East Lancashire Hospitals NHS
NHS Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

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TRUST BOARD PART 1 MEETING

28 SEPTEMBER 2016, 14:00, SEMINAR ROOM 6, ROYAL BLACKBURN HOSPITAL

AGENDA

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

OPENING MATTERS				
TB/2016/242	**Chairman's Welcome**	Chairman	v	14.00
TB/2016/243	**Open Forum** To consider questions from the public	Chairman	v	14.05
TB/2016/244	**Apologies** To note apologies.	Chairman	v	14.20
TB/2016/245	**Declarations of Interest** To note any new declarations of interest from Directors.	Company Secretary	v	
TB/2016/246	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 29 June 2016	Chairman	d✓	
TB/2016/247	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2016/248	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	
TB/2016/249	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	14.30
TB/2016/250	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	14.40
QUALITY AND SAFETY				
TB/2016/251	**Patient Story** To receive and consider the learning from a patient story.	Director of Nursing	p	14.50
TB/2016/252	**Board Assurance Framework** To receive an update on the Board Assurance Framework and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Medical Director	d✓	15.00
TB/2016/253	**Corporate Risk Register** To receive an update on the Corporate Risk Register and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Medical Director	d✓	15.05
TB/2016/254	**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 aware of the associated learning.	Medical Director	d✓	15.10
STRATEGY				
TB/2016/255	**Update on Recent Developments – Pennine Lancashire and Healthier Lancashire**	Chief Executive	v	15.20

TB/2016/256	**Obtaining Teaching Status**	Chief Executive	d✓	15.30
ACCOUNTABILITY AND PERFORMANCE				
TB/2016/257	**Integrated Performance Report** To note performance against key indicators and actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed: • Performance • Quality • Finance • HR • Safer Staffing • Consultant Job Planning Exception Report	Director of Operations	d✓ ✓	15.40
GOVERNANCE				
TB/2016/258	**Doctors Revalidation Report** To note and approve the annual revalidation report	Medical Director	d✓	15.50
TB/2016/259	**Emergency Planning Annual Statement** To consider the statement and approve for submission to NHS England	Director of Operations	d✓	16.00
TB/2016/260	**Finance and Performance Committee Update Report** To note the matters considered by the Committee in discharging its duties (July and September 2016)	Committee Chair	d✓	16.05
TB/2016/261	**Finance and Performance Committee Terms of Reference** To consider and approve the amended terms of reference for the Committee.	Company Secretary	d✓	16.10
TB/2016/262	**Audit Committee Update Report** To note the matters considered by the Committee in discharging its duties (September 2016)	Committee Chair	d✓	16.15
TB/2016/263	**Quality Committee Update Report** To note the receipt of the annual report on infection prevention and control	Committee Chair	d✓	16.20
TB/2016/264	**Trust Charitable Funds Committee Update Report** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	16.25
TB/2016/265	**Trust Board Part Two Update Report** To note the matters considered by the Committee in discharging its duties (July 2016)	Chairman	d✓	16.30
FOR INFORMATION				
TB/2016/266	**Any Other Business** To discuss any urgent items of business.	Chairman	v	16.35
TB/2016/267	**Open Forum** To consider questions from the public.	Chairman	v	16.40
TB/2016/268	**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? • Has the Board agenda the correct balance between formulating strategy and holding to account? • Is the Board shaping a healthy culture for the Board and the organisation? • Is the Board informed of the external context within which it must operate?	Chairman	v	16.50

	• Are the Trust's strategies informed by the intelligence from local people's needs, trend and comparative information? • Does the Board give enough priority to engagement with stakeholders and opinion formers within and beyond the organisation?			
TB/2016/269	**Date and Time of Next Meeting** Wednesday 26 October 2016, 15.00, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.	Chairman	v	16.55

East Lancashire Hospitals NHS Trust

TRUST BOARD PART ONE REPORT

Item 246

28 September 2016

Purpose Action

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

Summary:

The draft minutes of the previous Trust Board meeting held on 27 July 2016 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

(246) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 27 JULY 2016

MINUTES

PRESENT

Professor E Fairhurst	Chairman	
Mr K McGee	Chief Executive	
Mr S Barnes	Non-Executive Director	
Mrs M Brown	Acting Director of Finance	
Mrs C Pearson	Director of Nursing	
Dr D Riley	Medical Director	
Mr P Rowe	Non-Executive Director	
Mrs G Simpson	Director of Operations	
Mr R Slater	Non-Executive Director	
Mr D Wharfe	Non-Executive Director	

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Company Secretary	
Mr M Hodgson	Director of Service Development	
Mrs C Hughes	Interim Director of Communications	
Miss K Ingham	Minute Taker	
Mr B McBride	Caradigm	Observer/Audience
Mr K Moynes	Director of HR and OD	
Mr R Smyth	Member of the Public	Observer/Audience
Mr B Todd	Member of the Public	Observer/Audience
Mr M Wedgeworth	Healthwatch Lancashire	Observer/Audience
Mrs S Davies	Head of Speech and Language Therapy	For Item TB/2016/213
Mrs R Evans	Speech and Language Therapist	For Item TB/2016/213
Mr W Farrelly	Patient	For Item TB/2016/213

APOLOGIES

Mrs E Sedgley	Non-Executive Director

TB/2016/204 CHAIRMAN'S WELCOME

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

TB/2016/205 OPEN FORUM

Mr Todd asked whether there would be the option for members of the public attending the meeting to park their car on site at no cost. Mrs Bosnjak-Szekeres agreed to liaise with the Trust's parking services regarding this matter.

Mr Todd reported that Blackburn with Darwen Clinical Commissioning Group (CCG) were developing a policy in relation to equity and choice concerning married couples who may be split up depending upon their individual care needs. He asked whether a similar policy would be developed by East Lancashire CCG. Mr McGee reported that he had not received any information from the CCG on this matter.

Mr Wedgeworth asked for more information regarding Accountable Care Organisations/Systems. Mr McGee reported that the reasoning for the development of Accountable Care Organisations/Systems (ACO/ACS) was to bring organisations together to break down barriers for the benefit of the patients and realise financial savings across the component organisations. He confirmed that the Trust was part of the Pennine Lancashire initiative and was involved in the planned development of an ACS rather than one overarching organisation. This will mean that the Trust would remain as an organisation in its own right but, closer working amongst the organisations in the system would bring significant benefits, such as reduction in waste, duplication and inefficiencies. There would also be benefits for the patients, for example treatment in more appropriate places such as their place of residence or community setting.

ACTION: Mrs Bosnjak-Szekeres to liaise with the parking services.

TB/2016/206 APOLOGIES

Apologies were received as recorded above.

TB/2016/207 MINUTES OF THE PREVIOUS MEETING

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

RESOLVED: The minutes of the meeting held on 29 June 2016 were approved as a true and accurate record.

TB/2016/208 MATTERS ARISING

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

TB/2016/209 ACTION MATRIX

All items on the action matrix were reported as complete or were to be presented as agenda

items today or at subsequent meetings. Updates were received as follows:

TB/2016/181: Open Forum – Mrs Simpson confirmed that a meeting has been arranged to discuss Delayed Transfers of care with Mr Wedgeworth.

TB/185: Action Matrix – Mr McGee confirmed that he had written to East Lancashire CCG regarding the relocation of the fracture clinic from Burnley General Hospital and was awaiting a response.

TB/2016/188: Recent Developments in NHS Strategy and Sustainability – Mrs Hughes confirmed that she would be meeting with Mr Wedgeworth later in the week.

RESOLVED: The position of the action matrix was noted.

TB/2016/210 DECLARATIONS OF INTEREST

Directors noted that there were no amendments to the Directors' Register of Interests and there were no declarations in relation to agenda items.

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

TB/2016/211 CHAIRMAN'S REPORT

Professor Fairhurst reported that she had had the opportunity to present the Reverend David Atkinson to the Bishop of Lancaster as the new Chaplain for the Trust. She went on to report that she had attended the Health Service Journal (HSJ) providers summit in July and confirmed that one of the sessions that she attended focused on a report from the HSJ regarding the NHS non-clinical workforce. She reported that she had taken the opportunity to contribute some of the positive work that the Trust was undertaking and share areas of good practice.

RESOLVED: Directors received and noted the report provided.

TB/2016/212 CHIEF EXECUTIVE'S REPORT

Mr McGee referred the Directors to the report and highlighted a number of national and local issues, including the work being carried out at national level in relation to developing world class cancer services. Mrs Simpson confirmed that the Trust was taking an active part in this work by being a pilot site for shortening cancer diagnosis pathways.

Mr McGee went on to report that the Workforce Race Equality Standard report had been received and would be reported to the next Quality Committee meeting and the Trust Board in October. He confirmed that although the report was challenging for the Trust, it provided a good opportunity for development. Mr Moynes confirmed that a 'big conversation' event was being arranged for September with staff members from BME backgrounds.

Directors noted the positive feedback that the Trust had received from trainees in relation to obstetrics and gynaecology. Mr McGee confirmed that the outline business case for the Burnley Phase Eight development had been approved by NHS England and the Trust can now begin to develop the full business case which will be presented to the Trust Board prior to submission to NHS England.

Directors noted that the Trust had been shortlisted for three awards at the Patient Safety Congress. The first for the Refer to Pharmacy programme, the second one regarding the community falls prevention work with Lancashire County Council and the third one for the work across Pennine Lancashire in relation to the cancer pathways.

Professor Fairhurst commented that the Health Education England North West visit had been of significant importance to the Trust and there should be recognition of the work undertaken by Dr Riley and his team in relation to the medical training provided.

RESOLVED: Directors received and noted the report.

TB/2016/213 PATIENT STORY

Mrs Pearson introduced members of the Speech and Language team and Mr Farrelly. She explained that the patient story would take the form of a video which had been filmed to show the importance of staff introducing themselves to patients and effective communication with patients and carers. The video can be accessed via the following link: https://www.youtube.com/watch?v=7yiVw2eKs2o. Mr Farrelly reported that he had been diagnosed with throat cancer. Following unsuccessful treatment he had undergone a laryngectomy around two years ago. He provided a brief overview of the treatment he had received whilst an inpatient and the continued follow up care as an outpatient. He confirmed that he had experienced high quality care and had developed positive relationships with both the consultants and the nursing staff. In response to Professor Fairhurst's question, he reported that, had his family required any assistance or been in need of additional support, he was in no doubt that this would have been provided. Mr Farrelly went on to report that since his operation he had acted as a buddy for four patients who were undergoing similar operations.

Professor Fairhurst thanked Mr Farrelly for sharing his experience and commented that he and other volunteers within the Trust are a great asset to the organisation and its patients.

RESOLVED: Directors received and noted the information presented.

TB/2016/214 BOARD ASSURANCE FRAMEWORK

Dr Riley presented the report to the Directors for review and approval. He confirmed that the risk rating for risk BAF/16/006: *The Trust fails to earn autonomy and maintain a positive*

reputational standing as a result of failure to fulfil regulatory requirements had been increased from 15 to 20 based on the challenges and implications of not achieving the four hour standard.

Directors discussed the change and agreed that the proposed revision was appropriate.

RESOLVED: **Directors received and approved the proposed amendments to the Board Assurance Framework.**

TB/2016/215 CORPORATE RISK REGISTER

Dr Riley presented the register to the Directors and confirmed that there had been no changes to report since the last meeting. He confirmed that the Risk Assurance Group had held its first meeting and would report to the Board through the Quality Committee and its sub-committees. Directors received the report and approved the content of the register.

RESOLVED: **Directors received and approved the Corporate Risk Register.**

TB/2016/216 SERIOUS UNTOWARD INCIDENTS REQUIRING INVESTIGATION REPORT

Dr Riley presented the report to the Directors and confirmed that the information requested at the June Trust Board in relation to Never Events was contained within Section Three of the paper. He provided an overview of the eight reportable incidents that had taken place within the Trust in May and June 2016 and confirmed that there had been nine non-reportable incidents in the same period. Directors discussed the Never Event report and Dr Riley provided a brief overview of each incident. He confirmed that all had been reported fully to the necessary agencies and full Root Cause Analyses had been carried out in each case. Dr Riley also confirmed that he had asked each team involved in the five incidents to provide an update in relation to the learning from the incident and the actions that had been put in place as a result. He reported that the Never Event that had been reported within the Family Care Division had been downgraded externally. The Trust, however; had continued to treat it as a never event in order to maximise the learning opportunities from the event and change practice accordingly, if necessary.

In response to a question from Mr Barnes, Dr Riley reported that although any instance of a Never Event was unfortunate and a cause for investigation; he was not concerned by the number being reported in the Trust.

In response to Mr Slater's query, Dr Riley reported that the learning from incidents is shared across the Trust, specifically by divisional representation at the learning sessions and cascaded. In addition, regular reporting takes place through the Patient Safety and Risk Assurance Committee. The incidents are also reported and discussed at the Serious

Incidents Requiring Investigation (SIRI) panels.

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

TB/2016/217 PROFESSIONAL JUDGEMENT REVIEW

Mrs Pearson presented the report and confirmed that the six monthly reviews had been carried out in line with the required guidelines. She provided an overview of the report and the findings of the review. Directors noted that a benchmarking exercise was being undertaken in relation to the staffing requirements within the Emergency Department and the results would be shared with the Board when they become available. Mrs Pearson confirmed that the National Quality Board has recently revised the guidance and Boards will be required to receive an update on an annual basis in the future. Mrs Pearson proposed that future reports be presented to the Quality Committee; with reporting to the Board via the Quality Committee Summary Report. Directors agreed that this would be an appropriate assurance process.

Mr Rowe reported that a discussion had taken place at the last Quality Committee about staffing and the report provided the necessary assurance that had been sought.

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

Future Professional Judgement Review reports would be presented to the Quality Committee with reporting to the Board taking place via the Quality Committee Summary Report.

TB/2016/218 INTEGRATED PERFORMANCE REPORT

Mrs Simpson presented the Integrated Performance Report for the month of June, highlighting the continued good performance against the 18 week Referral to Treatment indicator and confirmed that complaints remained under the agreed threshold. Both the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital Mortality Indicator (SHMI) remain within the expected range and the Friends and Family survey results continue to show high levels of positive responses. Members noted that there had been no cases of MRSA identified in the month and three cases of Clostridium Difficile had been reported against a trajectory of two. There are two cases of patients waiting over 52 weeks for their operations. These are the same two patients as reported in the previous months; both cases are as a result of patient choice and they will be treated this month.

Performance against the four hour Emergency Department (ED) standard remains a significant challenge and 85.47% was achieved against the target of 95%. Mrs Simpson confirmed that the Trust was now in the bottom quartile of Trusts in terms of delivery against this indicator. Directors discussed the implications of not improving performance against this

indicator, including the possible reduction in Sustainability and Transformation Funding and the increased scrutiny that the Trust would be under. Mrs Simpson provided an overview of the additional work being undertaken in relation to the emergency care pathway, including the development of a senior clinical flow team, support and challenge sessions, discussions around the development of a Clinical Decision Unit and the introduction of a discharge lounge. Mrs Simpson confirmed that there had been two 12 hour breaches reported in the month; both patients were awaiting mental health assessment. Directors noted that the total number of such breaches was 10 since November 2015. The Trust continued to underperform against the ambulance handover time indicator with a total of 423 breeches in the month. Mrs Simpson confirmed that a significant programme of work is being implemented to improve performance against this indicator.

Delayed transfers of care remain above threshold with 37 patients delayed on the last Thursday of the month and 117 patients delayed across the month. Mrs Simpson reported that the Trust had failed the 62 day target for cancer by two cases in June. Directors discussed performance against the target and it was noted that the dip in performance had been expected due to the impact of the industrial action by junior doctors.

Mr Moynes reported that sickness absence was 4.5% against a target of 3.5% and it was linked to the operational pressures being seen across the organisation. Directors requested that Mr Moynes provide an update on Core Skills Training at the next Trust Board meeting.

Mrs Brown confirmed that the Trust had reported a deficit position at the end of June of £900,000 which was broadly in line with the planned position. She confirmed that income was below the planned position for both elective and non-elective activity but it is envisaged that it would return to the planned position in the coming months. Pay costs were reported to be in line with the forecast position with non-pay costs being £1,500,000 underspent at the end of month three. Mrs Brown confirmed that the Trust had continued to meet the non-NHS element of the Better Payment Practice Code and work was continuing to improve performance against the NHS element of the code.

Directors noted that £13,700,000 in Safely Releasing Costs Programme (SRCP) schemes had been identified. Mrs Pearson confirmed that all schemes are subject to a rigorous quality and safety process prior to approval and are assessed again following implementation.

In response to Mr Wharfe's question in relation to the Sustainability and Transformation Funding guidance, Mrs Brown provided an overview of the breakdown of payments and the performance targets that needed to be achieved to receive the payments. Directors discussed the guidance and the requirements set out in it. Mr McGee commented that the financial reset was important and suggested that providers and commissioners would need

to work closely to reduce deficits. The Board recognised the implications of the NHS financial reset.

Mr Barnes requested further assurance in relation to reducing variability of performance throughout the winter period.

Dr Riley reported that job planning was currently at 13%; however it is thought that the actual number is higher, but not all plans have been uploaded to the electronic system. Dr Riley offered to bring an exception report to the next Board meeting.

The Board welcomed the plan to improve performance within the ED to the required standard. Professor Fairhurst commented that the Board hoped that the increase in specialist commissioning funding for the Neonatal Intensive Care Unit (NICU) will have a positive effect on reducing the agency spend within the department.

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

ACTION: Mr Moynes to provide a report on Core Skills Training in September.
Dr Riley to provide an exception report on Consultant Job Planning for the next Board meeting.

TB/2016/219 QUALITY COMMITTEE UPDATE REPORT

Mr Rowe presented the report to the Directors and confirmed that is was an accurate reflection of the meetings held in May and July 2016. He confirmed that the Committee had spent considerable time discussing the End of Life Care report and requested that additional information be included, particularly around seven day working. He reported that the Committee received a report concerning the Nursing Assessment and Performance Framework visits and were pleased to see improvements where they had been required. Directors noted that the Committee were now receiving regular reports from the Health and Safety Committee and that the Medicines Strategy would be discussed at the next Committee meeting.

RESOLVED: Directors received the report and noted its contents.

TB/2016/220 FINANCE AND PERFORMANCE COMMITTEE UPDATE REPORT

Mr Wharfe presented the report to the Directors and confirmed that is was an accurate reflection of the meetings held in May and June 2016. He confirmed that the Committee had received the draft Annual Accounts at its meeting in May and had received assurance that the Trust had been able to effectively meet the control total set by the NTDA earlier in the financial year. He went on to confirm that the Committee had spent considerable time at both meetings discussing the Safely Releasing Costs Programme (SRCP) and

transformational schemes to gain a good understanding of the overarching programmes. In addition, the work around the Lord Carter of Coles review recommendations will also be reported by the Programme Management Office (PMO) to the Committee as part of the Sustaining Safe, Personal and Effective Care 2016/17 report.

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

TB/2016/221 **AUDIT COMMITTEE UPDATE REPORT**

Mrs Bosnjak-Szekeres presented the report to the Directors in the absence of Mrs Sedgley and confirmed that is was an accurate reflection of the meetings held in June and July 2016. She confirmed that the Committee had spent considerable time discussing the trust Annual Report, Accounts and Quality Account, all of which had been approved and had subsequently been submitted to the Regulators by the required deadlines. She went on to confirm that the Committee was beginning to see an increase in the number of limited assurance reports being received and work was being undertaken through the Committee to address that. Directors noted that the Committee had asked that managers responsible for areas where limited assurance reports had been issued attend the Committee to present the management response.

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

TB/2016/222 **AUDIT COMMITTEE TERMS OF REFERENCE**

Mrs Bosnjak-Szekeres presented the revised terms of reference for approval. She highlighted the proposed changes and confirmed that these were to accommodate the establishment of the Auditor Panel. Directors approved the revised terms of reference for the Committee.

RESOLVED: **Directors approved the revised terms of reference for the Audit Committee.**

TB/2016/223 **REMUNERATION COMMITTEE UPDATE REPORT**

The report was presented for information purposes.

TB/2016/224 **TRUST BOARD PART TWO UPDATE REPORT**

The report was presented for information purposes.

TB/2016/225 **ANY OTHER BUSINESS**

Professor Fairhurst confirmed that the Trust would be holding its Annual General Meeting, engagement cafés and healthcare marketplace on Wednesday 14 September 2016 from

2.00pm at Burnley Football Club. The Annual General Meeting would commence at 5.30pm.

TB/2016/226 OPEN FORUM

In response to Mr Todd's question, Dr Riley provided an explanation of the term 'Never Event' and the types of events that would be classed as such. He also provided a brief overview of the event that had been declared as a Never Event and then downgraded. He confirmed that the Trust continued to treat the event as a Never Event in order to learn as much as possible from the occurrence.

Mr Wedgeworth commented that the NHS financial reset information that had been made public earlier in the month seemed to be heavily weighted towards financial savings/sustainability rather than transformation. Mr McGee reported that the Trust had a plan to bring the organisation back into financial balance in two years, which was in line with the requirements in the NHS financial reset and it would also provide a solid foundation for the Trust within an Accountable Care System. In response to Mr Wedgeworth's question regarding emergency department staffing, Mrs Pearson confirmed that the Trust was looking to develop a number of Consultant Nurse roles. Dr Riley provided a brief overview of the work being carried out to develop the medical workforce within the emergency care pathway, including the work being carried out with local GPs and the offer of clinical assistant roles.

TB/2016/227 BOARD PERFORMANCE AND REFLECTION

Professor Fairhurst asked the Directors whether they felt there had been any areas where adequate assurance had not been received during the meeting. Directors commented that they did not feel as though there had been any gaps in assurance. Professor Fairhurst asked Directors for their comments and observations relating to the meeting. Mrs Pearson reported that the patient story had prompted professional and personal reflection. Mrs Hughes commented that a number of the papers presented and discussions undertaken had contained significant amounts of jargon and suggested that this should be minimised for future meetings.

TB/2016/228 DATE AND TIME OF NEXT MEETING

The next Trust Board meeting will take place on Wednesday 28 September 2016 at 14:00, in Seminar Room 6, Learning Centre, Royal Blackburn Hospital.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 248

28 September 2016

Purpose Action

Title	Action Matrix
Author	Miss K Ingham, Minute Taker
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The outstanding actions from previous meetings are presented for discussion.

Members 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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver anticipated benefits The Trust fails to deliver and develop a safe, competent workforce Partnership working fails to support delivery of sustainable safe, personal and effective care The Trust fails to achieve a sustainable financial position The Trust fails to achieve required contractual and national targets and its improvement priorities Corporate functions fail to support delivery of the Trust's objectives

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

East Lancashire Hospitals NHS
NHS Trust

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
2015/66: Talent Management	Update report to be provided in early 2016 *(this will be covered as part of the Board presentation on workforce in October 2016)*	Director of HR and OD	To be advised	Agenda Item October 2016
2016/133: Action Matrix	Update to be provided in relation to progress with the population centred workforce development *(this will be covered as part of the Board presentation on workforce in October 2016, same as action number 2015/66)*	Director of HR and OD	October 2016	Agenda Item October 2016
2016/155: Information Technology Management Strategy	Regular progress reports on implementation of the Strategy to be presented to the Board to ensure that the Board has a timely debate about the allocation of resources.	Acting Director of Finance	To be advised	Agenda Item November 2016 (indicative)
TB/2016/205: Open Forum	Mrs Bosnjak-Szekeres to liaise with the parking services regarding parking for members of the public attending Trust Board meetings	Company Secretary	September 2016	Oral Report
TB/2016/217: Professional Judgement Review	Future Professional Judgement Review reports will be presented to the Quality Committee with reporting to the Board taking place via the Quality Committee Summary Report.	Director of Nursing	To be advised	Quality Committee
TB/2016/218: Integrated Performance Report	Mr Moynes to provide a verbal update on Core Skills Training in September.	Director of HR and OD	September 2016	Oral Report

Item Number	Action	Assigned To	Deadline	Status
TB/2016/218: Integrated Performance Report	Dr Riley to provide an exception report on Consultant Job Planning for the next Board meeting.	Medical Director	September 2016	Agenda Item September 2016 Part of Integrated Performance Report

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 250

28 September 2016

Purpose Information

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

Summary:

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

Recommendation:

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

Report linkages

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

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

National Updates

1. **NHS England publishes Annual Report and Accounts 2015/16 -** NHS England's latest Annual Report and Accounts, show the organisation met each of the financial duties placed on it by Parliament in 2015/16, including once again balancing its budget of just over £100 billion. NHS England also contributed a £599 million managed underspend to help offset overspends elsewhere. Commenting on NHS England's performance on the mandate set for it by the Government, Health Secretary Jeremy Hunt told Parliament: "My annual assessment welcomes the good progress that NHS England has made against many of its objectives including managing the commissioning system."
2. **Maternity Transformation Programme set to drive forward implementation of the National Maternity Review -** NHS England has now launched the Maternity Transformation Programme to drive forward implementation of the vision set out in Better Births, the report of the National Maternity Review. The programme addresses a series of recommendations which set out wide-ranging proposals designed to make care safer, give women greater control and more choices. This gives a chance for the midwifery workforce across the country to review what is working well and what change may be needed to further improve maternity services for women.
3. **Mental health implementation plan launched -** NHS England has published an Implementation Plan to set out the actions required to deliver the Five Year Forward View for Mental Health. The plan brings together all the health delivery partners to ensure there is cross-system working to meet the recommendations made by the Mental Health Taskforce, and presents the timeframes and funding for delivery of the programmes of work which will transform mental health services.
4. **NHS action to strengthen Trusts' and Clinical Commissioning Groups' (CCG) financial and operational performance for 2016/17 -** NHS England, in partnership with NHS Improvement, has unveiled a suite of new measures for providers and commissioners to help ensure the ongoing financial sustainability of the NHS. The measures set out the legal responsibilities and direct accountability of trusts and clinical commissioning groups to live within the public resources made available by Parliament and the Government in 2016/17.
5. **Plans launched for seven day hospital pharmacy services -** NHS England delivered its first report on enhancing the quality of care and improving access to seven day pharmacy services for patients in hospital, at the Royal Pharmaceutical Society Annual Conference, on 5 September 2016. Transformation of Seven Day Clinical Pharmacy Services in Acute Hospitals sets out a vision where hospital pharmacy services could operate more efficiently and safely, and 13 key

recommendations of how clinical pharmacy services in hospitals can be strengthened, particularly at weekends, to benefit patients.

Local Developments

6. **ISDN Accreditation** – The Trusts Informatics Department has been independently assessed by the Informatics Service Development Network (ISDN). The Trust is really proud of the team for their excellent work. The Informatics team received the award at the ISDN September Conference. The assessors indicated that the team are an exemplar site with professional, committed and dedicated staff. The team passed the accreditation with flying colours. The Informatics Team are one of only 15 Informatics departments in the country that have received the award, putting them in the top 20% of services. The Informatics Team will receive a new logo which they can proudly display on their emails and correspondence.

7. **Trust Celebrates Graduation of New Advanced Nurse Practitioners -** East Lancashire Hospitals NHS Trust is celebrating the success of two nurses who have graduated from the University of Central Lancashire (UCLan) with degrees as Advanced Practitioners in Health and Social Care. Experienced nurses Lesley Macleod and Natalie Grady both completed two-year degree courses earlier this year before last week graduating at Preston Guild Hall.

8. **PLACE** - East Lancashire Hospitals NHS Trust (ELHT) has been awarded excellent marks for standards of Food, Privacy, Dignity and Wellbeing as well as being Dementia Friendly in the Patient-led Assessment of the care environment (PLACE) report. The Trust's overall Food rating rose to **81.78%,** a significant increase on the previous year's score of **74.73%.** This is in part a reflection of the new Food and Drinks Strategy the Trust has introduced. Part of the strategy focused on improving the food score from the last assessment. The new process ensures food has lost none of its great taste, which has always scored well, and is now served to patients in a much shorter time frame allowing improved temperatures which was an improvement area following the 2015 assessment. East Lancashire Hospital's PLACE rating also saw increases in Privacy, Dignity and Wellbeing **(86.41%)** and being Dementia Friendly, which scored **80.61%** compared to national average of **75.28%.**

9. **ELHT Trauma & Orthopaedics -** I am happy to inform you that Dr Robert Paton has been elected to the Council of the Royal College of Surgeons of Edinburgh, a five year appointment. This reflects on the high quality of surgery at ELHT (both management and clinical) and this is a National recognition of this quality. At the British Orthopaedic Association in September, both Dr Paton (King James IV

Professorial lecture) and Professor Jim Barrie (Naughton Dunn lecture) are presenting two of the most prestigious invited presentations this national meeting in Belfast. This is a reflection of Professor Barrie's commitment to education/ foot and ankle surgery, particularly in his expertise in the treatment of the diabetic foot. It is a remarkable achievement for ELHT to have this national profile.

10. **Double Awa4rd Success of Trust** - East Lancashire Hospitals NHS Trust's reputation as one of the country's most improving NHS organisations has been boosted with Trust staff winning two prizes at the national Patient Safety and Care Awards 2016. East Lancashire success came from the Trust's groundbreaking **Refer-to-Pharmacy technology** which won the 'Best Emerging Technology and IT' category and the East Lancashire Community Falls Team who created the STEADY ON! falls prevention programme funded by Lancashire County Council which received first prize in the 'Preventing Avoidable Harm' category.

11. **Trust signs up to Care Campaign to support maternity staff -** East Lancashire Hospitals NHS Trust is one of the first trusts in the country to sign a charter which will improve the health, safety and wellbeing of staff members who work in the demanding maternity departments. The 'Caring For You' campaign and charter, launched by the Royal College of Midwives (RCM) in June, aims to further support midwives, student midwives and maternity support workers who are under intense pressure. This can affect the quality of care given to women and their families.

