. Reduced ability to integrate primary and secondary care
4. Reduced ability to have the right workforce planning
5. Reduced ability to achieve access and operational standards
6. Reduced ability to improve quality standards

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		**2019/20**	
						Q3	**Q4**	**Q1**	**Q2**
We have developed the 2019 plan for the Trust in conjunction with the Pennine Lancashire ICP partners to achieve a single plan for the ICP. This focusses on delivering our quadruple aim of balancing quality with delivery/performance, finances and impact of change on people (patients, staff or the public). The Trust has invested in an Improvement Practice team who will work with transformation and quality improvement teams across Pennine Lancashire and the Trust to lead, facilitate and deliver improvement in line with the agreed priorities from the planning round. The programme also aligns the improvement methodologies utilised across the Trust and wider-ICP to ensure consistency of approach. The ICP programme is monitored through the Pennine Lancashire Programme Office and reports through the System leaders. The ELHT programme is monitored through the Improvement Practice Officer who report to the Operational Delivery Board, Finance and Performance Committee, Quality Committee and the Executives through the leadership wall and Improvement Guiding Board. The Quality Improvement programme is monitored through Divisional Clinical Effectiveness committees and Quality Improvement project triage group. A QI register details the projects by Division and Harm (if applicable). Contained within the Quality Improvement programme is the Harm Free Care programme which includes Falls, Deteriorating Patient, Medication errors, Pressure Ulcers, Infection Prevention. Divisional improvement is monitored through the Divisional Governance structures. Participation in the five year planning process which will bring CCG, ICP and Trust processes together (November 2019). This will allow alignment of finances across the ICP area.	**Internal Assurances** The Trust planning process has been designed to enable the identification of a single set of transformation priorities for the Trust in conjunction with ICP Partners. The priorities identified are aligned to the Trust's Clinical Strategy, the ICP priorities as outlined in the Pennine Plan, to key ICS priorities and to the NHS Long-Term Plan. The Trust has adopted and is implementing (and building capacity to undertake) improvement (incorporating quality improvement, transformation/service development and improvement) utilising a consistent improvement approach based on Lean. The Trust has invested in dedicated improvement capacity through the development of the Improvement Practice Team/Office and has sought, through the planning round, to align capacity across the organisation to the delivery of a single plan. The Trust has invested in external expert advice and support via the NHS Improvement Vital Signs Programme to ensure improvement is delivered to a high standard. Through alignment of priorities to the Improvement Practice Office there will be oversight of all improvement work. Operational and Executive oversight will be provided via: • Executive Visibility Wall – bi-weekly • Guiding Board (Improvement Board) - monthly Board assurance will be provided via reporting to: • Finance and Performance • Quality Committee • Trust Board (information papers and minutes) A revised clinical divisional structure has been implemented with a newly formed community services and intermediate care division to strengthen our leadership and provide capacity to support the transformation and partnership working with the wider system. The Acting Chief Executive of the Trust appointed as the Professional Lead for the Pennine Lancashire ICP influencing the collaborative work on transformation. Director of Operations responsible for community and intermediate care services is one of the portfolio delivery leads for the Pennine Lancs ICP. NHSI/E Vital Signs Programme Consultant now in place. **External Assurances** System-wide reporting is currently being developed through the Pennine Lancs Business Intelligence group and the Together a Healthier Future programme. ICP system level aiming to prioritise health improvements that can deliver beneficial outcomes more quickly. Care Professional Board workshop with a wider audience held in Q2 resulted in the creation of Pennine Lancashire Clinical Senate bringing together relevant professionals to support the Pennine Lancashire transformation. Several senior ELHT clinicians attending and actively participating in the Clinical Senate and associated workshops. System wide reviews completed including a discharge community and intermediate care diagnostic assessment by Newton Europe and a Lancashire intermediate care review completed by Carnall Farah. The progressions of these reviews and their associated recommendations are being overseen by the Pennine Lancashire intermediate care programme board which reports into the Pennine Lancashire Together a Healthier Future programme. To support a whole system multi agency approach to the development of community services, Integrated Neighbourhood Local Community partnerships (LCP's) have been established for Blackburn with Darwen and East Lancashire and these report into the Pennine Lancs Together Healthier Future programme. There is commitment to the alignment of the improvement approach across the ICP. Work is on-going to align approaches and deliver associated training to upskill across the ICP There has been good participation by system partners in several system-agreed improvement events. There is ongoing alignment of improvement resources across the ICP including commissioning portfolios. System-wide Programme Boards are currently being developed which will focus on delivery of system priorities and will dovetail to the Improvement Practice Office.These Boards cover Urgent and Emergency Care, Scheduled Care, Integrated Community Care and Mental Health. A Programme Coordination Group, consisting of senior responsible officers and delivery leads, is also being established and this will replace the existing Partnership Delivery Group. System-wide reporting is currently being developed through a review of current ICP governance structures. **Internal / External Assurances** A revised clinical divisional structure has been implemented with a newly formed community services and intermediate care division to strengthen our leadership and provide capacity to support the transformation and partnership working with the wider system. In addition a community services transformation board meets monthly and this includes a commissioner representative as part of its membership. A community systems board has also been established which meets monthly, reporting to the community services transformation board.	16	10	16	4x4	20	20	20	16

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.*
Capacity and resilience building in relation to improvement is in early phase Short term regulatory targets detracting from the delivery of short to medium term objectives of the transformation programme resulting in competing priorities in delivery of business as usual and improvement work Dependency on stakeholders to deliver key pieces of transformation Financial constraints Transformation priorities not yet fully aligned to appraisal and objective setting Capacity and time to release staff to attend training Linking between clinical effectiveness/quality improvement and the Improvement Office needs to be further developed System wide working is still developing, and priorities are not yet completely aligned	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. 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. Understanding what is happening to providers with regard to financial milestones in the ICS. Costs associated with the ICP/ICS 5 year plan may have an effect on Trust finances.	There will be a re-focus on delivery and impact via the Guiding Board and Executive Visibility Board which will improve assurance to Trust Board sub-committees Improve the robustness of reporting of impact through adoption of A3 Improvement Practice Team now fully established. Staff undertaking practice coach training and have an agreed portfolio of work aligned to agreed priorities. Continued alignment of improvement approach for the Trust – The Pennine Lancashire Way Establishment of system-wide Programme Boards e.g. Scheduled Care Board to ensure alignment of priorities across the ICP Consider options for continuation of external support Discussions are ongoing regarding the linking of QI and transformation. Refocus of the Improvement Guiding Board is almost complete. Completion date has been set for early Q4.

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		**2019/20**	
						Q3	**Q4**	**Q1**	**Q2**
Workforce Transformation strategy in place and associated Divisional and Trust-wide plans monitored through the ICS Workforce Transformation Board. Divisional Workforce Plans aligned to Business & Financial Plans. Divisional Performance Meetings and Operational Delivery Board monitor on-going performance, actions and risks. 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 ICS level, e.g. Apprenticeships, recruitment and retention initiatives, collaborative medical banks and talent management. Pennine Lancashire Workforce Transformation Group. People Strategy aligned to deliver National ICS, ICP and Trust workforce objectives and is cognizant of the NHS Interim People Plan. Development of Inclusion Strategy for presentation to Operational Delivery Board (ODB) in December 2019. Workforce Solutions Group meeting to target areas of concern.	**Internal Assurances** 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. Joint Medical and Non-Medical Agency Group in place. Dashboard giving overview of bank/agency usage presented to the Executive team meeting monthly. Additional scrutiny from a nursing perspective. The Performance Assurance Framework Lean Programme (Vital Signs) overall linking into workforce transformation. Implementation of Allocate rostering/ publication dates for rosters. Uptake of flu vaccine across the workforce. Completion rates of the annual staff survey and low rates of turnover. Integrated performance report. Implementation of new absence management process to support staff attendance and to mitigate need for use of bank and agency. Workforce Dashboard reporting key performance indicators within division on a monthly basis, Details of these reported on a quarterly basis to the Finance & Performance committee. A Senior Medical Staffing Performance Review Group established - responsibility for reviewing all consultant job plans, consultant vacancies etc. adding further rigor on our appropriate use of resource. Workforce Solutions Board now aligned to deliver Trust Business Plan & Clinical Strategy. **External Assurances** Friends and family test (further detail in BAF risk 5) Benchmarking of agency spend is available through the Model Hospital data. Collaboration across the ICS on agency usage. Joint work taking place across the ICS to consider implications and options to mitigate the impact on pensions. Broader quality and diversity group and a better understanding of workforce demographics in relation to the over 55 workforce. ICS collaboration on Careers, International Recruitment and Workforce mobility. Pensions link to Finance and Performance 'Gaps in Assurance'. ICS wide LWAB (Local Workforce Action Board) - looking at nurse recruitment across the whole system. Establishment of Pennine Lancashire Workforce Group.	16	10	20	5 x 4	12	20	20	20

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.*
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 The impact of the changes to the pension rules and taxation has resulted in a significant reduction in capacity and additional work being undertaken by senior medical staff. This has resulted in a reduction in clinical capacity.	Inability to control external factors (Brexit, visas etc). Awaiting national approach to pension issue. Regulators stance on safe staffing and substitution of roles in place of registered workforce. Lack of data/intelligence regarding the number of nurses and clinical staff in the 55+ age category and the related risk of 'brain drain' in the coming years. Work has been done by ICS across the system but it does not contain the level of detail needed for each Trust. Efforts need to be made to understand and refine the workforce data in order to address the issues in the Trust.	28 nurses have been sourced and started via the Global Learners Programme with a further 41in the registration process for the programme, with 11 of them likely to commence employment with the Trust by the end of January 2020. There are an additional 6 Physician Associates who have commenced in post in September 2019 who work across the ICP as part of the LIFT 2 pilot. HCA recruitment continues, contributing to the reduction in HCA bank shift requests adding further stability and flexibility to our support workforce. E&D Action Plan updated and developing Equality and Inclusion Strategy in October. Annual Festival of Diversity planned for May 2020. Culture and Leadership Programme 12 month delivery plan ongoing. The new Equality and Inclusion Group has been established to consider the wider diversity agenda. Three staff networks have been agreed to be stablished (BME, LGBTQ and Disability) Shadow Board completed its run, with participants being offered Talent Conversations. Vital Signs improvement programme is underway to improve employee experience from recruitment through to them leaving the organisation. The Hire to Retire VSA has now delivered improvements and is now working on refreshing potential improvement opportunities, including the Recruitment Strategy which is being reviewed and developed, the document will go to the Operational Delivery Board (ODB) in January 2020. An ICP workforce strategy has been developed and we are in the process of re-focusing the workforce transformation group. We are working with ICP partners to undertake systematic and integrated workforce transformation linked to the NHSI LEAN improvement programme. We are working across the ICS to develop a mobility agreement to assist with the movement of staff across the region. A Recruitment and Retention Strategy is being developed to underpin a system wide approach to recruitment. 2 Workforce Repository and Planning Tool (WRAPT) planning projects are underway across the organisation. HEE funding secured to develop clear clinical leadership for workforce transformation through the WRAPT process. Training commenced in May 2019 and future funding agreed for next year. Establishment of a Care Academy for Pennine Lancashire to secure a talent pipeline locally. The Trust is working with partners across the ICS to develop a co-ordinated response to the aforementioned pensions issues. Participation in ICS Bank and Agency Collaborative to manage agency rates across the region.

Reference Number: BAF/03

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

Aligned to Strategic Objectives: 3 and 4

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

Consequences of the Risk Materialising:
1. Failure to engage leadership and wider stakeholder groups
2. Failure to secure key services for Pennine Lancashire.
3. Failure to maximise our potential as a provider of key specialist services (Stroke etc.) across the ICS 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		**2019/20**	
						Q3	**Q4**	**Q1**	**Q2**
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 Committee (PLC) Number of senior clinicians involved with ICS work groups. Professional Leadership Committee (PLC) has ELHT representation. ICS Finance Group and ICP Finance and Investment Group with ELHT senior representation . The ELHT Accountable Officer is the senior responsible officer (SRO) for the Pennine Lancashire Transformation Programme, sits on the System Leaders Forum and on the Integrated Care System for Lancashire and South Cumbria (ICS) Programme Board. The Trust's Acting Chief Executive 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. Improvement and transformation programmes reviewed by ICP teams during October 2019.	**Internal Assurances** Verbal and written updates, where appropriate Board approvals will be established and permissions will be provided by the Board to let Executives progress the generation of ideas and options with external stakeholders. 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. Mitigation in place for creating single teams across the system, e.g, 'one workforce' with timelines for implementation. Progress covered under BAF risk 2. First draft of the ICP Five Year Plan has been submitted to the ICS. Draft Five Year Pipeline included within the Trust's Clinical Strategy. **Internal / External Assurances** 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. 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. 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 Delivery Board meets monthly, chaired by the ELHT Chief Executive. Progress on collaborative efforts in relation to the emergency pathway is covered under BAF risk 5. Vital Signs is a system wide transformation programme across the Pennine Lancashire ICP. Patient experience strategy envisages good patient and public involvement to support the collaborative transformation. Progress with work covered under BAF risk 1. Producing ELHT demand and capacity plan to be signed off by the Executive Team. The wider system demand and capacity plan will be signed off by the Partnership Delivery Group. Pennine Lancashire ICP Programme Co-Ordination Group is the engine/delivery room for the ICP. The group has been given delegated authority from the Pennine Lancashire Leaders' Forum and the planning process is driven through this group. The Pennine Lancashire system planning reports into the ICP Programme Co-Ordination Group. Joint accountable officer for CCG's is now in post. A system financial and investment group for the ICP looking into the priorities and aligning them with the financial envelope for the local system. Creation of single teams to deliver the transformation agenda at ICP system level. Priorities of the individual organisations and those of the system aligned/agreed. Tripartite meeting held at the end of July.	16	12	12	3x4	12	12	12	12

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.*
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. There is a need for consistent leadership across the system. in order to ensure that we continue prioritising in line with system affordability. Building trust and confidence and agreeing collaborative approaches to service provision . ICS level Planning Group has been formed and met for the first time on 3 December 2018. The Director of Service Development attends to represent the ICP. The role of the group is centred around the 5 year plan which is due to be developed by Summer 2019. Point being reached relating to ICS workstreams (e.g. Head and Neck services) where dependent on scoring implications there may be an impact on priorities and risks to the Trust. Case for Early Supported Discharge (EDS) for stroke services, this is critical to the work the Trust is doing to develop a Hyper Acute Stroke service. Funding will be available in the new financial year (2020/21). Lack of clarity regarding the investment priorities across the ICP have the potential to destabilise acute services.	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. 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. Understanding what is happening to providers with regard to financial milestones in the ICS. Costs associated with the ICP/ICS 5 year plan may have an effect on Trust finances.	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. Developed work programme discussed by the Provider Board at ICS level. and work on developing future configuration continues, no timelines for completion set at this stage. Meetings are ongoing regarding the acute Programme and more focused work is taking place in Stroke, Vascular, Urological Cancer and Diagnostics. A range of services are being developed for Head & Neck. Pennine Lancashire ICP component business case. Focus on ICP 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. Ongoing progress is being made with more focus on the future model of care (not the current model of care). An update was provided at the Trust Board in March 2019. Neighbourhood system event held at end of January 2019. Subsequent 'big ticket' events were held and Value Stream Analysis (VSA) planned under the Vital Signs Programme. Good co-production on developing clinical model across the ICS for CAMHS services was presented to the Commissioners. Clinical model accepted,. A neighbourhood system event held at end of January 2019. supporting, ongoing discussions about affordability with help from the Northumberland, Tyne and Wear Trust. The model (stage 1) had been signed and providers are working on the detail (stage 2). A timetable has been produced, presented to local commissioners and approved by them (1 year plan). Milestones have been developed and a financial exercise has been undertaken to determine the resources required to implement the new model. The Director of Service Development has led discussions with other providers of CAMHS services about potential future configurations and alliance, the model was universally supported. Agreement reached to focus on all aspects of improving the emergency pathway - ED, Assessment Same Day Emergency Care, Discharge and out of hospital services and the acute adult mental health pathway. The Trust is aiming to develop a clear and succinct integrated action plan with associated metrics over the next six weeks. The plans for the submission of the ICS Five Year Plan were presented to and discussed with the Board in September 2019. The draft plan was submitted on 27 September and was well represented at ELHT and ICP level. The final version of the ICP Five Year plan is due for submission on the 15 November. Event held on 1 October 2019 with senior operational and commissioning managers to discuss the plan. Executives from the Trust and Local Commissioners are having further meetings during November 2019 to discuss the investment priorities across the ICP.

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		**2019/20**	
						Q3	**Q4**	**Q1**	**Q2**
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. Additional financial controls implemented in September 2019 to address significant financial variances for 2019/20. Financial Assurance Board in operation, a detailed review of all financial positions is ongoing.	Internal Assurances 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. 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. Reinstatement of the monthly Finance Assurance Board (FAB) chaired by the Chief Executive. Attended by Executive and Finance colleagues to the financial position, forecast and SRCP performance. Monthly agency meeting. External Assurances External audit view on value for money. Model Hospital benchmarking (including cost per Weighted Activity Unit). ICS Led Theatre Productivity analysis. GIRFT Programme	16	12	20	5x4	20	20	20	20

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.*
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 FAB and the Finance Department with Division to be held to account via the FAB. Gaps in control regarding funding for A&E and PSF 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. Cost shunting of public sector partners increasingly managed through ICS and ICP. Failure to meet Provider Sustainability Fund requirements both as a Trust and an ICS. Agency and locum sign off with escalation of cost. Significant external pressures which may intensify internal financial pressure.	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. 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. Understanding what is happening to providers with regard to financial milestones in the ICS. Costs associated with the ICP/ICS 5 year plan may have an effect on Trust finances.	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 to the end of 2019/20 are being managed and reported to the Quality Committee. 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. Cash borrowings have increased above plan as a consequence of not delivering A&E PSF and non cash backed SRCP. Detailed plan for 2019-20 to be developed in light of additional financial focus. Divisional recovery plans sent out on the 23rd of August to be reported back to the FAB on the 19th of August and an update to be provided to the Finance and Performance Committee due on the 30th of September. Shared Cost Improvement Programme (CIP) and Quality, Innovation, Productivity and Prevention (QIPP) group established with the CCGs. Quality Improvement (QI) established Resources Committee to improve the business case process with CCG's - planned for Q1.

Reference Number: BAF/05

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

Aligned to Strategic Objectives: 1, 3 and 4.