12. **Green light for ELHT Elective Care at Burnley General Hospital** - East Lancashire Hospitals NHS Trust has given the go ahead for a major investment which will increase and modernise facilities for surgery and minor procedures at Burnley General Hospital. Work on the new East Lancashire Elective Centre begins this week to create a larger ward for short stay surgery with an additional 14 beds and the opening of a purpose-built facility for minor procedures. In addition, the East Lancashire Elective Centre will feature an extra Endoscopy Suite – the 4th at Burnley General Hospital – as the Trust plans ahead for anticipated growth in endoscopy services in the coming years.

13. **ELHT Triumph at 13th Annual Cadet Awards -** Nursing cadets on placement at East Lancashire Hospitals NHS Trust (ELHT) returned triumphant from the 13th Cadet Annual Awards ceremony held in Liverpool. **Burnley College Cadet Lydia Hunt** was named 'Cadet of the Year for Cumbria & Lancashire' but was unable to receive her trophy from Laura Roberts, National Director (North) Health Education England, as Lydia is at Camp America. Cadets **Niamh Smith** (Blackburn College), **Louise White** (Burnley College) and **Esther Williams** (Nelson & Colne College)

each received 'Special Merit Award's from John Rogers, Chief Executive, Skills for Health.

14. **Hospital celebrates graduation of new advanced nurse practitioners** - East Lancashire Hospitals NHS Trust is celebrating the success of two nurses who have graduated from the University of Central Lancashire (UCLan) with degrees as Advanced Practitioners in Health and Social Care. Experienced nurses **Lesley Macleod and Natalie Grady** both completed two-year degree courses earlier this year before last week graduating at Preston Guild Hall.

15. **200 junior doctors continue medical careers at East Lancashire Hospitals** - NHS patients in East Lancashire are set to benefit with the news that 72 newly qualified doctors began their two-year residencies with East Lancashire Hospitals NHS Trust (ELHT) this week. Officially known as Foundation Year doctors, they are joined by 128 more experienced core and specialty trainee doctors who are continuing their careers at ELHT as they begin training in specialist areas such as paediatrics, medicine for older people and surgery.

16. **East Lancs Midwife elected national research champion** - East Lancashire **Research Midwife, Bev Hammond**, has been appointed as the Greater Manchester Research Champion for Midwifery. Bev will join the National Institute for Health Research (NIHR) Reproductive Health and Childbirth Research Champion Group. The group focuses on professional development, research delivery and professional issues to enable an integrated clinical research workforce in reproductive health and childbirth. Drawing on years of experience supporting women's health research studies here in the Trust, Bev will contribute to the aims of the group and will help to ensure the successful delivery of reproductive health and childbirth research studies, not just within the Trust, but across Greater Manchester.

17. **EXPO 2016 Award** - I am writing to let you know that your fellow ELHT staff member, **John Jackson**, one of our night porters, last night won the prestigious Kate Granger Award for Compassionate Care in the individual category. The award was presented at the NHS Health and Care Innovation Expo event in Manchester in front of a large audience which included representatives from across the NHS including providers, commissioners, third sector and private sector organisations and national and regional media. It was the highlight of yesterday's Expo event. The Kate Granger awards focus on the importance of personal touches and Kate herself was the founder of the 'Hello, My Name is….' campaign. Kate's husband, Chris Tointon, presented John personally with his award on stage, saying that Kate had the honour of choosing John for the individual award just before she died and was deeply moved and inspired by the absolutely amazing work that he has done. The awards are all

about compassion and John epitomises that in how he carries out his work. That one of our staff members has secured this prestigious national award is testament to the importance of our vision - providing safe, personal and effective care - and John's commitment it. He, (like many of you) is the embodiment of those values and this makes a massive difference to our patients and their loved ones. I want to thank you all for that. I am sure you will all join me in congratulating John on his winning this award. This is a fantastic achievement and I am incredibly proud of John, and of ELHT.

18. **Improvement Collaborative for Infection Prevention and Control (IPC) –** ELHT received a letter from NHS Improvement congratulating the Trust on the success of being awarded **"Best Trust for Implementation of the IPC Programme"** at a summit event the 8th September 2016. They particularly commented on the commitment and enthusiasm of the Director of Nursing Chris Pearson and her teams which was deemed second to none and has proved invaluable to patient care.

19. **Trust Seal** - The Trust seal has been applied on the 21 July 2016 to the contracts for the sale of residential freehold lands with vacant possession at 26 and 28 Longshaw Lane, Blackburn BB2 3LU. The contacts have been signed by the Chief Executive, the Acting Deputy Chief Executive/Medical Director and the Acting Director of Finance. The Trust seal has also been applied on the 1 September 2016 to the contract for the sale of residential freehold with vacant possession at 50 Pritchard Street, Blackburn BB2 3PF. The contract has been signed by the Chief Executive and the Acting Deputy Chief Executive/Medical Director.

20. **Teaching Status –** The Trust will soon be amending the names of its two local acute hospitals to include the word 'Teaching', this is in relation to the great work that continues between ELHT and UCLan with regards to educating, developing and recruiting clinical staff.

Summary and Overview of Board Papers

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

22. **Safer Staffing** - The paper details the Boards commitment to the publishing of staffing data regarding nursing, midwifery and care staff. It provides details of the staffing fill rates (actual versus planned) in hours published on the NHS Choices website each month.

Summary of Chief Executive's Meetings for July 2016

01/07/16	CEOs Follow Up Development Workshop - Preston
01/07/16	Meeting with Harry Catherall – Blackburn
01/07/16	Meeting with Sally McIvor, ELCCG - Blackburn
04/07/16	MIAA Introduction – RBH
04/07/16	Teleconference STP Assurance Meeting
04/07/16	Meeting with Mike Burrows, GMAHSN – Manchester
05/07/16	STP Assurance Meeting – Preston
06/07/16	Graham Urwin Visit to BGH
06/07/16	Employee of the Month
07/07/16	NHSI IDM Meeting
07/07/16	Pennine Lancashire System Resilience Group – Walshaw House, Nelson
12/07/16	Meeting with Chair and CEO - Blackpool Hospitals NHS Trust
13/07/16	DUE Annual Conference – Mellor Lancashire
13/07/16	Board Development Session – RBH
15/07/16	Meeting with Julie Cooper MP - RBH
18/07/16	Team to Team meeting with LCFT - Preston
19/07/16	Meeting with The Christie CEO – Manchester
20/07/16	Lancashire & South Cumbria Programme Board – HLSCCP Board - Chorley
20/07/16	STP meeting with Simon Stevens – Leeds
21/07/16	Visit to Barnoldswick Clinic
22/07/16	Health Systems Leaders Briefing – Preston
25/07/16	Meeting with DH/PFU - Blackburn
26/07/16	Health and Wellbeing Board Summit – Preston
26/07/16	Lancashire CEO's Meeting - Preston
27/07/16	Trust Board – RBH
28/07/16	Back to the Floor - Quality and Safety
29/07/16	Team Brief – BGH & RBH

Summary of Chief Executive's Meetings for August 2016

02/08/16	Meeting with Sally McIvor - RBH
03/08/16	Meeting with Mike Thomas, Vice Chancellor UClan - RBH
04/08/16	NHSI Integrated Delivery Meeting
23/08/16	Meeting with Russ McLean - RBH
24/08/16	PL ACS Meeting with GGI - RBH
31/08/16	STP Meeting - Preston

Summary of Chief Executive's Meetings for September 2016

01/09/16	NHSI Integrated Delivery Meeting
02/09/16	Lancashire CEO's Meeting – Preston
05/09/16	Patient Safety Walkround
07/09/16	Health and Care Innovation Expo – Manchester
08/09/16	Health and Care Innovation Expo – Manchester
09/09/16	STP Leadership Forum – Preston
12/09/16	Board Development Session with the GGI – Burnley College
13/09/16	Pennine Lancs HE A&E Delivery Meeting - Preston
14/09/16	ELHT AGM – Burnley Football Club
15/09/16	Transformation Steering Group Meeting – Walshaw House, Nelson
20/09/16	CQC Well Led – RBH
21/09/16	CQC Well Led – RBH
21/09/16	Pennine Lancashire Transformation Programme System Leaders Forum – Blackburn Technology
23/09/16	Conversation with Kevin McGee – CCH
23/09/16	Conversation with Kevin McGee – AVH
26/09/16	ELCCG AGM
27/09/16	ELHT and UCLan Strategy Meeting - RBH
27/09/16	Health and Wellbeing Board – Blackburn
28/09/16	ELHT Trust Board - RBH
29/09/16	HFMA CEO Forum – London
30/09/16	Team Brief – BGH
30/09/16	Meeting with Julie Cooper MP for Burnley - Burnley

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

28 September 2016

Item 252

Purpose Information
Action

Title	Board Assurance Framework (BAF) Review
Author	Mrs A Bosnjak-Szekeres, Company Secretary
Executive sponsor	Dr D Riley, Medical Director

Summary:
The Executive Directors have reviewed the risks monitored on the BAF and updated the controls, assurances and actions in relation to each risk where appropriate.

As requested by the Board it can be confirmed that, in preparing this report the external context has been taken into account, such as legislative and regulatory requirements placed on NHS providers. Other elements such as local needs, trends and engagement with stakeholders have been considered and have influenced the review of the BAF risks.

Recommendation:

The Board is asked to discuss the BAF risks and the risk scores and note the report.

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: by the Operational Delivery Board (July 2016) and the Medical Director.

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

   a) **Risk 1** – the **risk score remains** 12 (likelihood 3 x consequence 4). New potential sources of assurance identified include continuing with the presentation of the individual transformation projects to the Trust Board and the revised RAG rating of the transformation projects presented to the Finance and Performance Committee should assist with the assurance about the delivery. Updates include recruitment of five staff to the Programme Management Office (PMO), three internal and two from Pennine Lancashire that will increase our capacity to deliver the transformation programme.

   b) **Risk 2 –** the **risk score remains** 12 (likelihood 3 x consequence 4). The controls and potential sources of assurance have been revised and they remain the same. There has been an increase in staff sickness levels but controls are in place to address this. Update on the actions includes work on the workforce transformation pilots and results of the pilots will be presented to the Quality Committee at the end of November 2016.

   c) **Risk 3** – the **risk score remains** 9 (likelihood 3 x consequence 3). A new potential source of assurance has been added relating to the planned review of clinical effectiveness. Actions update relate to the health improvement priorities initial assessment being reviewed at the Care Professionals Board in October as part of the Pennine Lancashire Transformation Programme and the start of the Lancashire review of specialist services.

   d) **Risk 4** – the **risk score remains** 16 (likelihood 4 x consequence 4). The updates include the Pennine Lancashire Case for Change being published, the solution design phase is ongoing and the Trust is actively involved in the programme. The Pennine Lancashire Memorandum of Understanding has been presented to the Trust Board at the end of July and the principles agreed.

   e) **Risk 5 –** the **risk score remains** 16 (likelihood 4 x consequence 4). No changes since the last report to the Board. The additional workforce controls remain in place and divisions are held to account for the delivery of the transformation and SRCP schemes.

   f) **Risk 6 –** following a review at the July Trust Boards the risk rating has increased from 15 to 20 (likelihood 5 and the consequence score increasing from 3 to 4) and the **risk score remains** the same currently. The suggested increase was mainly as a result of the challenges the Trust faces in relation to the 4 hour Accident and Emergency (A&E) standard. Updates include the submission of the

A&E performance improvement action plan aligned with the NHSI Rapid Improvement Collaborative and the continuing of the work on the Ambulatory Emergency Care Model and Model Wards. The key controls have been revised and the Nursing Assessment Performance Framework added as a control. The gaps in assurance have been updated and the change of provider rating from 'requires improvement' to 'good' has been included. The update on the actions includes the achievement of the closure of all 50+ days complaints by the end of July and a new target set to close all the 40+ days complaints by the end of October 2016. The emergency pathway transformation programme is being presented to the Trust Board in September 2016.

2. The Board is asked to note the changes to the Board Assurance Framework.

Angela Bosnjak-Szekeres, Company Secretary, 16 September 2016.

Board Assuran Board Assurance Framework

Ref	Ref No	Principle Director	Strategic Risk *What could prevent these objectives being achieved.*	Risk related to strategic objectives	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 2015/16				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.*
											Q1	Q2	Q3	Q4			
BAF/16/01	BAF/16/01	Director of Service Improvement	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives	Aligned to Strategic Objectives 1,2,3 and 4.	Integrated transformation plans agreed at organisational level, overarching tracker for transformation and SRCP, Transformation Board meetings (internal and external stakeholders), divisional Transformation Boards report into the Transformation Board that reports into the Finance & Performance Committee. Membership of the Pennine Lancashire Transformation Board (6 workstreams). Transformation/business plans linked to the clinical strategy, high level workforce and estate interdependencies identified.	Monthly report demonstrating progress against key targets reported to the Transformation Board and the Finance & Performance Committee Presentation to the Quality Committee on the quality aspect of the transformation programme Board presentation on individual transformation projects Revised RAG rating should assist with assurance about the delivery.	15	10	12	3x4	12	12			Capacity for delivery of transformation programme Service redesign methodology developed by the Trust (accepted by Pennine Lancashire). Workshops held at system level but ownership and training in relation to service redesign is outstanding.	Assurance in place about the process, but assurance about the delivery and benefits is still work in progress at this stage. Dependency on stakeholders to deliver key pieces of transformation.	New reporting format agreed following meeting with the NED's Using the Transformation Board meetings and our membership on Pennine Lancashire to influence delivery of transformation - update in July. Update - case for change at Pennine Lancashire level agreed, Trust senior leadership involved in the solution design phase. This is still ongoing. Resources allocated for the delivery of the transformation programme, but further resources needed. Update - PMO posts recruited. Three internal appointments and two from Pennine Lancashire, four started in post. Ownership/training in relation to the service redesign to be driven by the clinical leadership and by identifying early engagers to deliver the service redesign. Update - methodology presented to the Transformation Board and accepted for inclusion into the Pennine Lancashire Transformation Plan. Management of this issue is still ongoing.
BAF/16/02	BAF/16/02	Director of HR/OD	Recruitment and workforce planning fail to deliver the Trust objectives	Aligned to Strategic Objectives 2, 3 and 4.	Transformation plans relating to workforce in place monitored through Transformation Board. Divisional Workforce Plans aligned to Business & Financial Plans, Divisional Performance Meetings, Reports to Finance & Performance Committee, Workforce Controls Group, Population/Person Centric Workforce Planning Methodology	Performance measures, time limited focus groups with action plans, board and committee reports, regulatory and inspection agencies, stakeholders, internal audit	16	10	12	3x4	12	12			National recruitment shortages, capacity for delivery of transformation programmes, financial restrictions	Further work required on assurance reporting	Project Initiation Documents and project plans agreed for transformation programmes in relation to workforce. Overseas recruitment campaigns continue. 3 distinct Workforce Transformation (WFT) Pilots identified. Update - pilots on three wards started at the end of July re person centric workforce planning methodology. First workshops held and are linking in with the Pennine Lancashire workstreams. Results of the pilot and actions will be presented to the Quality Committee at the end of November. October Board will receive a presentation on workforce under the strategy item.
BAF/16/03	BAF/16/03	Medical Director	Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways	Aligned to strategic objectives 3 and 4.	New clinical pathways agreed at Care Professional Group of Pennine Lancashire and reporting to the Transformation Steering Group. Governance controls in place feeding into the Clinical Effectiveness Committee and into the Quality Committee	Clinical Effectiveness Committee acting as a governance mechanism for the agreement of the internal pathways and guideline. Stroke pathway already included in the transformation programme. ELHT Transformation Board has urgent care pathway reporting process. Clinical effectiveness review planned.	9	6	9	3x3	9	9			Not all pathway developments linked in fully with the transformation programme	No separate programme is place to consolidate internal clinical pathways. Mechanism for prioritisation of pathway development not in place at divisional/organisational level.	Prioritisation mechanism to be resolved at 2 levels - internally as part of the transformation programme & externally as part of the Pennine Lancashire. Heatlh improvement priorities innitial assessment being reviewed at Care Professionasl Board in October as part of the Pennine Lancashire Transformation Programme At Healthier Lancashire level the Medical Directors of the four Trusts agreed to focus on urology, vascular services, stroke, emergency department, interventional radiology and gastrointestinal bleed. Lancashire review of specialist services to serve the population is in progress.

Ref	Ref No	Principle Director	Strategic Risk *What could prevent these objectives being achieved.*	Risk related to strategic objectives	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 2015/16				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.*
											Q1	Q2	Q3	Q4			
BAF/16/04	BAF/16/04	Chief Executive/ Director of Finance/ Director of Service Improvement	Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust	3,4,5	Senior Leaders' Forum meets to discuss strategy. Engagement by senior leaders in wider transformation programmes. Regular Board updates and decisions on key actions. Strengthen links between internal transformation and external change processes.	Verbal and written updates, where appropriate Board approvals will be established and permissions will be provided by the Board to let Executives to progress the generations of ideas and options with external stakeholders. At Pennine Lancashire level a Case for Change has been published and is currently in the solution design phase, senior leaders from Trust involved at a strategic level.	16	12	16	4x4	16	16				Concise summarisation of discussions and decisions	Regular updates provided to Board Pennine Lancashire Memorandum of understanding was presented to the July Trust Board and principles agreed. Pennine Lancashire project entered solution design phase.
BAF/16/04	BAF/16/05	Director of Finance	The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with a single definition of success criteria.	3,4,5	Ensure suitable controls are in place to maintain budgetary control (income and expenditure). These controls need to extend to effective workforce arrangements. In addition to controls the Trust must ensure that measures are in place to close the financial gap (SRCP), via the Transformation and SRCP schemes effectively monitored by the PMO and the Finance Department.	Monthly reporting to Finance and Performance reports and the Board to reflect financial position. Separate reporting available to support assurances on the transformation programme.	16	12	16	4x4	16	16			Additional workforce controls to remain in place. policies and procedures may require amendments where they are no longer fit for purpose. Controls around transformation schemes and SRCP to be monitored by the PMO and the Finance Department with Division to be held to account via the PMO.	Utilise the internal audit programme to test for assurance on core controls and SRCP.	Regular updates to Board and Finance and Performance Committee
BAF/16/06	BAF/16/06	Director of Operations/ Director of Nursing/Medical Director	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements	Aligned to strategic objectives 1, 3 and 4.	Divisional business plans, weekly operational performance meetings, quarterly divisional performance meetings feeding into the ODB and Finance and Performance Committee, emergency pathway and elective pathway work linking into the broader Trust wide transformation. Engagement meetings with CQC, quality and safety compliance assessed by each division, divisional assurance boards feeding into the operational sub-committees and the Quality Committee. Nursing Assessment Performance Framework	IPBR reporting to the ODB and at Board/Committee level, regular reporting to the NHSI, monthly integrated delivery meeting with the NHSI and system resilience group (SRG). Positive feedback from the last CQC visit, no active action notices from the CQC since April 2014, 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. Action plans developed for the must do's and should do's from the last inspection, owned by the Divisions and reporting on progress to the Quality Committee. ED performance improvement action plan aligned with the NHSI Rapid Improvement Collaborative	15	9	15	5x4	15	20			Timelines for the delivery of the transformation projects not in place. Staffing potentially not sufficient to deal with the impact of external environment & high demand, difficulties with discharges. Staff guardian role not yet fully embedded across the Trust, complaints are a potential source of action by the CQC. Work needed on improving standardised clinical multiprofessional care and addressing variability of care across the organisation via the Nursing Assessment performance Framework.	Change of provider rating from 'requires improvement' to 'good'	Timeline for the transformation of the emergency pathway plan agreed. Working as part of the Emerency Care Delivery Board to resolve demand issues and participating in the delayed discharge collaborative with the NHSI. Work on reducing the number of complaints, 50+ days complaints, completed at the end of July. Target to clear all 40+ day complaints by the end of October 2016. Challenges of achieving the four hour standard are being worked on, measures put in place to address performance and action plan has been submitted to NHSI with a view to improve performance and sustain it in the longer term. Board received a presentation on the challenges surrounding the four hour standard at the July meeting, and will receive a presentaiton on the Emergency Pathway Transformation at the September meeting. Work on the Ambulatory Emergency Care Model and Model Wards continues.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 253

28 September 2016

Purpose Action / Monitor

Title	Corporate Risk Register
Author	Mrs F Murphy, Deputy Company Secretary
Sponsor	Dr D Riley, Medical Director

Summary:

This report presents the outcome of the most recent review of the Corporate Risk Register by the Patient Safety and Risk Assurance Committee.

Recommendation:

It is recommended that the Board:

a) Receive the report noting the assurances provided in relation to the Trust's Corporate Risk Register management processes
b) Approve the proposed changes to the Corporate Risk Register

Report linkages

Related committee aim and duties	Oversight of Corporate Risk Register
	Oversight of Divisional Risk Registers
	Promoting openness and transparency
	Effectiveness of the divisional governance and risk management arrangements
	Effectiveness of corporate governance and risk management processes
Related to key risks identified on assurance framework	Transformation schemes fail to deliver anticipated benefits
	The Trust fails to deliver and develop a safe, competent workforce
	Partnership working fails to support delivery of

	sustainable safe, personal and effective care
	The Trust fails to achieve a sustainable financial position
	The Trust fails to achieve required contractual and national targets and its improvement priorities
	Corporate functions fail to support delivery of the Trust's objectives

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Introduction

1. Following recent Risk Assurance Meetings a review of the Corporate Risk Register has been undertaken by the Risk Manager in consultation with the Associate Director of Quality and Safety. The Patient Safety and Risk Assurance Committee meeting in September 2016 considered the outcome of the review and recommends the inclusion of the following risks on the Corporate Risk Register:
   a) Risk 1810 – ED Pressures and Flow
   b) Risk 6095 – Availability of mental health beds.
2. The proposed Corporate Risk Register is attached at Appendix 1.

Risks to be considered for de-escalation within / from the Corporate Risk Register

3. There are no risks recommended for de-escalation.

Risks to be included on the Corporate Risk Register

4. The Patient Safety and Risk Assurance Committee has recommended that the following risks are included on the Corporate Risk Register:
   a) Risk 1810 – ED Pressures and Flow
   b) Risk 6095 – Availability of mental health beds.

Conclusion

5. Members are asked to note the assurances provided in relation to the ongoing management of the Corporate Risk Register and approve the proposed changes to it. A full review of the Corporate Risk Register will be undertaken with risk leads on a monthly basis.

Appendix 1 – Current Corporate Risk Register

Title:	Failure to meet service needs at times of increased attendance in ED/UCC/MAU impacts adversely on patient care				
ID	1810	Current Status	Live Risk Register – all risks accepted	Opened	05/07/13
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 3 Total: 9
Risk Handler:	Jill Wild	Risk Owner:	Gillian Simpson	Linked to Risks:	
What is the Hazard:	Increases in the volume of attendances in the Emergency Departments can lead to increased and extreme pressure resulting in a delayed delivery of the optimal standard of care across departments. At times of extreme pressure this increase in the numbers of patients within the emergency pathway makes medical/nursing care difficult and impacts on clinical flow		What are the risks associated with the Hazard:	Patients being managed on trolleys in the corridor areas of the emergency /urgent care departments impacting on privacy and dignity. Delay in administration of non-critical medication. Delays in time critical patient targets (four hour standard, stroke target) Delay in patient assessment Potential complaints and litigation. Potential for increase in staff sickness and turnover. Increase in use of bank and agency staff to backfill. Lack of capacity to meet unexpected demands. Delays in safe and timely transfer of patients	
What controls are in place:	Daily staff capacity assessment Daily Consultant ward rounds Establishment of specialised flow team Bed management teams Delayed discharge teams Bed meetings on a regular basis daily Ongoing recruitment Ongoing discussion with commissioners for health economy solutions ED/UCC/AMU will take stable		Where are the gaps in control:	Trust has no control over the number of attendees accessing ED/UCC services	

	assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley ED/UCC/AMU will take stable assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley		
What assurances are in place:	Regular reports to a variety of specialist and Trust wide committees Consultant recruitment action plan Escalation policy and process Monthly reporting as part of Integrated Performance Report Weekly reporting at Exec Team	What are the gaps in assurance:	None identified

Title:	Aggregated Risk – Failure to meet internal and external activity targets in year will result in loss of autonomy for the Trust				
ID	7017	Current Status	Being Reviewed and Challenged	Opened	01/09/16
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 3 Total: 9
Risk Handler:	Divisional General Managers	Risk Owner:	Gill Simpson	Linked to Risks:	1489 (DCS), 2310 (CEO), 4118 (FC), 6487 (ICG), 6509 (FC), 6893 (ICG)
What is the Hazard:	Non achievement of internal and external activity targets will result in increased external scrutiny and potential special measures		What are the risks associated with the Hazard:	Patient harm due to late/ no treatment Reputation of the Trust Special measures Contractual penalties	
What controls are in place:	Monitoring at Trust, Divisional, Directorate and service level Reporting to commissioners Reporting externally to regulators Data uploads e.g. HED Strong monitoring of performance standards		Where are the gaps in control:	Demand for non elective services impacting on planned service delivery	
What assurances are in place:	Action plans are in place for recovery of exceptions to performance reported on an ongoing basis Close monitoring of planned v actual activity and areas of pressure Continual monitoring and reporting of exceptions to expected performance Performance management processes in place to support appropriate escalation of issues and management of exceptions to expected performance Reviewed at Trust Board meeting and supporting committees Ongoing review at Executive Team meetings weekly		What are the gaps in assurance:		

Title:	Aggregated risk – Failure to reduce medical locum costs will adversely impact financial sustainability and patient care				
ID	5790	Current Status	Live Risk Register – All risks accepted	Opened	11/09/15
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 3 Total: 9
Risk Handler:	Simon Hill	Risk Owner:	Damian Riley	Linked to Risks:	908 (ICG), 4488 (ICG), 5702 (ICG),5703 (ICG), 6487 (ICG), 6637 (ICG), 6930 (ICG)
What is the Hazard:	Gaps in medical rotas require the use of locums to meet service needs at a premium cost to the Trust		What are the risks associated with the Hazard:	Escalating costs for locums Breach of agency cap Unplanned expenditure Need to find savings from elsewhere in budgets	
What controls are in place:	Divisional Director sign off for locum usage Ongoing advertisement of medical vacancies Consultant cross cover at times of need Medical Director sign off for overrides above agency cap		Where are the gaps in control:	Availability of medical staff to fill permanent posts due to national shortages in specialties. Medical Staffing gaps and shortages can come at very short notice and ability to convene a group is curtailed	
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 New establishment of Medical Locum Review Panel planned for October onwards		What are the gaps in assurance:		

Title:	Aggregated risk – Failure to reduce nursing and midwifery agency costs will adversely impact financial sustainability and patient care				
ID	5791	Current Status	Live Risk Register – all risks accepted	Opened	11/09/15
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 3 Consequence: 5 Total: 15	Target Rating:	Likelihood: 4 Consequence: 2 Total: 8
Risk Handler:	Deputy Chief Nurse	Risk Owner:	Christine Pearson	Linked to Risks:	3804 (ICG), 4640 (SAS), 4708 (DCS), 5789 (ICG), 6487 (ICG), 6637 (ICG), 6930 (ICG)
What is the Hazard:	Use of agency staff is costly in terms of finance and levels of care provided to patients		What are the risks associated with the Hazard:	Breach of agency cap Agency costs jeopardising budget management	
What controls are in place:	Daily staff teleconference Reallocation of staff to address deficits in skills/numbers Ongoing reviews of ward staffing levels and numbers at a corporate level 6 monthly audit of acuity and dependency to staffing levels Recording and reporting of planned to actual staffing levels E-rostering Ongoing recruitment campaigns Overseas recruitment as appropriate Establishment of internal staff bank arrangements Senior nursing staff authorisation of agency usage Monthly financial reporting		Where are the gaps in control:	Unplanned short notice leave Non elective activity impacting on associated staffing Break downs in discharge planning Individuals acting outside control environment	
What assurances are in place:	Daily staffing teleconference with Director of Nursing 6 monthly formal audit of staffing needs to acuity of patients Exercise of professional		What are the gaps in assurance:		

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

Title:	Aggregated Risk – Failure to meet internal and external financial targets in year will adversely impact the Continuity of Service Risk Rating				
ID	7010	Current Status	Being Reviewed and Challenged	Opened	25/08/16
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 4 Consequence: 4 Total: 16	Target Rating:	Likelihood: 4 Consequence: 3 Total: 12
Risk Handler:	Allen Graves	Risk Owner:	Michelle Brown	Linked to Risks:	1487 (DCS), 1489 (DCS), 4118 (FC), 6115 (FC), 6229 (ICG), 6230 (ICG), 6487 (ICG), 6509 (FC), 6868 (FC)
What is the Hazard:	Failure to meet the targets will result in the Trust having an unsustainable financial position going forward and the likely imposition of special measures		What are the risks associated with the Hazard:	If Divisions deliver their SRCP and meet their Divisional financial plans the Trust will achieve its agreed control total. Breach of control totals will likely result in special measures for the Trust, adverse impact on reputation and loss of autonomy for the Trust Sustainability and Transformational funding would not be available to the Trust Cash position would be severely compromised	
What controls are in place:	Standing Orders Standing Financial Instructions Procurement standard operating practice and procedures Delegated authority limits at appropriate levels Training for budget holders Availability of guidance and policies on Trust intranet Monthly reconciliation Daily review of cash balances Finance department standard operating procedures and segregation of duties		Where are the gaps in control:	Individual acting outside control environment in place	

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. SRCP Tracker reported to Transformation Board and Finance and Performance Committee	What are the gaps in assurance:	

Title:	Failure to meet demand in chemotherapy units due to staffing and accommodation will result in treatment breaches preventing safety and quality being at the heart of everything we do				
ID	3841	Current Status	Live Risk Register – all Risks accepted	Opened	04/08/14
Initial Rating	Likelihood: 3 Consequence: 3 Total: 9	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 2 Consequence: 2 Total: 4
Risk Handler:	Deborah Sullivan	Risk Owner:	Gill Simpson	Linked to Risks:	
What is the Hazard:	Capacity pressures in the chemotherapy units at both Blackburn and Burnley sites due to staffing and accommodation. Therefore capacity could potentially be unable to meet the demand of the service. This is having a significant effect on staff workload pressures		What are the risks associated with the Hazard:	Due to the increase in the number of patients requiring chemotherapy the chemotherapy units are at risk of being unable to cope with the demand of treatments required due to capacity issues. This could result in patients breaching and potentially serious errors could occur. In addition to the nursing staff, this presents pressure on the admin/reception support within the unit(s). Accommodation in both units is not adequate	
What controls are in place:	All patients are scheduled using the Varian (medonc) oncology computer system to schedule chair and nurse time. Nursing and clerical staff work across both sites to ensure adequate cover. Ongoing staff recruitment Development of business case for consideration 01/09/16		Where are the gaps in control:	Patient deferrals and unexpected emergency treatment mean the Varian system is not always efficient. Unplanned leave Lack of flexibility in accommodation Lack of suitably qualified/ experienced applicants for recruitment	
What assurances are in place:	Monitoring of chemotherapy activity is now included in the monthly cancer directorate meeting Monthly meetings taking place with Business manager cancer services, lead		What are the gaps in assurance:		

	Macmillan cancer nurse, and the 2 chemotherapy sisters. Elective centre in Burnley should provide extra capacity		

Title:	Failure to meet ICO requirements will lead to ICO intervention and financial penalties				
ID	6912	Current Status	Live Risk Register – all risks accepted	Opened	04/07/16
Initial Rating	Likelihood: 5 Consequence: 4 Total: 20	Current Rating:	Likelihood: 3 Consequence: 5 Total: 15	Target Rating:	Likelihood: 2 Consequence: 4 Total: 8
Risk Handler:	Frances Murphy	Risk Owner:	Michelle Brown	Linked to Risks:	
What is the Hazard:	Insufficient resources to support current demand for Data Protection / Freedom of Information / Information Governance (including potential litigation) requests have resulted in a number of ICO decision notices over the last six months		What are the risks associated with the Hazard:	Current involvement by ICO in a number of FOI and DPA requests escalates to enforcement action / sanctions resulting in potential fines Further decision notices being issued due to poor information governance practice across the Trust Continued decline in IG toolkit score jeapordising contracts	
What controls are in place:	Temporary support for FOI's from Q&S admin staff - unsustainable due to other duties IG structure increased - no alignment to FOI function or other departmental SAR / health record / DPA request functions IG steering group - frequency and attendance are issues SIRO function		Where are the gaps in control:	Annual and unplanned leave arrangements Workload of two staff dealing with FOI does not always allow daily checking and follow up	
What assurances are in place:	Bi- monthly report to IG Steering Group Summary report from IG Steering Group to Patient Safety and Risk Assurance Committee Annual SIRO report to Trust Board on Information Governance IG Toolkit Audit annually		What are the gaps in assurance:	Occasional cancellation of IG Steering Group	

Title:	Aggregated Risk - Failure to provide timely Mental Health treatment impacts adversely on patient care & safety and quality				
ID	6095	Current Status	Live Risk Register – all risks accepted	Opened	16/10/15
Initial Rating	Likelihood: 3 Consequence: 4 Total: 12	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 2 Consequence:3 Total: 6
Risk Handler:	Jill Wild	Risk Owner:	Damien Riley	Linked to Risks:	4423 (FC), 2161 (FC)
What is the Hazard:	Mental Health patients requiring hospitalisation with decision to admit may have extended waits for bed allocation,		What are the risks associated with the Hazard:	Impact on patient care : patients do not get timely access to specialist mental health services and interventions in an Acute Trust setting Impact on 4 hour and 12 hour standards in ED Risk of harm to other patients Impact on staffing to monitor/ manage patient with MH needs	
What controls are in place:	Frequent meetings to minimise risk between senior LCFT managers and Senior ELHT managers to discuss issues and develop pathways to mitigate risk including; Mental Health Shared care policy, OOH Escalation pathway for Mental health patients, Instigation of 24hrs a day Band 3 MH Observation staff. Ring fenced assessment beds within LCFT bed base (x1Male, x1Female). In Family Care – liaison with ELCAS New Terms of Reference to be agreed by Interface Group starting in October. Primary care to be invited to join Interface group		Where are the gaps in control:	Unplanned demand ELCAS only commissioned to provide weekday service Limited appropriately trained agency staff available	
What	Ongoing meetings with LCFT		What are the		

assurances are in place:	and commissioners Regular review at Divisional and Executive team level	gaps in assurance:	

Title:	Aggregated Risk – Failure to deliver stroke care within national guidance will adversely impact patient care and attract financial penalties				
ID	6828	Current Status	Live Risk Register – All risks accepted	Opened	03/05/16
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 2 Consequence: 3 Total: 6
Risk Handler:	Nick Roberts	Risk Owner:	Gill Simpson	Linked to Risks:	2051 (DCS), 6893 (ICG) 2256 (ICG)
What is the Hazard:	Lack of capacity combined with a model focused on inpatient care is leaving some patients without the level of quality care expected Therapy services do not meet the recommended levels of intervention in terms of frequency, intensity and range of service deliveries.		What are the risks associated with the Hazard:	Compliance against the quality indicators within SSNAP Care is provided below the standard expected by non-stroke specialists and will impact on patient outcome. Lack of therapy support leads impacts on outcomes, clinical flow, length of stay & performance	
What controls are in place:	Ongoing monitoring of SSNAP data Ongoing identification, and where possible, transfer of stroke patients not on stroke unit. Prioritisation of stroke services by therapies staff		Where are the gaps in control:	Unplanned demands for service	
What assurances are in place:	Monitoring through Stroke Steering Group Reporting to Operational Delivery Board Reporting to Divisional Quality and Safety Board		What are the gaps in assurance:		

Title:	Failure to meet HIMOR standards in staff residences at RBH adversely impacts the financial position and workforce				
ID	5180	Current Status	Live Risk Register – All Risks Accepted	Opened	29/04/15
Initial Rating	Likelihood: 5 Consequence: 4 Total: 20	Current Rating:	Likelihood: 4 Consequence: 4 Total: 16	Target Rating:	Likelihood: 2 Consequence: 4 Total: 8
Risk Handler:	Jim Maguire	Risk Owner:	Gill Simpson	Linked to Risks:	
What is the Hazard:	Failure to meet the HIMOR (Housing (Management of Houses in Multiple Occupation) Regulations 1990) in the staff residence buildings at Royal Blackburn Hospital will impact on the Trust's achievement of a sustainable financial position and its ability to support workforce.		What are the risks associated with the Hazard:	The current residences do not meet the regulations under which accommodation must be provided to medical students on placement. This could result in • loss of accreditation to provide medical training • breach of statutory obligations • financial penalties • damage to reputation of the Trust.	
What controls are in place:	Faults are reported to relevant manager. Highlighted to head of Estates that action needs to be taken to rectify these faults immediately.		Where are the gaps in control:		
What assurances are in place:			What are the gaps in assurance:		

Title:	Failure to provide refurbished ward areas due to delays in refurbishment programme impacting on regulatory, contractual & national performance targets				
ID	1660	Current Status	Live Risk Register – all risks accepted	Opened	17/10/12
Initial Rating	Likelihood: 5 Consequence: 4 Total: 20	Current Rating:	Likelihood: 4 Consequence:4 Total: 16	Target Rating:	Likelihood: 3 Consequence: 4 Total: 12
Risk Handler:	Jim Maguire	Risk Owner:	Gill Simpson	Linked to Risks:	
What is the Hazard:	Failure to gain access to patient occupied areas for a set period of time without patients being present will not allow PFI partners access to undertake statutory maintenance work, additional refurbishment work and Trust cleaning programs to be undertaken. Failure to undertake the refurbishment programme at the Royal Blackburn Hospital site will impact on the Trust's ability to achieve regulatory, contractual and national performance targets and achieve a sustainable financial position.		What are the risks associated with the Hazard:	Backlog maintenance continues to increase having a long and medium term impact on the physical estate and environment and implications for the PFI contract. Failure to implement the refurbishment programme may lead to suboptimal environments for the delivery of care and an inability to demonstrate compliance with regulatory and contractual requirements. This will impact on the delivery of care, trust performance, the imposition of financial penalties and reputational damage and may result in a requirement to derogate PFI provider from contractual responsibilities.	
What controls are in place:	Reporting through to PFI partners for urgent works		Where are the gaps in control:		
What assurances are in place:	Monitoring at Divisional meetings		What are the gaps in assurance:		

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD REPORT

Item 254

28 September 2016

Purpose Information
Action
Monitoring

Title	Serious Incidents Requiring Investigation Report
Author	Sonia Nosheen, Patient Safety Manager
Executive sponsor	Dr D Riley, Medical Director

Summary: This report provides a summary of the Serious incidents that have occurred within the Trust in July and August 2016, a status report on the delivery of Duty of Candour and assurance on actions taken following a number of Never Events that have occurred since July 2015.

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.

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

Report linkages

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

Recruitment and workforce planning fail to deliver the Trust objectives

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

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

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

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

Impact

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

Previously considered by: NA

Introduction

1. This paper provides the Board with:

- **Part 1:**
  An overview of all Serious Incidents Requiring Investigation (SIRIs) that have been reported during July and August 2016

- **Part 2:**
  A Duty of Candour performance report

Part 1: Overview of SIRIS reported

STEIS SIRIs reported in July and August 2016

2. There were 12 Strategic Executive Information System (STEIS) events reported in July and August 2016 which is an increase of 4 compared with the last reporting period. All will undergo Root Cause Analysis (RCA) which will be performance managed by the Trust's SIRI Panel and East Lancashire Clinical Commissioning Group.

No	Eir1	Division	Ward/ dept.	Description
1	109880	ICG	Marsden rehab stroke unit	Fractured neck of femur
2	111473	ICG	ED	Death due to underlying condition
3	110604	SAS	Theatre 4	Breach of confidentiality
4	108635	FC	Birth Suite BGH	Unexpected deterioration
5	110618	ICG	AMU B	Fractured neck of femur
6	111370	ICG	C4	Fractured neck of femur
7	101965	ICG	C11	Head injury due to fall
8	111876	ICG	ED	Mental Health Breach
9	111976	ICG	C4	Fractured neck of femur
10	108157	FC	Birth suite BGH	Still birth
11	110335	ICG	Reedyford Ward	Fractured neck of femur
12	109978	SAS	Theatres	Never event

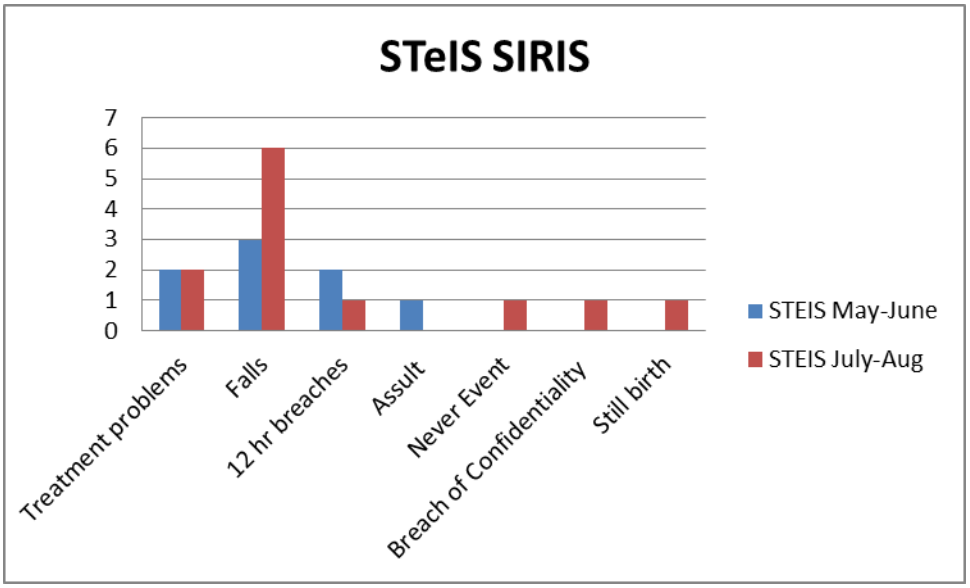
Non STEIS SIRIs reported in July and August 2016

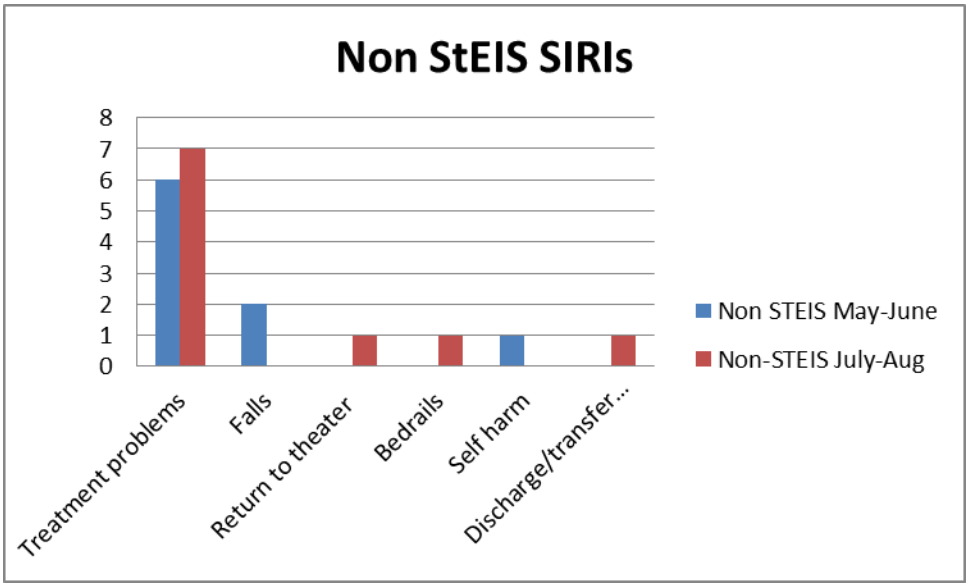
1. There were 10 non STEIS incidents deemed to be serious incidents requiring investigation in July and August 2016 compared to 9 in the previous reporting period. All

will undergo RCA and will be performance managed by the Serious Incident Review Group (SIRG).

No	Eir1	Division	Ward/dept.	Description
1	104459	SAS	Ward C22	Diagnosis failure/problem
2	106780	ICG	WardC11	Delay to diagnosis/problem
3	100890	ICG	Ward C5	Diagnosis failure/problem
4	111371	ICG	Ward C1	Serious injury associated with entrapment in bedrails
5	106309	SAS	Ward B22	Diagnosis failure/problem
6	111712	SAS	Ward B24	Diagnosis failure/failure to carry out appropriate diagnostic test
7	107253	ICG	Ward B22	Discharge/transfer problem (death due to underlying condition)
8	105719	SAS	Theatre 4	Return to theatre
9	109478	ICG	Ward C1	Diagnostic test failure/problem
10	109462	DCS	Radiology	Diagnosis failure/cancer misdiagnosis

2. *STEIS and non STEIS SIRIs reported above compared with previous months in graphical format*





Part 2: Duty of Candour (DOC) performance report

1. 27 patient safety incidents graded as moderate or above were reported in July and August 2016 which was a decrease on the 39 that were reported in the previous reporting period.

   At the time of writing this report there are 3 incidents where Duty of Candour has not as yet been served within the 10 day timeline.

   These incidents were subject to the DoC regulations which dictate that DoC should be served within a 10 day timeline.

   An update report setting out the rationale for the non-completion of DoC is shared with the Deputy Medical Director on a daily basis. The aim of this report is to facilitate a discussion between the Deputy Medical Director and the senior lead clinician responsible for each of the DoC cases to resolve any perceived difficulties

   In addition, a weekly meeting is held with the divisional governance leads to review any outstanding DoC cases and to agree plans to bring them back on track.

Sonia Nosheen, Patient Safety Manager, 20.09.16

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 256

28 September 2016

Purpose Information

Title	Obtaining Teaching Status
Author	Mr L Stove, Assistant Chief Executive
Executive sponsor	Mr K McGee, Chief Executive

Summary:

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

Recommendation:

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

Report linkages

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

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

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: N/A

Background

1. "A **Teaching Hospital** is a hospital that provides a wealth of training and development for future and current health professionals through a programme of both undergraduate and postgraduate clinical education, placements and training. Teaching hospitals are generally closely affiliated with one or more medical schools and schools for nursing, healthcare scientists and allied health care professionals. In addition to offering a wide spectrum of clinical education, many teaching hospitals also serve as research hospitals."

Teaching Hospital Status for ELHT

2. ELHT is on an adventurous journey to achieve University Status and sees that achieving 'Teaching Status' is a very important step towards achieving University Status. Changing the names of the two local hospitals will help the Trust in attracting high quality clinical staff (Dr's, Nurses, AHP's etc) and Professors.
3. In addition to this proposal the Trust has received a letter from UCLan fully supporting the Trust on its proposal and congratulates the Trust on its vision which shows the level of commitment from both parties.
4. At this stage changing the names of both Blackburn and Burnley hospitals will not affect the Trusts overarching title (its Establishment Order) which is East Lancashire Hospitals NHS Trust; the Trust can consider changing its establishment order when it achieves University Status.

Cost

5. The cost to change the existing titles to new titles which would include the word "Teaching" has been considered and will be minimal. The Trust at this stage proposes to change external signs that currently say "Royal Blackburn Hospital and "Burnley General Hospital" (mostly on entrance and exit to the sites) The Trust has also looked at stationary (letter heads paper, compliment slips etc) and because the Trust doesn't store months of stationary in advance and that the Trust currently buys in its stationary (because it's cheaper) the cost to change the logo will be minimum, this has been confirmed by the supplier. The Trust will only need to change all signage (internal, external, fleet of vehicles etc) once it achieves University Status which means it will have to formally change its establishment order with the DH.

Recommendations

6. This paper asks the Board to endorse the proposal of changing the names of “Royal Blackburn Hospital” and “Burnley General Hospital” to the “Royal Blackburn Teaching Hospital” and “Burnley General Teaching Hospital” so it can continue on its journey and achieve University Status.

TRUST BOARD REPORT PART 1

Item 257

28 September 2016

Purpose Monitoring

Title	Integrated Performance Report for the period to August 2016
Author	Mr M Johnson, Associate Director of Performance and Informatics
Executive sponsor	Mrs G Simpson, Executive Director of Operations

Summary: This paper presents the corporate performance data at August 2016 against the Trust Development Authority Standards and other key areas. This will be adjusted to the NHSI Single Oversight Framework from 1st October.

The report shows our key risks as:

- A&E 4-hour standard delivery
- Ambulance handover times increasing
- Cancer 62 day targets
- Achievement of STF funding in year related to performance targets
- Efficiency scheme slippage and financial position

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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	The Trust fails to deliver and develop a safe, competent workforce Partnership working fails to support delivery of sustainable safe, personal and effective care The Trust fails to achieve a sustainable financial position The Trust fails to achieve required contractual and national targets and its improvement priorities Corporate functions fail to support delivery of the Trust's objectives

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	Yes

Previously considered by: Not applicable

Trust performance report – September 2016

Key messages:

- Accident and emergency four-hour standard failed in August 2016 alongside the number of ambulance handover over 30 minutes
- The 62-day cancer treatment measure has improved and is now achieving the standard.
- Referral to treatment 18 week ongoing pathways continue to achieve, although continued pressure in some areas remains a risk.
- The number of delayed transfers of care remains above threshold.
- Financial position in line with plan at £1.5m deficit; forecast remains at £3.7m deficit
- Increase in the use of agency staffing over the summer period; above trajectory

Introduction/Background

1. This paper presents the Trust performance data for August 2016 against the Trust Development Authority Standards and other key measures. (please note: This will be adjusted to the recently published NHSI Single Oversight Framework from 1st October).

   With the exception of:
   - Mortality – SHMI – June 2016
   - Mortality – HSMR –June 2016
   - Cancer performance – July 2016
   - Sickness rates – July 2016
   - Ambulance indicators – July 2016
   - Venous Thromboembolism – July 2016

Achievements

2. **Main achievements for August 2016:**

   - No MRSA infections since December 2015
   - There was one Clostridium difficile toxin positive isolates identified in August 2016 against a trajectory of two. The year to date cumulative figure is 11 against the Trust threshold of 28.
   - Complaints remain below the 0.4 per 1000 contacts threshold with 31 new complaints in August.
   - Mortality indicators - The latest Trust SHMI continues to be within expected levels, as published in June 2016 at 1.06
   - Mortality indicators - The latest indicative 12 month rolling HSMR (June 15 – May 16) is reported 'as expected' at 97.59 against the monthly rebased risk model.
   - The Trust continues to receive a high response rate and positive scores for the friends and family test.
   - The Trust continues to achieve the hospital ambulance screen data quality compliance measure
   - Referral to treatment incomplete pathways remains above the 92% target.
     - There were no patients waiting over 52 weeks at the end of August.
   - The Cancer 62-day treatment measure has improved for July 2016 with 87.8% after underachieving the standard for May and June. At tumor site level Colorectal,

hematology, head & neck, upper GI and urology underachieved the 62-day standard.

- The new Trust core skills training package has been implemented replacing the core mandatory training. Compliance for most areas is good.
- Financially the Trust is reporting a deficit in line with plan and has identified efficiency schemes totaling £14m as planned.

Key Issues

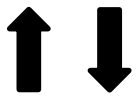
3. **Main issues for August 2016:**

- Overall performance against the Accident and Emergency four-hour standard continues to under achieve with 77.90% in August 2016.
- There have been nine breaches of the 12-hour standard from decision to admit, all mental health. A root cause analysis is being completed for each breach. There have now been twenty-eight 12-hour trolley waits since November 2015. These occurred in November (1), December (2), February (1), April (1), May (3), June (2), July (7) and August (9).
- There were 553 validated over 30-minute handover breaches in July 2016.
- The number of delayed transfers of care remains above threshold with 4.24%. This equates to 143 patients delayed in month with 38 patients still delayed at the month end.
- There were two patients in July treated after day 104.
- The sickness absence rate increased slightly from 4.86% in Jun 2016 to 4.91% in July 2016. This is higher than in the previous year (4.73%).
- Full receipt of the sustainability and transformational funding of £12.5m is dependent on the 4-hour target, RTT and cancer 62-day target. The pressure year to date is £360,000.
- Non-achievement of the Safely Releasing Cost Programme (SRCP) £9.9m has been actioned against the £14m target (71%), (59% in the previous month)
- Non-achievement of the new agency maximum threshold of £10.5m. £6.0m has been spent in 5 months.
- Non–achievement of the 3% Qualified Nurse Agency cap - current performance is 3.6%
- The operational and financial impact of any future industrial action
- The cash impact of any financial non-delivery

Key

4. The information assurance framework provides detail on the main key performance indicators detailed in this report and is intended to serve as a point of reference for Board member. It will also provide a useful reference point for staff who may view the performance report or other similar indicators in other business unit level reports.

The data for this measure is not currently available for this period.



These arrows identify whether high or low performance is required to achieve the standard.

Safe

		Threshold 16/17	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Monthly Sparkline
M64	CDIFF	28	2	4	4	5	3	3	1	2	1	2	3	4	1	
M65	MRSA	0	0	0	0	0	1	0	0	0	0	0	0	0	0	
M66	Never Event Incidence	0	0	0	0	0	1	1	0	1	0	0	0	1	0	
M67	Medication errors causing serious harm (Steis reported date)	0	0	0	0	0	0	0	0	0	0	0	1	0	0	
C28	Percentage of Harm Free Care	92%	98.77%	99.37%	98.96%	99.11%	99.20%	99.14%	99.37%	99.06%	99.74%	98.77%	99.06%	99.41%	99.20%	
M68	Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	98.44%	97.39%	98.94%	98.69%	99.08%	99.40%	99.34%	99.07%	99.12%	99.03%	99.00%	99.17%		
M69	Serious Incidents (Steis)		8	3	3	8	10	7	9	7	10	2	6	5	7	
M70	CAS Alerts - non compliance	0	4	0	0	0	1	0	0	0	0	0	0	0	0	
M146	Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80%	86%	87%	91%	92%	90%	89%	89%	86%	88%	89%	87%	86%	85%	
M147	Safer Staffing -Day-Average fill rate - care staff (%)	80%	106%	105%	105%	109%	105%	105%	105%	107%	110%	114%	116%	118%	126%	
M148	Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80%	98%	98%	99%	98%	97%	97%	97%	97%	97%	99%	98%	99%	98%	
M149	Safer Staffing -Night-Average fill rate - care staff (%)	80%	109%	114%	112%	117%	116%	120%	120%	121%	124%	122%	129%	136%	142%	
M150	Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80%	0	18	10	6	3	9	8	12	19	16	11	17	15	21	
M151	Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80%	0	0	0	1	0	0	0	0	0	0	0	1	1	0	
M152	Safer Staffing - Day -Average fill rate - care staff- number of wards <80%	0	5	4	1	1	2	3	4	3	2	0	0	0	0	
M153	Safer Staffing - Night -Average fill rate - care staff- number of wards <80%	0	2	2	1	1	1	3	2	3	2	1	1	1	1	

Caring

		Threshold 16/17	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Monthly Sparkline
C38	Inpatient Friends and Family - % who would recommend	92.07%	98.59%	98.71%	98.16%	98.10%	98.77%	99.08%	96.90%	98.44%	98.63%	97.91%	98.64%	98.54%	98.16%	
C40	Maternity Friends and Family - % who would recommend	91.86%	94.15%	94.90%	94.09%	95.80%	92.60%	93.37%	95.50%	96.60%	96.42%	96.68%	95.87%	95.78%	96.98%	
C42	A&E Friends and Family - % who would recommend	74.90%	84.42%	84.66%	83.20%	83.90%	85.14%	78.28%	80.80%	76.52%	80.44%	75.73%	76.25%	75.03%	73.91%	
C44	Community Friends and Family - % who would recommend	88.62%	93.51%	91.57%	94.59%	93.90%	93.67%	94.37%	93.70%	93.70%	93.95%	94.94%	94.34%	93.63%	94.33%	
C15	Complaints – rate per 1000 contacts	0.4	0.25	0.20	0.22	0.21	0.18	0.28	0.30	0.18	0.26	0.24	0.21	0.22	0.23	
M52	Mixed Sex Breaches	0	0	0	2	0	0	0	0	0	0	0	0	0	0	

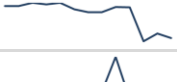
Effective

		Threshold 16/17	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Monthly Sparkline
M73	Deaths in Low Risk Categories - relative risk	Outlier	68.69	65.22	68.76	68.60	68.50	75.49	75.59	70.40	67.80	71.60				
M74	Hospital Standardised Mortality Ratio - Weekday (DFI Indicative)	Outlier	102.01	103.06	100.25	100.94	98.64	96.36	94.82	94.88	96.08	96.08				
M75	Hospital Standardised Mortality Ratio - Weekend (DFI Indicative)	Outlier	106.92	106.47	106.88	104.01	101.63	101.91	101.73	101.56	106.52	101.96				
M54	Hospital Standardised Mortality Ratio (DFI Indicative)	Outlier	103.35	104.02	101.94	101.72	99.40	97.76	96.58	96.98	99.12	97.59				
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Outlier		1.06			1.06									
C16	Emergency re-admissions within 30 days		12.75%	12.65%	12.69%	13.44%	13.33%	13.34%	12.56%	12.76%	12.31%	12.94%	13.08%	10.98%	9.82%	
M89	CQUIN schemes at risk	0		0			3			2						

Responsive

		Threshold 16/17	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Monthly Sparkline
C2	Proportion of patients spending less than 4 hours in A&E	95%	93.32%	94.79%	93.56%	94.42%	94.49%	88.15%	89.95%	87.77%	88.50%	85.47%	85.47%	84.26%	77.90%	
M62	12 hour trolley waits in A&E	0	0	0	0	1	2	0	1	0	2	3	3	7	9	
C1	RTT admitted: percentage within 18 weeks	95%	89.9%	85.0%	85.3%	85.0%	86.3%	82.5%	83.2%	81.2%	78.5%	80.4%	79.2%	73.7%	79.0%	
C3	RTT non- admitted pathways: percentage within 18 weeks	90%	97.5%	97.5%	96.3%	97.5%	95.9%	95.3%	95.6%	96.3%	94.4%	94.4%	95.0%	93.8%	94.9%	
C4	RTT waiting times Incomplete pathways	92%	97.9%	96.7%	95.9%	94.6%	93.9%	94.5%	95.2%	95.6%	94.8%	93.7%	94.7%	95.7%	93.9%	
C37.1	RTT 52 Weeks (Ongoing)	0	0	0	0	0	0	0	0	0	1	2	1	1	0	
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1%	0.09%	0.11%	0.02%	0.1%	0.08%	0.19%	0.15%	0.15%	0.22%	0.11%	0.24%	0.31%	0.26%	
C18	Cancer - Treatment within 62 days of referral from GP	85%	86.6%	85.90%	93.2%	89.2%	91.0%	93.7%	86.6%	88.4%	85.6%	82.8%	81.6%	87.8%		
C19	Cancer - Treatment within 62 days of referral from screening	90%	93.9%	95.70%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%		
C20	Cancer - Treatment within 31 days of decision to treat	96%	98.1%	100.00%	100.0%	100.0%	100.0%	98.3%	100.0%	98.9%	100.0%	98.4%	99.1%	99.4%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98%	100.0%	100.00%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94%	100.0%	100.00%	97.4%	100.0%	100.0%	99.0%	97.3%	94.1%	97.1%	100.0%	97.8%	97.7%		
C24	Cancer - seen within 14 days of urgent GP referral	93%	96.0%	96.40%	96.3%	96.7%	96.7%	97.6%	95.5%	95.6%	95.2%	95.1%	94.3%	95.4%		
C25	Cancer - breast symptoms seen within 14 days of GP referral	93%	94.6%	94.70%	97.1%	93.0%	97.2%	96.4%	97.3%	93.6%	95.2%	94.1%	93.0%	97.5%		
M9	Urgent operations cancelled for 2nd time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	1	0	0	0	0	0	0	0	0	1	0	1	1	
M55	Proportion of delayed discharges attributable to the NHS	3.5%	3.69%	3.62%	3.64%	3.0%	4.16%	4.42%	4.75%	4.76%	4.02%	4.20%	4.37%	5.21%	4.24%	
M90	Average LOS elective and daycase		3.5	2.8	2.4	2.9	2.8	2.9	3.0	2.8	2.8	2.6	2.9	2.3	2.9	
M91	Average LOS non-elective		4.7	4.4	4.6	4.6	4.6	4.6	4.6	4.9	4.8	5.0	5.0	4.5	4.9	