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

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

Key Controls *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		**2019/20**	
						Q3	**Q4**	**Q1**	**Q2**
Weekly operational performance meeting covering RTT, holding lists and key operational indicators. Separate dedicated weekly cancer performance meetings. Fortnightly deep dive at the Executive team meetings. Engagement meetings with CQC 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. Weekly operational flow meetings at 08.30, 12.30, 15.30, 18.00 and 19.30 Weekly ED / urgent care performance and improvement meeting. Appointed Clinical Scheduled Care Lead (Associate Medical Director) who will work with Clinical Leads to create and monitor improvement plans for the RTT and holding list positions. Outpatient Improvement Group established in July. Focused on reducing face to face outpatient appointments to improve the RTT and holding list position. Fortnightly phone calls with the NHSI. Improvement dashboard and breach analysis report developed and presented to the Executive team, this will continue on a regular basis. Refreshed the Trust's long length of stay process to provide increased scrutiny at Divisional level. Patients who have a length of stay in excess of 40 days are highlighted to the Divisional Triumvirate who will work to identify any management delays. Any patients with a length of stay in excess of 80 days are highlighted by the Divisional Triumvirate to the Executive Medical Director, Executive Director of Nursing and Director of Operations (the responsible Executive Triumvirate) who will undertake a review. The Trust has developed the Effective Flow Board to oversee a range of actions to improve patient flow and improve discharges before 1.00pm.	**Internal Assurances** IPR reporting to the ODB and at Board/Committee level. Regular deep dive into the IPR through Finance and Performance Committee including RTT, all cancer standards and the emergency care standards. 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 weekly operational meeting, Scheduled Care Board (joint Board with CCG) 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. Silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments continues. Increased number of assessments under the framework planned all inpatient wards completed in ICG and SAS. Work started on Family Care and Community Services and a plan is in place for 2019/20. 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. Quality Committee will oversee the CQC action plan. 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 agency staff continues. The Trust is also part of the ICS-wide agency staffing collaborative. 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. Quality Walkrounds in all clinical areas. The Performance Assurance Framework. Recovery plans in relation to the risks around some of the national trajectories addressed through the Emergency Care Pathway Transformation programme, Scheduled Care Programme, Cancer Improvement Action Plan and Outpatients Improvement Group. Regular monitoring by Executive Team and ODB. Weekly monitoring of complaints and reporting to the Patient Experience Committee and End of Life Care Group, focusing on reducing any 50+ day complaints (non currently in the system). Staffing (nursing/midwifery) report to Quality Committee. NAPF - operational monitoring through the Nursing and Midwifery Leaders' Forum monthly, receiving assurance from the Assistant Director of Nursing and NAPF team and monitoring by matrons at ward level where they carry out mini-NAPFs on a weekly basis to keep up the improvement work and report to Quality Committee (every other meeting). Escalation area in the Victoria Wing at BGTH is now in place. ED senior nurse and substantive ED manager appointed to improve productivity and performance and patient experience. Directors of Operation aligned to each division to provide senior operational support and oversight. **External Assurances** Trust rated 'Good' by CQC in 2018 with improvements in various areas and some outstanding services. 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. MIAA have carried out an emergency care risk assessment audit which gained an assurance rating of 'Significant Assurance'. Cancer Alliance commissioned a review of internal processes for cancer performance management and patient tracking. Highly commended with strong processes in place. **Internal / External Assurances** System wide approach to Emergency Care Pathway, as part of monthly A&E Delivery Board supported operationally by the A&E Delivery Group. 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 receives minutes of the PLACE Steering Group. NAPF Team also monitors environmental issues linking to PLACE Assessments. PLACE assessments for 2019/20 took place throughout the month of October 2019, with data expected to be published in Q4 of 2019/20. Positive responses to Friends and Family Test and patient surveys with improvement areas identified. Monitoring at ward level, local divisions prepare monthly patient experience action plans that feed into the Patient Experience Committee that reports to the Quality Committee. Monthly monitoring is provided by the Nursing and Midwifery Leaders' Forum. Positive response and results from the 2018 National Staff Survey. Inpatient survey 2018/19 results were presented to the Executive team by Quality Health.	15	12	16	4x4	16	12	16	16

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.*
Restrictions in the supply of medical, nursing, midwifery and other staff groups to meet demand. Reference 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. Insufficient bed capacity to ensure there are no delays from decision to point of admission. The impact of the changes to the pension rules and taxation has resulted in a significant reduction in capacity and additional work being undertaken by senior medical staff. This has resulted in a reduction in clinical capacity which is affecting the Trust's ability to deliver against 18 week RTT and cancer targets. Histopathology pressures affecting cancer performance. Outsourcing in place but external firms are unable to deliver within the required timeframes.	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. 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. Understanding what is happening to providers with regard to financial milestones in the ICS. Costs associated with the ICP/ICS 5 year plan may have an effect on Trust finances.	Complaints reviewed weekly by the Executive team. Patient Participation Panel members will commence involvement in the Trust's Vital Signs programmes in Q4. The Trust is developing a full clinical model regarding the emergency care pathway and this s anticipated to be ready for presentation and sign off in 2019. External support sourced for patient flow modelling. 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. 2. Ambulatory Care Emergency Unit opened as planned on 14 September 2018. Fortnightly service reviews carried out to ensure service delivery as expected. 3. Business case approved by the Trust Board and submitted to NHSI in July 2018 for the extended acute medical facility. 4. Frailty Assessment Unit opened on 7th January 2019. Surgical & Ambulatory Emergency Care unit moved to the old ambulatory care on 7th of Jan 2019 and additional beds opened on B14. Board receives regular SRCP and transformation updates. Further rollout of E-rostering system. Nursing Assessment and Performance Framework (NAPF) assessments are continuing. 13 Silver Accreditation of wards approved by the Trust Board, with a further two to be presented to the Trust Board in November for approval. 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 and IHSS. Objective is for a 50% reduction in all red wards was achieved by the end of March 2020. As of 30 September 2019 there are no ward areas rated as red. Core 24 (Lancashire Care Foundation Trust mental health programme) implementation commenced in April 2018 and ran until March 2019. Development of mental health decision unit planned by July 2018 had been delayed by external partners. Unit has opened in August 2018. The Trust continues to work with external partners. The system wide action plan for mental health services has been agreed by the ICS in November. Trust's lifecycle upgrade programme (Estates and Facilities) was developed and signed off by the end of April 2019. Programme now commenced. CQC report published on 12 February 2019, improvements in some areas and outstanding services. Action plan monitored by the CQC and through the Quality Committee. Returned action plan in relation to notices regarding fridges, document storage and fluid thickening. Refocused efforts across clinical teams and system partners to reduce long length of Stay (LoS) patients and Delayed Transfers of Care (DTOC). Monitored at the Executive team meetings. Report to the Quality Committee on the holding list and 18 week RTT action plans to be provided bi-monthly, with the next update to be provided at the meeting in September. Clinical model review and development of Medicine and Emergency Care division - improvement for future for Phase 6 - 13 June was carried out. RTT and Holding Lists - streamlined directorate level trajectories and action plans are now in place and reviewed at weekly operational meetings. Updates will be provided via the Finance & Performance committee with the next report due at the meeting in September. A new performance dashboard is also in development for use across the Trust. NHSI have confirmed the dates for this year's PLACE assessments as running from 16th of September to the 22nd of November. Oversight of the reports will be provided by the Quality Committee and summary updates as part of the committee updates to the committee to the Board. Lisa Grendall to provide training for key members. Increase in the numbers of pathways that go to ambulatory care directly, such as low risk chest pain patients - this is intended to reduce pressure on A&E and improve the patient experience. OPRA expansion completed and opened on 3 October 2019. The unit provides additional assessment capacity and support the reduction in the length of stay. The expansion has increased from six beds to nine beds in dedicated accommodation which is supported by the Older Persons Unit and has been achieved by merging wards C1 and C3. Substantive ED senior nurse recruited and starting in September, this is part of the accelerated Ambulatory Care Programme monitored by the NHSI - a visit is planned for the 02nd of October to enable the Trust to gain assurance that we are utilising our ambulatory pathways to their full potential. Redesign of the Acute Mental Health Pathway by LCFT is expected to be associated with improved crisis intervention services in the community. This is planned to allow the closure of the mental health decision units across Lancashire. Whilst the changes are welcomed in principle, ELHT have emphasised the need to see appropriate community services in place to support the changes, and are working closely with LCFT. Plans are also being developed for an enhanced mental health assessment unit co-located to the Emergency Department, staffed by Mental Health liaison teams. Agreement being reached in relation to Histopathology services with University Hospitals Morecambe Bay (UHMB) to support additional capacity. This is expected to commence in November 2019. PLACE assessments for 2019/20 took place throughout the month of October 2019, with data expected to be published in Q4 of 2019/20.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 146

13 November 2019

Purpose Information Assurance

Title	Serious Incidents Requiring Investigation Report (August and September 2019)
Author	Mrs J Hardacre, Assistant Director Safety & Risk, Mrs R Jones, Incident & Risk Manager
Executive sponsor	Dr D Riley, Director of Clinical Strategy (on behalf of the Acting Executive Medical Director)

Summary: This report provides a summary of the Serious incidents Requiring Investigation report, a breakdown of Serious Incidents reported in August and September 2019 and an overview of the CCGs Quality Dashboard.

Recommendation: Members are asked to receive the report, note the contents and take assurance that serious incidents are suitably investigated.

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 and improvement 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 Partnership (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

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Oversight Framework.

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

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	Yes

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Executive Summary

1. In August and September the Trust reported 31 serious incidents:
   a) 14 to the Strategic Executive Information System (StEIS)
   b) 17 to Divisional Serious Incident Review Group (DSIRG).
2. The top 3 incident categories are:
   a) Pressure Ulcers (35)
   b) Slips, Trips and Falls (16)
   c) Diagnosis Failure / Problem (16)
3. These are the same categories as the previous SIRI reports. The falls Steering Group are working with the Quality Improvement team on the harm reduction programme in line with national recommendations and CQUIN indicators. Pressure Ulcers Steering Group report of the 35 pressure ulcers reported 21 have been de-escalated, 4 have learning identified and a further 10 are under investigation. Ongoing monitoring of the diagnosis/failure problems is in place over the next 6 months.
4. There have been no never events reported since June 2019.
5. There have been no breaches of the duty of candour for the months August and September 2019.
6. All rapid reviews were uploaded within the 72 hour target.
7. The Clinical Commissioner Group (CCG) dashboard provides assurance on improvements of investigations. There are currently 33 incidents open on StEIS:
   a) 2 for 2018/2019 (reduced from 11 since last SIRI report) and 31 ongoing investigations for 2019/20
   b) One of the open investigations is an external incident investigation (Maternity) which is showing above 100 days overdue – the report was presented at SIRI panel in October 2019 and approved for de-escalation.
8. Development of the new theme lessons learnt will be included in the next SIRI report.

Part 1a: Overview of serious incidents reported through Strategic Executive Information System (StEIS) from October 2017 to September 2019

9. There has been an increase in the number of Serious Incidents (SIs) reported to the CCG when comparing the figures year on year:
   a) 97 SIs reported StEIS incidents 2017/18
   b) 118 SIs reported StEIS incidents 2018/19; an increase of 22% on the previous year's data.

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10. The increase in reporting shows an open and transparent reporting culture developing within the Trust. It is important to state that a high number of these incidents are de-escalated by the CCG on completion of the investigation as they are deemed unavoidable. Table 1 w below shows the reported ELHT figures compared to the final CCG figures for Oct 2017 to Sept 18 and Oct 2018 to Sept 19.

Table 1: No of Serious Incidents De-escalated by CCG

Year	ELHT	Incidents De-escalated	% of Incidents De-escalated
Oct 17 to Sept 18	97	29	30%
Oct 18 to Sept 19	118	42	36%

11. In July there was an increase in the number of incident reported on StEIS when comparing year on year. Of the 14 incidents reported, 6 were Pressure Ulcers and of these 2 have been de-escalated and 2 are awaiting approve for de-escalation from the CCG.

12. The top four categories for StEIS incidents reported over the last 12 months account for (8) 69% of all incidents reported:
    a) Pressure Ulcers x 35 (30%)
    b) Slip, Trip and Falls x 16 (14%)
    c) Diagnosis failure / problem x 16 (14%)
    d) Treatment problem / issue x 15 (13%)

13. Falls Steering Group is working with the Quality Improvement Team on Harm Reduction programmes in line with National recommendations and CQUIN indicators. A monthly Pressure Ulcer Steering Group reviews all categories of pressure ulcers. Of the 35 reported on StEIS to date 21 have been deescalated and 4 closed with harm and lessons learnt identified.

14. A thematic review has been completed for Diagnosis Failure/Problem and the main findings and reported in September to the Quality committee. Monitoring of these categories will continue over the next 6 months to identify if improvements have been made.

15. There are currently 11 incidents being investigated by the Healthcare Safety Investigation Branch (HSIB) as part of a national programme.
    a) 1 HSIB investigation that also met StEIS criterion was presented at October 2019 SIRI Panel and approved for closure and de-escalation

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b) 10 incidents will be presented to Family Care DSIRG.

16. The Trust is not provided with any clear timescales from HSIB investigation completion dates but receive monthly updates on progress.

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

17. There have been 14 serious incidents requiring investigation (Table 2) which have been reported through Strategic Executive Information System (StEIS). This is a decrease of 13% on the same time period last year when 16 incidents were reported.

Table 2: Breakdown of StEIS reported incidents by Category for Aug and Sept 2019

Incident Category	No. of Incidents	Sub Categories	Immediate action or Quality Improvement Group working to address issues raised
Treatment Problem/Issue	1	• Wrong treatment / decision given	Discussion and reflection with surgeons involved and support offered. No further treatment req'd
Safeguarding – Child	2	• Child Death Overview Panel(CDOP) • Physical	Referral to CDOP Police informed and safeguarding put in place for child
Diagnosis Failure/Problem	1	• Failure to refer to hospital	Medical team informed the Clinical Lead for Radiology to make them aware of this breakdown in communication.
Ill health	1	• Deterioration of condition	Staff offered support, review of escalation process in radiology
Antenatal and Newborn Screening	1	• NIPE Screening	
Pressure Ulcers	4	• Unstageable	Pressure Ulcer Steering Group coordinating

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			response
Slips, Trips and Falls	1	• Suspected / un-witnessed fall	Falls Steering Group reviewing and identifying themes
Medication	1	• Controlled drug	Patient assessed by the on-call neonatal Middle tier as soon as the error was identified and corrective action taken.
Problems with appointments/ admissions	1	• Failure of follow up arrangements	Failsafe lead contacted to ensure not missed again Dr discussed with Consultant Correct treatment instigated
Maternity/Obstetrics	1	• Intrauterine Death	Findings shared with antenatal clinic and community managers.
Total Incidents	14		

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

a) No incidents has breached the duty of candour at the time of writing report (see Table 4)

b) All serious incidents were reported within the required 2 working days of the trust being aware of the incident and confirming level of harm.

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

2019	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Reported in month	**11**	**11**	**17**	**12**	**15**	**11**	**19**	**17**	**10**
Completed in 10 days	**11**	**9**	**13**	**11**	**13**	**11**	**11**	**17**	**10**
Breached	**0**	**1**	**2**	**1**	**2**	**0**	**0**	**0**	**0**
Structured Judgement	**0**	**1**	**2**	**0**	**1**	**1**	**1**	**0**	**0**

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reviews meeting the DoC threshold									

Part 2a: Overview of Divisional Serious Incident review group (DSIRG) from October 2017 to September 2019

19. There has been a decrease in the number of Serious Incidents (SIs) requiring investigation by Divisions when comparing the figures year on year:
    a) 91 reported RCA incidents Oct 2017 to Sept 18
    b) 69 reported RCA incidents Oct 2018 to Sept 19 a decrease of 26% on previous years data.
20. The decrease in DSIRG reporting is partially due to the increase in the Trust external reporting on StEIS stated in Part 1a. Increased reporting paired with increased amounts of cases being de-escalated by the CCG, demonstrates an honest and open reporting culture across ELHT.
21. The top four categories for incidents requiring investigation by division over the last 12 months account for 58% of all incidents reported:
    a) Pressure Ulcers (new and old coding) (13) 19%
    b) Diagnosis failure/problem (11) 16%
    c) Treatment problem / issue (8) 12%
    d) Slips, trips and falls (8) 12%
22. These are similar categories as the StEIS reported incidents and will receive scrutiny and response through the same routes.

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

23. There were 17 incidents (Table 4) that did not meet the reporting requirements for strategic executive information system incidents (StEIS) but deemed to be serious enough to require a Trust Level RCA investigation.
24. This indicates a 21% increase on the same time period last year when 14 incidents were reported and demonstrates a positive incident investigation approach. Divisions are increasingly eager to report, investigate and find opportunities to continuously improve.

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Table 4: Breakdown of DSIRG reported incidents by Category for Aug and Sept 2019

Incident Category	No. of Incidents	Sub Categories	Immediate action or Quality Improvement Group working to address issues raised
Treatment problem/ issue	5	• Concern around care given • Delay in treatment • Delay in Treatment • Concern around care given • Concern around care given	• Complaint received Divisional RCA being completed to identify any learning required • Highlighted poor documentation • RCA to be completed to identify if any lapses in care • Double checks in place
Diagnosis failure / problem	3	• Results incorrectly / communicated • Potential lapse in assessment / care planning • Missed Fracture	• Patient informed RCA being completed to identify any learning required • RCA being completed • Patient recalled and RCA being completed •
Infection control	1	• MSSA Bacteraemia	• Infection Control Panel
Maternity/obstetrics	1	• Stillbirth	Incidental learning identified
Slips, trips and falls	3	• Unexpected / unwitnessed fall x2 • Fall from height (bed/chair)	Falls steering group
Pressure ulcer	2	• Deep tissue injury (2.5cm) • Deep tissue injury – device related	Pressure ulcer steering group

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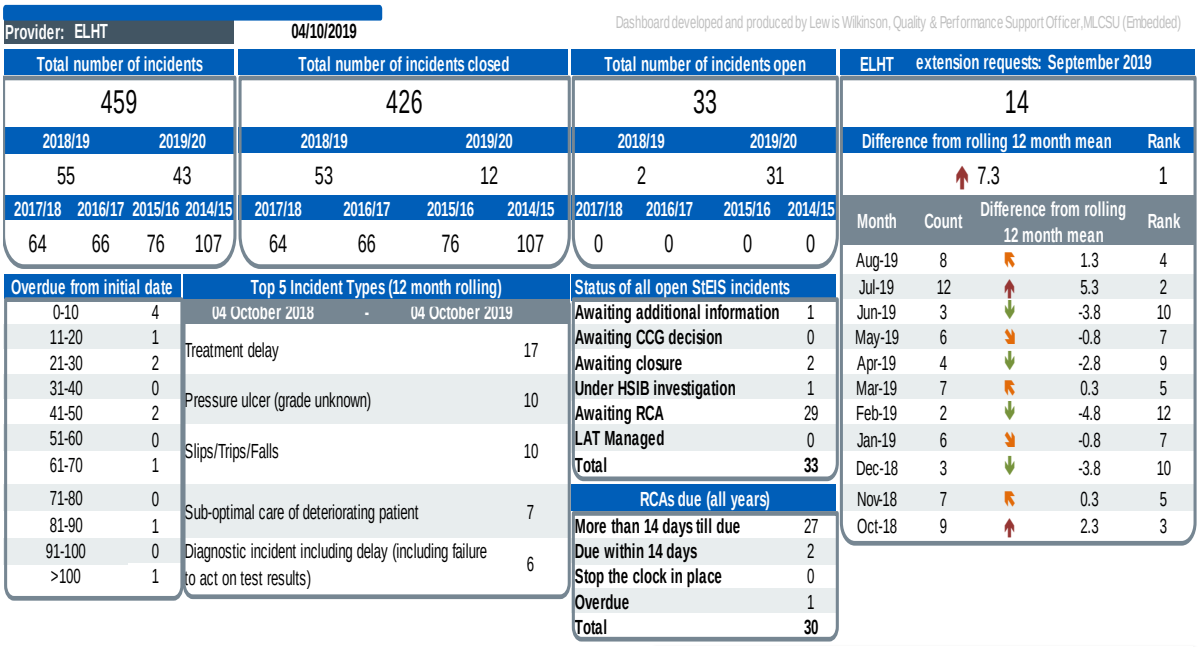
Incident Category	No. of Incidents	Sub Categories	Immediate action or Quality Improvement Group working to address issues raised
Medication	1	• Administration	Medicines management group
Problems with appointments / admissions	1	Failure of follow up arrangements	Failsafe system now in place (incident 2013)

- *All above incidents either reported as No harm or lower harm.*

Part 3: Overview of the CCG StEIS Dashboard



25. There are currently 33 incidents open on StEIS:

a) 2 for 2018/2019 (reduced from 11 since last SIRI report) and 31 for 2019/20

b) There is one incident investigation (Maternity) which is overdue by more than 100 days, HSIB are completing this investigation and its due at the SIRI Panel in October.

c) There have been 14 extension requests in September

d) There have been no late submissions of rapid reviews for August and September

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East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

13 November 2019

Item 147

Purpose Information
Action
Monitoring

Title	Integrated Performance Report
Author	Mr M Johnson, Associate Director of Performance and Informatics
Executive sponsor	Mrs N Hudson, Director of Operations

Summary: This paper presents the corporate performance data at September 2019

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do 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 Partnership (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	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

Board of Directors, Update

Corporate Report

Executive Overview Summary

Positive News

- There were no never events in September.
- % Harm free care remains above threshold.
- There were no breaches of the 52wk standard at the end of September.
- The number of ambulance handovers over 30 minutes continues to show improvement.
- HAS compliance is showing significant improvement.
- The 6wk diagnostic target was met at 0.98% in September.
- The vacancy rate remains above threshold at 5.4%, although is improving.
- Trust turnover rate continues to show significant reductions.
- Inpatient friends and family performance is showing significant improvement and is consistently above threshold.