Well led

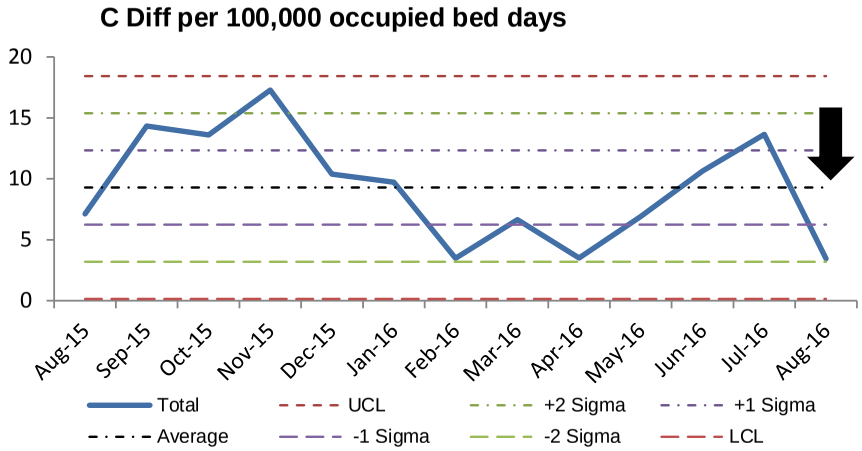
		Threshold 16/17	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Monthly Sparkline
C31	NHS England Inpatients response rate from Friends and Family Test	16%	55.12%	45.92%	49.05%	43.70%	49.81%	48.87%	48.50%	50.14%	45.89%	53.95%	50.48%	47.73%	51.24%	
C32	NHS England A&E response rate from Friends and Family Test	4%	25.44%	25.04%	25.42%	23.00%	23.69%	21.06%	21.71%	22.18%	21.80%	19.75%	19.65%	20.45%	21.50%	
M77	Trust turnover rate	12%	9.6%	9.7%	9.6%	9.5%	9.4%	9.3%	9.2%	8.7%	8.9%	8.9%	9.0%	9.0%	9.4%	
M78	Trust level total sickness rate	3.75%	4.87%	4.81%	4.91%	4.93%	4.74%	4.81%	4.74%	4.45%	4.5%	4.5%	4.9%	4.9%		
M79	Total Trust vacancy rate	5%	6.1%	5.2%	6.8%	6.5%	7.5%	7.8%	7.1%	7.3%	8.0%	6.7%	7.7%	8.0%	7.3%	
M80.1	Mandatory Training	95%	84.0%	89.0%	92.0%	93.0%	90.0%	89.0%	85.0%	82.0%						
M80.2	Safeguarding Children	80%	81.0%	84.0%	85.0%	86.0%	86.0%	87.0%	87.0%	88.0%	88.0%	88.0%	90.0%	91.0%	93.0%	
F8	Temporary costs as % of total paybill	4%	7%	8%	8%	8%	8%	8%	9%	9%	7%	7%	8%	9%	10%	
F9	Overtime as % of total paybill	0%	0%	1%	0%	1%	0%	0%	1%	0%	1%	0%	0%	0%	0%	
F1	Cumulative Retained Deficit for breakeven duty (£M)	(3.7)	(7.5)	(8.2)	(8.8)	(9.5)	(10.1)	(10.8)	(11.2)	(11.5)	(0.3)	(0.6)	(0.9)	(1.2)	(1.8)	
F2	SRCP Achieved % (green schemes only)	100.0%	33%	46%	49%	54%	60%	62%	64%	64%	52%	54%	56%	59%	71%	
F3	Liquidity days	>(14.0)	(10.8)	(13.2)	(12.7)	(13.2)	(13.5)	(14.0)	(14.4)	(5.0)	(5.3)	(5.9)	(5.6)	(5.5)	(5.8)	
F4	Capital spend v plan	85%	81%	75%	72%	71%	71%	72%	71%	90%	93%	91%	79%	73%	75%	
F5	FSSR (Continuity of risk rating)	3	2	2	2	2	2	2	2	3	2	2	3	3	3	
F6	FSSR - Liquidity rating	2	3	3	2	2	2	1	1	3	3	3	3	3	3	
F7	FSSR - Capital Servicing Capacity rating	1	1	1	1	1	1	1	1	3	1	1	2	2	2	
F10	FSSR - I&E Margin	3				1	1	1	1	4	2	2	2	2	2	
F11	FSSR - I&E Margin variance from plan	4				4	4	4	4	4	2	2	3	3	4	
F12	BPPC Non NHS No of Invoices	95%	96.2%	96.0%	96.0%	95.9%	95.9%	95.7%	95.5%	95.5%	96.8%	96.3%	96.0%	96.2%	96.4%	
F13	BPPC Non NHS Value of Invoices	95%	95.1%	94.5%	94.8%	94.8%	95.1%	95.3%	95.2%	95.4%	98.2%	96.7%	95.7%	95.8%	96.2%	
F14	BPPC NHS No of Invoices	95%	95.4%	95.4%	95.6%	95.5%	95.6%	95.2%	95.0%	95.0%	95.3%	95.3%	93.2%	93.7%	93.4%	
F15	BPPC NHS Value of Invoices	95%	96.4%	96.4%	97.0%	96.6%	96.6%	96.6%	96.6%	96.4%	99.5%	95.8%	95.9%	96.6%	96.6%	

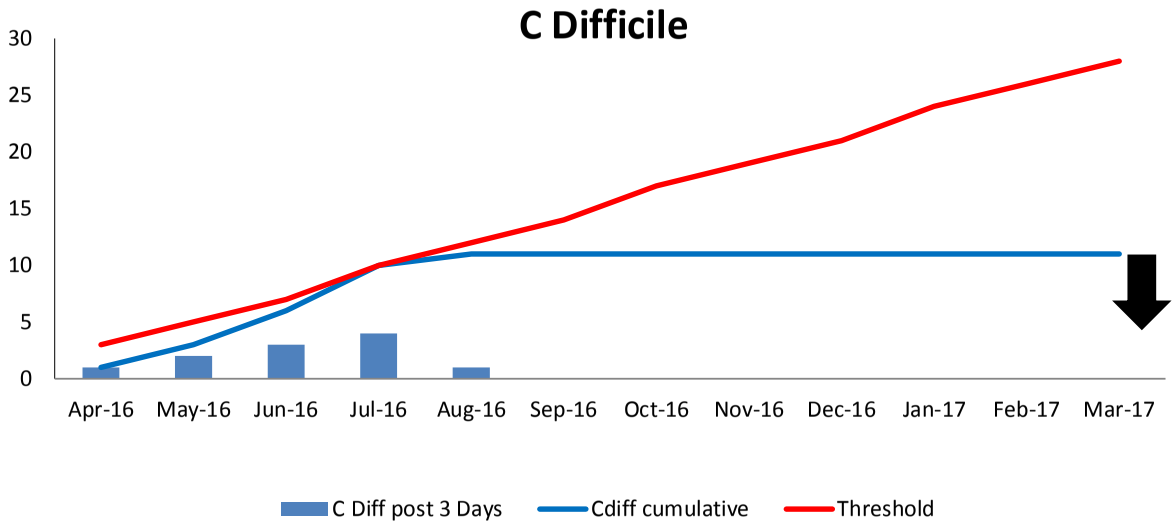
Safe – Infection Control (M64, M65)

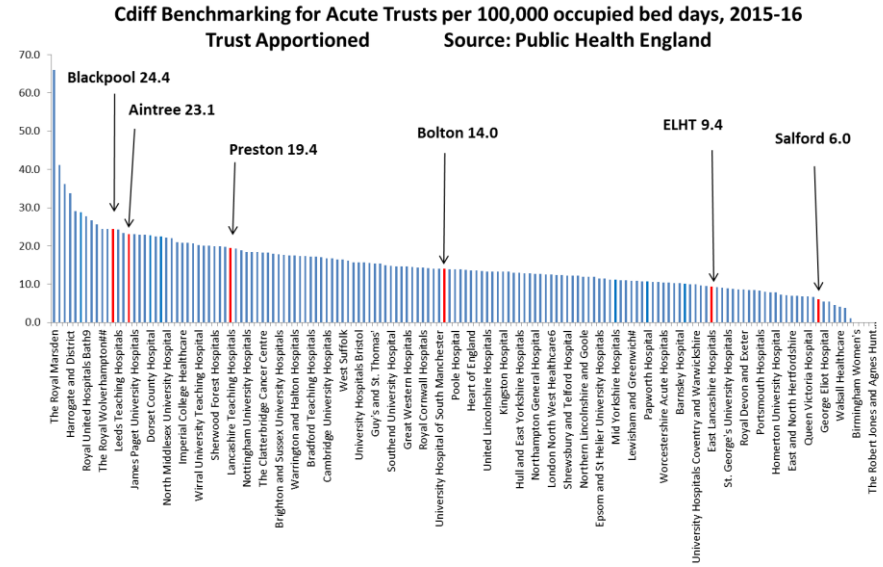
No MRSA infections detected in August post 2 days of admission. Zero attributed YTD against threshold of zero.

There was one Clostridium difficile toxin positive isolate identified in the laboratory in August which were post 3 days of admission. The year to date cumulative figure is 11 against the trust target of 28.

ELHT ranked 31st out of 154 trusts in 2015-16 with 9.4 clostridium infections per 100,000 bed days.







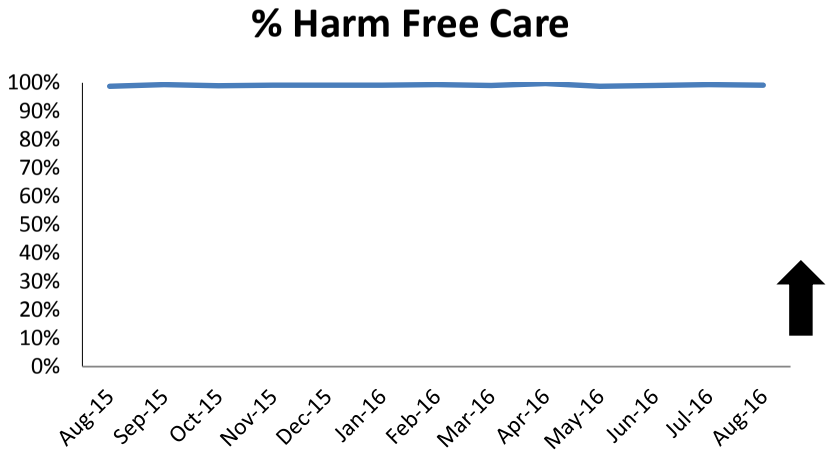
Safe – Harm Free Care

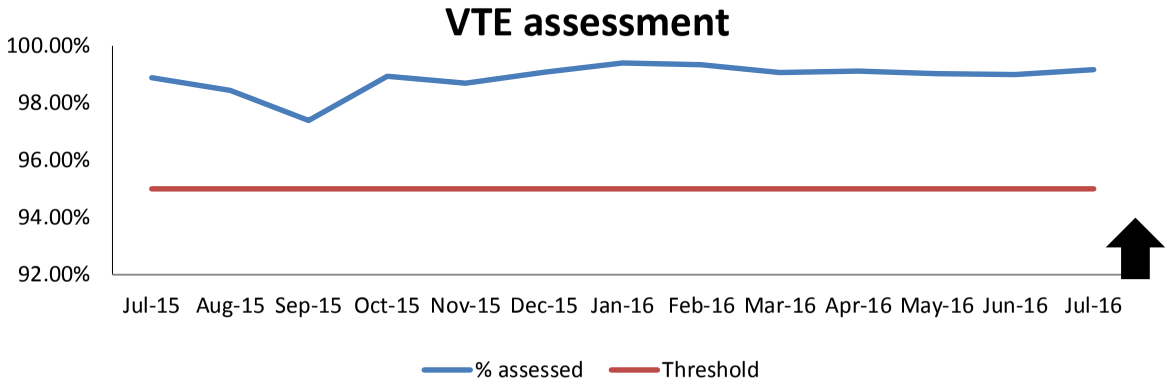
Never events
There were no never events reported to Steis in August.

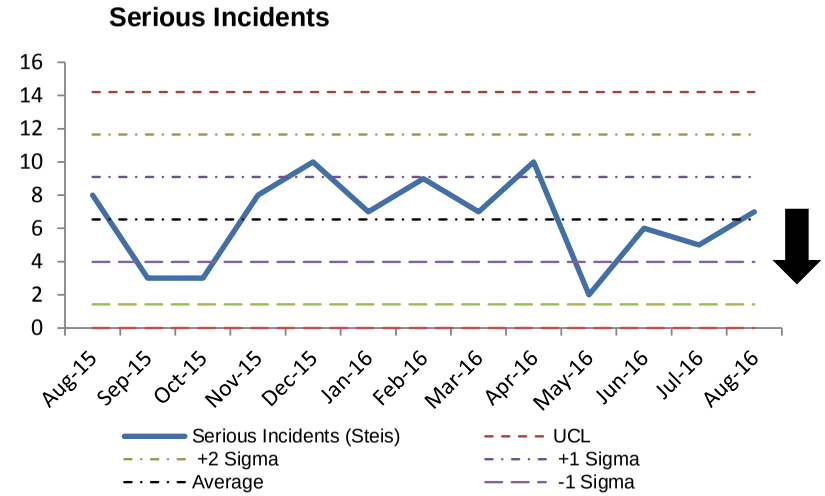
Serious Incidents
The Trust unverified position for incidents reported to the Strategic Executive Information System (StEIS) in the month of August was seven incidents. These incidents were categorised as three slips, trips and falls, two maternity and obstetric, one commissioning and one diagnostic incident.
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
The Trust remains consistent with the percentage of patients with harm free care at 99.20% for August 2016 using the National safety thermometer tool.

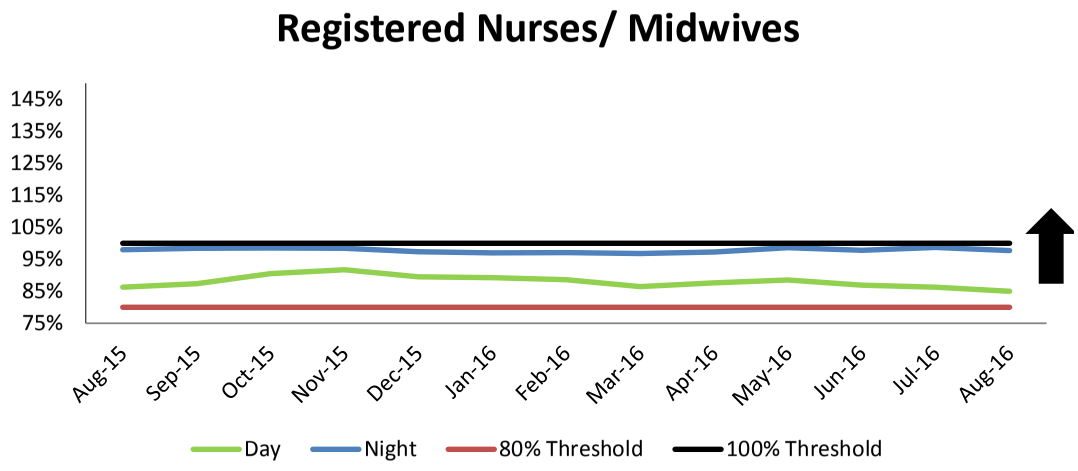
For August 2016 we are reporting the current position as one grade 2 hospital aquired, two grade 2 community acquired and one grade 3 community acquired pressure ulcers. All pending investigation.

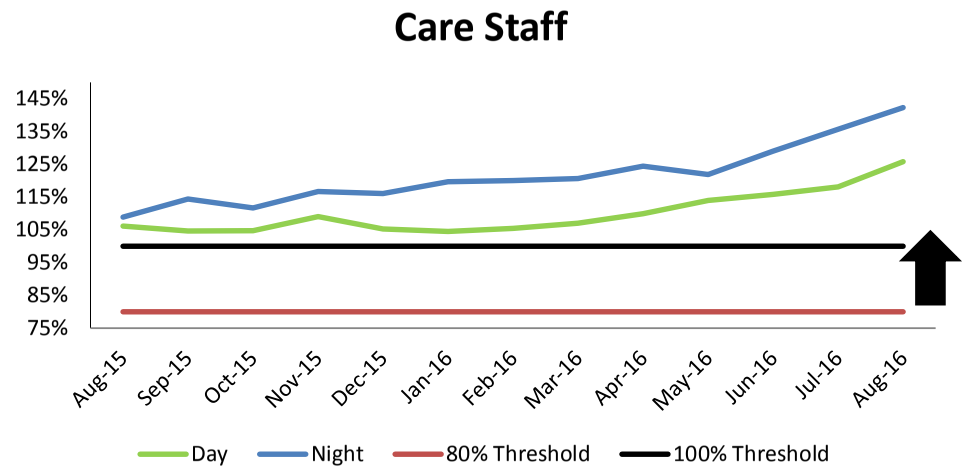






Safe – Safer Staffing





Nursing and midwifery staffing in August 2016 continued to be extremely challenging. The causative factors remained as in previous months, compounded by escalation areas on Ward C3 and the Surgical Day Case unit. 21 areas fell below an 80% average fill rate for registered nurses on day shifts, which was deterioration by 6 areas on the previous month.

Of the 21 areas below the 80% average fill rate, 7 of these wards areas were entirely due to coordinator availability, which is in addition to the agreed safe staffing levels, of the remaining 14 areas, 7 of those were minimally different than the 7, which left 7 areas of concern:

B2 –following on from the professional judgment staffing review B2 has had had its registered and unregistered nursing established increased and we are in the process of recruiting to these vacancies.
C14 – carrying high level of vacancies, a significant proportion of which will be filled by September 2016. No harms were identified.
Ward 16 – whilst some shifts fell below the 1:8 (6 early shifts and 12 late shifts). This was due to unfilled bank shifts and sickness. No harms were identified.
B22 – Carrying a high level of vacancies. Staff have been moved from other Orthopaedic wards. However, there was a higher than usual short term sickness level in the month of August 2016. No harms were identified.
B20 – Carrying a high level of vacancies which are all recruited to. However, there was a higher than usual level of short term sickness in August 2016. No harms were identified.
D1 – Carrying a high level of vacancies and some short term sickness within the month of August (4 shifts fell below minimum staffing levels). No harms were identified.
D3 – Carrying a high level of vacancies and some short term sickness within the month of August (4 shifts fell below minimum staffing levels). No harms were identified.

It should be noted that actual and planned staffing does not denote acuity and dependency, bed occupancy or women in labour. The divisions consistently flex staffing resources to ensure safety is maintained. Of the DATIX incidents reported the divisions have given assurance that no harm has been identified as a consequence. To mitigate the risk of staffing shortfalls the Director of Nursing has authorised an increase in the 'Allocation of Arrival' bank/agency staff to 15 RN's and 15 CSW's per shift. This process has been in place during and since the last 2 weeks of August 2016 to the present time. This process is under weekly review.

4 red flag incidents were reported, one related to maternity (see below), one to less than 2 registered nurses present on duty which was inaccurate, and 1 relating to a delay of more than 30 minutes in providing pain relief. On further investigation this incident was related to staffing and feedback has been given to the night manager who made the decision to move the staff. The other is related to staff missing breaks.

Family Care

Incidents
1 incident was reported within Maternity Services as a "Red Flag" incident in August 2016.
There was no injury from the incident and on further investigation, the incident occurred on Burnley Birth Centre which is alongside Central Birth Suite and all appropriate actions were taken. A further 5 Incidents were reported under the staffing category and all were reported on the Antenatal ward and recorded as no injury or financial loss.

Maternity
Midwifery staffing remains challenging due to maternity leave, sickness, absence and vacancies. These gaps are currently filled by midwives filling bank shifts and rotating staff around the areas according to acuity. On a daily basis midwife staffing levels and workloads are assessed and action is taken to maintain safe services. This has been escalated to the Director of Nursing and an agreement to increase bank payments to encourage midwives to fill the shifts to maintain a safe service has been extended to the end of October 2016. There are 7 new recruits who start early September 2016 and 7 at the end of September 2016 along with 6 in October 2016. However all of these are newly qualified and are unlikely to have registration with the Nursing & Midwifery Council until late October 2016. There is still 11 WTE vacancies and shortlisting and interviews are being planned.
Intrapartum services at the Blackburn Birth Centre have been reduced to one woman in labour. Recruitment in maternity is on-going.

NICU
The establishment has now been increased in NICU and but nurse vacancies are yet to be recruited to. To ensure safe staffing levels bank and agency is being used.

Paediatrics
Currently experiencing nursing gaps due to sickness and vacancies which are being filled by the shift co-ordinators and bank. Recruitment to these posts is in progress.

August Maternity staffing/Birth Ratios
The midwifery staffing for ELHT is currently calculated using the below 3 criterion
The midwife to birth ratio based on full midwifery establishment In the last 12 months
for the month of July this was **1:30.3**
The midwife to birth ratio based on the staff in post (excluding vacancies and mat leave) this was **1:31.5**
The midwife to birth ratio based on staff in post with midwife bank shifts worked included was **1:29.1**

To reach the 1:29.1 for the month of August, the equivalent of 15 WTE midwife bank shifts were worked across maternity services. No agency staff were used.

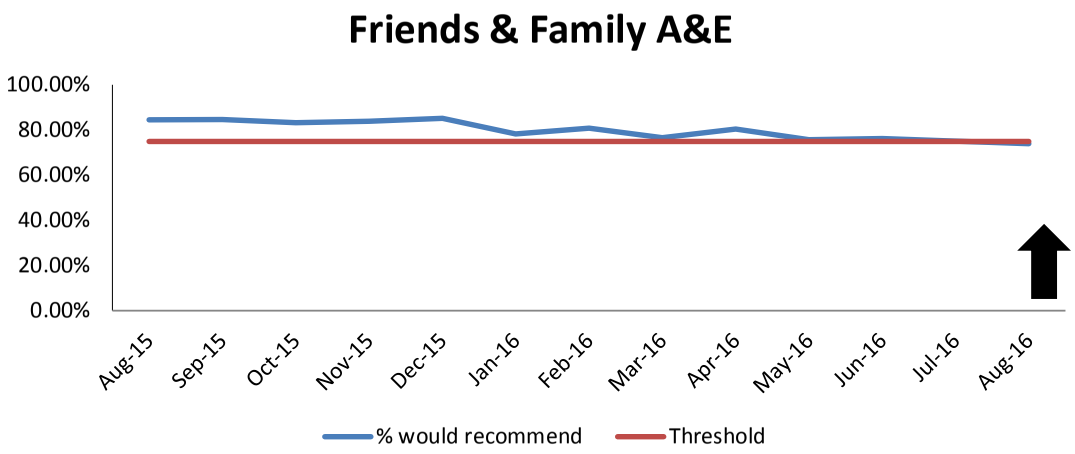
The figures only reflect staffing for a midwife to birth ratio and does not include other activities or acuity across the services.

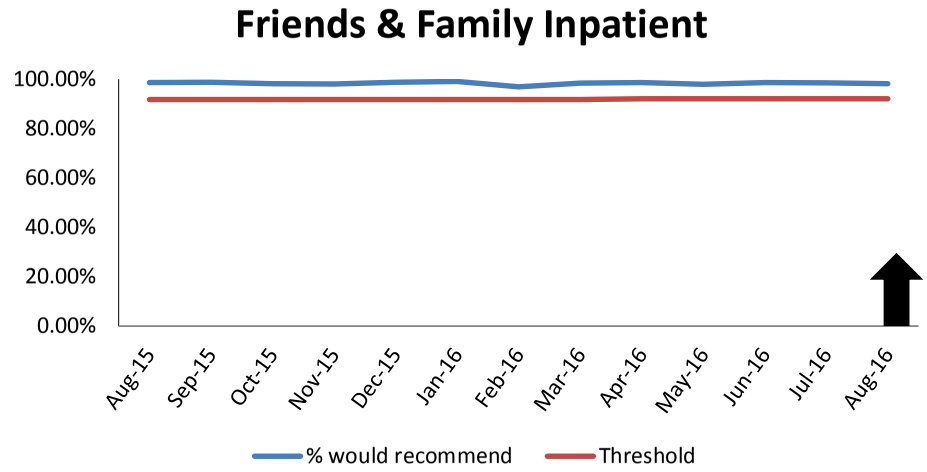
The above figures are calculated using the WTE against the births over the previous 12 months. These figures are also reported on the maternity dashboard.
A targeted piece of work is currently being undertaken, benchmarking ELHT maternity staffing with other providers.

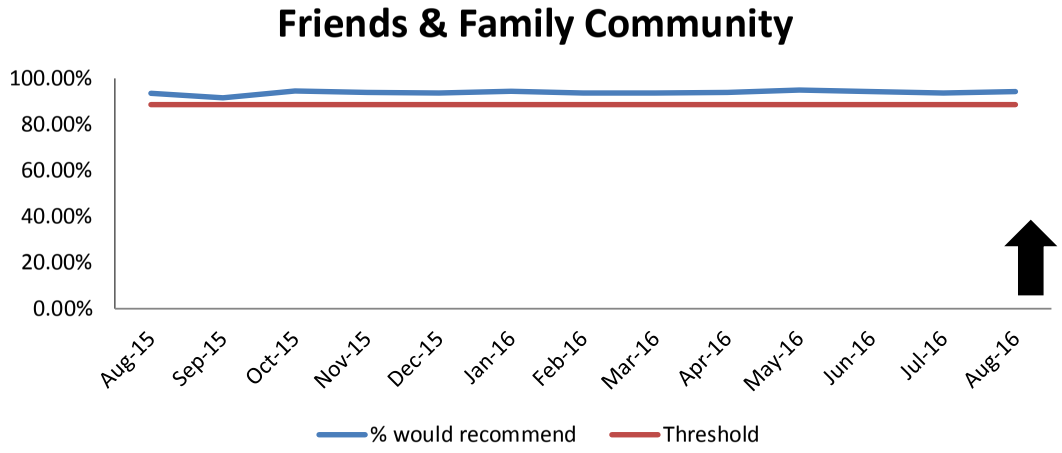
Please see Appendix 1 for UNIFY data and Appendix 2 for nurse sensitive indicator report

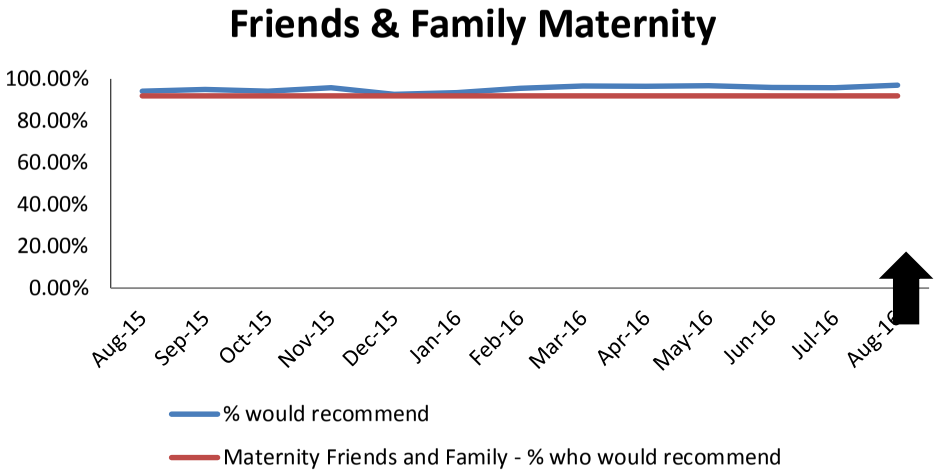
Caring – Friends and Family Test (C38, C42)

This report reflects national measurement methodology, which measures the proportion of patients that would recommend the Trust to friends and family. The latest Trust development authority thresholds have been included where available.
In August the number that would recommend A&E to friends and family decreased to 73.9%, whilst the proportion that would recommend inpatient services, decreased slightly to 98.2%. Community services would be recommended by 94.3% and maternity 97.0%









Caring – Complaints and Patient Experience

Complaints
The Trust received 31 new complaints during August which is an increase on last month.

Patient Experience Surveys
The table demonstrates divisional performance from the range of patient experience surveys for August 2016. The threshold is a positive score of 90% or above for each of the 4 competencies.

The Divisional performance from the range of patient experience surveys is above the threshold of 90% for all of the 4 competencies in August 2016.

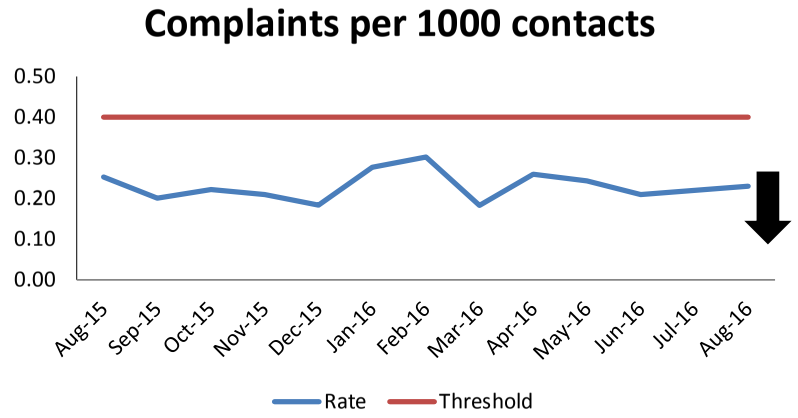
Overall performance by the Integrated Care Group – Acute increased to 98%. Performance against the information and involvement competencies increased to 99% and performance against the quality competency increased to 96% from 95% the previous month.

Overall performance by the Integrated Care Group – Community fell to 99% in August from 100% in July. There were slight falls in performance against Dignity, Involvement and Quality in August but performance against involvement remained at 100%.

Surgery – overall performance in August fell to 97% from 98% the previous month. Performance against the information, involvement and quality competencies also fell slightly but performance against Dignity increased to 99% from 97% the previous month.

The Family Care Division's overall performance increased to 96% from 95% the previous month. Performance against Information increased to 97% from 95% in July.

Overall performance for the Diagnostic and Clinical Care Directorate remained the same as the previous month as did performance against information, involvement and Quality. However, performance against dignity decreased slightly to 95%.



August 2016 Totals	Overall		Dignity	Information	Involvement	Quality
	No.	%	%	%	%	%
Trust	2434	97%	98%	98%	99%	97%
Integrated Care Group - Acute	742	98%	99%	99%	99%	96%
Integrated Care Group - Community	343	99%	99%	99%	100%	99%
Surgery	421	97%	99%	97%	97%	98%
Family care	479	96%	99%	97%	98%	96%
Diagnostic and Clinical	430	95%	95%	95%	98%	95%

Effective - Mortality

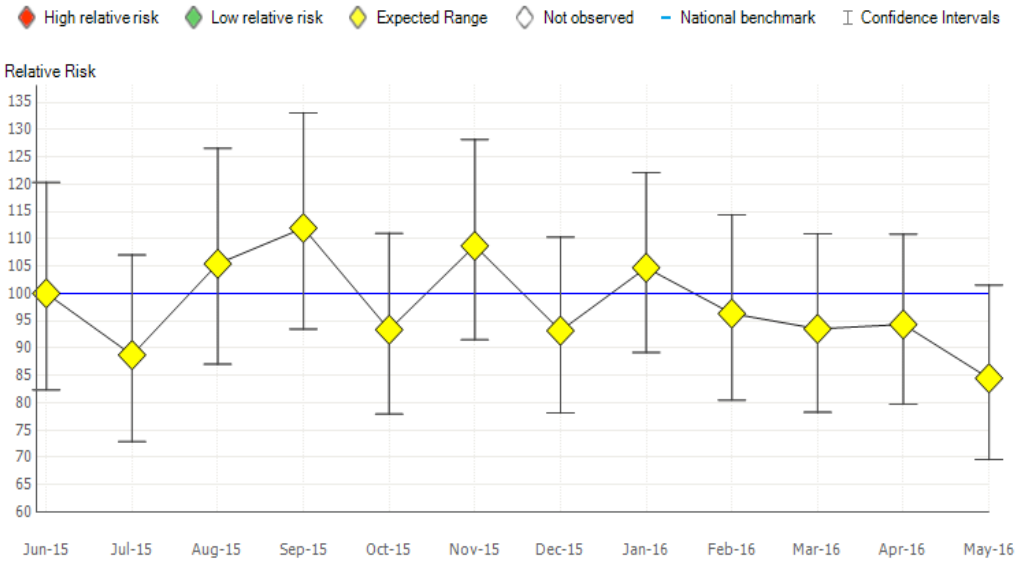
The latest Trust SHMI value as reported by the Health and Social Care Information Centre and Care Quality Commission is within expected levels, as published in June 2016 at 1.06

The TDA published HSMR is currently within expected levels at 103.03 (July 14 - June 15)

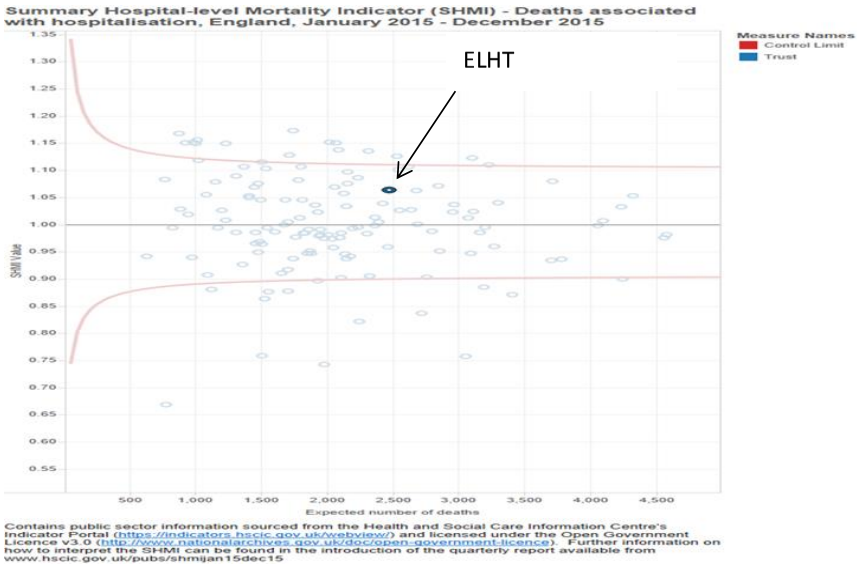
DFI Indicative HSMR - rolling 12 month - Green rating
The latest indicative 12 month rolling HSMR (June 15 – May 16) is reported 'as expected' at 97.59 against the monthly rebased risk model.

	TDA Reported HSMR July 14 – June 15	DFI Rebased on latest month June 15 – May 16 (Risk model Feb 16)
TOTAL	103.03	97.59 (CI 92.8 – 102.57)
Weekday		96.08 (CI 90.61 – 101.80)
Weekend	103.94	101.96 (CI 92.26 – 112.41)
Deaths in Low Risk Diagnosis Groups		71.57 (CI 43.07 – 111.77)

Dr. Foster Indicative HSMR monthly Trend



SHMI Published Funnel Plot

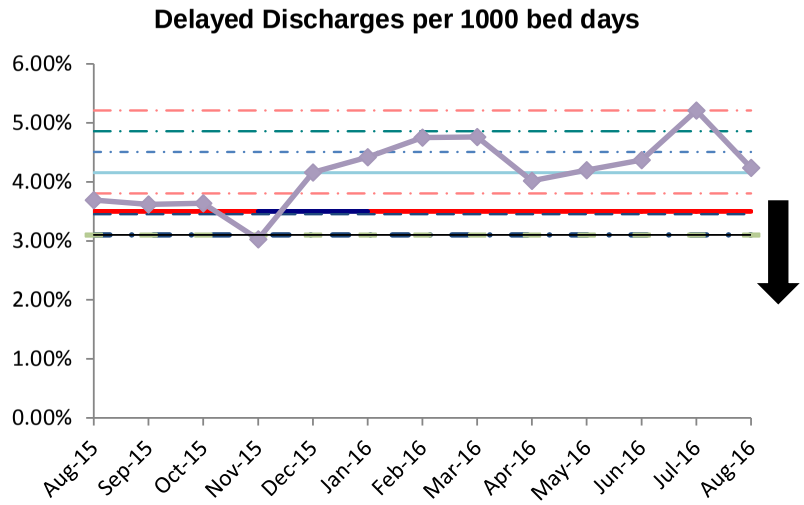


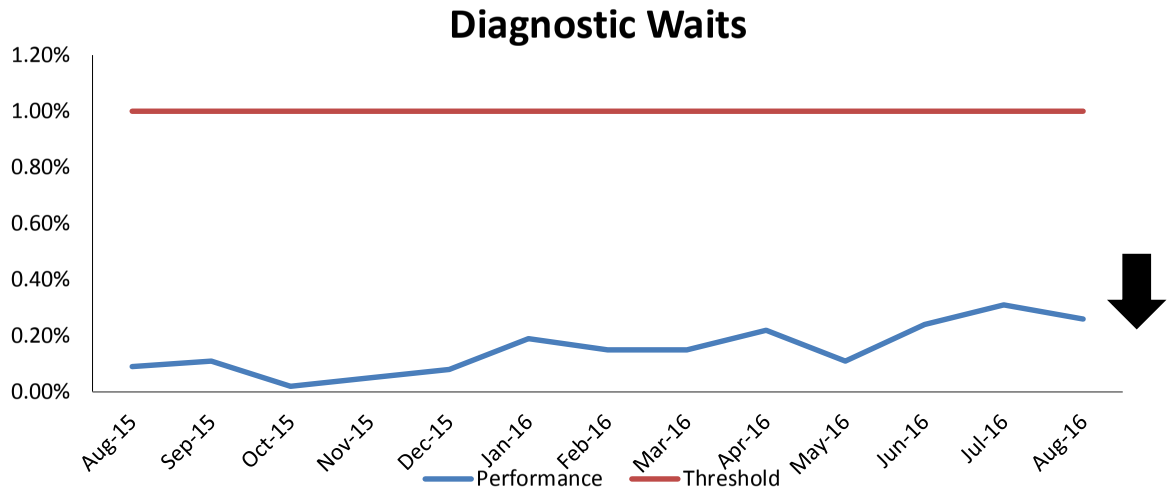
Effective/Responsive - Readmissions, Diagnostic Waits, Delayed Discharges

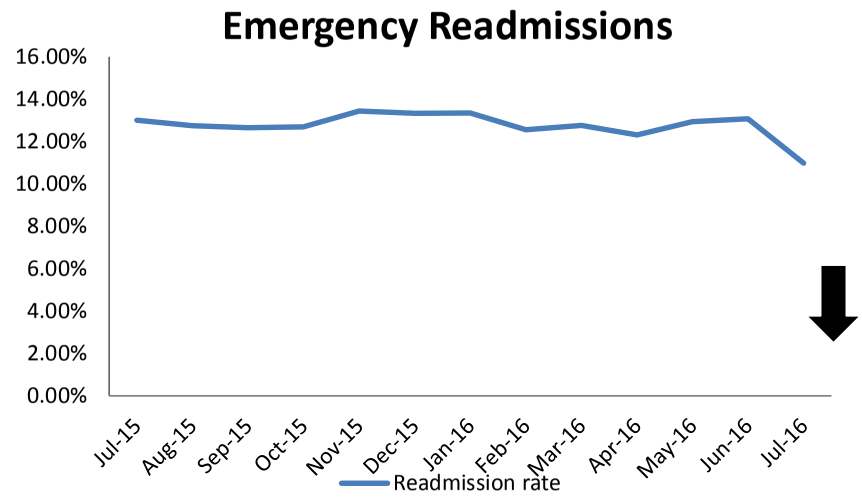
Delayed Discharges. The number of delays reported against the delayed transfers of care standard has increased and remained above threshold at 4.24%.

Emergency Readmissions (Reported 1 month behind). The emergency readmission rate is reported at 10.98% in July 2016 compared with 13.01% in July 2015.

Diagnostic Waits. This measures the proportion of patients exceeding the 6 week target for a diagnostic procedure. In August, 0.26% waited longer than 6 weeks.







Effective - CQUIN

Commissioning for Quality and Innovation (CQUIN)

CQUIN Scheme		Data Collection Freq	Reporting Freq	Target		Apr-16	May-16	Jun-16	Q1
national	**NHS STAFF HEALTH & WELLBEING** - Flu Vaccine Uptake	**Mthly**	**Dec-16**	**75%**					
national	**SEPSIS PART A**- screening in **emergency department** - Adult	**Mthly**	**Qtrly**	**90.0%**		**100.0%**	**100.0%**	**100.0%**	100.0%
	- screening in **emergency department** - child	**Mthly**	**Qtrly**	**90.0%**		**100.0%**	**100.0%**	**100.0%**	100.0%
national	- antiobiotic administration & review - adult - number eligible	**Mthly**	**Qtrly**			**4**	**6**	**0**	10
national	- antiobiotic administration & review - adult %	**Mthly**	**Qtrly**			**100.0%**	**66.7%**	**n/a**	81.8%
national	- antiobiotic administration & review child - number eligible	**Mthly**	**Qtrly**			**0**	**0**	**0**	0
national	- antiobiotic administration & review child %	**Mthly**	**Qtrly**			**n/a**	**n/a**	**n/a**	n/a
national	**SEPSIS PART B**- screening in an inpatient setting - adult	**Mthly**	**Qtrly**	**90.0%**		**100.00%**	**100.00%**	**100.00%**	100.0%
national	- screening in an inpatient setting -child			**90.0%**		**100.00%**	**100.00%**	**100.00%**	100.0%
national	- antiobiotic administration & review - adult - number eligible	**Mthly**	**Qtrly**			**8**	**5**	**2**	15
national	- antiobiotic administration & review - adult %	**Mthly**	**Qtrly**			**100.0%**	**100.0%**	**50.0%**	93.3%
national	- antiobiotic administration & review - child - number eligible	**Mthly**	**Qtrly**			**0**	**0**	**0**	0
national	- antiobiotic administration & review - child %	**Mthly**	**Qtrly**			**n/a**	**n/a**	**n/a**	n/a

CQUIN Scheme		Data Collection Freq	Reporting Freq	Target		Apr-16	May-16	Jun-16	Q1
national	**ANTIMICROBIAL RESISTANCE PART A**- Total antiobiotic consumption per 1000 admissions	Qtrly	Annual	Reduction of 1%					
national	- Total consumption of carbapenem per 1000 admissions	Qtrly	Annual	Reduction of 1%					
national	- Total consumption of piperacillin per 1000 admissions	Qtrly	Annual	Reduction of 1%					
national	**ANTIMICROBIAL RESISTANCE PART B** - Empiric Review of antiobiotic prescriptions	Mthly	Qtrly			84%	78%	74%	79%
local	**SAVING BABIES LIVES** - Induction rate	Mthly	Qtrly			24.7%	23.9%	25.7%	
local	- Induction rate (FGR/ Reduced fetal movements)	Mthly	Qtrly			46.7%	49.3%	51.4%	49.10%
local	- No. Stillbirths, TOTAL	Mthly	Qtrly			1	3	5	9
local	-Smoking Status at Booking	Mthly	Qtrly			18.2%	17.7%	17.6%	17.8%
local	-Smoking Status at Delivery	Mthly	Qtrly			15.8%	16.2%	16.1%	16.1%
local	-Number of staff who have undertaken PROMPT (CTG training) - rolling 12 months	Qtrly	Qtrly				337		337
local	-Percentage of staff who have undertaken PROMPT (CTG training) - Rolling 12 months	Qtrly	Qtrly			86.6%	78.0%	76.0%	76.0%
local	-Training in the use of customised growth charts	Mthly	Qtrly			90.2%	103.8%	90.2%	90.2%
local	-Feedback from women on information provided on reduced fetal movements	Mthly	Qtrly			98.2%	87.3%	94.0%	93.10%
local	**REFER TO PHARMACY** - Referrals	Qtrly	Qtrly	Q1 1000 Q2 1300 Q3 1600 Q4 2000			1275		1275
Spec Comms	**NEONATAL CRITICAL CARE** - 2 year Outcomes	Qtrly	Mthly			100%	100%	100%	100%
Spec Comms	- Hypothermia Prevention - Temperature taken within 1 hr	Qtrly	Mthly	98.0%		100%	100%	100%	100%
Spec Comms	- Hypothermia Prevention - Temperature >=36 degrees	Qtrly	Mthly	95.0%		91%	100%	88%	93%
Spec Comms	**CANCER** - Dose Banding	Qtrly	Qtrly				0%		0%

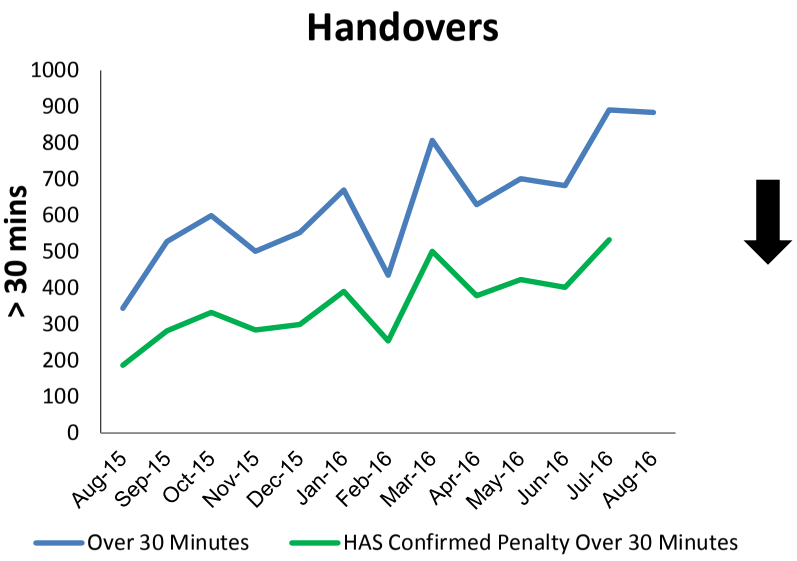
Responsive – A&E

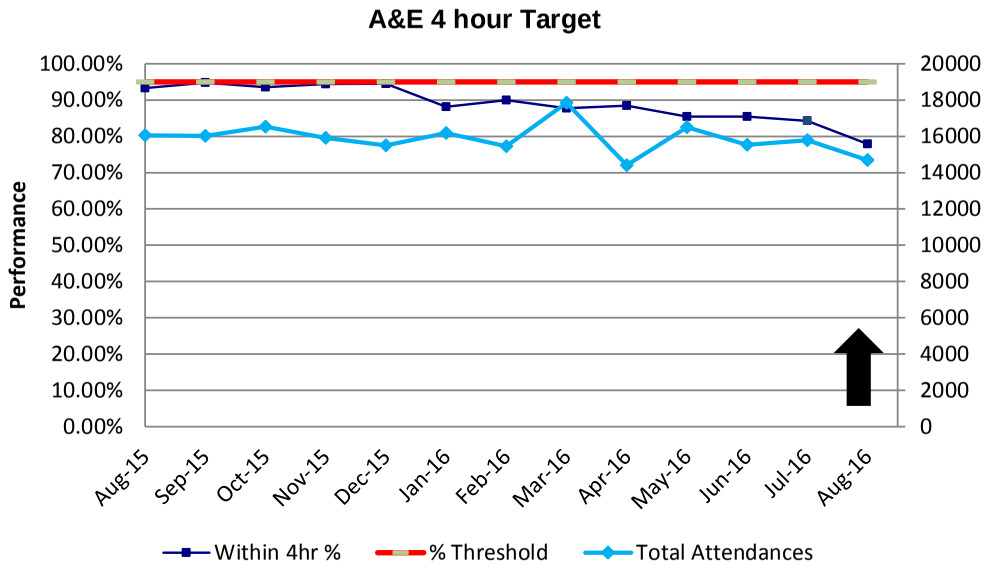
Overall performance against the Accident and Emergency four hour standard was reported as 77.9%, below the 95% threshold. The Trust saw 14,697 attendances in August.

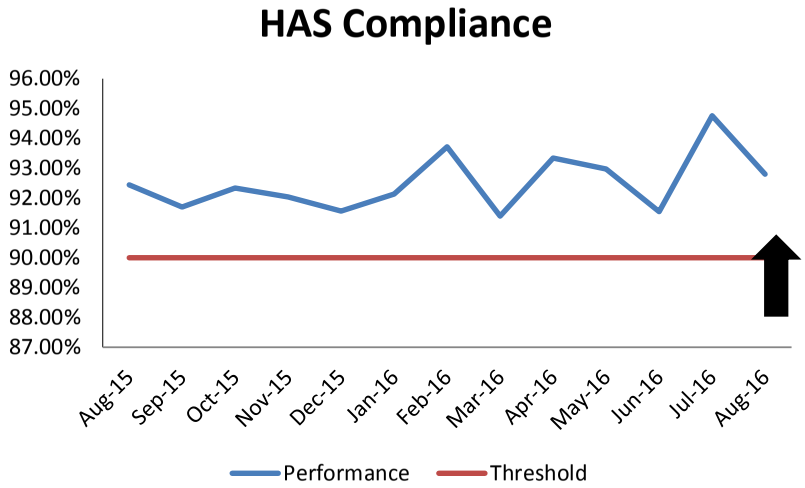
There have been nine breaches of the 12 hour standard from decision to admit, in August., all mental health. A root cause analysis is being completed for each breach.

The ambulance handover compliance indicator is reported at 92.8% in August, which is above the 90% threshold.
The number of handovers over 30 minutes has slightly decreased to 884 for July compared to 891 for June.

The validated NWAS penalty figures for August are not available at the time of this report and so data is as at July. There are 117 missing timestamps, 431 handover breaches (30-60 mins) and 102 handover breaches (>60 mins).







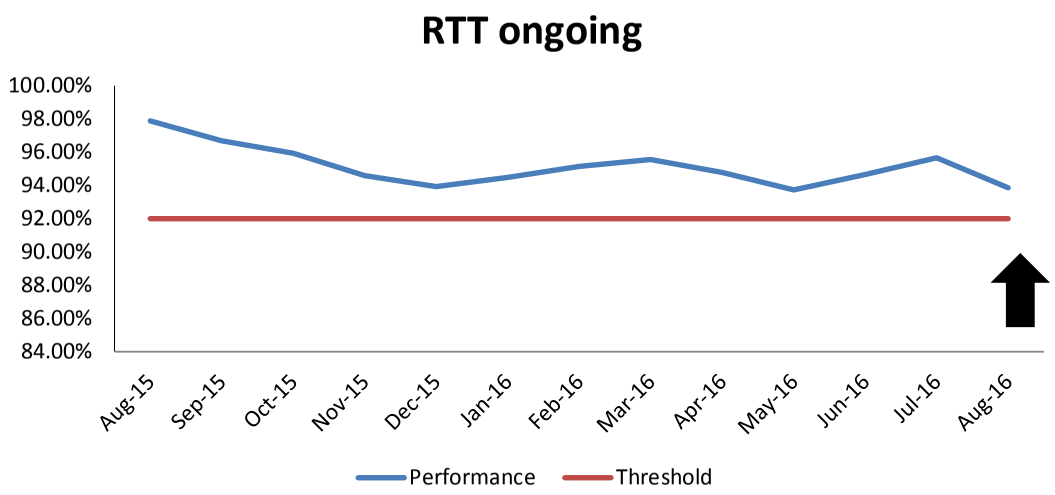
Responsive – Referral to Treatment (18 week target)

The 18 week referral to treatment % ongoing position has deteriorated to 93.9% but remains above the 92% threshold for July 2016.

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

Four specialties have failed the target in August:

Chronic Pain -91.4%
Trauma & Orthopaedics - 91.5%
Maxillofacial - 88.5%
Gastroenterology - 90.8%

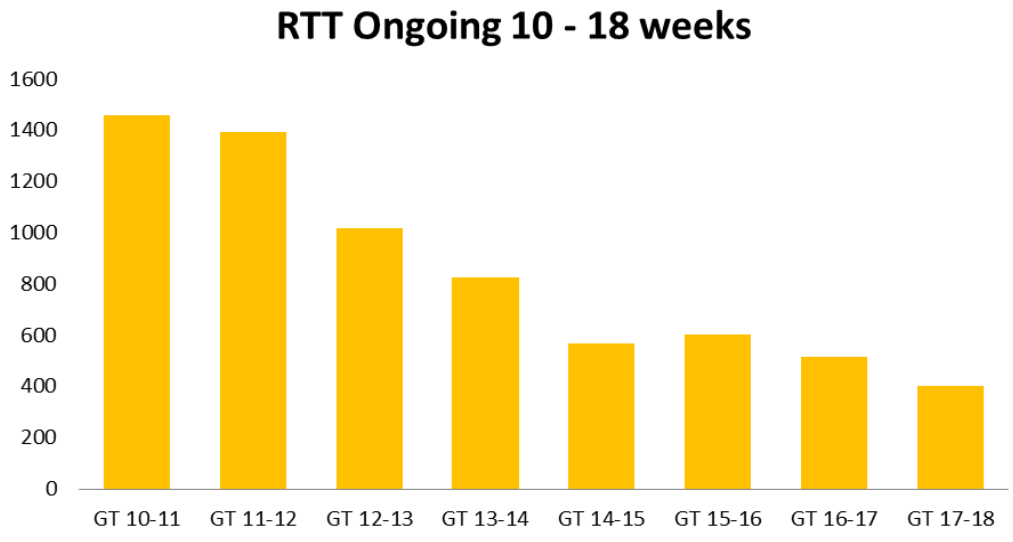


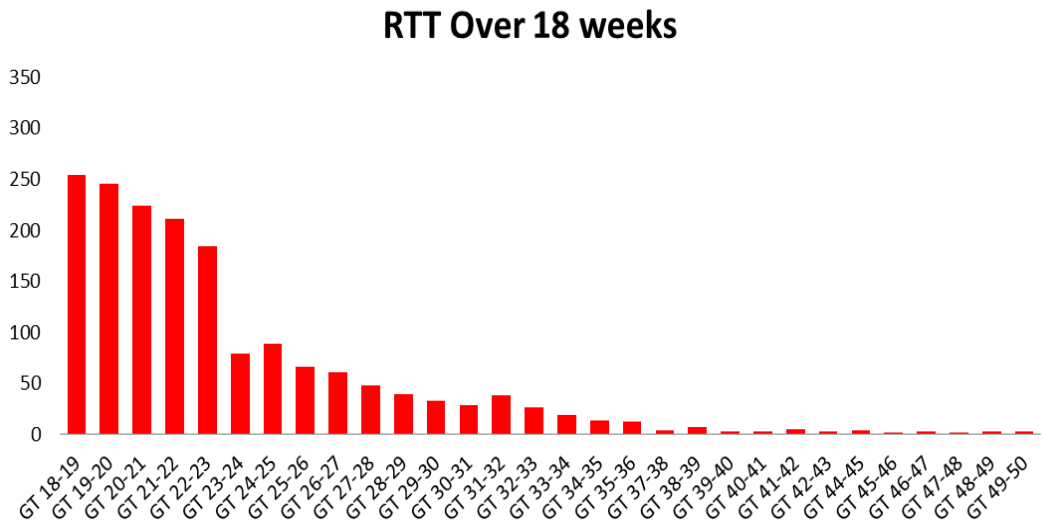
Chronic Pain
The service are experiencing continued pressures in relation to capacity, with one consultant on long term sickness absence, resulting in cancellation of theatre and clinic lists. One vacant post due to be filled in September, currently being covered by bank and locum staff The service are also considering options for utilising the private sector for planned procedures with long waits.

Trauma & Orthopaedics
Work is underway to review the nerve conduction study service to reduce diagnostic delays, and recruitment of a locum consultant to increase theatre capacity and reduce waiting lists.

Maxillofacial
Increased pressure from cancer referrals requiring biopsy and review appointment from MFS and dermatology causing delays in outpatients. Some lists for procedure rooms had been reorganised to outpatient clinics meaning that there has been a delay for some patients on the waiting list, this has been reversed and the procedure room lists have been reinstated.

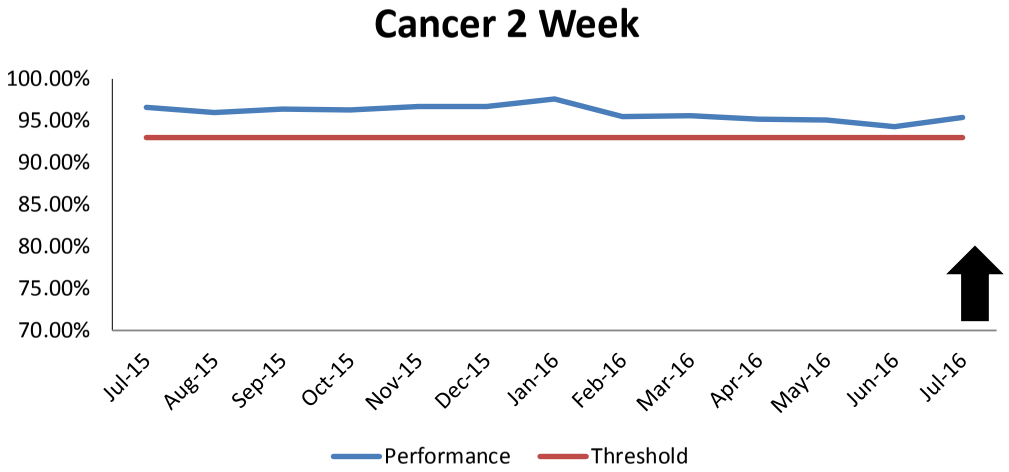
Gastroenterology
Increase in cancer two week rule patients has provided an increased pressure to the referral to treatment standard. Clinical slots are currently being reviewed to accommodate this pressure.