Areas of Challenge

- There were nine clostridium difficile infections detected during September ('Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)', which is above trajectory for the month. The cumulative position is 38 against the trajectory of 26. The end of year threshold is 51.
- E-coli post 2 day bacteraemia was above trajectory in September.
- Nursing and midwifery staffing in September 2019 continued to be a challenge, with 2 areas falling below an 80% average fill rate for registered nurses on day shifts.
- The 'Emergency Care 4 hour standard' (Pennine A&E Delivery Board) remains below standard at 85.2%
- A&E Friends & Family is consistently below threshold
- There were 6 breaches of the 12 hour trolley wait standard in September. All were as a result of waits for mental health beds within LCFT.
- The Referral to Treatment (RTT) number of total ongoing pathways is above the year-end target at 32,678.
- RTT over 40wks has increased to 172.
- The cancer 62 day standard was not met in August.
- The cancer subsequent treatment within 31 days (surgery) was not met in August.
- There were 3.5 breaches of the 104 day cancer wait standard.
- There were 2 breaches of the 28 day standard for operations cancelled on the day.
- Delayed discharges were above the 3.5% standard at 4.1% in September.
- Average length of stay for elective and non-elective has increased.

- There were 5 stillbirths in September.
- Sickness rates remain above threshold at 4.7%
- Compliance against the Information Governance Toolkit and Appraisal (AFC staff) remains below threshold.
- Temporary costs as % of total pay bill remains above threshold at 9%
- For 2019-20, the Trust has agreed an underlying control total of a £7.0 million deficit. At month 6, the Trust is reporting a £4.9 million underlying deficit, in line with its financial plans. However, the forecast outturn position as at 31st March 2020 is demonstrating a current gap of £10.0 million, assuming the £16.4 million SRCP target will be fully achieved on a cash releasing basis.

No Change

- There were 6 steis reportable incidents in September. The trend does not show any significant change.
- All areas of core skills training except IG and Appraisal compliance are above threshold
- HSMR remains 'better than expected'.
- VTE risk assessment remains above threshold.
- There were 85 operations cancelled on the day. The trend shows no change.
- Emergency readmissions stands at 12.8%

Introduction

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

Key to Scorecard Symbols

Variation

	No significant variation or change in the performance data (Common cause variation)
	Significant improvement in the performance data that is not due to normal variation (Special case variation)
	Significant deterioration in the performance data that is not due to nornal variation (Special case variation)

Assurance

	The indicator may or may not meet the target - the variation in data sometimes meets the target and sometimes not
	The indicator will consistently meet the target. The variation in the data always falls within the target
	The indicator will consistently fail the target. The variation in the data always falls outside the target

	Indicator	Target	Actual	Variation	Assurance
Safe					
M64	CDIFF - HOHA	2	7		
M64.3	CDIFF - COHA	2	2		
M64.4	Cdiff Cumulative from April (HOHA& COHA)	26	38		
M65	MRSA	0	0		
M124	E-Coli (post 2 days)	4	7		
M155	P. aeruginosa bacteraemia (total post 2 days)	0	0		
M157	Klebsiella species bacteraemia (total post 2 days)	3	0		
M66	Never Event Incidence	0	0		
M67	Medication errors causing serious harm (Steis reported date)	0	0		
M68	Maternal deaths	0	0		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)		26.6		
M69	Serious Incidents (Steis)		6		
M70	CAS Alerts - non compliance	0	0		
C28	Percentage of Harm Free Care	92%	99%		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	98%		
M146	Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80.0%	90.6%		
M147	Safer Staffing -Day-Average fill rate - care staff (%)	80.0%	104.8%		
M148	Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80.0%	97.1%		
M149	Safer Staffing -Night-Average fill rate - care staff (%)	80.0%	117.9%		
M150	Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80%	0	2		
M151	Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80%	0	2		
M152	Safer Staffing - Day -Average fill rate - care staff- number of wards <80%	0	1		
M153	Safer Staffing - Night -Average fill rate - care staff- number of wards <80%	0	1		

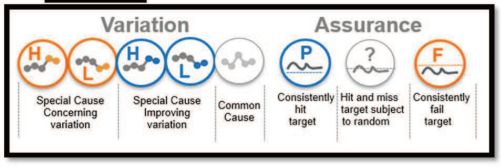
	Indicator	Target	Actual	Variation	Assurance
Caring					
	Indicator	**Target**	**Actual**	**Change**	**Capability**
C38	Inpatient Friends and Family - % who would recommend	90%	98%		
C31	NHS England Inpatients response rate from Friends and Family Test		52%		
C40	Maternity Friends and Family - % who would recommend	90%	97%		
C42	A&E Friends and Family - % who would recommend	90%	86%		
C32	NHS England A&E response rate from Friends and Family Test		19%		
C44	Community Friends and Family - % who would recommend	90%	99%		
C15	Complaints – rate per 1000 contacts	0.40	0.24		
M52	Mixed Sex Breaches	0	0		
Effective					
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Within Expected Levels	1.05		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at May-19)	Within Expected Levels	93.5		
M74	Hospital Standardised Mortality Ratio - Weekday (as at May-19)	Within Expected Levels	93.4		
M75	Hospital Standardised Mortality Ratio - Weekend (as at May-19)	Within Expected Levels	93.7		
M73	Deaths in Low Risk Conditions (as at May-19)	Within Expected Levels	99.8		
M159	Stillbirths	<5	5		
M160	Stillbirths - Improvements in care that impacted on the outcome				
M89	CQUIN schemes at risk				

	Indicator	Target	Actual	Variation	Assurance
Responsive					
	Indicator	**Target**	**Actual**	**Change**	**Capability**
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95.0%	84.3%		F
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95.0%	85.2%		F
M62	12 hour trolley waits in A&E	0	6		?
M81	HAS Compliance	90.0%	92.9%		?
M82	Handovers > 30 mins ALL	0	285		F
M82.6P	Handovers > 30 mins ALL (NWAS Confirmed Penalty)	0	90		F
C1	RTT admitted: percentage within 18 weeks		57.5%		
C3	RTT non- admitted pathways: percentage within 18 weeks		88.8%		
C4.1	RTT waiting times Incomplete pathways Total	<29,619	32,678		F
C4.2	RTT waiting times Incomplete pathways -over 40 wks		172		
C37.1	RTT 52 Weeks (Ongoing)	0	0		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1.0%	0.98%		?
C18	Cancer - Treatment within 62 days of referral from GP	85.0%	74.8%		?
C19	Cancer - Treatment within 62 days of referral from screening	90.0%	100.0%		?
C20	Cancer - Treatment within 31 days of decision to treat	96.0%	97.6%		?
C21	Cancer - Subsequent treatment within 31 days (Drug)	98.0%	100.0%		P
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94.0%	84.0%		?
C36	Cancer 62 Day Consultant Upgrade	85.0%	82.3%		?
C25.1	Cancer - Patients treated > day 104	0	3.5		?
M9	Urgent operations cancelled for 2nd time	0	0		
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	2		

	Indicator	Target	Actual	Variation	Assurance
M138	No.Cancelled operations on day		85		
M55	Proportion of delayed discharges attributable to the NHS	3.5%	4.1%		
C16	Emergency re-admissions within 30 days		12.8%		
M90	Average LOS elective (excl daycase)		2.9		
M91	Average LOS non-elective		5.1		
Well Led					
M77	Trust turnover rate	12.0%	7.1%		
M78	Trust level total sickness rate (Reported 1 Month in arrears)	4.5%	4.7%		
M79	Total Trust vacancy rate	5.0%	5.4%		
M80.3	Appraisal (AFC)	90.0%	81.0%		
M80.35	Appraisal (Consultant)	90.0%	96.0%		
M80.4	Appraisal (Other Medical)	90.0%	97.0%		
M80.2	Safeguarding Children	90.0%	96.0%		
M80.21	Information Governance Toolkit Compliance	95.0%	93.0%		
F8	Temporary costs as % of total paybill	4%	9%		
F9	Overtime as % of total paybill	0%	0%		
F1	Adjusted financial performance (deficit) including PSF (£M)	6.7	(0.5)		
F1.1	Adjusted financial performance (deficit) excluding PSF (£M)	(7.0)	(5.0)		
F2	SRCP Achieved % (green schemes only)	100.0%	42.0%		
F3	Liquidity days	>(14.0)	(5.6)		
F4	Capital spend v plan	85.0%	97.0%		
F16	Finance & Use of Resources (UoR) metric - overall	3	2		
F18	Finance and UoR metric - capital service capacity	3	3		
F17	Finance and UoR metric - liquidity	3	2		
F19	Finance and UoR metric - I&E margin	1	2		
F20	Finance and UoR metric - distance from financial plan	1	1		
F21	Finance and UoR metric - agency spend	3	3		
F12	BPPC Non NHS No of Invoices	95.0%	98.4%		
F13	BPPC Non NHS Value of Invoices	95.0%	97.8%		
F14	BPPC NHS No of Invoices	95.0%	95.9%		
F15	BPPC NHS Value of Invoices	95.0%	98.4%		

NB: Finance Metrics are reported year to date.

KEY

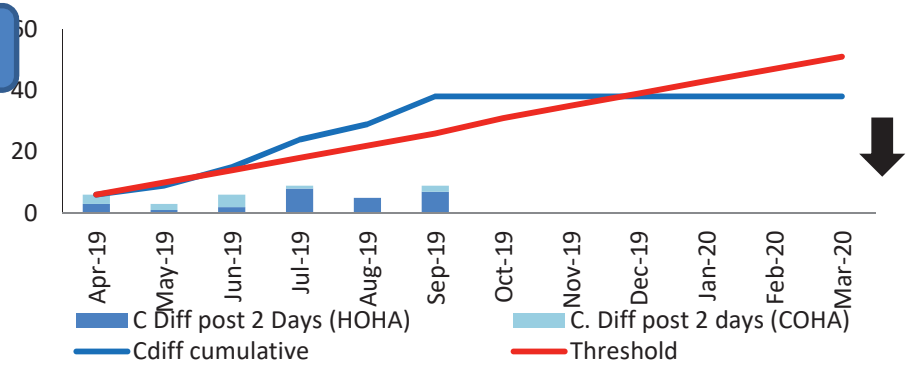


SPC Control Limits

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

SAFE

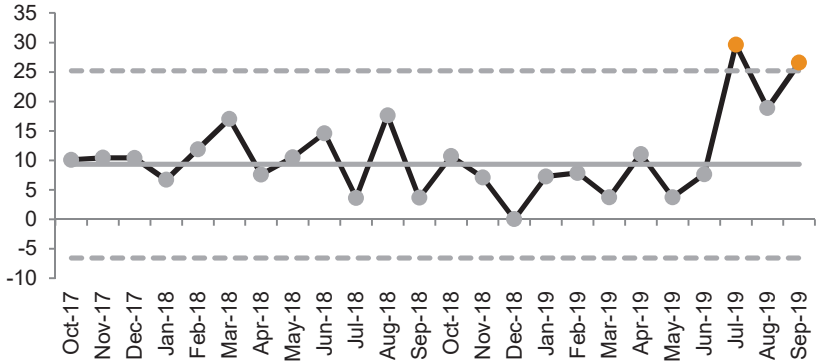
C Difficile



There were no post 2 day MRSA infections reported in September. So far this year there has been 1 case attributed to the Trust.

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

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

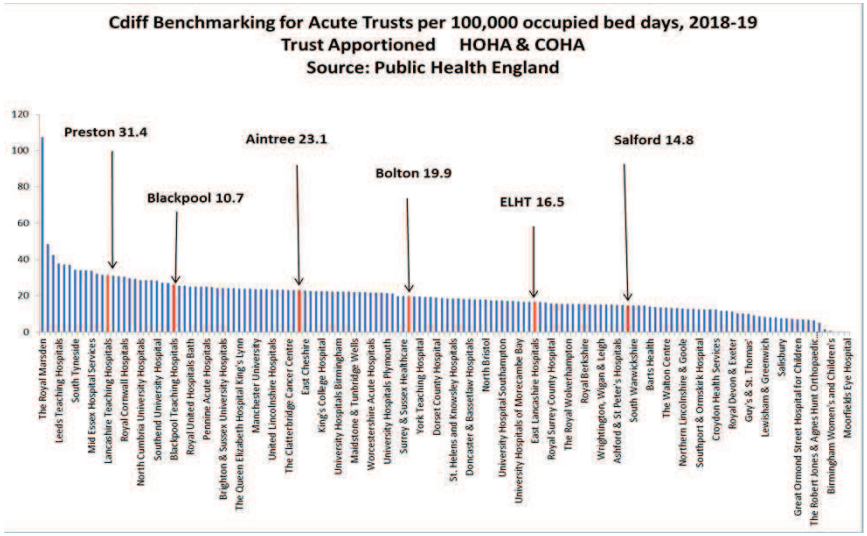


There were 9 Clostridium difficile toxin positive isolates identified in the laboratory in August, post 2 days of admission, 7 of which were 'Hospital onset healthcare associated (HOHA)' and 2 were 'Community onset healthcare associated (COHA)'.

The year to date cumulative figure is 38 against the trust target of 51. The detailed infection control report will be reviewed through the Quality Committee.

The rate of HOHA infection per 100,000 bed days has increased again in September.

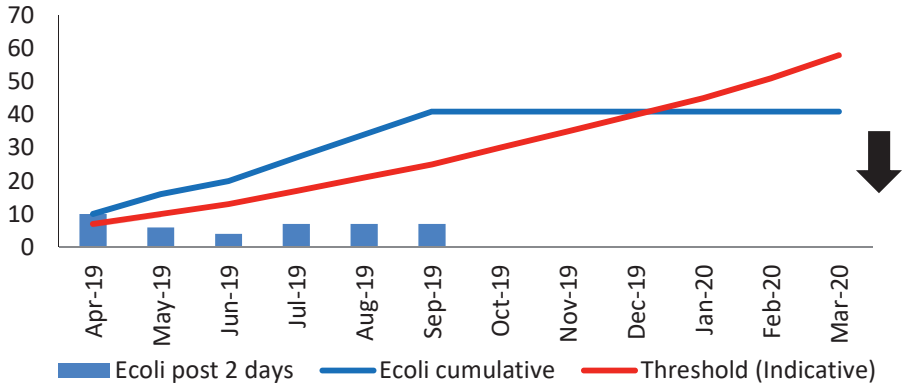
C Difficile benchmarking



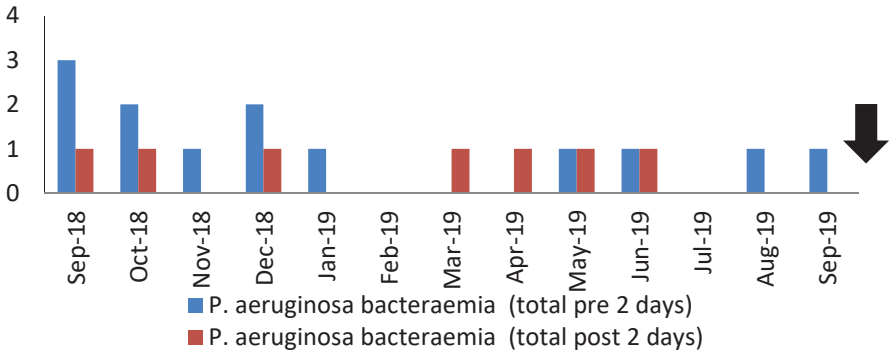
ELHT ranked 58th out of 148 trusts in 2018-19 with 16.5 HOHA & COHA clostridium infections per 100,000 bed days. The best performing trust had 0 and the worst performer had 107.4 infections per 100,000 bed days.

SAFE

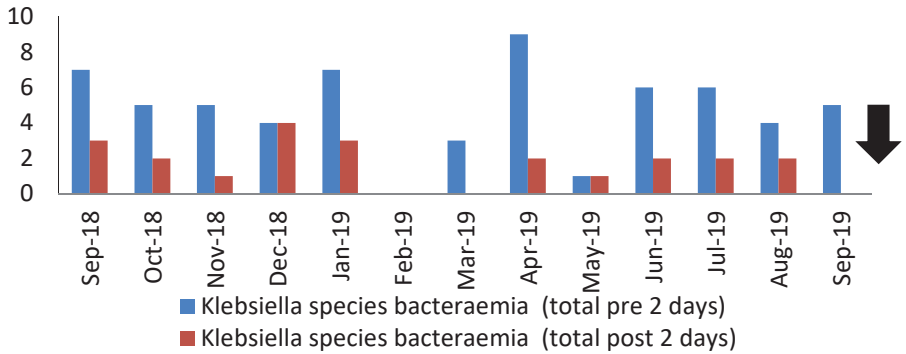
E. Coli



P.aeruginosa



Klebsiella



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

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

This year's trajectory for reduction of E.coli has not yet been published, so an indicative trajectory of 58 has been included for information.

There were 7 E.coli bacteraemia detected in September, which is above the indicative monthly threshold.

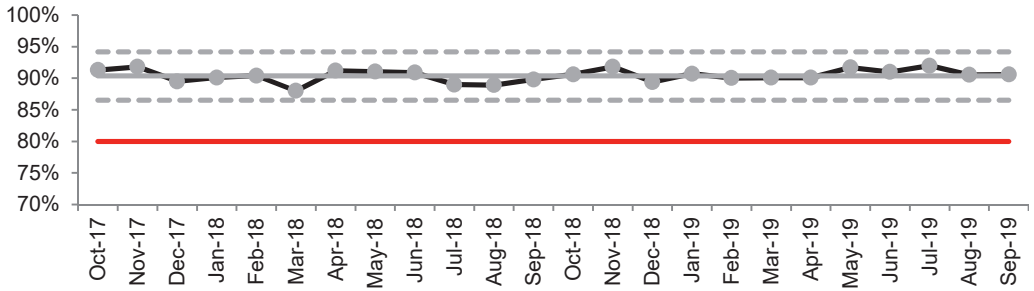
From April 2017, NHS Trusts must report cases of bloodstream infections due to *Klebsiella species* and *Pseudomonas aeruginosa* to Public Health England.

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

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

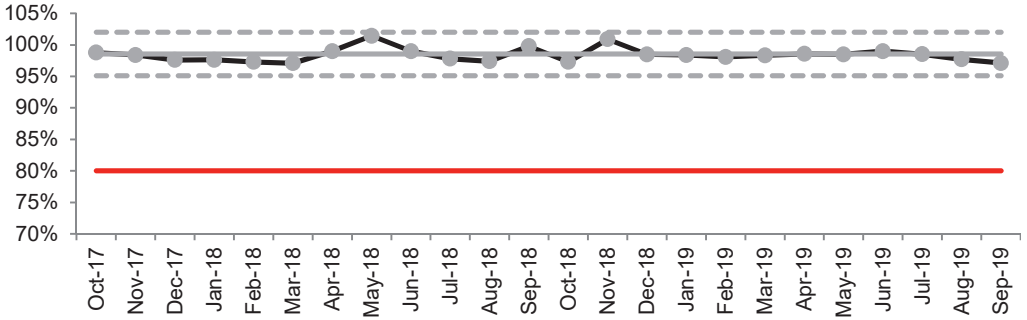
SAFE

Registered Nurses/ Midwives - Day



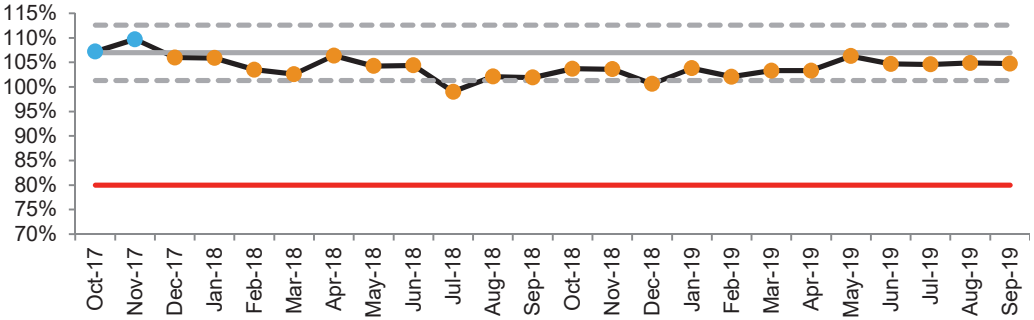
The average fill rate for registered nurses/ midwives during the day is showing no significant change and based on current variation will consistently be above threshold.

Registered Nurses/ Midwives - Night



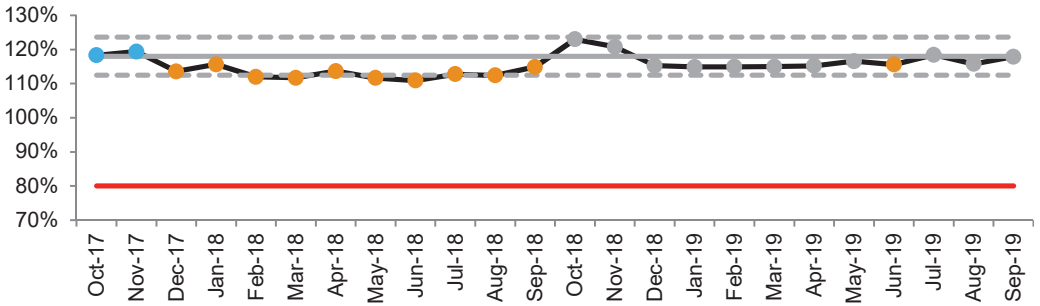
The average fill rate for registered nurses/ midwives at night is showing no significant change and based on current variation will consistently be above threshold.

Care Staff - Day



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

Care Staff - Night



The average fill rate for care staff at night is showing normal variation. The indicator remains above the threshold and based on current variation will consistently be above the threshold.

SAFE

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

There were 2 areas below the 80% for registered nurses on day shifts; all were due to lack of co-ordinator presence which is in addition to safe staffing levels. And one area on night duty below 80% for registered nurses, this being the Childrens Unit, which is extremely unusual.

Children's Unit - In September the nursing establishment was increased to accommodate the previously agreed professional judgment recommendations, demonstrating a gap in terms of actual and planned hours. These outstanding registered nurse posts are being recruited to. There are 7 newly qualified nurses in post working as either health care support workers whilst they await their PIN or as supernumerary band 5 nurses as part of their preceptorship period. Each shift was assessed based on acuity and was deemed safe on the numbers available apart from 4 shifts which were put out to agency. The matron has given assurance that the unit was safely staffed.

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.

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-19	90.6%	104.8%	97.1%	117.9%	26,350	8.81	2	2	1	1

Red Flag Incidents

There were 2 red flag incidents reported in the red flag category of DATIX (for nursing) in September 2019

C18A – There was one red flag IR1 in September on ward C18a where an incident was reported by the nursing staff due to being unable to reliably carry out intentional rounding, delayed pain relief and less than one registered nurse on night duty. This was due to the agency nurse reporting for duty late, therefore, was not for the whole shift. The division can provide assurance that no known harm occurred as a result of this incident and can confirm this is not a regular theme on this ward.

SAFE

B2 - Unable to reliably carry out intentional rounding. Acuity on the ward was very high, 2 patients required enhanced observation and there were 2 acutely unwell patients requiring intensive interventions, an escalation bed was also in use. The staff felt that due to the above care delivery was delayed. Staffing numbers for the shift met the planned numbers, although based on the acuity the hours would appear slightly short. No patient harms were identified. Other staffing incidents reviewed within the Medicine and Emergency Care Division highlighted that several should have been reported under the red flag category. This has been reiterated to the division and further work will commence to remind staff of the importance of correct categorisation.

Ward C7 - missed staff break due to acuity

Ward AMU A – Delays with care delivery to due to high acuity

Ward D3 – unable to carry out intentional rounding due to high acuity

No harms were identified

Ward C4 - raised concerns regarding acuity on the ward. I patient fell with low harm sustained

Actions taken to mitigate risk:

- Safe staffing conference at 10 am followed up with meetings through out the day where required to ensure safe staffing, with contingencies agreed for weekends and out of hours, utilising acuity and dependency (Safe Care)
- Extra health care assistant shifts are utilised to support registered nurse gaps if required
- On going recruitment.
- Global learners continue to arrive. 18 have passed OSCE, with a further 8 taking OSCE in near future. Further 10 global learners expected between October and December
- A further cohort of trainee nurse associates has been recruited to.
- Aiming to increase student nurse placements by a further 80 places in the coming year

SAFE

Family Care September 2019

Maternity

September once again has been an extremely challenging month for maternity staffing. Staff Sickness was high and with the support of the matrons clinically there were management plans in place to ensure safe staffing levels at all times. This is reflected via the maternity safety huddles which take place four times within a 24 hour period.

Some staffing gaps were covered by using bank and staff swapping shifts. Redeployment of midwives, maternity support workers and health care assistant to other areas have covered staffing gaps on days of lower acuity/activity to support the areas of higher acuity/activity.
Acuity and activity was reviewed more frequently via additional safe staffing huddles in view of the staffing pressures, to ensure gaps for the pending days were covered in view of unexpected sickness, a focus on competencies and skillset was paramount. A multi professional team approach remains embedded as part of the safety huddles which take place on the Central Birth Suite with representation from all areas , these safety huddles host a helicopter view of maternity services at ELHT.

On reviewing Datix, 16 incidents were reported overall as Red Flag events in Family Care Division in September 2019. Of the 16 incidents reported, 8 have been excluded as they were not red flag events when analysed further.

Of the remaining 8 incidents reported, 6 of them occurred within Maternity Services and 1 in Paediatric Services and 1 in Neonatal Intensive Care Unit and were reported under the following categories and sub-categories

Maternity Services -
4 Staffing issue –staff shortage midwives. *No harm - Impact prevented.*
1 Maternity / Obstetrics – delayed or cancelled time critical activity. *No harm - Impact not prevented.*
1 Maternity / Obstetrics – missed or delayed care. *No harm - Impact prevented.*

Neonatal Services-
1 staffing issue – staff shortage nurses. *No harm - Impact prevented.*

Paediatric Services-
1 staffing issue – inability to attend rostered training. *No harm - Impact prevented.*

No harm was caused.
There was appropriate escalation and implementation of the escalation policy when acuity and activity was high. Workload was prioritised and staff moved to the areas with the highest workload. All area leads, shift co-ordinators, Matron on Call, and Night Manager were informed of plans and communication with all disciplines involved in care and service delivery was excellent throughout

SAFE

Maternity Midwife to Birth Ratio

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Staffed to full Establishment	01:26	01:28	01:27	01:27	01:27	01:27	01:28	01:27	01:29	01:27.5	1.27.5	01:26
Excluding mat leave and vacancies	01:27.5	01:29	01:28	01:28	01:28	01:28	01:29	01:28	Staffed up to mat leave	01:28.7	1.28.6	01:27
With gaps filled through ELHT Midwife staff bank	01:26	01:28	01:27	01:27	01:27	01:27	01:28	01:27	01:28	01:27.7	1.27.3	01:26
	Bank Usage 6.5WTE	Bank Usage 5.74WTE	Bank Usage 5.8WTE	Bank Usage 7.0WTE	Bank Usage 4.8WTE	Bank Usage 6.3WTE	Bank Usage 5.17 WTE	Bank Usage 7.27 WTE	Bank Usage 9 WTE	Bank Usage 7.94 WTE	Bank Usage 10.14wte	Bank Usage 7.77wte

The staffing figures do not reflect how many women were in labour or acuity of areas.
The midwife to birth ratio should be 1:27-28

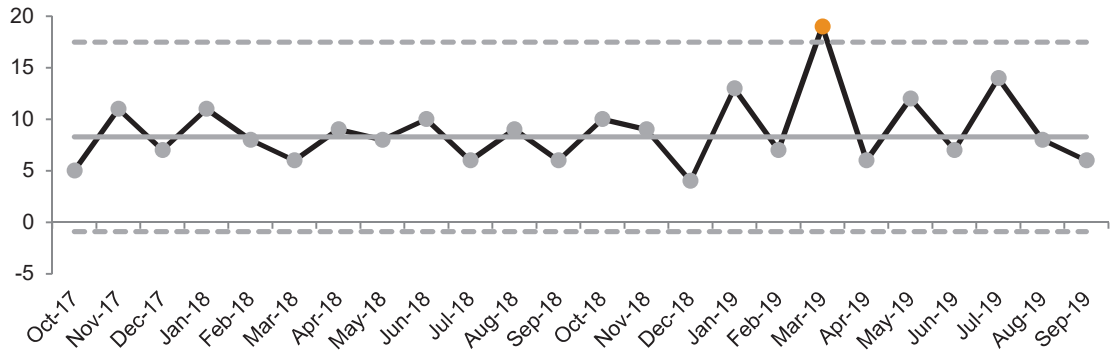
NICU- No exceptions reported. The escalation/ British association of perinatal medicine (BAPM) tool is used to risk assess the acuity/activity in order to determine the request for bank usage, if unfilled the next option has been to use agency. All duties have reflected safe staffing levels to meet the requirements of the tool.

Paediatrics- No exceptions reported. Acuity and activity is closely monitored and recorded three times throughout the day with reference to safe staffing levels with appropriate plans made point prevalent. Recruitment and selection processes are ongoing. Professional judgment nursing gaps have all been recruited to with three posts remaining only, starts dates are mid-September. Professional judgment HCA gaps are in the process of being recruited to with bank shifts being the plan to cover in the interim period

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

SAFE

Serious Incidents



There were no never events reported in September.

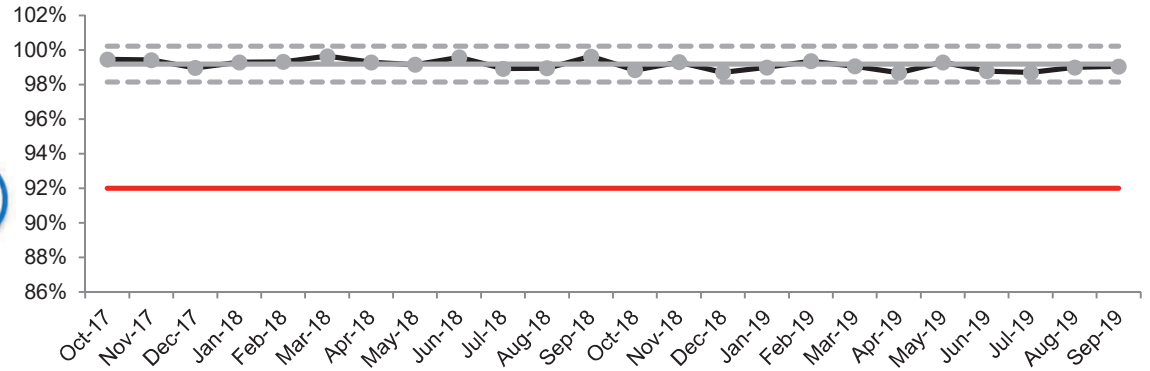
The Trust unverified position for incidents reported to the Strategic Executive Information System (StEIS) in September was 6 incidents.

The trend is not showing any significant change.

StEIS Category	No. Incidents
Pressure Ulcer	2
Treatment Delay	2
Surgical/ Invasive Procedure	1
Maternity/ Obstetrics (Baby only)	1

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

% Harm Free Care from safety

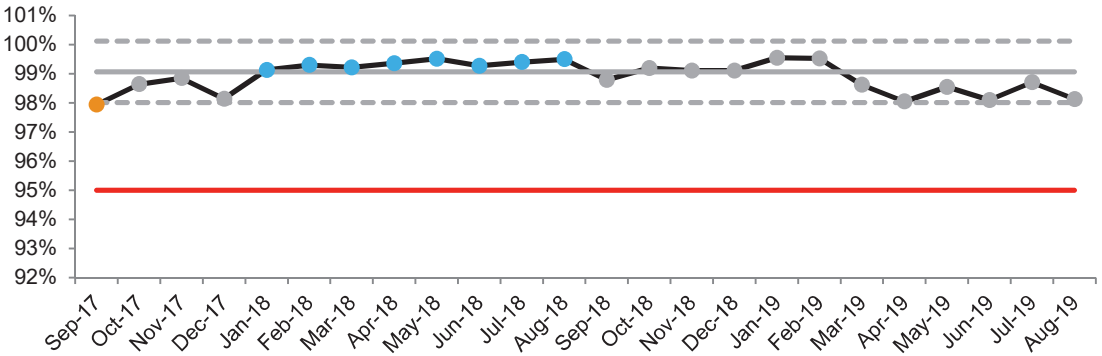


The Trust remains consistent with the percentage of patients with harm free care at 99.0% for September using the National safety thermometer tool.

The trend is showing no significant change.

SAFE

VTE assessment



The VTE assessment trend is showing normal variation and based on recent performance will consistently achieve the standard.

Pressure Ulcers

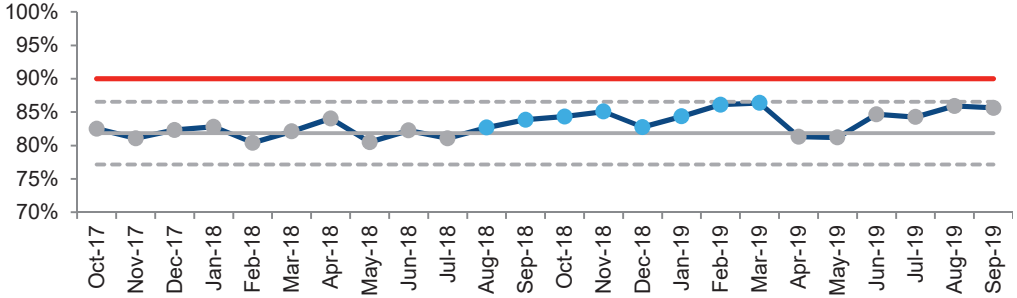
Pressure Ulcer - Cat 2 - Device related - developed/ deteriorated during ELHT care	0
Pressure Ulcer - Cat 2 - Developed / Deteriorated during care of ELHT	5
Pressure Ulcer - Cat 3 - Device related - developed / deteriorated during care of ELHT	1
Pressure Ulcer - Cat 3 - Developed / deteriorated during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

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

CARING

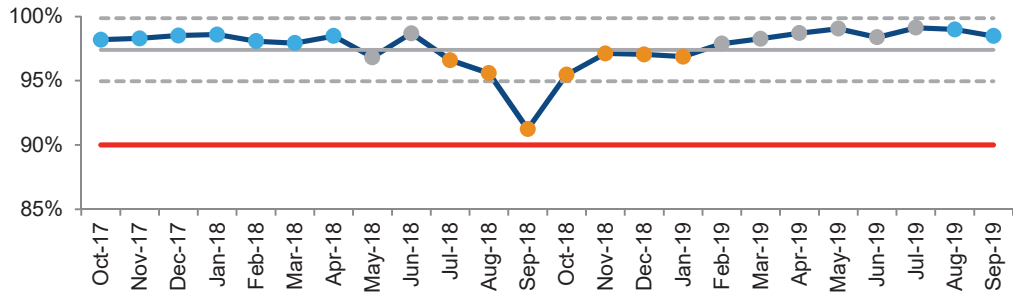
These metrics reflect national measurement methodology, which measures the proportion of patients that would recommend the Trust to friends and family. The threshold has been set at 90% since April 2018.

Friends & Family A&E



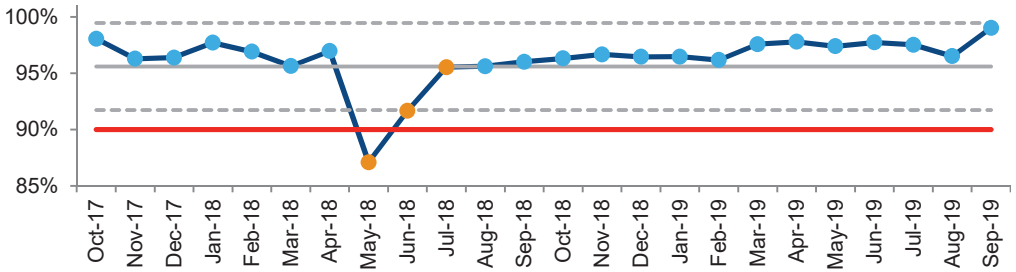
A&E scores show normal variation following a period of significant improvement since August 2018. Based on current variation this indicator is not capable of hitting the target.

Friends & Family Inpatient



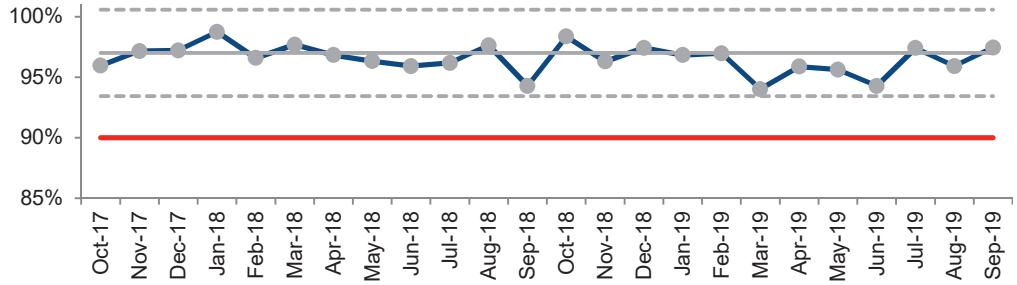
Inpatient scores are showing improvement after a period of significant low scores ending in February 19 . Based on current variation this indicator should consistently hit the target.

Friends & Family Community



Community scores show significant improvement for the past 14 months. Based on current variation this indicator should consistently hit the target.

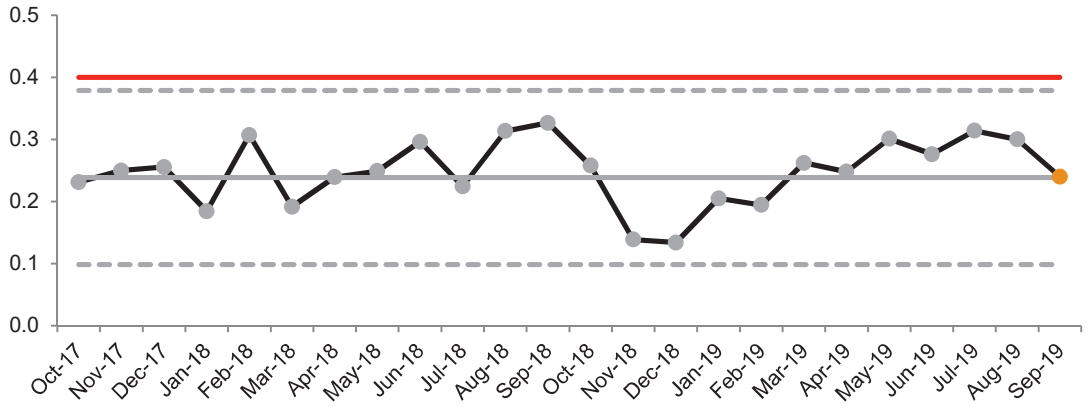
Friends & Family Maternity



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

CARING

Complaints per 1000 contacts



The Trust opened 28 new formal complaints in September.
The number of complaints closed was 41.

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 August the number of complaints received was 0.24 Per 1,000 patient contacts.

The trend is showing a worsening position, however based on current variation will remain below the threshold.

Patient Experience

September 2019 Totals	Dignity	Information	Involvement	Quality	Overall
	Average Score %	Average Score %	Average Score %	Average Score %	Average Score %
Trust	96	93	94	95	95
Medicine and Emergency Care	95	93	95	95	94
Community and Intermediate Care Services	97	94	95	96	96
Surgery	97	93	91	91	93
Family care	99	94	97	96	97
Diagnostic and Clinical	88	88	86	88	88

The table demonstrates divisional performance from the range of patient experience surveys in September 2019.