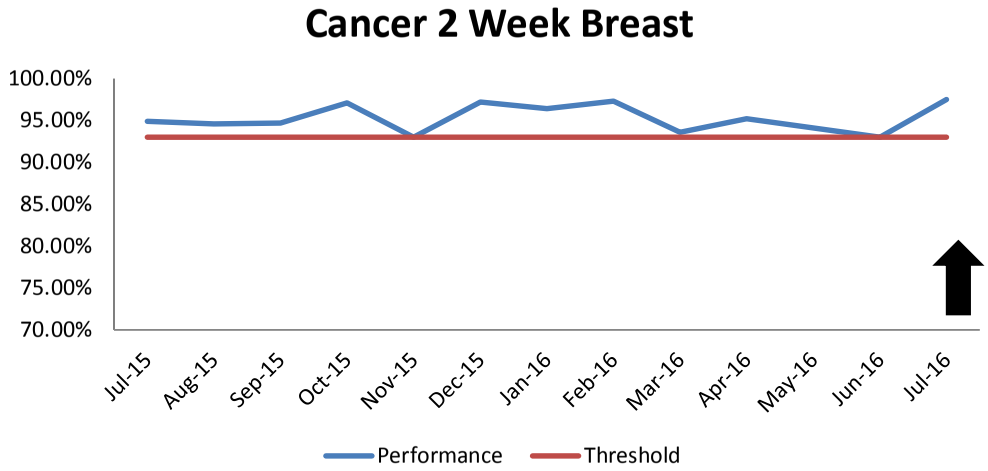

RTT Ongoing 10 - 18 weeks
1600
1400
1200
1000
800
600
400
200
0
GT 10-11
GT 11-12
GT 12-13
GT 13-14
GT 14-15
GT 15-16
GT 16-17
GT 17-18

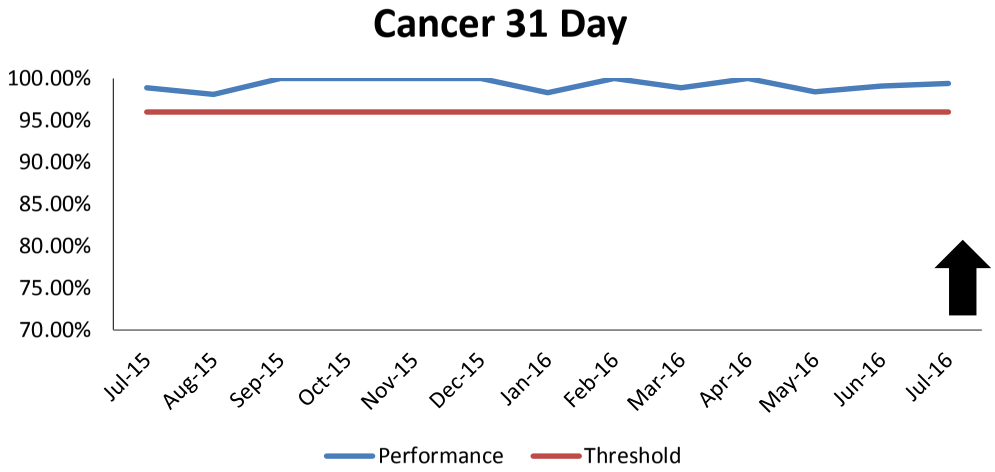

RTT Over 18 weeks
350
300
250
200
150
100
50
0
GT 18-19
GT 19-20
GT 20-21
GT 21-22
GT 22-23
GT 23-24
GT 24-25
GT 25-26
GT 26-27
GT 27-28
GT 28-29
GT 29-30
GT 30-31
GT 31-32
GT 32-33
GT 33-34
GT 34-35
GT 35-36
GT 37-38
GT 38-39
GT 39-40
GT 40-41
GT 41-42
GT 42-43
GT 44-45
GT 45-46
GT 46-47
GT 47-48
GT 48-49
GT 49-50

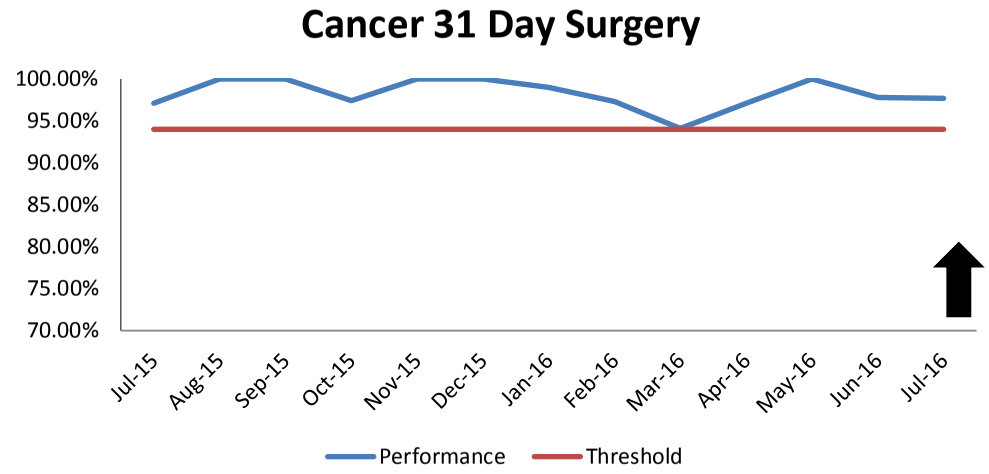
Responsive – Cancer Waits

All targets met in July. The two week breast target is at the threshold in July at 93% At tumour site level, four groups did not meet the 62 day target in July; Colorectal, head & neck, upper GI and urology. There were two patients in July treated after day 104.

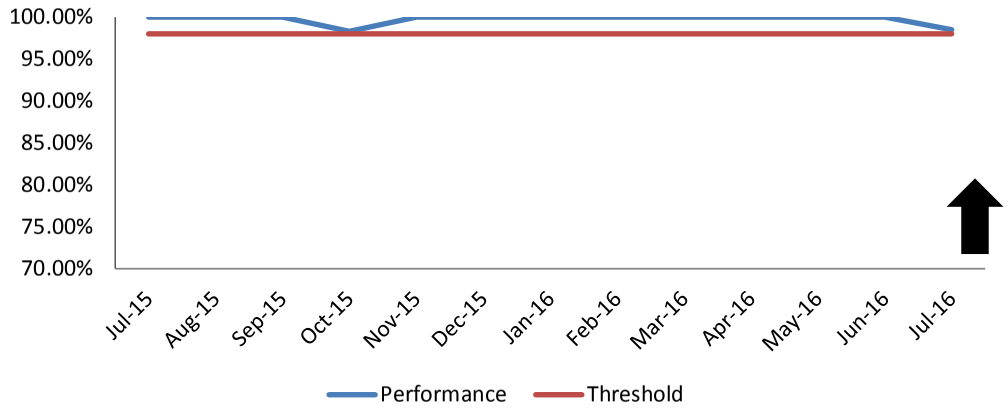




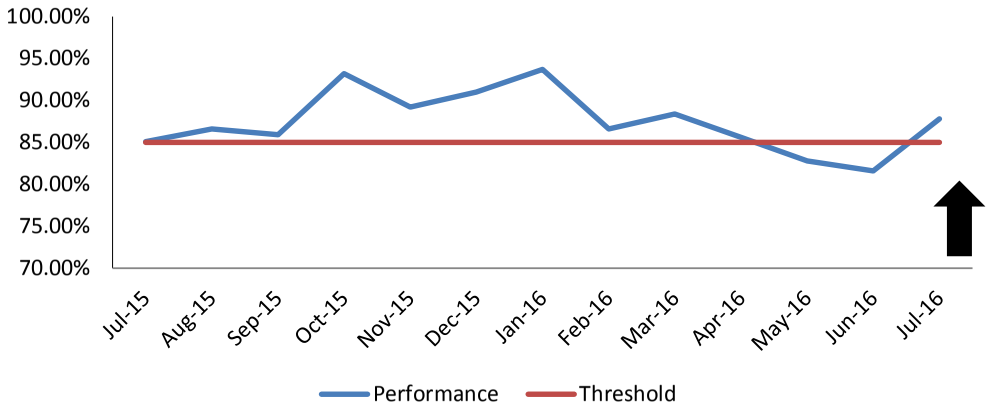




Cancer 31 Day Drug



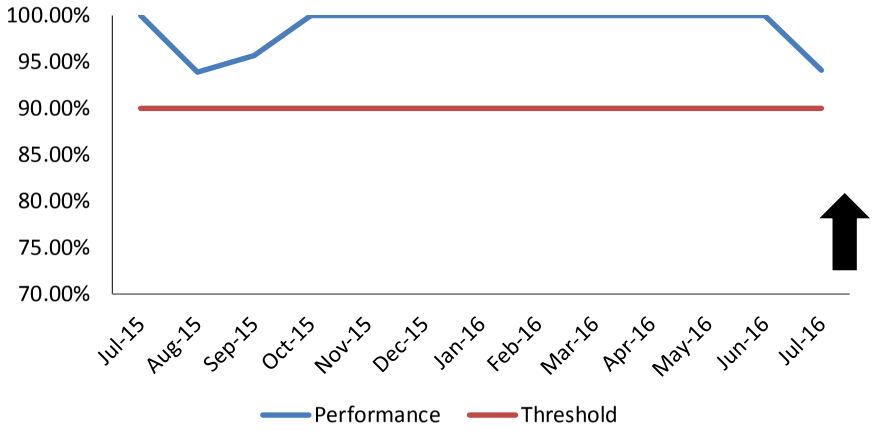
Cancer 62 Day



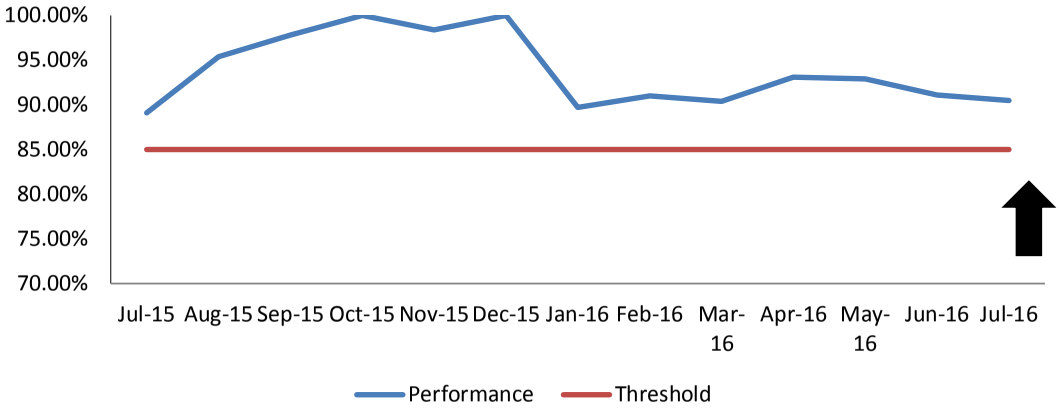
Cancer 62 Day by Tumour Site

Tumour Site	Q1	Jul-16
Breast	98.1%	100.0%
Colorectal	71.4%	71.4%
Gynaecology	86.2%	100.0%
Haematology	79.3%	100.0%
Head & Neck	64.9%	83.3%
Lung	84.9%	92.3%
Other	100%	
Skin	89.0%	100.0%
Upper GI	58.5%	78.6%
Urology	85.0%	75.0%

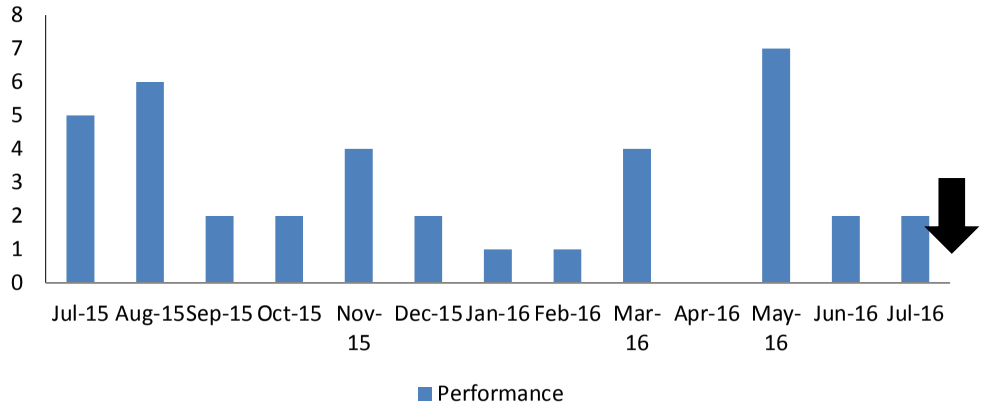
Cancer 62 Day Screening



Cancer 62 Day Consultant Upgrade



Cancer Patients Treated > Day 104

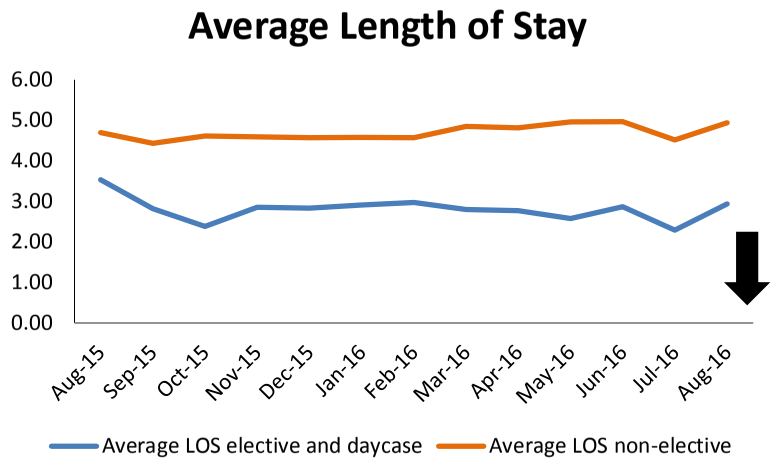


Responsive – Average Length of Stay

Trust non elective average length of stay has increased on last month to 4.9 for August.

The elective length of stay has increased on last month to 2.9.

Dr Foster benchmarking shows the Trust length of stay to be below the expected when compared to national casemix adjusted, for elective and on parr for non-elective, however significantly higher for patients transferred to us.

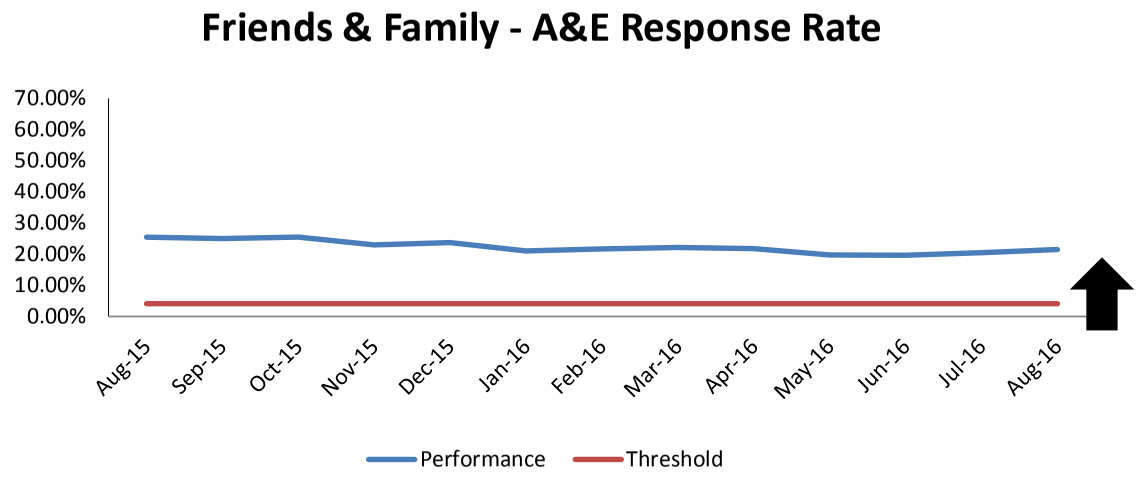


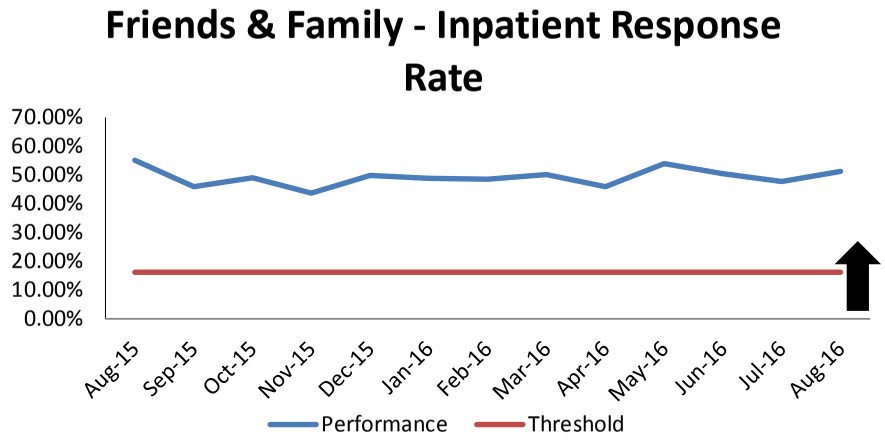
Average Length of Stay vs expected, June 15 - May 16, Dr Foster Information

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	57,163	9,918	47,245	3.3	2.8	-0.6
Emergency	54,492	54,492	0	4.8	4.8	0.0
Maternity/Birth	14,568	14,568	0	2.2	2.6	0.4
Transfer	215	215	0	10.6	31.6	21.0

Well Led – Response Rates from Friends & Family Test

Friends and family response rates continue to be above threshold for inpatients and A&E.



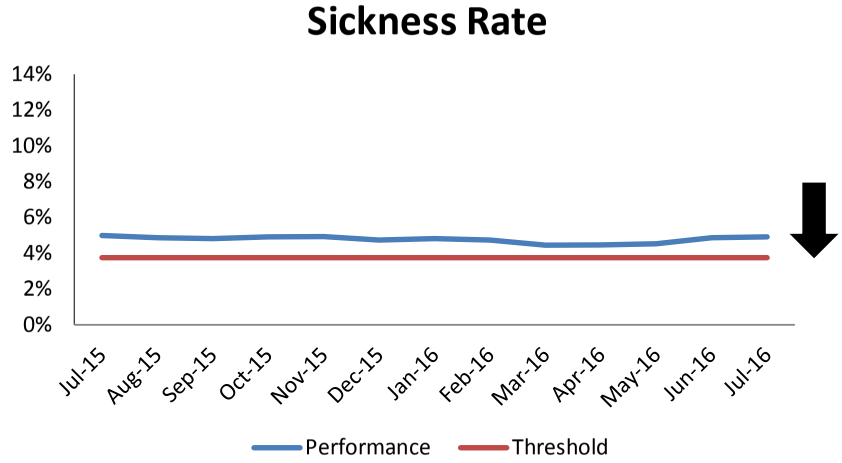


Well Led – Workforce - Sickness

Sickness rate

The sickness absence rate increased slightly from 4.86% in Jun 2016 to 4.91% in Jul 2016. This is higher than in the previous year (4.73%). The final average for 2015/16 is 4.79%.

Rates are highest in Estates (currently 6.97%) and ICG (currently 6.03%)
Unusually high levels of short term seasonal sickness are driving underperformance (2.61%)
Long Term sickness (2.30%) attributed to anxiety/stress and musculoskeletal problems continue to be the main reasons for sickness absence.
See Exception reports for actions being taken to reduce sickness absence



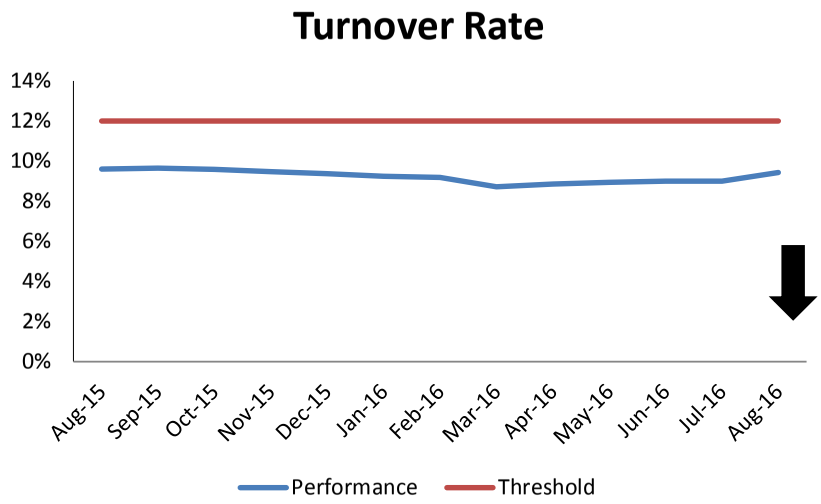
Well Led – Workforce – Staff in Post, Recruitment

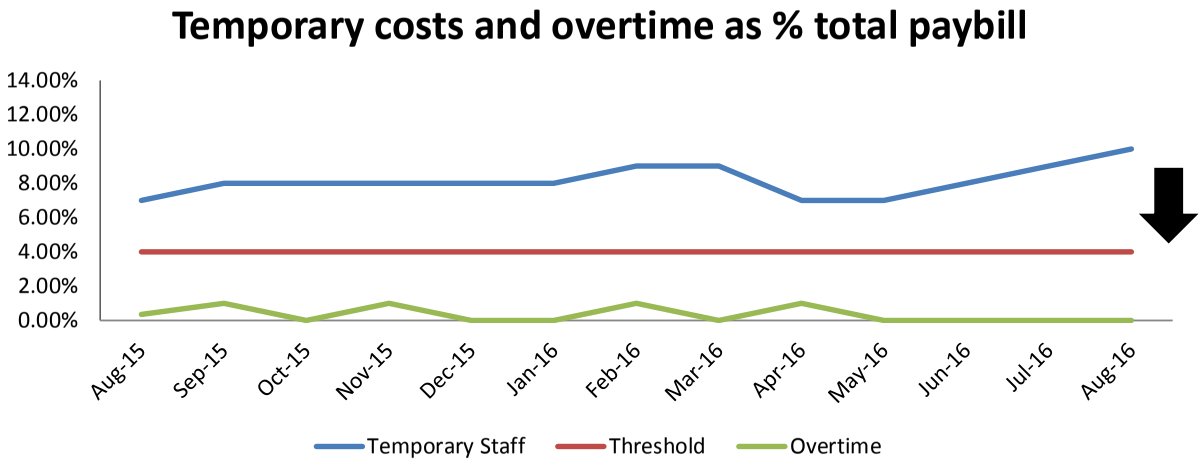
Turnover rate, Vacancy rate and temporary costs

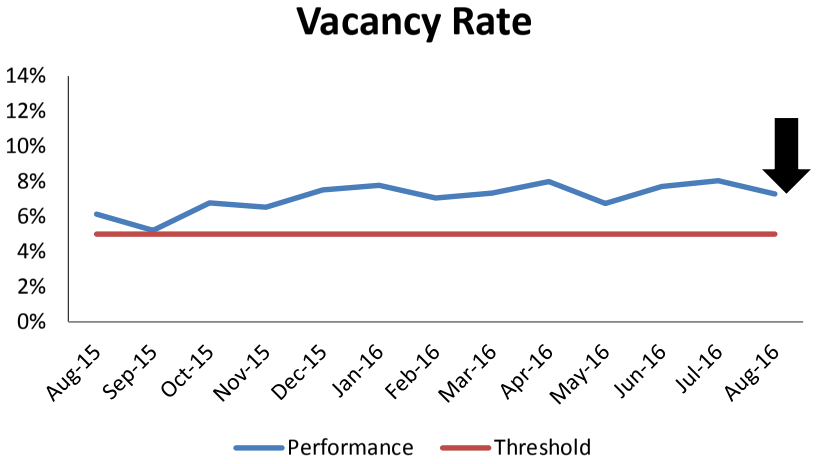
Overall the Trust is now employing 6888 FTE staff in total. This is a net increase of 54 FTE from the previous month. The number of nurses in post at Aug 2016 stood at 2206 FTE which is a net decrease of 10 FTE since last month and a net increase of 152 FTE since 1st April 2013. There are a further 223 nurses in the recruitment pipeline. The vacancy rate for nurses now stands at 11.9% (298 FTE)

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

In August the Trust spent £2,581,701 on bank and agency. This is worse than in Aug 2015 (£1,869,257)



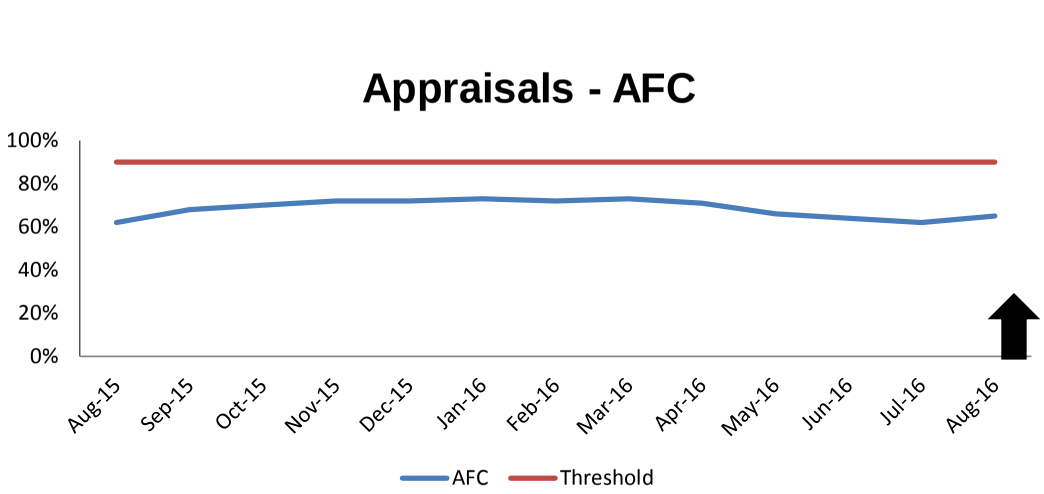


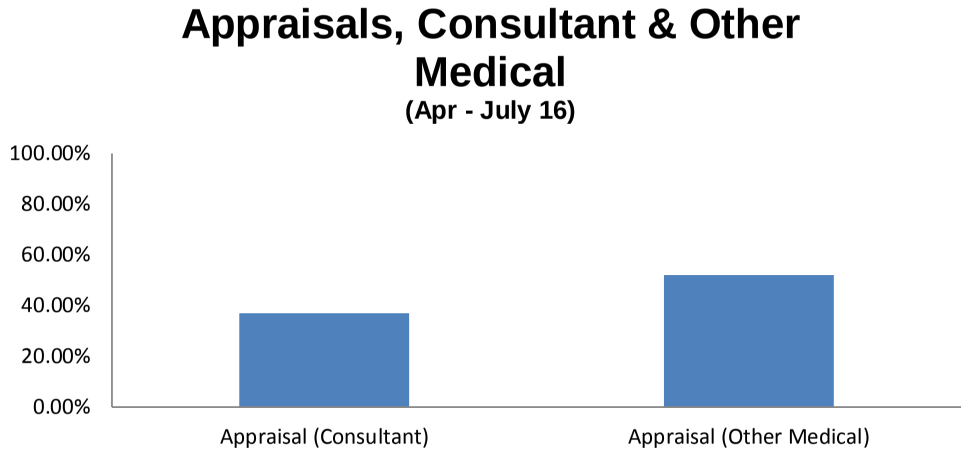


Well Led – Workforce – Appraisals & Job Plans

The 2015/16 year end job plan completion rate was 80%. The 2016/17 job planning round was re-launched in May, with a window of June to August to undertake the reviews. The current completion figure for 2016/17 at the end of August was 32%, including reviews that have taken place since January 2016. The Deputy Medical Director is working closely with the Divisional Diretcors to ensure that job plans are undertaken.

There has been a new system implemented (MyL2P) to capture the appraisal rates for consultants and career grade doctors. The completion rates reported from this system are cumulative year to date, April - August 2016. The AFC appraisal rates continue to be reported as a rolling 12 month figure.



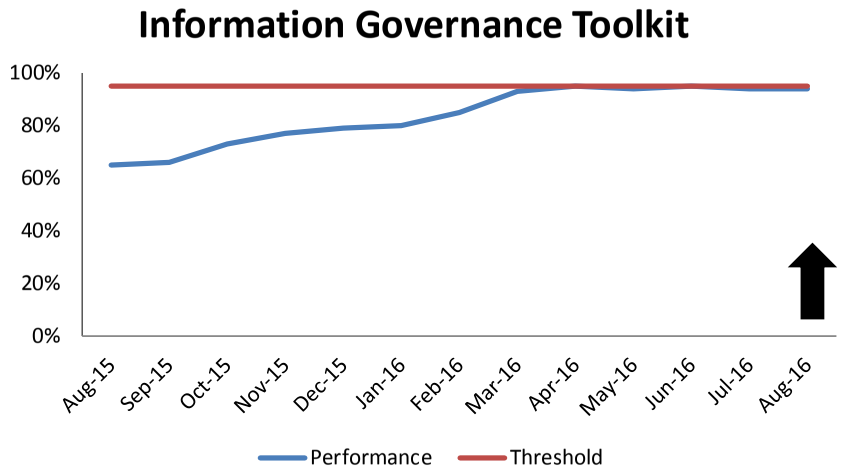


Job Plans

	2015	2016 (YTD)
Trust Total	80%	32%
Integrated Care Group	66%	0%
Surgery	75%	39%
Family Care	100%	18%
Diagnostics & Clinical Support	84%	76%

Well Led – Workforce – Core Skills Training

From April 2016, the core mandatory training has been replaced by a core skills framework consisting of eleven mandatory training subjects. Training is via a new suite of e-learning modules and knowledge assessments on the learning hub.