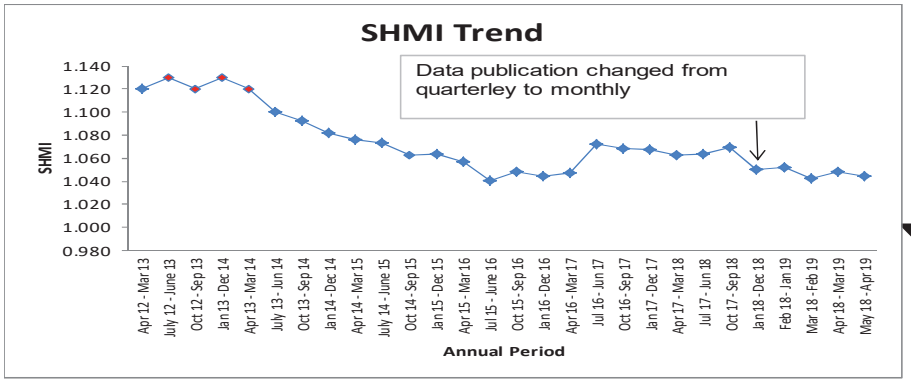
The threshold is a positive score of 90% or above for each of the 4 competencies.

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

The diagnostic and cliical support division fell below threshold in all 4 categories.

EFFECTIVE

SHMI Published Trend



The latest Trust SHMI value as reported by the Health and Social Care Information Centre and Care Quality Commission for the period April 18 to March 19 has remained within expected levels at 1.05, as published in August 19.

Dr Foster HSMR rolling 12 month

	HSMR Rebased on latest month June 18 – May 19 (Risk model Feb 19)
TOTAL	93.5 (CI 89.0 – 98.2)
Weekday	93.4 (CI 88.2 – 98.9)
Weekend	93.7 (CI 84.8 – 103.4)
Deaths in Low Risk Diagnosis Groups	99.8 (CI 63.0 – 151.0)

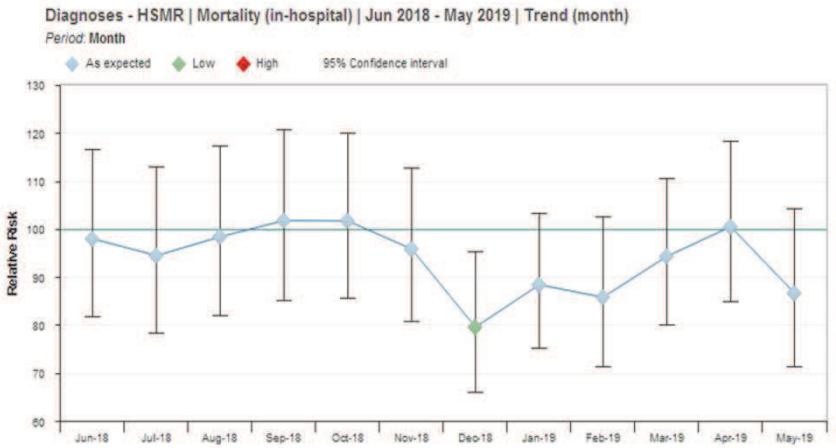
The latest indicative 12 month rolling HSMR (June 18 – May 19) remains 'significantly better than expected' at 93.5 against the monthly rebased risk model.

The weekday HSMR is also 'significantly better than expected'

There are currently no diagnosis groups alerting on the HSMR.

There are currently four 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.

Dr. Foster HSMR monthly Trend



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

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

EFFECTIVE

Structured Judgement Review Summary

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

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

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

	Month of Death																				
Stage 1	pre Oct 17	Oct 17 - Mar 18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	TOTAL
Deaths requiring SJR (Stage 1)	46	212	41	26	21	26	19	27	21	14	15	19	4	9	26	21	27	24	10	4	612
Allocated for review	46	212	41	26	21	26	19	27	21	14	15	19	4	9	26	21	27	24	10	4	612
SJR Complete	46	212	41	26	21	25	19	27	21	14	15	19	3	8	22	17	23	18	2	0	579
1 - Very Poor Care	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
2 - Poor Care	8	19	2	2	4	2	0	1	3	1	2	2	0	2	1	4	4	2	0	0	59
3 - Adequate Care	14	68	10	9	1	9	7	10	4	5	4	4	0	3	5	4	7	5	2	0	171
4 - Good Care	20	106	26	11	13	11	9	14	13	7	7	12	3	2	14	7	12	7	0	0	294
5 - Excellent Care	3	18	3	4	3	3	3	2	1	1	2	1	0	1	2	2	0	4	0	0	53
Stage 2																					
Deaths requiring SJR (Stage 2)	9	20	2	2	4	2	0	1	3	1	2	2	0	2	1	4	4	2	0	0	61
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	7
Allocated for review	6	18	2	2	4	2	0	1	2	1	2	2	0	2	1	4	4	1	0	0	54
SJR-2 Complete	6	18	2	2	4	2	0	1	2	1	2	2	0	2	1	4	3	1	0	0	53
1 - Very Poor Care	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
2 - Poor Care	3	6	1	0	0	0	0	1	0	1	1	1	0	1	1	2	1	0	0	0	19
3 - Adequate Care	2	10	1	1	4	2	0	0	2	0	1	1	0	1	0	2	2	1	0	0	30
4 - Good Care	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
5 - Excellent Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	pre Oct 17	t 17 - Mar	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Total
stage 1 requiring allocation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
stage 1 requiring completion	0	0	0	0	0	1	0	0	0	0	0	0	1	1	4	4	4	6	8	4	21
Backlog	0	0	0	0	0	1	0	0	0	0	0	0	1	1	4	4	4	6	8	4	21
stage 2 requiring allocation	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	2
stage 2 requiring completion	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Backlog	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	0	0	3

EFFECTIVE

Commissioning for Quality and Innovation (CQUIN)

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

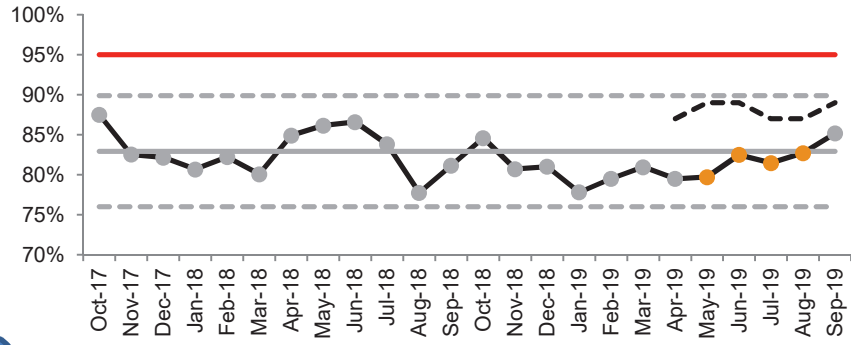
1. NHS Staff Health and Wellbeing - Staff Flu Vaccinations
2. Alcohol and Tobacco Brief advice
3. Three High Impact interventions to prevent Hospital Falls
4. Antimicrobial Resistance –Urinary Tract Infections and Antibiotic Prophylaxis for Elective Colorectal Surgery
5. Same Day Emergency Care –Pulmonary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

Data has been submitted for quarter 1 with no risks raised. Quarter 2 data submission is underway.

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

RESPONSIVE

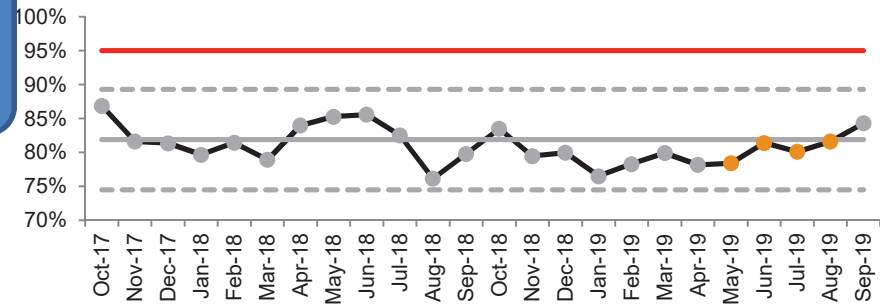
A&E 4 hour standard % performance -



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 85.2% in September, which remains below the 95% threshold.

The trend is showing a return to normal variation following a period of statistical deterioration and based on current variation is not capable of hitting the target.

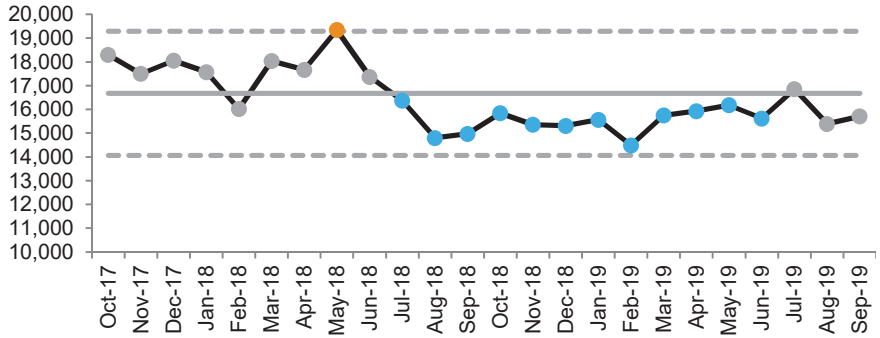
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 84.3% in September.

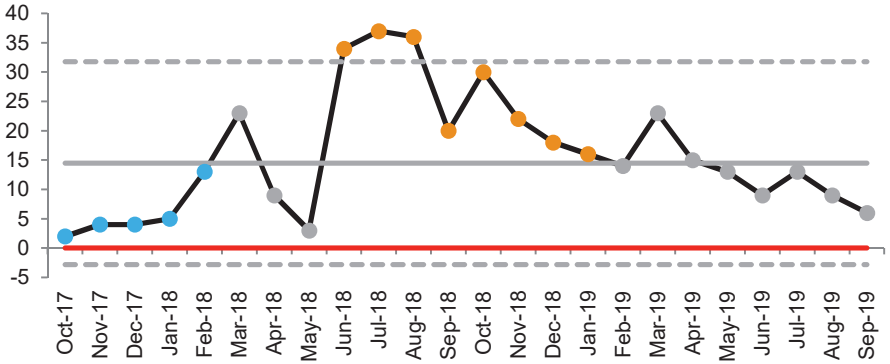
The national performance was 85.4% in September (All types) with 3 out of 133 reporting trusts with type 1 departments achieving the 95% standard. (Field testing sites excluded)

A&E Attendances - Trust



The number of attendances during September was 15,706 and the trend is showing normal variation, following a period of significant reduction in attendances since June 18, when the HAC closed.

12 Hr Trolley Waits

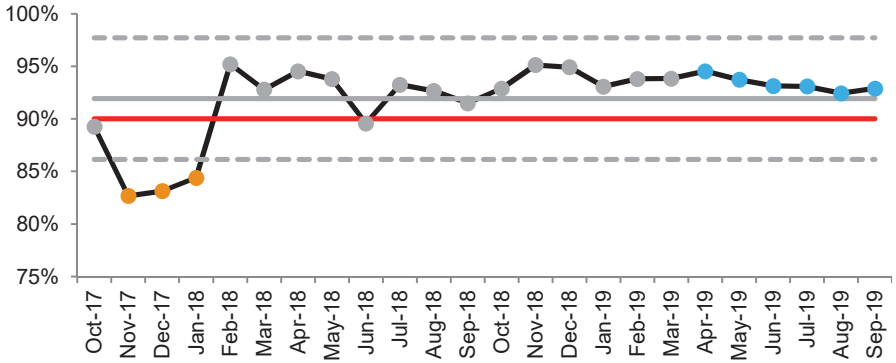


There were 6 reported breaches of the 12 hour trolley wait standard from decision to admit during September. All were mental health breaches. Rapid review timelines are completed in accordance with the NHS England Framework and a root cause analysis will be undertaken.

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

RESPONSIVE

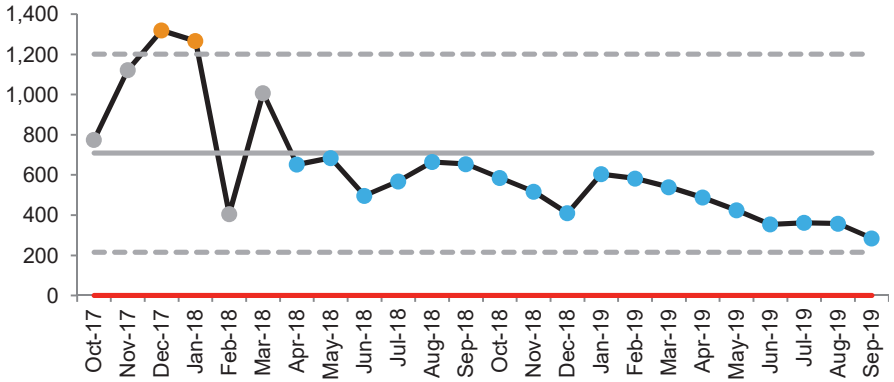
HAS Compliance



The ambulance handover compliance indicator measures the compliance with PIN entry on completion of patient handover. This was achieved at 92.9% in September, which is above the 90% threshold.

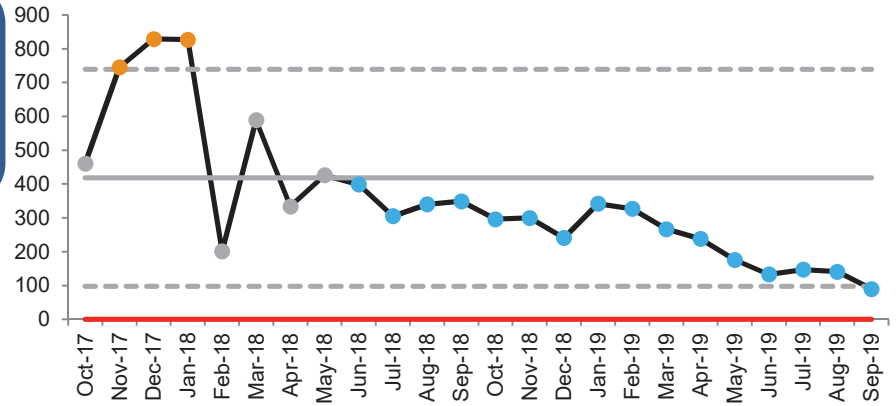
The trend is showing significant improvement, however based on current variation, the target is still at risk of failure.

Ambulance Handovers - >30Minutes



The number of handovers over 30 minutes is showing significant improvement, with 285 reported for September.

Ambulance Handovers - HAS Confirmed Penalty >30Minutes



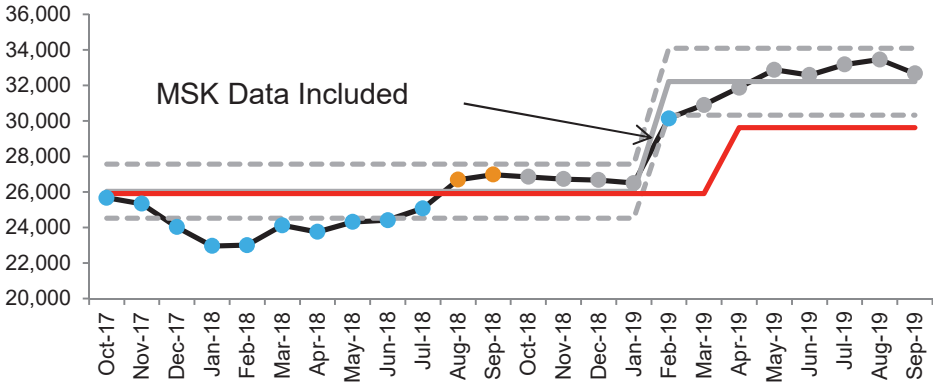
The validated NWAS penalty figures are reported as at September as;- 133 missing timestamps, 83 handover breaches (30-60 mins) and 7 handover breaches (>60 mins).

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

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

RESPONSIVE

RTT Total Ongoing

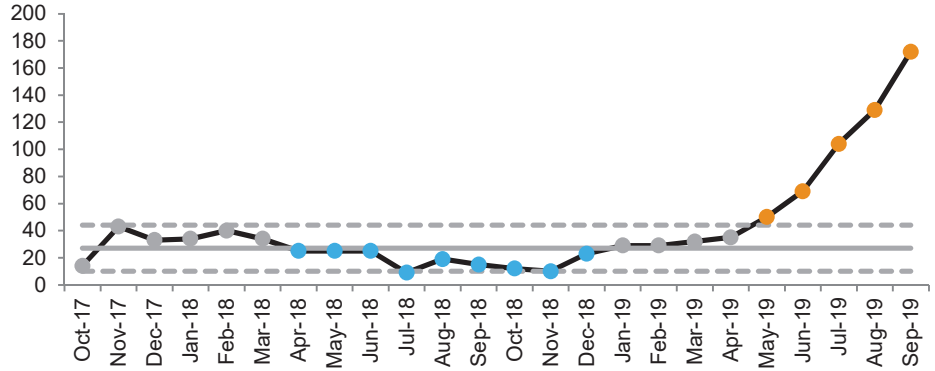


The total ongoing RTT pathways is showing normal variation in total numbers ongoing at the end of the month, following the inclusion of additional patients from the MSK service, from February 2019.

The target has been revised for 2019/20 to reduce the total to less than 29,619 by end of March 2020.

The rebased trend shows a likelihood that this reduction will not be acheived, based on current performance.

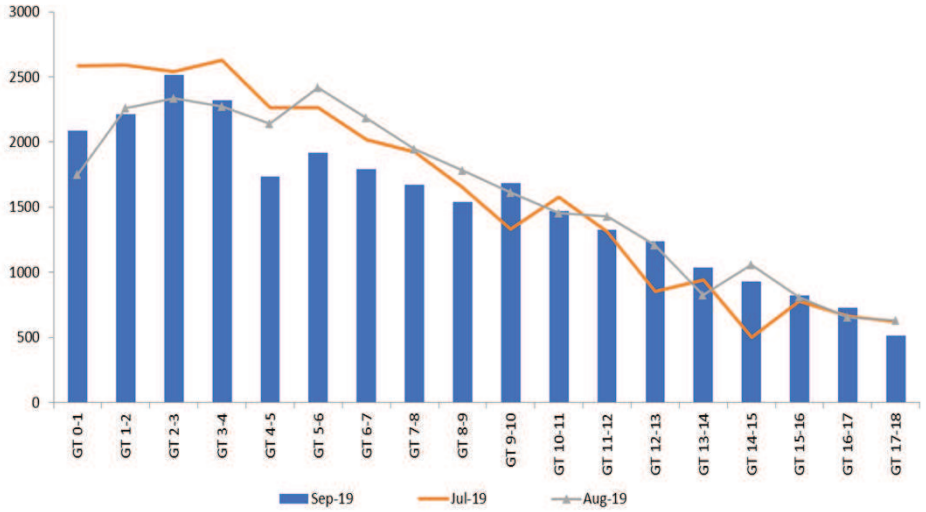
RTT Total Over 40 wks



The number of pathways over 40wks has increased significantly in September with 172 patients waiting over 40 wks at month end.

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

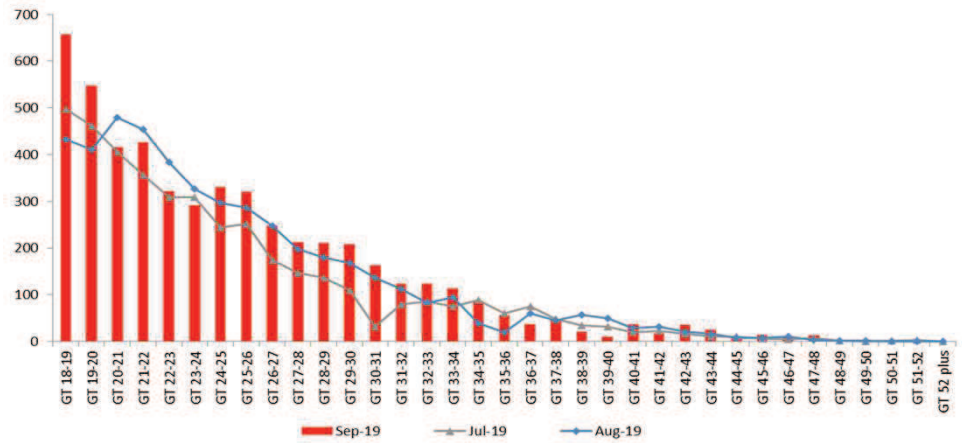
RTT Ongoing 0-18 Weeks



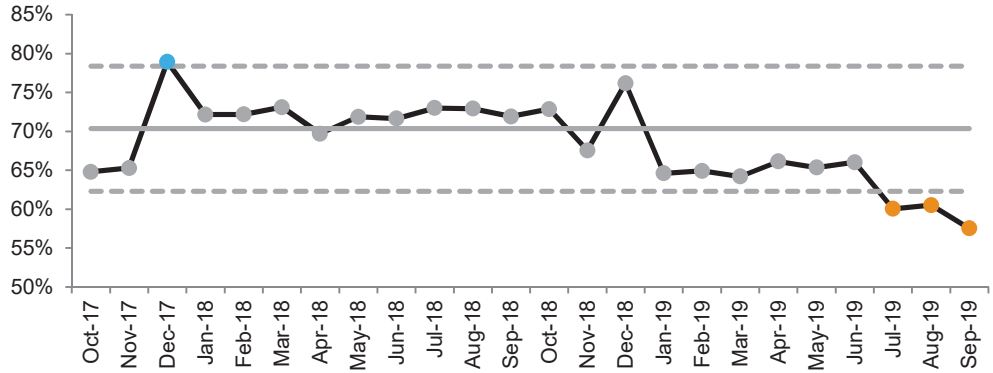
The bar charts show the numbers of RTT ongoing pathways by weekband, compared with previous 2 months.

RESPONSIVE

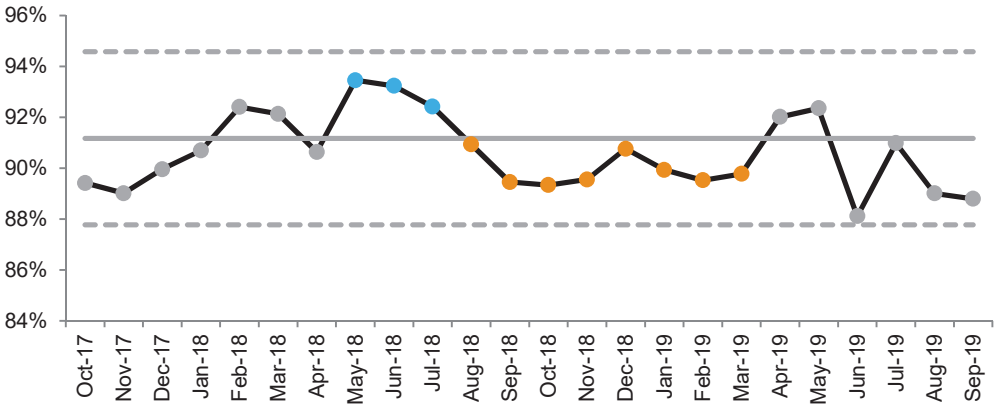
RTT Over 18 weeks



RTT Admitted



RTT Non-Admitted

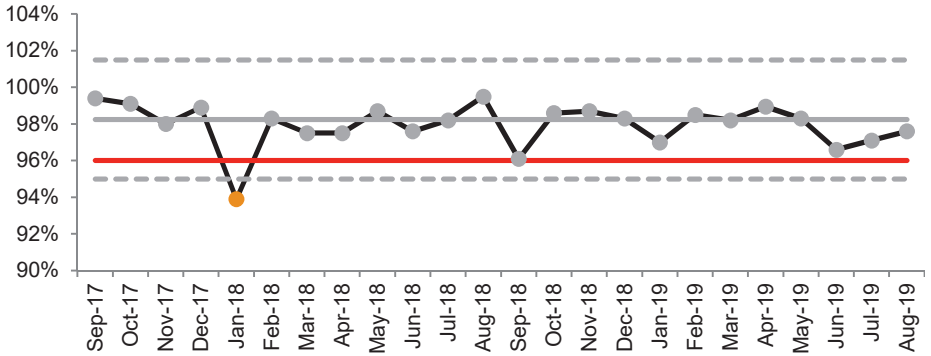


Although no longer a national target, the proportion of admitted and non-admitted patients is included for information.

The trend for RTT admitted is now showing significant deterioration, whilst the non-admitted trend is showing normal variation.

RESPONSIVE

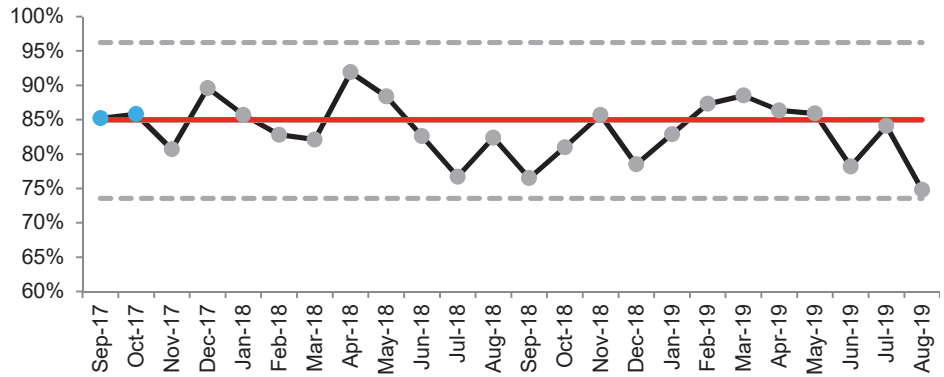
Cancer 31 day



The 31 day standard was achieved in August at 97.6%, above the 96% threshold.

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

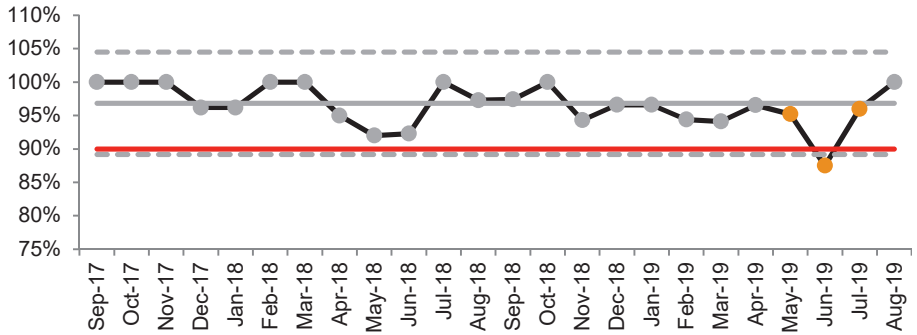
Cancer 62 Day



The 62 day cancer standard was not achieved in August at 74.8% below the 85% threshold.

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

Cancer 62 Day Screening

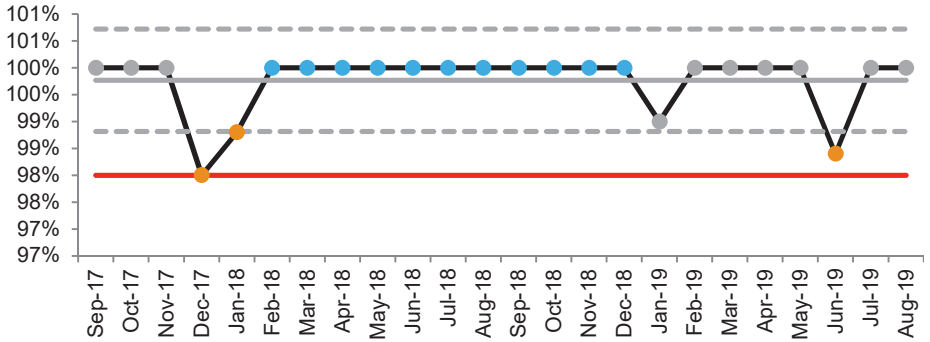


The 62 day screening standard was achieved in August at 100%, above the 90% threshold.

The trend has returned to normal variation following a period of deterioration in performance and based on current variation may occasionally fall below standard.

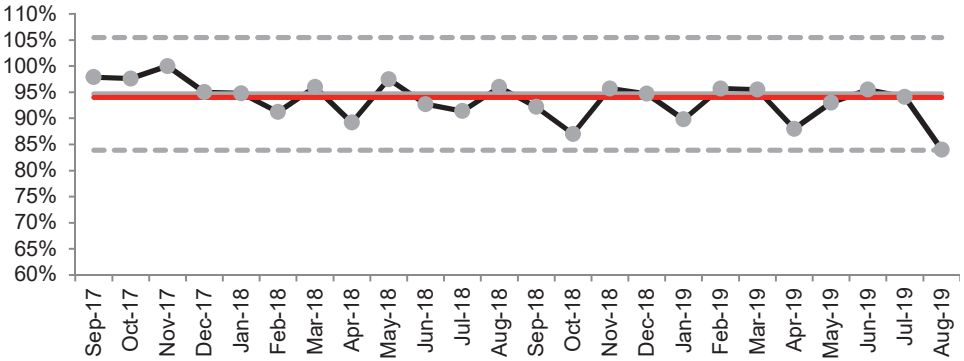
RESPONSIVE

Cancer - Subsequent treatment within



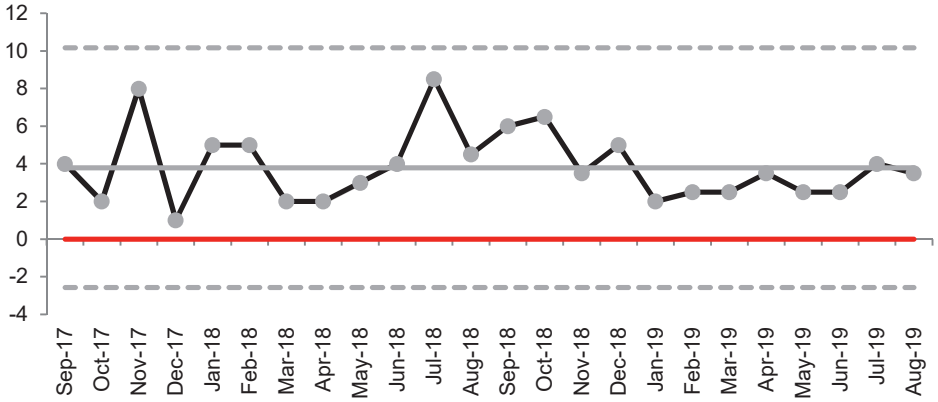
The subsequent treatment - drug standard was met in August at 100.0%. The trend shows normal variation, following a significant drop in June, however based on the current variation, the indicator will consistently achieve the standard.

Cancer - Subsequent treatment within 31 days (Surgery)



The subsequent treatment - surgery standard was not met in August at 84.0%, below the 94% standard. The trend shows no significant change and based on the current variation, the indicator is at risk of falling below threshold.

Cancer Patients Treated > Day 104

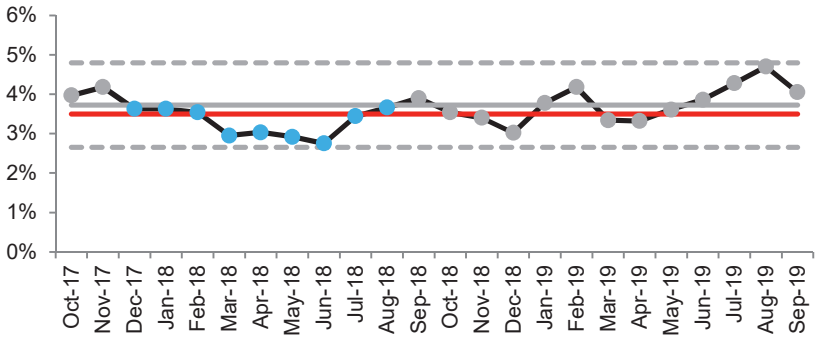


There were 3.5 breaches allocated to the Trust, treated after day 104 in August and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the Consultants involved in the pathway as required.

The trend is showing no significant change.

RESPONSIVE

Delayed Discharges per 1000 bed days

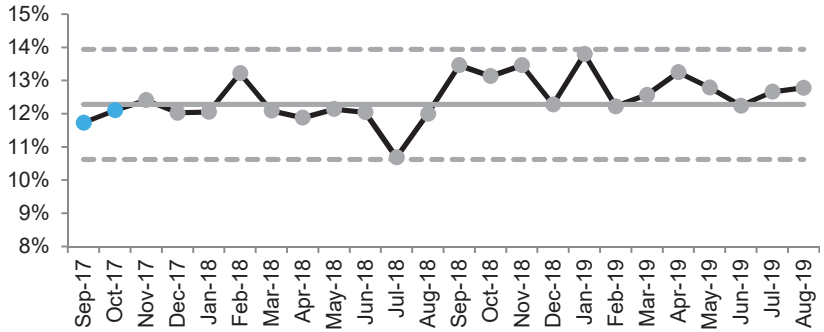


The proportion of delays reported against the delayed transfers of care standard was 4.1% for September, above the 3.5% threshold.

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

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

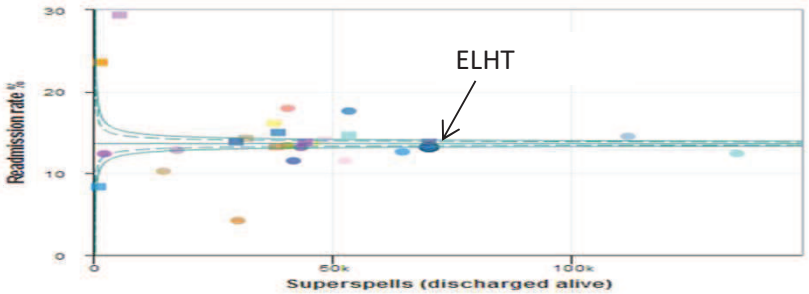
Emergency Readmissions



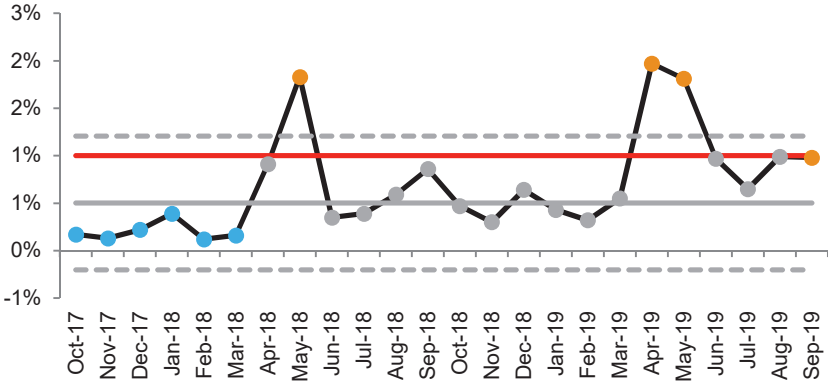
The emergency readmission rate trend is showing no significant change.

Dr Foster benchmarking shows the ELHT readmission rate is

Readmissions within 30 days vs North West - Dr Foster



Diagnostic Waits



In September 0.98% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is below the 1% threshold.

The trend is showing a deterioration in performance and based on current variation this indicator is at risk of failing the target.

Nationally, the performance is still failing the 1% target at 4.3% in August (reported 1 month behind).

RESPONSIVE

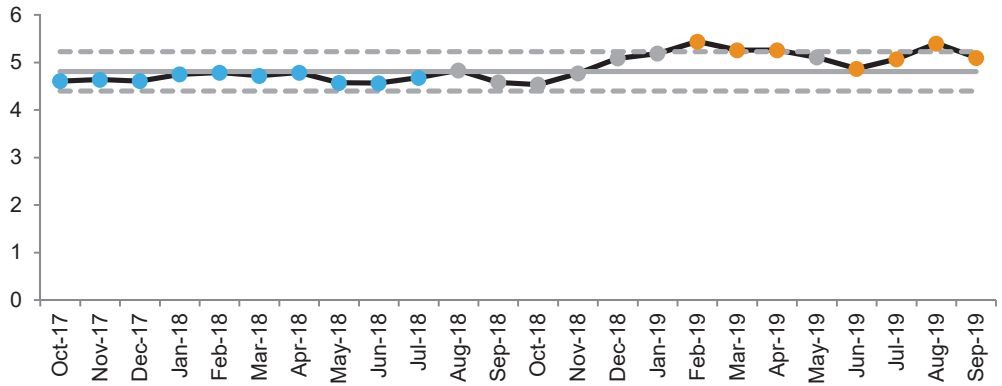
Average length of stay benchmarking

Dr Foster Benchmarking June 18 - May 19

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	62,307	9,385	52,922	3.5	2.7	-0.8
Emergency	59,511	59,511	0	4.5	4.4	-0.1
Maternity/ Birth	13,436	13,436	0	2.1	2.4	0.3
Transfer	199	199	0	11.3	27.1	15.8

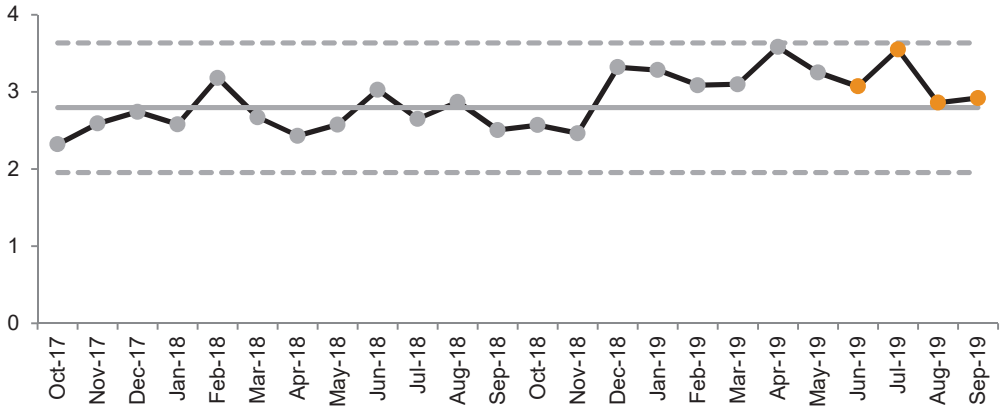
Dr Foster benchmarking shows the Trust length of stay to be below expected for non-elective and elective when compared to national case mix adjusted.

Average length of stay - non elective



The Trust non elective average length of stay is now showing a statistically significant increase, with the last 9 months being above the average of 4.8 days.

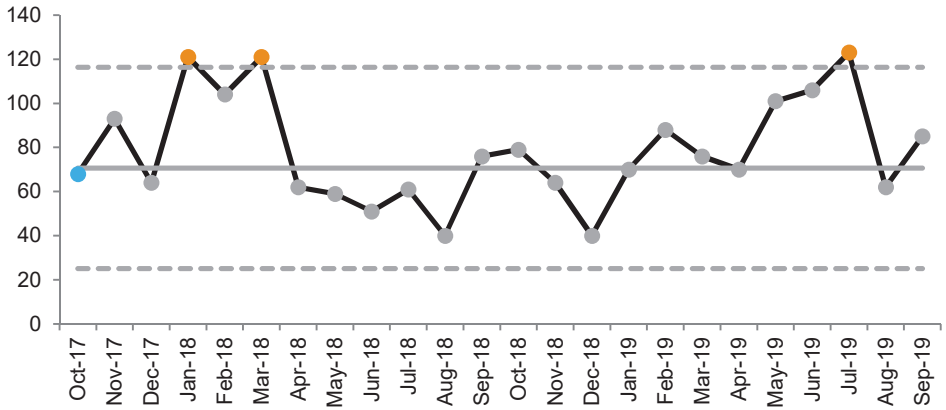
Average length of stay - elective



The Trust elective average length of stay is now showing a significant increase, with the last 9 months above the average of 2.8 days.