% Compliance

Overall Trust Core Skills Training Compliance - Excluding New Starters Month ending 31 August 2016*											
	Basic Life Support	**Conflict Resolution Training Level 1**	**Equality, Diversity and Human Rights**	**Fire Safety**	****Health, Safety and Welfare Level 1**	****Infection Prevention**	**Information Governance**	**Prevent Healthwrap**	****Safeguarding Adults**	**Safeguarding Children**	**Safer Handling Theory**
Target	**80%**	**80%**	**80%**	**80%**	**80%**	**80%**	**95%**	**80%**	**80%**	**80%**	**80%**
435 Chief Executive	-	80%	80%	78%	38%	42%	see graph above	66%	24%	90%	80%
435 Diagnostics & Clinical Support	78%	92%	93%	88%	53%	49%		83%	31%	94%	92%
435 Estates & Facilities	-	79%	72%	66%	44%	46%		59%	35%	88%	81%
435 Family Care	72%	91%	94%	81%	56%	53%		78%	24%	89%	89%
435 Finance & Informatics	-	96%	97%	94%	60%	60%		91%	44%	99%	96%
435 Governance	-	98%	100%	94%	64%	64%		91%	47%	100%	96%
435 HR & OD	78%	91%	92%	86%	59%	58%		79%	45%	90%	91%
435 Integrated Care Group	70%	89%	88%	81%	48%	46%		75%	30%	94%	88%
435 Research & Development	50%	97%	97%	97%	77%	77%		89%	34%	100%	89%
435 Surgical & Anaesthetics Services	67%	86%	88%	79%	48%	45%		65%	23%	93%	86%
Compliance as at 31 Aug 16	**71%**	**89%**	**89%**	**81%**	**50%**	**48%**		**74%**	**29%**	**93%**	**88%**
Compliance as at 31 Jul 16	**69%**	**87%**	**86%**	**78%**	**36%**	**35%**		**73%**	**36%**	**91%**	**87%**
Trend analysis from Jul 16 to Aug 16	Ç	Ç	Ç	Ç	Ç	Ç		Ç	-	Ç	Ç
	2%	**2%**	**3%**	**3%**	**14%**	**13%**		**1%**	**-**	**2%**	**1%**

Well Led – Financial Position

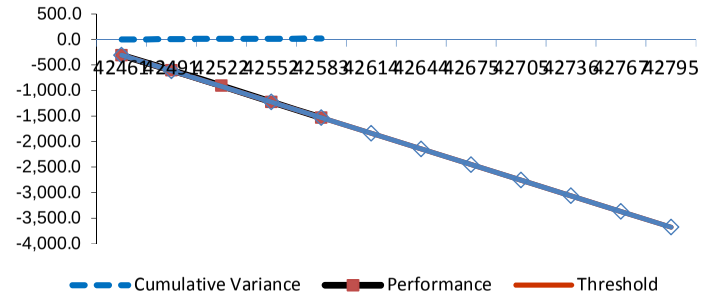
The Trust is reporting a deficit of £1.5m for the period ending 31st August 2016, a further deterioration of £0.3m, in line with expectations at this stage.

Key risks to highlight at 31st August 2016 include:

- Partial achievement of the sustainability funding
- Non-achievement of the Safely Releasing Cost Programme (SRCP)
- Continued usage of agency and locum staff over and above the resources available.
- Non-achievement of the new agency maximum threshold of £10.5m.
- Non–achievement of the 3% Qualified Nurse Agency cap
- The impact of any future industrial action
- The cash impact of any non-delivery

Break-Even duty

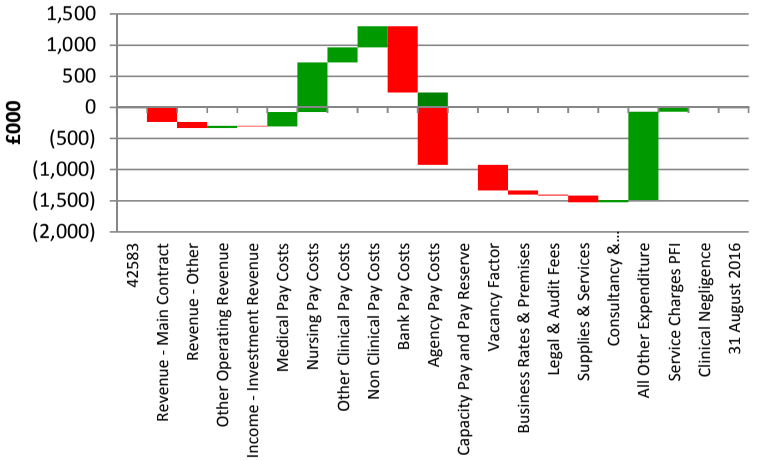
Break even duty - The Trust is reporting a deficit at month 5 of £1.5m, against an initial planned deficit of £1.5m.



Statement of Comprehensive Income

Statement of Comprehensive Income	In-month Plan £m	In-month Actual £m	In-month Variance £m	Year to date Plan £m	Year to date Actual £m	Year to date Variance £m
Income	**38.2**	**38.2**	**0.0**	**198.9**	**198.8**	**(0.2)**
Expenditure	**(36.8)**	**(36.5)**	**0.3**	**(189.6)**	**(189.4)**	**0.2**
EBITDA	**1.7**	**1.7**	**0.0**	**9.3**	**9.4**	**0.0**
PDC/Depreciation/Interest	(2.0)	(2.0)	(0.0)	(11.0)	(11.0)	(0.0)
(Impairments)/reversals	0.0	0.0	0.0	0.0	0.0	0.0
Surplus/(Deficit)	**(0.3)**	**(0.3)**	**0.0**	**(1.6)**	**(1.6)**	**0.0**
Donated assets	0.0	0.0	0.0	0.1	0.1	0.0
(Impairments)/reversals	0.0	0.0	0.0	0.0	0.0	0.0
Retained (deficit) for the year	**(0.3)**	**(0.3)**	**0.0**	**(1.5)**	**(1.5)**	**0.0**
Donated Asset reserve elimination	0.0	0.0	0.0	0.1	0.1	0.0
Retained (deficit) for Break-even duty	**(0.3)**	**(0.3)**	**0.0**	**(1.4)**	**(1.4)**	**0.0**

Income and Expenditure variances



Fill rate indicator return
Staffing: Nursing, midwifery and care staff

East Lancashire Hospitals NHS Trust

2016-17

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

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

Comments

Only complete sites your organisation is accountable for					Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
RXR60	ACCRINGTON VICTORIA HOSPITAL	Ward 2	314 - REHABILITATION		1395	1020	930	1537.5	651	651	325.5	724.5	73.1%	165.3%	100.0%	222.6%	528	3.2	4.3	7.4
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Acute Stroke Unit (ASU)	300 - GENERAL MEDICINE		2325	1807.5	1162.5	1507.5	987	976.5	651	997.5	77.7%	129.7%	98.9%	153.2%	688	4.0	3.6	7.7
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B18	320 - CARDIOLOGY		2092.5	1785	930	1222.5	666.5	688	666.5	795.5	85.3%	131.5%	103.2%	119.4%	731	3.4	2.8	6.1
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B20	100 - GENERAL SURGERY		1612	1098.5	806	1384.5	682	693	341	814	68.1%	171.8%	101.6%	238.7%	512	3.5	4.3	7.8
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B22	110 - TRAUMA & ORTHOPAEDICS		1612	1196	1612	2385.5	682	682	1023	1606	74.2%	148.0%	100.0%	157.0%	665	2.8	6.0	8.8
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B24	110 - TRAUMA & ORTHOPAEDICS		1612	1313	1215.5	1391	682	682	682	1166	81.5%	114.4%	100.0%	171.0%	642	3.1	4.0	7.1
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B4	430 - GERIATRIC MEDICINE		1860	1447.5	1627.5	2565	651	682.5	651	1396.5	77.8%	157.6%	104.8%	214.5%	716	3.0	5.5	8.5
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Blackburn Birth Centre	501 - OBSTETRICS		930	855.5	465	427.5	666.5	666.5	333.25	333.25	92.0%	91.9%	100.0%	100.0%	25	60.9	30.4	91.3
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C1	300 - GENERAL MEDICINE		1627.5	1327.5	1395	1815	666.5	688	666.5	1128.75	81.6%	130.1%	103.2%	169.4%	554	3.6	5.3	9.0
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C10	300 - GENERAL MEDICINE		1860	1417.5	1627.5	1905	651	661.5	651	1029	76.2%	117.1%	101.6%	158.1%	668	3.1	4.4	7.5
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C11	300 - GENERAL MEDICINE		1860	1395	1162.5	1507.5	666.5	677.25	666.5	860	75.0%	129.7%	101.6%	129.0%	669	3.1	3.5	6.6
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14	100 - GENERAL SURGERY		2418	1761.5	1612	1826.5	1023	902	1023	1221	72.8%	113.3%	88.2%	119.4%	998	2.7	3.1	5.7
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18	100 - GENERAL SURGERY		2418	1943.5	1612	1612	1023	1023	1023	1023	80.4%	100.0%	100.0%	100.0%	1025	2.9	2.6	5.5
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C2	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1860	1492.5	1162.5	2010	666.5	677.25	666.5	1182.5	80.2%	172.9%	101.6%	177.4%	717	3.0	4.5	7.5
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C22	101 - UROLOGY	120 - ENT	2418	1982.5	1612	1670.5	1023	1023	1023	1045	82.0%	103.6%	100.0%	102.2%	984	3.1	2.8	5.8
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C3	300 - GENERAL MEDICINE		1627.5	1267.5	930	1672.5	666.5	666.5	666.5	1064.25	77.9%	179.8%	100.0%	159.7%	593	3.3	4.6	7.9
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C4	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1860	1417.5	1162.5	1822.5	666.5	752.5	666.5	1279.25	76.2%	156.8%	112.9%	191.9%	726	3.0	4.3	7.3
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C5	430 - GERIATRIC MEDICINE		1116	798	1502	1710	651	661.5	651	1785	71.5%	113.8%	101.6%	274.2%	414	3.5	8.4	12.0
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C6	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	1860	1470	1162.5	1282.5	666.5	666.5	666.5	731	79.0%	110.3%	100.0%	109.7%	745	2.9	2.7	5.6
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C7	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	1860	1530	1162.5	1777.5	666.5	666.5	666.5	1150.25	82.3%	152.9%	100.0%	172.6%	644	3.4	4.5	8.0
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C8	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	2325	1770	1162.5	1290	999.75	999.75	666.5	666.5	76.1%	111.0%	100.0%	100.0%	584	4.7	3.4	8.1
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C9	300 - GENERAL MEDICINE		1860	1425	1395	2010	666.5	677.25	666.5	967.5	76.6%	144.1%	101.6%	145.2%	681	3.1	4.4	7.5
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Children's Unit	420 - PAEDIATRICS		3906	3634	1116	1052	3255	3071.5	325.5	325.5	93.0%	94.3%	94.4%	100.0%	803	8.4	1.7	10.1
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Coronary Care Unit (CCU)	320 - CARDIOLOGY		1860	1507.5	465	840	999.75	946	0	0	81.0%	180.6%	94.6%	-	241	10.2	3.5	13.7
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Critical Care Unit	192 - CRITICAL CARE MEDICINE		6500	6318	988	923	5335	5192	0	33	97.2%	93.4%	97.3%	-	558	20.6	1.7	22.3
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D1	300 - GENERAL MEDICINE		1860	1440	1395	1837.5	666.5	666.5	666.5	1021.25	77.4%	131.7%	100.0%	153.2%	636	3.3	4.5	7.8
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D3	300 - GENERAL MEDICINE		1860	1402.5	1162.5	1635	666.5	688	666.5	849.25	75.4%	140.6%	103.2%	127.4%	598	3.5	4.2	7.7
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUA)	300 - GENERAL MEDICINE		3487.5	3232.5	1743.75	2238.75	3138.75	2801.25	1046.25	1316.25	92.7%	128.4%	89.2%	125.8%	1203	5.0	3.0	8.0
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUB)	300 - GENERAL MEDICINE		3720	3600	2790	2850	1953	2068.5	1302	1302	96.8%	102.2%	105.9%	100.0%	1163	4.9	3.6	8.4
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Neonatal Intensive Care Unit	420 - PAEDIATRICS		5022	4974	372	344	4464	4380	372	204	99.0%	92.5%	98.1%	54.8%	898	10.4	0.6	11.0
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Surgical Triage Unit	100 - GENERAL SURGERY		1612	1592.5	806	963.5	1023	1012	341	671	98.8%	119.5%	98.9%	196.8%	574	4.5	2.8	7.4
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Antenatal Ward	501 - OBSTETRICS		1488	1496.5	744	708	1116	1116	744	768	100.6%	95.2%	100.0%	103.2%	108	24.2	13.7	37.9
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Burnley Birth Centre	501 - OBSTETRICS		1395	1284.75	372	389	1116	1104	372	372	92.1%	104.6%	98.9%	100.0%	84	28.4	9.1	37.5
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Central Birth Suite	501 - OBSTETRICS		4092	3816	744	840	4092	3792	744	744	93.3%	112.9%	92.7%	100.0%	223	34.1	7.1	41.2
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Gynaecology and Breast Care Ward	502 - GYNAECOLOGY		1314	1284	564	558	837	837	327	322.5	97.7%	98.9%	100.0%	98.6%	344	6.2	2.6	8.7
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Postnatal Ward	501 - OBSTETRICS		2232	2238	1116	1140	2232	1932	1116	1392	100.3%	102.2%	86.6%	124.7%	764	5.5	3.3	8.8
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Rakehead	314 - REHABILITATION		1395	1095	1860	2595	589	589	589	1187.5	78.5%	139.5%	100.0%	201.6%	414	4.1	9.1	13.2

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

East Lancashire Hospitals NHS Trust

2016-17

Please provide the URL to the page on your trust website where your staffing information is available

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Comments

Only complete sites your organisation is accountable for					Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
RXR60	ACCRINGTON VICTORIA HOSPITAL	Ward 2	314 - REHABILITATION		1395	1020	930	1537.5	651	651	325.5	724.5	73.1%	165.3%	100.0%	222.6%	528	3.2	4.3	7.4
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 15	110 - TRAUMA & ORTHOPAEDICS		1391	1293.5	942.5	981.5	638	638	550	605	93.0%	104.1%	100.0%	110.0%	554	3.5	2.9	6.4
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 16	300 - GENERAL MEDICINE		2325	1732.5	1627.5	2377.5	651	651	976.5	1669.5	74.5%	146.1%	100.0%	171.0%	844	2.8	4.8	7.6
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 28	300 - GENERAL MEDICINE		1522.5	1402.5	487.5	495	129	129	150.5	150.5	92.1%	101.5%	100.0%	100.0%	38	40.3	17.0	57.3
RXR70	CLITHEROE COMMUNITY HOSPITAL	Ribblesdale	314 - REHABILITATION		2325	1890	1920	2452.5	976.5	966	976.5	1596	81.3%	127.7%	98.9%	163.4%	860	3.3	4.7	8.0
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Hartley	314 - REHABILITATION		1860	1380	1162.5	1462.5	666.5	677.25	666.5	849.25	74.2%	125.8%	101.6%	127.4%	731	2.8	3.2	6.0
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Marsden	314 - REHABILITATION		1860	1395	1860	1830	666.5	666.5	666.5	817	75.0%	98.4%	100.0%	122.6%	717	2.9	3.7	6.6
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Reedyford	314 - REHABILITATION		1860	1462.5	1162.5	1575	666.5	666.5	666.5	1118	78.6%	135.5%	100.0%	167.7%	746	2.9	3.6	6.5

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD REPORT

28 September 2016

Item 257b

Purpose Information
Monitoring

Title	Integrated Performance Report: Consultant Job Planning Exception Report
Author	Mr S Hill, Deputy Medical Director
Executive sponsor	Dr D Riley, Medical Director

Summary:

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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Recruitment and workforce planning fail to deliver the Trust objectives The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: Audit Committee 07.09.2016

(257b) Integrated Performance Report: Consultant Job Planning

Introduction

1. In 2015 the Trust reported an in year Job Plan completion or review rate of 82%. This value is the highest reported since Job Planning became a mandatory requirement of the Consultant contract implemented in 2003.
2. A job plan can be described in simple terms as a prospective, professional agreement that sets out the duties, responsibilities, accountabilities and objectives of the consultant and the support and resources provided by the employer for the coming year. However, in order to drive measurable and sustainable improvements in quality, an effective job plan needs to be more than a high level timetable which sets out in general terms the range of a consultant's activity. It is vital that it articulates the relationship between the organisation and the consultant and the desired impact on patient care.
3. The job planning process should align the objectives of the NHS, the organisation, clinical teams and individuals in order to allow, consultants, managers and the wider NHS team to plan and deliver innovative, safe, responsive, efficient and high-quality care. At the same time the job plan should provide opportunities to develop both personally and professionally to help drive quality improvement in line with the present and future needs of patients.
4. To achieve these objectives the process of job planning must be timely, coordinated (ideally to the business planning cycle), and hence meaningful to clinicians and clinical managers alike.
5. The current system of work diary completion and subsequent process of discussion, validation, sign off and recording is not uniform through each Directorate, and the method of escalation to Medical Staffing, neither robust nor accurate.

Current Job Planning Status

	Trust total	**Integrated Care**	**Surgery**	**Family Care**	**DCS**
Total number returned	**52**	**0**	**42**	**0**	**10**
% returned	**19%**	0%	38%	0%	23%
Total number in Mediation process	0	0	0	0	0

6. Current levels of completed job plan reviews are disappointing but it is not viewed as high risk and is not seen to present any short term clinical challenges to the running

of services. All consultants employed by ELHT had a job plan and 98% completed a job plan review within the last 3 years.

Action to Improve Recording of Job Planning for the Current Cycle

7. All Divisional Directors have been contacted and requests made to encourage all Directorates have a 100% completion rate by March 2017.
8. In the interim period, job planning should be prioritised. Those consultants whose job plans have not changed in the last three years will be classed as low priority and those whose jobs have been modified in the last year will be classed as higher priority.
9. All Clinical Directors have been reminded of their responsibilities to complete the Job Planning process for each consultant in their directorate by March 2017.
10. The importance of completing the Job Planning process will be discussed at the next Clinical Leaders Forum, led by Mr Simon Hill
11. The Medical Staffing Department have been asked to liaise with Divisional Directors regarding agreed job plans which remain unrecorded centrally.
12. All consultants have been reminded of their responsibility to participate in job planning and that unless a job plan has been submitted eligibility for CEA or pay progression will be withheld.

Action to Improve the Job Planning Process over next 12-24 months

13. To enable a better approach to utilisation of service planning, to provide intelligent job planning built on the business objectives of the Trust translated into quantifiable measures, and also to reform the process of recording completed job plans, the Trust has completed the purchase of a cloud based system called “Allocate” to replace our current paper/spread sheet arrangement.
14. The Allocate system will transform the process for consultants, clinical managers, business managers and divisional managers.
15. All job plans will be uploaded to the system which provides a secure unalterable job plan repository of signed off job plans. Prior to the next business planning cycle and an agreed review date allocated by the system, ensuring a more rigorous approach for 2017. This may uncover discrepancies between practical application of timetables and the paper-based timetable, and each of these will require individual assessment.

Action to Link Job Planning to Performance Management

16. On completion of Allocate implementation, which may take at least one year, all job plans will be more efficiently evaluated at an individual and Directorate level on an annual basis.

17. Linking job planning review to business planning will become embedded into the Corporate Business planning cycle, and consultant appointment process and ultimately delivery of the annual service requirement.

TRUST BOARD REPORT	**Item**	**258**
28 September 2016	**Purpose**	Monitoring

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

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

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	The Trust fails to deliver and develop a safe, competent workforce

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

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: NA

Executive summary

1. This is the sixth annual report on doctors' appraisal to come to the Board, the third since Revalidation was introduced. This year, 2015.2016, was Year 3 of Revalidation, during which 127 doctors had a revalidation recommendation made at ELHT.
2. This report follows the template provided for the Appraisal and Revalidation annual report in NHS England's Framework for Quality Assurance of Appraisal and Revalidation.
3. There were 399 doctors with a prescribed connection to ELHT as their Designated Body (DO) in 2015.2016. These are Consultants, SAS doctors and clinical fellows. This number changes over the year as doctors start and leave. Doctors in training have a prescribed connection to HENW with the Postgraduate Dean as their Responsible Officer and are not included in this report.

Purpose of the Paper

4. NHS England's 2014 Framework for Quality Assurance for Appraisal and Revalidation considers an Annual report to Board on medical revalidation and appraisal an essential organisational requirement for Trusts.
5. This report provides assurance to the Board that statutory requirements for Medical Appraisal and Revalidation of these doctors are being met.
6. This report will inform the Board's Compliance Statement to NHS England, which is due 30.09.2016 (see Appendix 1)

Background

7. Following the General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012, all doctors undertaking medical work in the UK must hold a licence to practise issued by the GMC, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Each NHS employing organisation ('Designated Body' - DO) has had to appoint a Responsible Officer (RO) to oversee the process. The introduction of the Responsible Officer Regulations in 2010[1] gave ROs a statutory responsibility to monitor the performance of every doctor. All doctors were issued with a licence in 2009, as well as a revalidation date between 2013 and 2016 for licence renewal. Renewal of the licence depends on the RO making a positive recommendation to the GMC for renewals every 5 years.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

8. Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards will oversee compliance by:

1. monitoring the frequency and quality of medical appraisals in their organisations;
2. checking there are effective systems in place for monitoring the conduct and performance of their doctors;
3. confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
4. ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

9. The links (and differences) between appraisal and job planning are detailed in Trust policy HR46: Appraisal Policy for Consultants, Associate Specialists, Specialty Doctors and Non-Deanery Training Grade Doctors. In summary, the focus at job planning is on service delivery and patient care. The job plan review is a performance assessment of recent past and the new job plan is a forward plan for future performance in the same context (with SMART objectives). The appraisal is focussed on personal and professional development and patient care, in the context of the GMC's Good Medical Practice and revalidation. The objectives in a doctor's Personal Development Plan (PDP) should feed into his/her job plan, and vice versa.

Governance Arrangements

10. The organisational structures and responsibilities for medical appraisal and revalidation are described in detail in Trust policy HR46v3, which was reviewed, revised and updated in August 2014 to be in line with NHS England's Framework for Quality Assurance for Appraisal and Revalidation, published in April 2014.
11. This policy covers roles and responsibilities, the organisation and governance of appraisal and revalidation as well as the process, inputs and outputs of the appraisal itself.
12. The Responsible Officer (RO) role transferred on 1.02.2016 from the Chief Medical Officer to the Executive Medical Director with Board approval. The RO is accountable to the Chief Executive and the Board of ELHT for implementing and managing the appraisal and revalidation process including appraisal outcomes. The RO is supported in his role by the Deputy Medical Director for Professional Standards and the Clinical Director to Medical Director's Office (CDMDO) who is the designated Trust Clinical Appraisal lead.

13. The Appraisal and Revalidation team hold bimonthly core group meetings. The core team comprises of the Deputy Medical Director, Appraisal Lead, designated members from the Employment Services, Medical Staffing, Post Graduate Medical Education, and the Appraisal Administrator. The group serves to ensure a well aligned strategic and operational direction for the medical appraisal and revalidation structure, system and process exists within the Trust.
14. The number of consultants and other doctors who have had their annual appraisal is monitored through the monthly performance reports to the Operational Delivery Board and Trust Board. The Board has also received monthly updates on all doctors with either local and/or GMC restrictions on their practice.
15. In April 2015 the Internal Audit report into the Medical Revalidation system provided 'significant assurance'. The recommendations have been fully implemented.
16. A 'Doctor's in Difficulty' Group was established in December 2015 with representation from HR, governance, medical staffing, and senior clinicians. It meets monthly to review cases of doctors with health, capability and/or conduct concerns and monitor progress with investigations. Terms of reference including membership is included in Appendix 3.
17. Following a review, in April 2016 a Non-Executive Director, Mr Peter Rowe, has been appointed as 'Designated Non-Executive Board member' in line with MHPS ('Maintaining High Professional Standards in the modern NHS' – the national policy for dealing with capability/conduct/health concerns about doctors). Prior to this, a board member has only been appointed in this role if a doctor was excluded; our legal advisor recommended one to be appointed for all doctors under formal investigation.
18. As per paragraph 13 of part I MHPS, the role of the designated Board member is:

    'Representation may be made to the designated Board member in regard to exclusion, or investigation of a case if these are not provided for by the NHS body's grievance procedures. The designated Board member must also ensure, among other matters, that time frames for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights (which, broadly speaking sets out the framework of the rights to a fair trial).

Appraisal and Revalidation Performance Data

19. The Annual Organisational Audit ('AOA': Appendix 2) was submitted to NHS England in May 2016.
20. In summary, table 1 summarises the position of medical appraisal on 31.03.2016

Table 1 Summary appraisal numbers 2015.2016

	No. prescribed connections	Completed appraisal 2015.2016	Approved incomplete/missed appraisal 2015.2016	Unapproved incomplete/missed appraisal 2015.2016	**Total**	**% completed appraisal 2015.2016**	% completed appraisal 2015.2016	% completed **ELHT** appraisal **2014.2015**
Consultants	265	251	14	0	265	**95%**	91%	91%
SAS doctors	113	100	13	0	113	**88%**	83%	89%
Temporary/short term doctors	22	19	3	0	22	**86%**	74%	67%
Total	400	370	30	0	400	**93%**	86%	86%

21. An audit of missed appraisals can be found in Appendix 4

Appraisers

22. Currently we have 72 appraisers, 68 of whom are active (four of the newly trained appraisers are waiting to be allocated appraisees). The average number of appraisees an appraiser has is 7 with a range of 1 to 12. (Standard: no less than 5, no more than 10). We have appointed 11 new appraisers to reduce the workload of those with more than 5, and have asked all appraisers to have at least 3 appraisees in 2016.2017.
23. Seven appraisers ceased to be an appraiser in 2015.2016; common reason cited is workload, changes to job plan, leaving the Trust, retirement.
24. Eleven new appraisers were trained in February 2016 through a two day competency assessed training course delivered by Edgecumbe at Royal Blackburn Hospital.
25. On-going training and support to appraisers is through appraiser network evenings. In 2015.2016 three networking/update training sessions for appraisers were held.
26. These events are used to enable appraisers to learn from each other as well as from the appraisal leads, and to ensure a consistent, equitable and quality assured approach to appraisal. The session contents include learning brought back from the Regional appraiser network, lessons learnt from local audits, and outcomes of appraisal quality assurance reviews. Updates are provided on educator CPD requirements, feedback to appraisers on their performance, discussions on how to overcome barriers and challenges faced in appraisals. The forum provides the appraisers with the opportunity to raise any issues faced at appraisals and the opportunity to network, reinforcing

strengths and good practice. Any changes to policy and/or processes are discussed here.

27. The networks have been used to improve appraiser's practice, e.g. interactive sessions on appraisal summaries. This has led to a marked improvement in these summaries.

28. Individual support to appraisers is provided by the Clinical Appraisal Lead through individual feedback on every appraisal completed through the quality assurance review process, telephone support, and meeting appraisers in person as required. .

29. As appraisals are part of their scope of work, appraisal of the appraisers should include:
    a) An annual record of the appraiser's reflection on appropriate continuing professional development
    b) An annual record of the appraiser's participation in appraisal calibration events such as reflection on appraisal network meetings
    c) 360 feedback from doctors for each individual appraiser. This feedback is collated and anonymously fed back at appraisers network events.

30. A sample of 10% of appraisers revealed that only 50% of the appraisers included the role of Trust appraiser in their 'scope of work'. A similar percentage included CPD and/or reflections in their appraiser role in their documentation. This is being addressed through individual and group feedback.

Appraisee Support

31. Quarterly newsletters are sent to all appraisees and appraisers with updates, shared learning, and FAQs.

32. Intranet access is available for all doctors to the site where all documents outlining the appraisal policy, all the relevant paperwork and a training support tool, and online GMC support.

33. All new doctors joining ELHT receive a recruitment pack which includes information regarding appraisal and revalidation and relevant key contact information.

34. The appraisal lead meets all new consultants joining ELHT to provide them with an appraisal and revalidation specific induction meeting. The SAS lead holds a similar meeting with new SAS doctors. The Appraisal Administrator is available for telephone support on the MyL2P System and regularly meets to give 1:1 support to doctors who need assistance completing their MyL2P appraisal input.

35. The appraisal lead holds one to one coaching sessions with appraisees and appraisers who require additional support to enhance their understanding of the process and improve the quality of appraisals

36. A series of trust-wide educational workshops for appraisees was held to facilitate the use of MyL2P, understanding of GMC and trust requirements for medical appraisals.

Quality Assurance

37. The output of all appraisals goes through a quality assurance process. The appraisal lead reviews every appraisal to ensure that:
    a) Appraisal inputs (e.g. activity and governance information, declaration of good standing from other organisations if applicable,) were available and appropriate
    b) Recommended content and supporting evidence (e.g. patient and colleague feedback) present for all domains
    c) Appraisal outputs (PDP, appraisal summary and sign offs) are complete and to an appropriate standard
    d) Key items identified pre- appraisal are included in the appraisal outputs

38. This information is recorded on a structured template for scoring. An audit of the quality assurance process is appended (See Appendix 5: Quality assurance audit of appraisal inputs and outputs).

39. The process has been significantly strengthened by the procurement of an electronic Appraisal and Revalidation management system, MyL2P. Before submitting an appraisal, the appraisee and appraiser must complete a checklist of statements and supporting evidence. The reporting function of the system also greatly simplifies the data submission requirements to NHS England.

40. However, quality assurance of every individual appraisal is very work intensive, and is proving difficult to achieve in a timely manner with current resources. A system of sampling appraisal outputs for those appraisers who have demonstrated high quality appraisals is being implemented in 2016.2017.

Access, security and confidentiality

41. Access, security and confidentiality arrangements are described in the Appraisal and Revalidation policy HR46.

42. From the 1.04.2015 all appraisal documentation is accessed through MyL2P. This system meets the information governance requirements set out in *Information Management for Medical Revalidation in England.*

43. Appraisers are trained to delete/destroy all files relating to an appraisal once it has gone through the quality assurance process.