RESPONSIVE

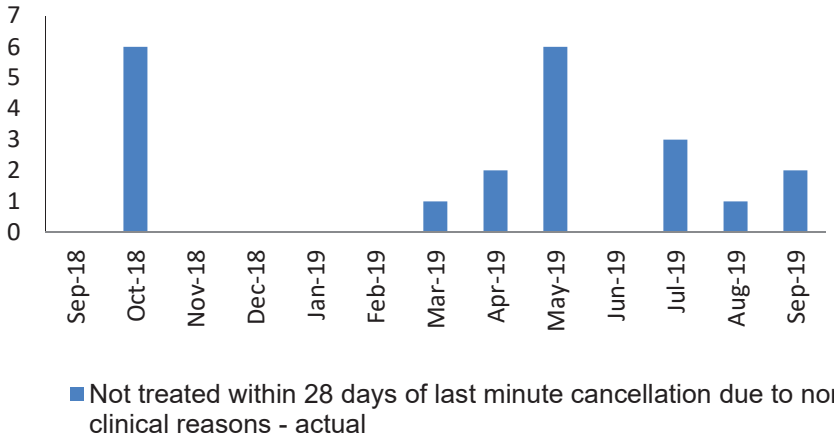
Operations cancelled on day



There were 85 operations cancelled on the day of operation - non clinical reasons, in September.

The trend has returned to normal levels following a spike in July.

Operations cancelled on day - breaches of 28 day standard

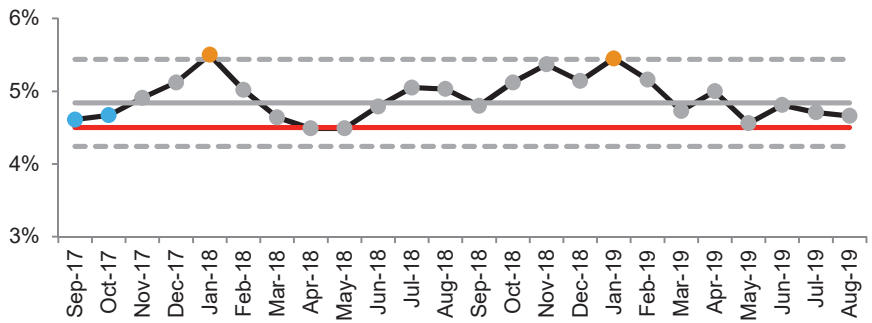


There were 2 'on the day' cancelled operations not rebooked within 28 days in September.

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.

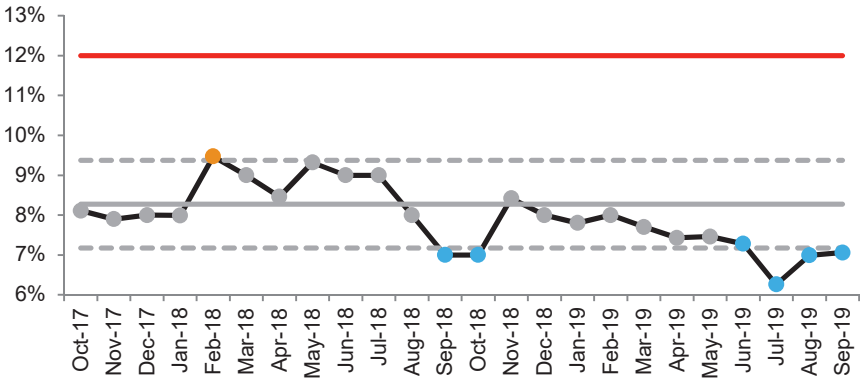
WELL LED

Sickness



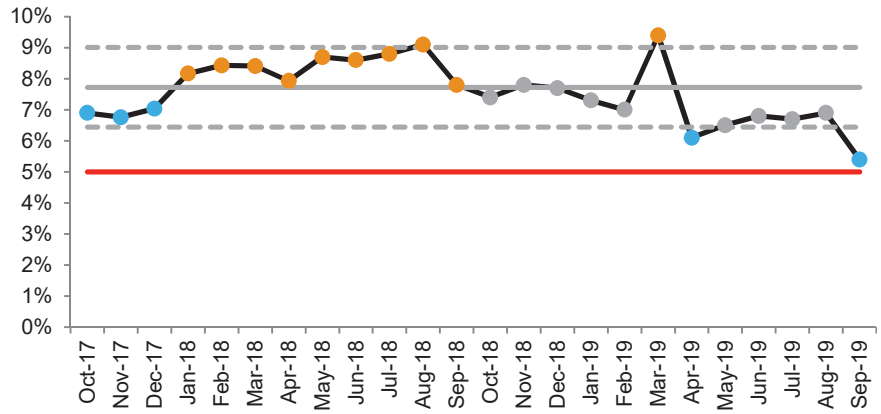
The sickness absence rate is 4.7% for August which is above threshold. The trend is showing normal variation and based on the current level of variaton, may occasionally acheive the target.

Turnover Rate



The trust turnover rate continues to show a significant reduction at 7.1% in September which is below threshold. Based on current variation, the indicator will consistently be below the threshold.

Vacancy Rate



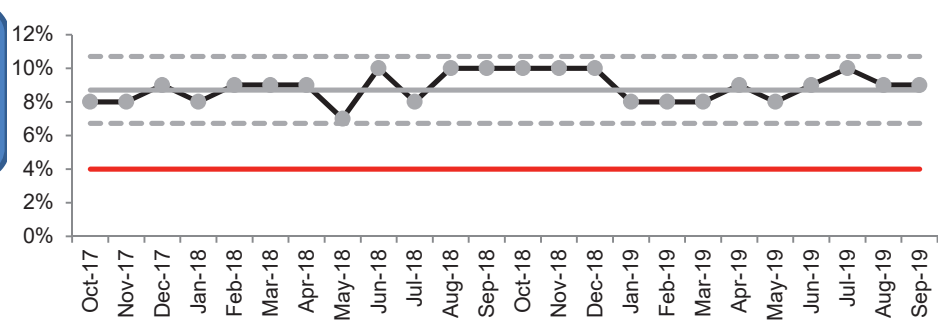
The vacancy rate is 5.4% for September which is above the 5% threshold.

The trend is showing a significant reduction, however based on current variation, will consistently be above threshold.

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

WELL LED

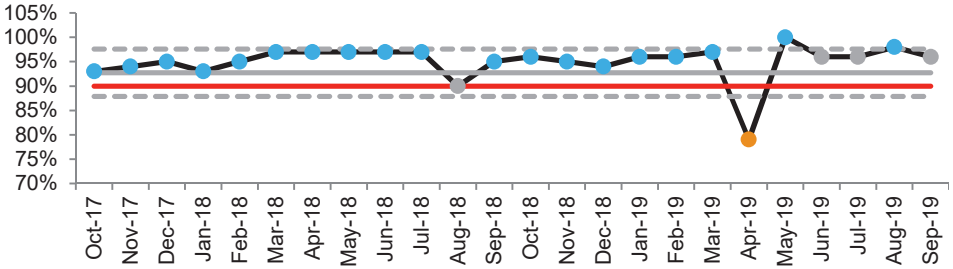
Temporary costs and overtime as % total pay bill



In September 2019, £2.9 million was spent on temporary staff, consisting of £1.2 million on agency staff and £1.7 million on bank staff. Wte staff worked (8,396 wte) was 33 wte more than is funded substantively (8,363 wte). Pay costs are £1.8 million more than budgeted establishment in September

At the end of September 19 there were 440 vacancies

Appraisals, Consultant

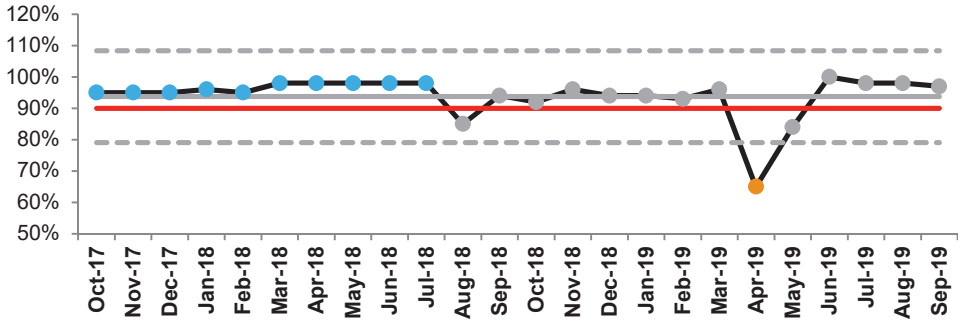


The temporary staffing cost trend shows no significant change and is not capable of hitting the target.

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

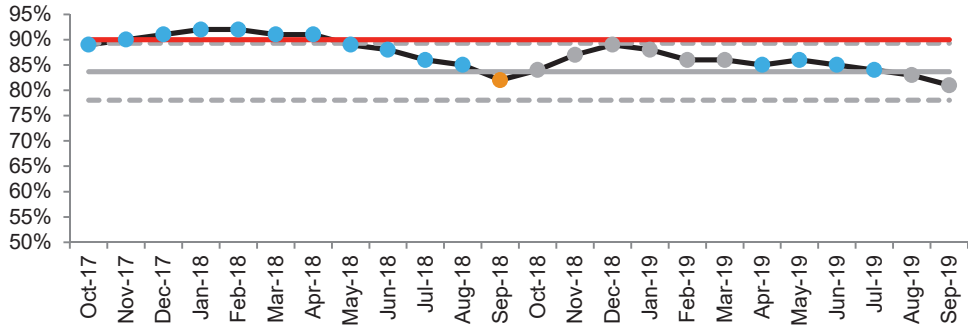
The trend for consultant appraisals is showing normal variation and based on current variation is still at risk of not achieving the target.

Appraisals, Other Medical



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

Appraisals AFC



The AFC appraisal rate continues to be reported as a rolling 12 month figure and remains below threshold.

The trend is showing normal variation and based on current variation the indicator is not capable of achieving the target

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

WELL LED

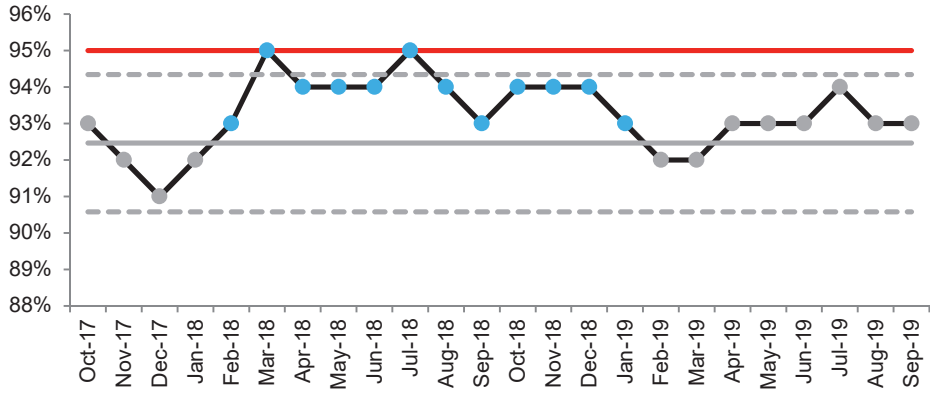
Job Plans

Stage	Consultant	SAS Doctor
Draft	0	0
In discussion with 1st stage manager	185	27
1st stage sign off by consultant	23	0
1st stage sign off by manager	36	1
2nd stage sign off	18	0
Signed Off	45	0

There are 307 Consultants and 28 SAS doctors registered with a job plan on Allocate.

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

Information Governance Toolkit Compliance



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

Core Skills Training % Compliance

	Target	Compliance at end September
Basic Life Support	90%	92%
Conflict Resolution Training Level 1	90%	98%
Equality, Diversity and Human Rights	90%	97%
Fire Safety	90%	94%
Health, Safety and Welfare Level 1	90%	95%
Infection Prevention	90%	94%
Information Governance	95%	93%
Prevent Healthwrap	90%	96%
Safeguarding Adults	90%	94%
Safeguarding Children	90%	96%
Safer Handling Theory	90%	97%

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

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

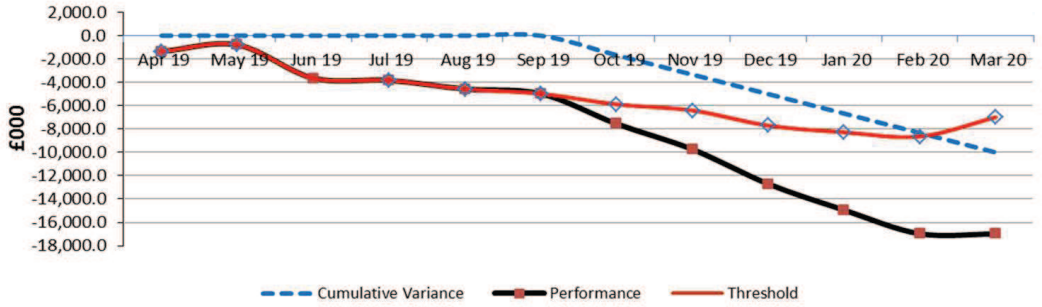
Divisional actions plans to address non-compliance are in place and are being monitored through divisional meetings. Furthermore, a range of Trust-wide measures to support staff to be fully compliant are in place. These include facilitated e-Learning sessions, bespoke training for wards and departments, 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	1.4	3	1.2	4
	Liquidity (days)	(5.6)	2	(7.4)	3
Financial efficiency	I&E margin	0.2%	2	(0.6%)	3
Financial control	Variance from control total rating	0.0%	1	(1.9%)	3
	Agency spend	37.9%	3	34.0%	3
Total			2		3

Adjusted financial performance (deficit)



* - excludes PSF allocation and MRET funding

At month 6 the Trust is reporting an underlying £4.9 million deficit in line with the financial plan; and a £0.5 million surplus, after receipt of the 2019-20 non-recurrent Provider Sustainability Funding (PSF) and Marginal Rate Emergency Tariff funding (MRET).

The Trust accepted the 2019-20 Control Total to deliver a £7.0 million underlying deficit giving access to £9.2 million non-recurrent PSF. In addition the Trust is receiving a Marginal Rate Emergency Tariff (MRET) allocation of £4.4 million which is unconditional and will enable the Trust to report a £6.7 million surplus assuming the control total is achieved.

The Safely Releasing Cost Programme (SRCP) is £16.4 million; £3.9 million has been actioned year to date, of which £2.3 million (58%) is recurrent and £3.0 million is cash releasing. Of the full year £6.9 million (42%) actioned, £4.3 million is recurrent and £6.0 million cash releasing.

The forecast outturn as at 31st March 2020 is demonstrating a current gap of £10.0 million, assuming the £16.4 million SRCP target will be fully achieved on a cash releasing basis. Mitigations have been discussed that would aim to address this gap.

As a result, the year end Finance and use of resources (UoR) metrics score of 3 is below the planned rating of 2, although the year to date position remains is in line with the planned score of 2.

The Better Payment Practice Code (BPPC) targets continue to be achieved year to date.

The cash balance at 30th September 2019 of £12.0 million represents a reduction of £1.5 million in month.

Efficiency Savings

Division	Green £000s	Amber £000s	Red £000s	Non Rec £000s	Rec £000s	Total £000s	Target £000s	Gap £000s
Medicine & Emergency Care	1,179	150	0	0	1,329	**1,329**	1,932	(603)
Community & Intermediate Care	84	0	0	84	0	**84**	1,043	(959)
SAS	649	179	2,053	382	2,498	**2,880**	4,844	(1,964)
Family Care	647	498	254	962	437	**1,399**	3,040	(1,641)
DCS	1,113	0	0	0	1,113	**1,113**	1,113	0
Estates & Facilities	626	136	300	415	647	**1,062**	1,356	(294)
Corporate Services	251	18	419	0	688	**688**	672	16
Cross divisional	0	2,612	0	0	2,612	**2,612**	0	2,612
Targeted Transformation	2,320	0	1,010	2,357	973	**3,330**	2,433	897
Total	**6,869**	**3,593**	**4,036**	**4,200**	**10,297**	**14,497**	**16,433**	**(1,936)**

Green Schemes		
Annual Non Rec	Annual Rec	Annual Identified
0	1,179	**1,179**
84	0	**84**
106	543	**649**
563	84	**647**
0	1,113	**1,113**
415	211	**626**
0	251	**251**
0	0	**0**
1,357	963	**2,320**
2,525	**4,344**	**6,869**

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

13 November 2019

Item 148

Purpose Information

Title	Emergency Preparedness and Resilience Statement Update
Author	Mrs A Whitehead, EPRR Manager Mr T McDonald, Director of Operations
Executive sponsor	Mr M Hodgson, Executive Director of Service Improvement

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 *substantially 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

Impact

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

To be considered by:

Emergency Preparedness and Organisational Resilience Committee (October 2019).

Executive Summary

1. 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.
2. The EPRR Core Standards Assurance Process for 2019/20 demonstrates a level of **Substantial Compliance**, which this Board is asked to ratify (Appendix A).
3. Although the Trust declared full compliance in 2018 / 2019, some gaps have been identified in relation to the Trusts decontamination systems and processes. As such, the Trust is declaring that 5 of the standards are amber (partially complaint with an action plan to achieve them in 12 months). These are addressed in the EPRR work plan (Appendix B).

Trust activity in EPRR over the previous 12 months

4. The Emergency Preparedness and Organisational Resilience Committee (EPORC) now convenes once a month rather than every two months. This will support the achievement of the EPRR action plan ensuring that the Trust will become fully complaint for 2019/20.
5. During 2018/19, all wards and departments reviewed their departmental business continuity plans. These were converted into the standard Trust template as developed by the EPRR Manager and in line with recommended best practice standards. These plans provide assurance that wards and departments are able to respond effectively to a variety of potential risks including:
   a) Loss of staff
   b) Loss of premises / equipment
   c) Surges in activity
   d) Fuel shortage
   e) Loss of IT systems
   f) Loss of communications (phone / bleep)
   g) Supply chain failure.
6. An outstanding 93% of Clinical Divisions and Corporate Directorates have now written a suite of comprehensive of business continuity plans that will provide the Trust with more robust and resilient services. The remaining plans are under review and will be submitted in September.
7. The Trust's overarching corporate business continuity plan was re-written in February 2019 and all of its services have been given a priority rating based on business impact analysis and the maximum period of tolerable downtime.

8. A Disruption to Road Fuel Supply Plan has been written based on the National Emergency Fuel Plan. This Plan outlines the various national schemes that may be implemented during a disruption to fuel supply, and also outlines the Trusts response in relation to maintaining business as usual as far as is possible.
9. The Switchboard Manager and her team continue to undertake the six monthly communications test named Exercise Starlight. These test the response rates of key individuals who would be notified in the event of a major incident and are undertaken at different times of the day and week, 24/7. 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.
10. The EPRR Manager has facilitated several Loggist training sessions to ensure that in the event of a major incident, the Incident Commander has access to a dedicated, trained Loggist, a critical role needed to capture decision making and action allocation.

Supporting Evidence

11. An overview of the evidence to support this year's Core Standards Assurance Process can be found in Appendix C.
12. An overview of the 'Deep Dive' standards (Severe Weather and Long Term Adaptation Planning) and supporting evidence can be found at Appendix D. Work is ongoing in relation to the partially compliant non-mandatory standards 16, 18 and 19 (around long term adaptation planning).

Conclusion

13. The Trust has achieved substantial compliance with the EPRR core standards.
14. Through training, exercising and live incidents, 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, critical or business continuity incident (including Senior Managers, Directors / Assistant Directors, Clinicians and Loggists).

Recommendations

15. The Board is asked to approve the EPRR Statement of Compliance 2019 / 2020 for signature by the Accountable Emergency Officer.
16. The Board is asked to approve this assurance report and action plan which will be submitted to the lead commissioning CCG as per the NHS assurance process.

Appendices:

		Page
Appendix A	Emergency Preparedness, Resilience and Response (EPRR) Assurance Statement of Compliance 2019 - 2020.	5
Appendix B	Annual EPRR Work Plan for the Trust in 2019 / 2020.	EPRR Appendix B.docx
Appendix C	EPRR Core Standards Assurance Compliance Evidence.	EPRR Appendix C.docx
Appendix D	Deep Dive Return – Severe Weather Response / Long Term Adaptation Planning	EPRR Appendix D.docx

Appendix A – Statement of Compliance 2019 - 2020

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2019-20

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 2019-20 standards: **Substantial**

Compliance Level	Criteria
Full	The organisation is **100%** compliant with all core standards they are expected to achieve.
Substantial	The organisation is **89-99%** compliant with the core standards they are expected to achieve.
Partial	The organisation is **77-88%** compliant with the core standards they are expected to achieve.
Non-compliant	The organisation is complaint with **76%** or less of the core standards the organisation is expected to achieve.

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	5	59
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 seperately.*

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.

Martin A. Halpin
Signed by the organisation's Accountable Emergency Officer

11/9/19
Date of board / governing body meeting

16/9/19
Date signed

Statement of Compliance Version 1 09/07/19

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East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 149

13 November 2019

Purpose Information
Action

Title	Flu Vaccination Programme 2019/20
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 2019/20 campaign aimed at exceeding last year's achievement of **93.6%.**

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	Recruitment and workforce planning fail to deliver the Trust objectives

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: NA

(149) Flu Vaccination Programme 2019/20

Executive summary

1. On the 17th September 2019 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 2019. This paper details East Lancashire Hospitals NHS Trust's (ELHT) plan for the 2019/20 Flu season.
3. The Annual Flu Letter can be viewed by double clicking the word icon below:

East Lancashire Hospitals NHS Trust F

Introduction

4. ELHTs 2019/2020 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 2019 can be viewed by double clicking the word icon below:

Seasonal Flu Plan - 2019.pdf

6. During the 2018/19 Flu season the uptake of the Flu vaccine in healthcare workers nationally was 70.3%. Within ELHT the uptake was 93.6% during the 2018/19 season. This represents the *second highest* uptake nationally for vaccination of frontline healthcare workers (HCW).

Our key activities for the 2019/20 campaign

7. The 2019/20 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. The following summary of *Appendix 1 – Healthcare worker flu vaccination*

best practice management checklist - for public assurance via Trust Boards by December 2019 has been provided below:

a) Committed Leadership:

i. The Quadrivalent (QIV) vaccine has been provided for healthcare workers.

ii. 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.

iii. The Trust Board received an evaluation of 2018/19 campaign on the 13th March 2019.

Executive Summary
Report to outline the

iv. Flu planning has been cascaded through the Health & Safety Committee and through the Infection Control Committee and the Emergency Preparedness and Organisational Resilience Committee.

b) Communications Plans:

i. 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.

ii. Corporate induction continues to be visited to offer vaccinations.

iii. 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.

iv. Weekly feedback on percentage has been provided.

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

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

c) Flexible Accessibility:

i. Peer Vaccinators in the Family Care setting are being utilised.

ii. 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.

d) Incentives:

i. Success has been celebrated weekly through the CEO Blog.

Recommendations

8. It is recommended that the board note the actions in place for the 2019/20 Flu campaign and continue to support the implementation of the plan across the organisation.

9. A further report summarising the outcome of the 2019/20 Flu campaign is scheduled for the March 2020 Trust board meeting.

Conclusion

10. All necessary measures are being taken to ensure the 2019/20 campaign exceeds last year's achievement of 93.6%. The current uptake for Flu vaccination is **37.8%**

Next steps

11. Further report to be provided at the March 2020 Trust board meeting.

Phil Denney, Head of Occupational Health & Wellbeing

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 150

13 November 2019

Purpose Information Assurance

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

Summary: The report sets out the matters discussed and decisions made at the Audit Committee meetings held on 7 October 2019.

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 Partnership (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

Previously Considered by: NA

Audit Committee Update

At the meeting of the Audit Committee held on 7 October 2019 members considered the following matters:

1. The internal audit reports listed below were presented to the Committee:
   a) Risk Management Follow-Up - Substantial Assurance
   b) Agency Locums (Funding Controls) – Substantial Assurance
   c) Cyber Essentials: Gap Analysis Progress Update – Significant Progress
2. The Committee received the management response to the recent Legal Services (Claims) audit. Members noted that a number of actions had been undertaken to address the recommendations set out in the audit report, including increasing the capacity of the team; mapping of processes between internal quality and safety teams to ensure appropriate triangulation and sharing of information; and evaluating the current risks within legal services and include them on the relevant risk registers.
3. In relation to the update on Policy Management, members noted that the responsibility for policy management had been realigned to the new Risk Manager's portfolio and a dedicated member of staff would be recruited in the coming months and a further.
4. The Committee members received the progress report from external auditors and noted that work was being planned for the 2019/20 audit of the Trust's accounts and work had almost been concluded on the independent examination of the Trust's Charitable Funds financial accounts for the 2018/19 financial year. Members sought clarification around the revised costing proposal for the 2019/20 audit work and it was agreed that this matter would be discussed further outside the meeting and an explanation provided to members prior to the next scheduled meeting.
5. Members received the Anti-Fraud Service Progress Report and noted the progress being made in relation to referrals and investigations. The Committee members noted the launch of the NHS Counter Fraud Authority phases one and two national exercise relating to prevention of procurement fraud. In addition the Committee were made aware of two recent fraud alerts regarding ESR and pension related phishing scams.
6. The Committee members received the proposed revised standing orders and spent some time discussing the proposed changes. It was agreed that pending some further clarifications and potential revisions to the document they would be presented

to the Trust Board, along with the revised Standing Financial Instructions in January 2020 for approval.

7. Committee members also received an update on Policy Management, the Risk Management Audit Closing Report, and an update on the ICG Governance review that had recently taken place.

8. In addition the Committee received the minutes from the following Trust Committee's:
   a) Information Governance Steering Group
   b) Finance and Performance Committee
   c) Quality Committee

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 5 November 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 151

13 November 2019

Purpose Information Assurance

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

Summary: The report sets out the matters discussed and decisions made at the Finance and Performance Committee meeting held on 30 September 2019.

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do 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 30 September 2019 members considered the following matters:

1. The Committee received the Integrated Performance Report in its revised format, including an overview of the current financial position to the end of August 2019. Committee members sought clarification as to whether there was any correlation between the lower than average staffing rates for midwives and the number of stillbirths reported in the month. It was confirmed that whilst there was a need to report the number of stillbirths as it was over the statistical threshold all of the occurrences in the month had been expected/unavoidable and were not as a result of poor care or staff shortages. Members noted there had been a total of 137 two week wait breaches in the reporting month; however 99 of these had been as a result of patient choice. It was confirmed that work was taking place across the Pennine Lancashire Integrated Care Partnership (ICP), particularly with colleagues in primary care to address anxiety about coming into hospital and to impress upon patients the importance of undergoing diagnostic testing in a timely manner. Members noted that the ongoing issues relating to pension taxation changes continued to negatively affect the compliance with RTT and cancer standards. It was confirm that the Trust was experiencing increasing difficulty in managing holding lists within some areas, specifically Maxillo Facial services. Non-Executive Director members were keen to understand the extent to which the Trust communicates and engages with patients on holding lists to update them on their estimated wait times. It was confirmed that although patients could possibly be kept more informed, there were financial considerations to be made concerning written communication with patients and other methods of communication could be considered. It was agreed that further information would be included in future versions of the report which would allow the Committee to compare performance across the ICS's emergency departments. Members noted that the main constraints to achieving the required ED position related to workforce, estate and patient flow through the pathway.
2. The members received the financial performance report for the month of August 2019 and noted that the underlying financial position at the end of the reporting period was a deficit of £4,600,000, which was in line with the financial plan prior to the non-recurrent Provider and Sustainability Funding (PSF) and Marginal Rate Emergency Tariff funding (MRET). The income position at the end of the month was

below the planned position of £923,000. Members noted the higher than planned expenditure figures and that the majority of these costs related to continued use of bank and agency staff. Pay related expenditure was noted to have increased within the reporting month due to the costs associated with temporary staffing to cover the volume of staff taking annual leave. Members noted that the capital plan remained pressured due to matters beyond the control of the Trust, and as such, there had been a number of bids for capital that had been rejected. Members noted that the associated delay in implementing an electronic patient record (EPR) system was concerning, although it was already included on the corporate risk register. Members were reminded of the various financial controls that had been implemented recently to improve the overall financial position as agreed at the last meeting of the Trust Board (Closed Session).

3. An update was provided regarding the requirements of the Integrated Care System (ICS) in relation to the five year plan, including the requirement for a system narrative plan and a system delivery plan. Members noted that a series of templates had been developed for the submission to the ICS for aggregation into an overarching plan, which included financial recovery plans, plans for alignment across systems and performance plans. An overview of the ICP plan for delivery of transformation was provided which includes prevention, integrated community care, mental health and wellbeing, scheduled care and urgent and emergency care. The Committee received an overview of the ICS financial position and confirmed that the total financial deficit position at the end of the 2019/20 financial year had been set at £100,000,000, with current performance bringing the ICS as a whole £85,000,000 away from achievement of the required financial position. Members expressed their concerns about the possible need for Trusts to over perform financially in order to bolster the overall financial position of the ICS at the end of the year. The Committee were informed of the revision of financial plans to achieve the required financial position.

4. The Committee received the workforce report and noted the areas of challenge for the Trust in relation to workforce continued to be sickness absence; vacancies and recruitment; temporary staffing usage/spend; and workforce profile. The areas of challenge were noted to be managed through the monthly Divisional Management Board (DMB) meetings which HR Business Partners attend. Committee members noted that staff sickness was 4.66% for August 2019 and according to the latest benchmarking figures for the North West (April 2019) the Trust had a sickness

absence rate below the regional average. Members discussed the main reasons for staff taking time off work due to sickness (MSK and mental health related issues) and noted that a new service was being implemented which would help to improve access to services for staff suffering with either issue. Non-Executive Director members of the Committee noted that the Trust had recently undertaken a review of the staff sickness absence policy and, as part of the work, had benchmarked similar policies across the ICS area. Despite the reduction in vacancies in the month there remain a number of areas of concern, primarily Surgery, Diagnostic and Clinical Services and the Emergency Department. Members noted that work was being undertaken at local and Trust levels to address these pressures.

5. The Committee members received a presentation in relation to the work undertaken by the Trust's Education Directorate, the funding received by the Trust for education, the sources of the funding and the impact on the Trust. Members noted that the majority of funding into the Trust for education and library services is received from UCLan/independent medical school, Health Education England, local colleges, and the apprenticeship levy with the total income for education being approximately £2,884,826. Non-Executive Members asked for, and received, an overview of the Training Needs Analysis tool that is used internally to determine training and development needs for individuals prior to applications for funding being submitted. In addition, the Committee spent some time discussing the policies and processes relating to education and training within the Trust. It was agreed that the Deputy Medical Director responsible for education and workforce would provide a report detailing the requirements of the Trust in terms of the future education/training needs of the workforce to the Committee in March 2020. The report would also need to take into consideration the funding available and how to make best use of it.

6. The Committee members received a report relating to the leases of occupancy on ELHT premises. It was confirmed that the Trust was working with third party organisations to gain an understanding of any outstanding issues on leases across the Trust sites. Members briefly discussed the signing of leases across community premises and it was noted that, should the Trust need to undertake any alterations/variations to the premises it would be difficult to action as they were not part of the leases. Therefore, it was agreed that the matter would be progressed outside the meeting and an update provided to the next meeting of the Committee.

7. The Committee also received an update on tenders; and the minutes of the Contract and Data Quality meeting for information.

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 2 November 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 152

13 November 2019

Purpose Information

Title	Quality Committee Update Report
Author	Miss K Ingham, Corporate Governance Manager/Assistant Company Secretary
Executive sponsor	Ms N Malik, Committee Chair

Summary: The report sets out the summary of the papers considered and discussions held at its meeting on 4 September 2019. 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 that same meeting.

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	Transformation and improvement 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 Partnership (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

Quality Committee Update

At the meeting of the Quality Committee held on 4 September 2019 members considered the following matters:

1. The Committee received an update on patient safety matters and noted that there had been an increase in the numbers of assaults on staff by patients/visitors over recent months, with several staff members coming to harm. The Committee members were advised that a dedicated task and finish group, involving estates and facilities and security colleagues, had been formed to tackle the problem. The group had developed eight key actions, progress against which would be monitored at future meetings. Members discussed the development of a wider 'zero tolerance' policy and expressed their concerns that the policy would be difficult to enforce given the range of physical and mental health conditions that could complicate matters. In response to a question raised, the Non-Executive Director members received clarification that the main causes of assaults were either criminal behaviour or complications arising from mental health issues. Members went on to discuss the security provision for the Trust was it was noted that this particular function was part of the larger Private Finance Initiative (PFI) contract and that it was currently being reviewed to determine whether improvements could be made to scheduling and the time taken to respond to incidents as part of the current contract. Members of the Committee requested further sources of assurance regarding the progression of actions to address the issue raised. Following further reassurance being provided, it was noted that, at this stage, it was too early to say whether or not the actions that had been implemented were working. It was agreed that a further update be provided at the next meeting.
2. The Committee received the Maternity Services Floor to Board Report and noted that there continued to be significant midwifery staffing challenges due to high levels of sickness and maternity leave, but were assured that these issues were being actively managed and staff redeployed as appropriate in order to ensure patient safety and positive patient experiences. The Committee noted that the revised version of 'Saving Babies' Lives' was due to be rolled out following the success of the original scheme and would incorporate an additional element to reduce pre-term births from 8% to 6%. A gap analysis was being done to in order to develop an action plan for this and pledged to share it at a future meeting once it had been completed. The Committee raised concerns regarding the number of stillbirths recorded in August

2019 and were advised that all but one of these cases had been reviewed and it had been determined there had been no gaps in care provided by the Trust that had contributed to any of the outcomes. Committee members were informed that the Trust had achieved compliance with all 10 standards on year 2 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme. The Committee asked that their concerns regarding the timeliness and conduct of the Healthcare Safety Investigation Branch (HSIB) team when carrying out Perinatal Mortality Review Tool (PMRT) investigations to be escalated to the Board.

3. The Committee received the Serious Investigations Requiring Investigation (SIRI) report and noted the incidents that had been reported through the Strategic Executive Information System (StEIS), with the top three incident categories were pressure ulcers, falls and diagnosis failures. The Committee were advised that a thematic analysis had been commissioned around diagnosis failures. This analysis had identified small clusters of similar incidents occurring in specific areas and Dr Stanley confirmed a range of actions were being taken to improve the situation.
4. The Committee received the Annual Report from the Director of Infection Prevention and Control (DIPC). A detailed review of the paper is included in a separate section below for the Board's attention. A link to the full report can be found here.
5. In addition the Committee received the annual Doctors Revalidation Report for review prior to presentation to the Trust Board in September 2019 for formal approval and submission. This was completed at the last Trust Board meeting and the report has since been submitted to the regulator.
6. The Committee received the Learning Disability Mortality Review Report and were informed that the Trust ensured that comprehensive reviews were carried out for any patient registered with a learning disability who passed away whilst in its care. Clarification was provided that the reviews were carried out by a team consisting of a specialist with knowledge of learning disabilities and two others specialising in nursing and medical care. The Committee noted that the reviews would continue and confirmed that they were satisfied with the assurance provided by the process and the level of oversight provided by the Mortality Steering Group.
7. The Committee received a detailed update on holding lists and noted that regular monitoring of the lists took place across the Trust, including within the Directorates, Divisions, the monthly Operational Delivery Board and two weekly via the Operational Executive Briefing sessions. Members spent some time discussing the

levels of assurance gained around this issue and it was noted that greater assurance would realistically only be possible once an Electronic Patient Record (EPR) system was in place. It was agreed that a request would be made to the Board to discuss the progress of the procurement of an EPR system.

8. The Committee received the Committee specific elements of the Board Assurance Framework. The members had a detailed discussion about the proposal to decrease the risk score of BAF risk 1 (transformation schemes) from 20 to 16 based on a decreased likelihood score of 4 (likelihood 4 x consequence 4). The rationale for the decrease in scoring was noted to be related to the implementation of a number of additional controls.

9. The Committee received an update on CQC compliance, a review of the winter plan for 2018/19; an update on the Nurse Revalidation process; the Quality Dashboard; Corporate Risk Register; and Summary Reports from the following Sub-Committee Meetings:

   a) Patient Safety and Risk Assurance Committee (July 2019)
   b) Infection Prevention and Control Committee (June and July 2019)
   c) Health and Safety Committee (June and August 2019)
   d) Patient Experience Committee (June 2019)
   e) Clinical Effectiveness Committee (August 2019)

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. The Annual Report of the DIPC for East Lancashire Hospitals NHS Trust covers the period from 1 April 2018 to 31 March 2019. It also contains the work plan for the period 1 April 2019 to 31 March 2020.

2. The report informs on the progress made and the processes in place including the key activities undertaken by the Infection Prevention and Control (IPC) Team and the Trust in managing and preventing infection and recognising this as a key element of patient safety. The report also summarises the work of the IPC team during 2018/19, the progress made and the significant infection prevention and control challenges that have been faced by the Trust.

3. The major challenge for the year was to continue making good progress against the Government's targets to reduce health care associated infections and the numbers of

MRSA blood stream infections, Clostridium difficile infections and Gram negative blood stream infections, while maintaining other important activities required for compliance with the Health Act, such as policy development and review, education, audit and providing a responsive service to unpredictable occurrences such as outbreaks.

4. All NHS Organisations must ensure that they have effective systems in place to control healthcare associated infection. The prevention and control of infection is part of the Trust's overall risk management strategy. Evolving clinical practice presents new challenges in infection prevention and control, which need continuous review. Emphasis is given to prevention of healthcare associated infection, the appropriate use of antibiotics and the improvement of cleanliness in the hospital.
5. The reduction of health care associated infections, particularly MRSA/gram negative blood stream infections and Clostridium difficile infections are challenging for the team and the rest of the organisation and require substantial effort from all to achieve.
6. The trajectory for MRSA blood stream infections for the year 2018/2019 was to have no more than 0 blood stream infections; the year end outturn attributable to the Trust was 1.
7. The national target of MRSA screening for all eligible elective and emergency admissions has continued satisfactorily.
8. The post 3 days trajectory target set for Clostridium difficile infections for 2018/2019 was 27 post 3 days of admission cases and the outturn was 26 This included the mandatory inclusion criterion for reporting all diarrhoea samples from patients 2 years and above and also diagnosis of Pseudomembranous colitis (PMC) by CT and endoscopy.
9. NHS Trusts must report cases of E. coli, Klebsiella species and Pseudomonas aeruginosa bloodstream infections to Public Health England. This is to support the Government ambition to work to halving healthcare associated gram negative blood stream infections and delivering a 25% reduction by 2021-2022 with the full 50% by 2023-24.
10. There have been a number of outbreaks due to symptoms of Norovirus this year Actions were implemented to prevent further spread and areas opened as soon as possible. This resulted in 57 lost bed days which is a reduction on last year with 102 lost bed days.

11. 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.
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 across both sites with stalls on main entrance, ward visits with Glo-box and '5 moments' leaflets given to staff on wards.
13. The Divisional antimicrobial quarterly audits continued in 2018/19 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.
14. 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.
15. 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.
16. During 2018/19, Infection Control policies have been developed or reviewed to ensure they incorporate current best practices.
17. 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, Corporate Governance Manager/Assistant Company Secretary, 4 November 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 153

13 November 2019

Purpose Information

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

Summary: The list of matters discussed at the Remuneration Committee held on 11 September 2019 are presented for Board members' information.

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do 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 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 11 September 2019 members considered the following matter:
   a) Direction of Travel: Joint Chief Executive Arrangements
   b) Appointment of Medical Director
   c) Appointment of Director of Finance
   d) Fit and Proper Persons Test Annual Report
   e) Terms of Reference Annual Review

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 5 November 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 154

13 November 2019

Purpose Information

Title	Trust Board (Closed Session) Information Report
Author	Miss K Ingham, Corporate Governance Manager/Assistant Company Secretary
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 11 September 2019.

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do 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 Partnership (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 11 September 2019, the following matters were discussed in private:
   a) Round Table Discussion: ICP/ICS Update
   b) Finance and Performance Update 2019/20: Finance Report
   c) Finance and Performance Update 2019/20: Performance (National Elective Care Access Standards Field Testing Memorandum of Understanding)
   d) Tenders Update
   e) Serious Untoward Incident Report
   f) Doctors with Restrictions

1. The matters discussed were private and confidential and/or identified individuals and/or were commercially sensitive at this time and so the decision was taken that these items should not be discussed in the public domain. As these items progress, reports will be presented to part 1 of Board Meetings at the appropriate time.

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 5 November 2019