44. Appraiser and appraisee have access to an individual's appraisal folders on MyL2P. The Clinical Appraisal Lead, Responsible Officer, and Appraisal Administrator all have access to all data on MyL2P.

45. The system clarifies that no patient identifiable data should be entered. Any such entry would lead to an IR1 information governance breach being submitted.

Revalidation Recommendations

46. The process for making recommendations is detailed in the Appraisal Policy (HR46) under appendix 6: Process for making recommendations to the GMC for revalidation, and includes process to be followed for deferrals and non-engagement.

47. Between 1.04.2015 and 31.03.2016 the Responsible Officer made 127 recommendations regarding revalidation to the GMC. The Table below shows the trends since revalidation commenced. One recommendation for non-engagement was required (see below).

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

48. The increase in deferral rates identified can be explained by the cohort of doctors involved. Year 3 includes doctors with short term contracts, doctors new to the NHS and doctors recently appointed.

49. One recommendation of 'non-engagement' was made. This was with full knowledge of the doctor who made it clear that he found the whole process of revalidation too difficult and had no intention of ever practising as a doctor again. He resigned from his post having found alternative employment that did not require a license to practise.

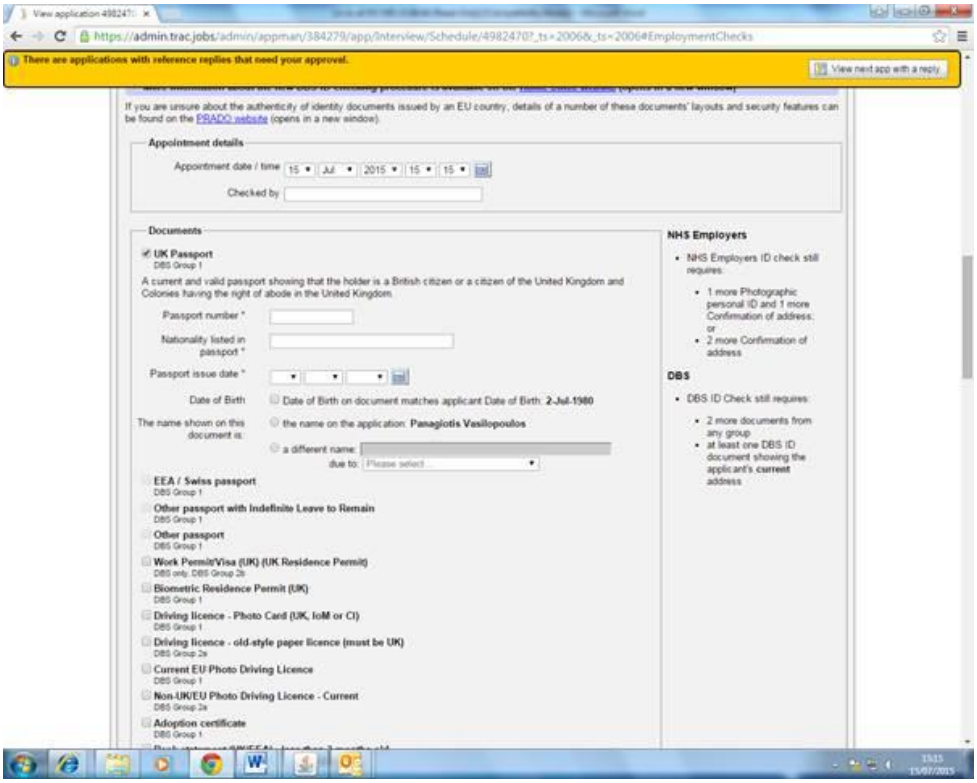
50. All doctors deferred receive an action plan from the RO with detailed objectives and timescales leading to the new revalidation date. The Appraisal Lead provides extra support to those who have been deferred to ensure revalidation readiness. Failure to engage with the deferral action plan may lead to a recommendation of 'non-engagement'.

51. Late recommendations: There was one late recommendation. This recommendation could not be made as there was a conflict of interest between the Responsible Officer and the doctor at the time. No alternative RO could be identified prior to the doctor leaving the employ of ELHT.

Recruitment and engagement background checks

52. As noted in paragraph 8, provider Boards have an overseeing role in ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed

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



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

55. An audit of recruitment and engagement background checks is summarised in Appendix 7. 25 recruitment records were sampled.

Monitoring Performance

56. Performance concerns, whether due to capability or conduct, can be raised through several routes. These include (serious) incident reports, complaints, claims, colleagues/other health professionals raising concerns, and clinical indicator reports (e.g. Dr Foster)

57. Appraisers are trained to stop appraisals if serious concerns come to light, and refer to the Responsible Officer.

58. The RO pro-actively monitors the performance of those with GMC restrictions/undertakings or conditions.

59.

60. Appendix **6**: Audit of concerns about a doctor's practice, summarises all performance concerns arising in 2015.2016, and includes a breakdown of ethnicity and gender. Statistically the numbers are too small to draw any significant conclusions. However, we will continue to monitor these numbers and at appointment of new consultants what additional support they might need, particularly if coming from a non NHS background.

Responding to Concerns and Remediation

61. ELHT HR policy 039 (v3.1) details the processes to be followed for the investigation, monitoring and response to concerns about a doctor's practice. This policy is consistent with the national guidance Maintaining High Professional Standards (MHPS).
62. A review of this policy is currently in progress and will be finalised by the end of July 2016.
63. ELHT has invested in training ten senior clinicians in investigation concerns about doctors, following MHPS guidelines. A number of HR professionals at ELHT have now also had this training. This allows them to investigate cases that do not have a clinical component, and support clinical investigators in those that do.
64. Many low level concerns can be easily resolved with local remediation. For more serious concerns, NCAS (National Clinical Advisory Service) is consulted for advice, as well as support for formal assessment and remediation.
65. HR policy 63 sets out the approach and processes for remediation. A review of this policy will follow during 2016.2017.

Risk and Issues

66. As set out in paragraph 45, revalidation deferral rates have increased. This is in line with the rest of the UK, but will need continued monitoring. Whilst the most common reason for deferral is missing supporting information, e.g. patient feedback, deferrals should not be used to conceal capability or conduct issues. This risk will be mitigated by scrutiny of appraisal inputs and execution and monitoring of deferral action plans.
67. Ensuring that appraisals are carried out and completed in a timely manner requires a significant resource in administrative tracking and pursuing. Increasing understanding amongst doctors that appraisal and revalidation are first and foremost the responsibility of the individual doctor is a priority both internally and externally (e.g. GMC).

68. Performance data report through trust systems such as Dr Fosters and Theatre man is available for all consultants but not for non-consultant grade doctors. (Because data is capture as 'FCE' – finished consultant episodes – work done by non-consultants is recorded as consultant work). For non-consultant grades, there is therefore a greater reliance on their self-maintained log of work for appraisal discussions.

69. Governance information is provided for all doctors as a report based on data extracted from Datix governance system on the preceding 15 months up to appraisal. This includes information on incidents reported by the doctor or where the doctor was named in complaints and claims. However, as most claims take a long period to be processed, this may not always appear on the governance report for that year.

70. Thus, ensuring high quality inputs into appraisal (e.g. data quality regarding performance, activity, governance information) continues to be challenge. (see below: next steps)

Next Steps

71. In 2016.2017 the appraisal and revalidation team will work with appraisers and CDs to further develop and improve the inputs of appraisal, e.g. ensuring not just satisfactory submission and reflection on the 6 key element of supporting information (CPD, quality improvement, compliments and complaints, incidents, colleague and patient feedback) but also:

    a) any issues that have been raised by the Responsible Officer and/or his deputies for discussion at appraisal where the judgement was that reflective comment to be discussed with the appraiser is the most appropriate professional response (generally relate to specific incidents, investigations)
    b) Completion of all generic and specialty specific mandatory training
    c) Demonstration of ongoing reliability of care by showing and reflecting at appraisal on performance in any national database relevant to the individual's work and any local and personal audits undertaken, including any "resource usage" data. Examples (not exclusive: every Directorate to develop agreed list to be approved by Clinical and Divisional Director)
        i. Discrepancies of a radiologist
        ii. Hip revisions of an orthopaedic surgeon
        iii. Complication rate surgeons
        iv. MRI requests of an acute physician

v. CTPA requests from AMU physician

vi. Achievement of Sepsis 6 one hour antibiotics in ED,

72. To reduce the workload associated with quality assuring every single appraisal, a system of sampling appraisal outputs for those appraisers who have demonstrated high quality appraisals in being implemented in 2016.2017.

73. Progress with deferral action plans will be closely monitored by the Appraisal Lead.

74. Following the procurement of a new clinical benchmarking system (due to be completed by August 2016) the appraisal and revalidation team will work with the suppliers to provide improved individualised reports of clinical indicators such as mortality, complications, length of stay, readmissions, day case rates and conversion rates for reflection and discussion at appraisal.

75. Appraisal workshops will be further rolled out to ensure appraisees understanding of the importance of appraisal for professional development and revalidation, and to ensure understanding of personal responsibilities.

Recommendations

75. The Board is asked to:

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

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

Appendix 1 Designated Body Statement of Compliance

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

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

   Comments: Dr Damian Riley Executive Medical Director

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

   Comments: Yes, see Annual Report 2015.2016

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

   Comments: Yes, see Annual Report 2015.2016

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

   Comments: Yes, see Annual Report 2015.2016

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes, see Annual Report 2015.2016

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

   Comments: Yes, see Annual Report 2015.2016

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

   Comments: Yes, ELHT policy HR 39

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

   Comments: Yes, ELHT policy HR 46

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

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[3] have qualifications and experience appropriate to the work performed; and

Comments: Yes, see Annual Report 2015.2016

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

Comments: Yes, see Annual Report 2015.2016

Signed on behalf of the designated body

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

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

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

Appendix 2 Annual Organisational Audit 2015.2016

East Lancashire NHS Trust_Aoa_2015-16.pd

Appendix 3 ToR

Terms of Reference
Doctors in Difficulty Group

Constitution and authority

ELHT has established the Doctors in Difficulty Group (DiDG). It has authority to undertake any activity within these terms of reference.

Membership

The DiDG is a group of senior clinical and non-clinical individuals with in-depth knowledge of medical performance procedures and professional standards and able to provide advice on handling individual cases.

Membership:

1. Responsible Officer*
2. Deputy Medical Director (*Professional Standards*) who will be Chair of the meeting*
3. Deputy Medical Director (Quality and Education)*
4. Deputy Director of HR
5. Head of Medical Staffing
6. Head of Safety and Risk Assurance
7. Head of Education

Deputies:

1. For Responsible Officer the deputy is DMD (Professional Standards)
2. For DMD (professional Standards the deputy is Deputy Medical Director (Quality and Education)
3. For Deputy Director of HR the Deputy is Senior HR manager
4. For Head of Medical Staffing Deputy is member of medical staffing team
5. Head of Safety and Risk Assurance deputy is member of team
6. Head of Education

Quoracy

A minimum of four members or named deputies must be present with at least one of the * members.

Decisions

All members have a vote and the chair has the casting vote, if necessary. Additional non-voting individuals may be invited by the chair. This includes specialty specific advisors.

Frequency

The DIDG will meet monthly or more frequently as is required, as dictated by caseload. Where expediency is required, teleconference, videoconferencing or virtual (email based) meetings may be held, providing decisions indicate quoracy for agreement.

Purpose

(Whilst recognising the statutory obligations of the Responsible Officer)

1. To provide advice, support, and take action where performance concerns have been raised
2. To ensure that all concerns about medical staff with a prescribed connection to ELHT are managed in accordance with ELHT policies and Department of Health's 2005 'Managing High Professional Standards in the Modern NHS' (MHPS)
3. To ensure that all concerns about medical staff without a prescribed connection to ELHT are referred to their Responsible Officers and any immediate threats to patient safety or public interest are mitigated.
4. To ensure the appropriate supervision and monitoring of doctors (with or without prescribed connection to ELHT) with restrictions, undertakings or conditions on their practice from the regulator (GMC) or employer.

Objectives

1. To ensure that all concerns and all complaints related to a named clinician are received, considered, investigated where appropriate, and managed in the interest of patient safety and high standards of patient care.
2. To ensure that doctors whose performance, conduct or health has given cause for concern are supported to return to a satisfactory standard where possible. Where this is not possible, to advise on appropriate restrictions or exclusions from work.
3. To ensure a fair, open, consistent and non-discriminatory approach to the management of concerns.
4. To facilitate the resolution of concerns through appropriate agreed local action and support for improvement where possible, and to refer to other agencies such as National Clinical Assessment Service, General Medical Council or Counter Fraud Services where appropriate to do so.

Duties

1. To consider each individual case related to and decide whether further action or further information is required, or that there is no case to answer
2. To decide upon and agree, ideally through consensus but if not through the majority, a relevant course of action, the level of support required and the resources required.
3. To make recommendations to the RO with regards to referral to the GMC
4. To ensure that details of individual case where a concern has been discussed, details of the actions and outcome, and details of the whistleblower, if applicable, are managed in accordance with ELHT policies.
5. To monitor progress in relation to the investigation of concerns and where appropriate of compliance and progress with remediation for cases and action plans and decide when the case can be closed, or whether further action is required.
6. Where appropriate, to request a formal investigation and ensure the proper appointment of a case investigator.
7. Where appropriate, to refer to occupational health.

8. Where appropriate, to refer to external agencies for advice, for example National Clinical Assessment Service (NCAS), national professional and representative bodies, local representative committees, local education and training boards, or other advisory bodies.
9. Review relevant policies annually

Reporting

1. Monthly report to part 2 of Trust Board on all doctors with GMC or local restrictions/undertakings/conditions on their practice, to include summary of number and category of concerns about doctors
2. An annual audit of concerns about doctors will be included in the Annual Appraisal and Revalidation Report to the Trust Board

Appendix 4 Audit of all missed or incomplete appraisals

Doctor factors (total)	Number
Maternity leave during the majority of the 'appraisal due window'	1
Sickness absence during the majority of the 'appraisal due window'	4
Prolonged leave during the majority of the 'appraisal due window'	2
Suspension during the majority of the 'appraisal due window'	
New starter , previous NHS job	6
New starter first job in the NHS	12
Postponed due to incomplete portfolio/insufficient supporting information	1
Appraisal outputs not signed off by doctor within 28 days	
Lack of time of doctor	3
Lack of engagement of doctor	
Other doctor factors	
One doctor delayed his appraisal due to being the main carer for his wife after an accident.	
Appraiser factors	
Unplanned absence of appraiser	
Appraisal outputs not signed off by appraiser within 28 days	
Lack of time of appraiser	1
Other appraiser factors (describe)	
(describe)	
Organisational factors	
Administration or management factors	
Failure of electronic information systems	
Insufficient numbers of trained appraisers	
Other organisational factors (describe)	
Total:	30

Total number of appraisals completed		370	%	Comment
	No. in audit			
Appraisal inputs	200	182	91%	18 had gaps identified at QA review before sign off
Scope of work: Has a full scope of practice been described?	200	192	96%	
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	200	199	99%	One had insufficient CPD evidence and was allowed time to address this within 28 days and also addressed through strengthened PDP.
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	200	200	100%	All 200 had QIA included within the annual appraisal input, or within 3 years mentioned in summary or included as part of the PDP agreed within output. All revalidation ready appraisals had this assurance in place.
Patient feedback exercise: Has a patient feedback exercise been completed?	200	199	99%	One was due 360 and it was also their revalidation year and yet it was not completed fully prior to appraisal. Fed back through QA review and appraisal signed off after completion, prior to revalidation recommendation.
Colleague feedback exercise: Has a colleague feedback exercise been completed?	200	199	99%	As above
Review of complaints: Have all complaints been included?	200	194	97%	The self declaration data field within MYL2P system for significant events was completed by all 200. There is a process whereby a Trust Governance report compiled based on Datix data which includes all incidents reported, significant events, complaints and claims is made available to all GMC connected doctors, the month before the appraisal month. This allows time for doctors to review the data, and enable documented reflections with a personal action plan to address complaints or Significant events if any as appropriate. Appraisers are expected to triangulate the information within this report against the self declaration in MyL2P and with submitted reflections. Number: Six appraisals did not include Trust governance report within their appraiser summary and it was also found to be missing within appraisal portfolio. QA review identified the gap, ensured that reports were included and where

				complaints were noted within report, appropriate reflection was also presented to appraiser. Appraisal sign off occurred only after QA review feedback actions were completed.
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	200	194	97%	As above
Is there sufficient supporting information from all the doctor's roles and places of work?	200	191	96%	Nine doctors did not submit letter of good standing from other places of work which was identified during appraisal QA review. Appraisal sign off occurred only after QA review feedback actions were completed and missing information presented to appraiser and assurance received.
Appraisal Outputs				
Appraisal Summary	200	182	91%	
Appraiser Statements	200	182	91%	
PDP	200	200	100%	

Appendix 6 Audit of concerns about a doctor's practice

Concerns about a doctor's practice (these include doctors without a prescribed connection, i.e. doctors in training)	High level	Medium level	Low level	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern				47
Capability concerns in the last 12 months		8	5	13
Conduct concerns in the last 12 months	2	10	16	28
Mixed conduct/capability in the last 12 months		2	2	4
Health concerns (as the primary category) in the last 12 months			2	2
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2016 who have undergone formal remediation between 1 April 2015 and 31 March 2016 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				6
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				1
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				2
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				3
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All DBs				1
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All DBs				0
TOTALS				**6**
Other Actions/Interventions				

Local Actions:	
Number of doctors who were excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	1
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	1
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	5
GMC Actions: Number of doctors who:	
Were referred to the GMC between 1 April and 31 March	1
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	10 (incl. 5 no longer working at ELHT)
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	2
Had their registration/licence suspended by the GMC between 1 April and 31 March	
Were erased from the GMC register between 1 April and 31 March	

Gender and ethnicity distribution of Doctors investigated for concerns:

	Investigated doctors		All ELHT doctors	
White - British	12	23.5%	188	34.5%
White - Any other White background	2	3.9%	52	9.5%
Mixed - White & Black African		0.0%	2	0.4%
Mixed - White & Asian		0.0%	7	1.3%
Mixed - Any other mixed background	1	2.0%	7	1.3%
Asian or Asian British - Indian	10	19.6%	107	19.6%
Asian or Asian British - Pakistani	10	19.6%	72	13.2%
Asian or Asian British - Bangladeshi	1	2.0%	5	0.9%
Asian or Asian British - Any other Asian background		0.0%	29	5.3%
Black or Black British - Caribbean		0.0%	2	0.4%

Black or Black British - African	1	2.0%	14	2.6%
Black or Black British - Any other Black background	1	2.0%	4	0.7%
Chinese		0.0%	11	2.0%
Any Other Ethnic Group	2	3.9%	18	3.3%
Undefined	11	21.6%	27	5%
Male	47	90%	341	63%
Female	5	10%	204	37%

Appendix 7 Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	19
Temporary employed doctors	81
Locums brought in to the designated body through a locum agency	n/a
Locums brought in to the designated body through 'Staff Bank' arrangements	22
Doctors on Performers Lists	1
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	Number
TOTAL	123

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers) (sample of 25 cases)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	BDS	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	4	4		4		4	4	4	3	4		4	4	4		
Temporary employed doctors	15	14		15		14	15	15	15	15		15	15	15		
Locums brought in to the designated body through	n/a															

a locum agency																
Locums brought in to the designated body through 'Staff Bank' arrangements	5	5		5		5	5	5	5	5		5	5	5		
Doctors on Performers Lists	1															
Other (independent contractors, practising privileges, members, registrants, etc)	n/a															
Total (these cells will sum automatically)																

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 259

28 September 2016

Purpose Information

Title	EPRR Status Report 2016 (Emergency Planning, Resilience and Response)
Author	Mrs B Mitchell, Emergency Planning Manager
Executive sponsor	Mrs G Simpson, Director of Operations

Summary: This paper describes the current position of ELHT with regard to emergency preparedness and outlines the annual workplan for 2016/17.

It includes the Statement of Compliance with the NHS England Core Standards for EPRR Audit, 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 Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

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

Previously considered by: Emergency Preparedness Group, 8 September 2016

Executive Summary

1. This paper summarises the current position of the Trust in relation to emergency preparedness and business continuity arrangements, incorporating information gained from an audit of the EPRR core standards from NHS England.
2. It looks at how the Trust might improve practice, what it needs to commit in terms of resources and sponsorship to enable sustainable improvement and contains an action plan (at Appendix B) to implement the required change.
3. Throughout the paper, effort has been made to identify the least disruptive, most cost effective changes to produce the maximum desired response.
4. The Core Standards annual audit for 2016/17 demonstrates a level of Substantial Compliance.

Trust activity in EPRR over the preceding 12 months

5. Since the last annual report, there has been activity in this area of practice which describes a clear improvement process.
6. The Trust has substantially altered its approach to documentation of emergency plans. The concept of one large plan, containing detailed standard operating procedures for every eventually has been discontinued.
7. The Trust now employs an All Hazards Approach to emergency preparedness. This concentrates planning on the effects on core business of any given threat, rather than the threat itself. The approach allows for streamlining and targeting of documentation.
8. Once the planning programme has been fully developed, each Directorate, Division and Department will have contingency plans to deal with the most severe threats to continuity, as part of the Business Continuity Planning programme. Separately, key services, such as Emergency Department, Switchboard and Surgery/Critical Care, have their own specific Major Incident Response Plans, which form a foundation for the overarching Corporate Major Incident Plan.
9. The Trust Plans are overseen and ratified by the Emergency Preparedness Group (a strategic level group, chaired by the Accountable Emergency Officer). A sub group of the EPG is the Business Continuity Planning Group, which operates at a tactical level to develop a business impact analysis of the Trust and coordinate business continuity/contingency planning at a local level, via Divisional Lead staff, reporting to EPG for governance purposes. The BCPG is in the process of establishing its workplan and terms of reference. Policies and protocols are owned/ developed by

departments and divisions, passing through Policy Council and subsidiary governance groups toward ratification.

10. The Trust has adopted the JESIP (Joint Emergency Services Interoperability Programme) nomenclature and systems, to prepare for the extension of the JESIP programme from blue light services only to collateral services. The terms Gold, Silver and Bronze have been discontinued in favour of the terms Strategic, Tactical and Operational respectively.

11. In line with this advice, the Silver Command Room has been renamed the Incident Coordination Centre and relocated from Park View Offices to Trust HQ. This has allowed for the separation of decision makers from information handlers, to provide a more structured environment to facilitate both functions.

12. Three wide scale exercises took place across the Trust in 2015/2016. Two were to test the communication cascade used in response to a major incident declaration (Starlight 2 and Starlight 3). These exercises take place on a six monthly cycle, alternating between tests carried out during business hours and tests performed out of hours. Both exercises tested the Switchboard Major Incident Activation Plan and demonstrated the robustness of the alert system. Exercise EMERGO was a live exercise, conducted by Public Health England, to test the Trust's plans for responding to a Mass Casualty incident with a CBRN element. The exercise demonstrated that the Trust has good basic systems for responding to such an incident but also highlighted areas for improvement. As a result, specific response plans for Surgery & Anaesthetics, as well as Critical Care, are being formulated to improve the response arrangements.

13. The Trust also participated in a Health Economy wide pandemic influenza table top exercise to examine our arrangements for responding to an outbreak. The exercise demonstrated the value of an all hazards approach as opposed to threat specific planning.

14. The Trust used the Command & Control system in response to the industrial action by junior doctors of the BMA, between December 2015 and April 2016. The national level Command & Control arrangements were invoked for each strike day, as the action escalated, the system was able to accommodate the management of the withdrawal of labour. There were no significant difficulties arising from the industrial action. The system worked well and provided the required level of coordination. Feedback was provided to the centre about the response. The UNIFY 2 data collection system was used for reporting and there were no major problems encountered.

15. The Trust was asked, in March 2016, to provide assurance to NHS England regarding our capability to respond in a mass casualty event. This was generated by concerns around an incident in Paris, France, November 2015. Substantial assurance was given, since the Trust has limited access to specialists in surgery for ballistic or explosive injuries, support in this area would be required. However, the skill set of our general surgeons would be sufficient to the immediate need. The fact that we have both surgical and nursing staff who are members of 207 Field Hospital (Army Reservists) supports our ability to respond.
16. We need to embed a top-down approach to business continuity and resilience across the organisation. The Business Continuity Planning Group was set up to facilitate this. However, the "Understanding our business" component of the ISO 22301 standard represents a large piece of work. It would be a good resource for the Trust to have a basic map on which to build plans. This task will require commitment to achieve success.
17. A detailed report, as provided to the CCGs, explaining how we meet the core standards, is available from the Emergency Planning Manager on request.

Conclusion

18. The Trust is achieving a robust level of compliance with the EPRR core standards. We have a solid core of staff trained to respond in a major incident (on call directors, managers, clinicians, loggists and an operational CBRN cadre in ED).
19. Our biggest challenge is embedding a collaborative approach to resilience and business continuity to align the Trust with ISO 22301. NHS England will be monitoring this area of work very closely in the next 12 months.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 260

28 September 2016

Purpose Information

Title	Finance and Performance Committee Update Report (July and September 2016)
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Mr David Wharfe, Non-Executive Director

Summary: The report sets out the matters discussed and decisions made at the Finance and Performance Committee meeting held on the 25 April 2016.

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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Finance and Performance Committee Update Report: July 2016

1. At the last meeting of the Finance and Performance Committee held on Monday 25 July 2016 members considered the following matters:
2. The Committee received the Sustaining Safe, Personal and Effective Care 2016/17 update report. It was agreed that the RAG rating of Safely Releasing Costs Programme (SRCP) would be reviewed to ensure a more realistic overview of schemes could be provided. The Committee noted that planning for 2017/18 schemes had begun.
3. As part of the Sustaining Safe, Personal and Effective Care 2016/17 item the Committee received and update about the Programme Management Office (PMO). The PMO were in the process of recruiting to additional posts due to the shift towards more operational management and delivery of schemes. It was noted that the Associate Director of the PMO was working with the Pennine Lancashire Transformation Programme for one day per week and that discussions were ongoing with commissioners in relation to the associated capacity issues within the PMO. Non-Executive Directors raised concerns over the delivery of the current and future year programme and requested assurance.
4. The Committee received an update in relation to the Carter Review. Members noted that a benchmarking website has been set up by the regulator with information being populated when available. The Trust has been selected as one of the eight Trusts to take part in the scoping and classification of Allied Health Professionals measures.
5. The Committee members discussed the issues that were being experienced in relation to the community equipment service and it was noted that operational issues with the service were being reported through the Datix IR1 risk system in order to ensure a suitable audit trail is created and they would be presented to the commissioner of the service for resolution.
6. The Committee received a presentation about the NHS financial document *"Strengthening Financial Performance and Accountability in 2016/17"*. The presentation covered a number of items, including: the legal responsibilities of individual NHS bodies to manage within centrally allocated funding and the relating action points. The presentation covered an overview of the current regulatory environment for providers and commissioners; the Single Oversight Framework consultation and the themes contained within it. The Committee noted the criteria for the release of the Sustainability and Transformation Funds.

7. The Committee also received the Integrated Performance Report and requested assurance about the actions taken in relation to cancer performance, Finance Report and Integrated Reference Costs Report. In addition the Committee received the minutes of the Contract and Data Quality Board and E-Health Board.

Finance and Performance Committee Update Report: September 2016

8. At the last meeting of the Finance and Performance Committee held on Monday 12 September 2016 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.
9. The Committee received the Sustaining Safe, Personal and Effective Care 2016/17 update report and noted that the RAG ratings of schemes had been revised as requested at the previous meeting. It was confirmed that the revised ratings had been shared with members of the Transformation Board at its last meeting. Members discussed the potential issues around savings being double counted at various points as Pennine Lancashire and Healthier Lancashire level organisations could account twice for the same savings through the various transformation programmes.
10. The Committee wished to escalate to the Board its concerns over the delivery of the 2017/18 transformation programme. The Committee requested assurance in this matter.
11. The Associate Director of the PMO provided a presentation in relation to the work being undertaken within the Emergency Care Pathway to streamline flow and realise savings. The transformation work on the Emergency Care Pathway will be presented to the September Trust Board.
12. The Committee received the proposed revised Standing Orders and Standing Financial Instructions for comments. Members requested further amendments including the responsibilities of the Trust in relation to appointment of Directors. The Standing Orders and Standing Financial Instructions will be presented to the Audit Committee in December for ratification.
13. The Committee received the proposed revised terms of reference. The revised terms of reference were approved pending inclusion of a third Non-Executive Director member and the continuation of the Medical Director as a member of the Committee. The revised terms of reference are presented to the September Trust Board for ratification.
14. The Committee received the Integrated Performance Report and wishes to escalate to the Board its concerns about the A&E four hour performance and its potential

impact on finances and the receipt of the Sustainability and Transformation Funds in the event of not achieving the required level of performance.

15. The Committee also received the Finance Report, Contract and Data Quality minutes and E-Health Board minutes. In addition the Committee received updates about the Carter Review and Procurement. The Carter Review will be a standing item on the Committee's agenda in the future.

Kea Ingham, Company Secretarial Assistant, 15 September 2016

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD REPORT

Item 261

28 September 2016

Purpose Action

Title	Finance and Performance Committee Terms of Reference
Author	Mrs A Bosnjak-Szekeres, Company Secretary

Summary:
The Finance and Performance Committee terms of reference have been reviewed and agreed by the Committee at its meeting on the 12 September 2016. The revised terms of reference are presented to the Board for ratification.

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

Recommendation:

The Finance and Performance Committee is recommending to the Board to ratify its revised terms of reference.

Report linkages

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

position and appropriate continuity of service risk rating.

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: NA

Finance and Performance Committee Terms of Reference

Constitution

The Board has established the Finance and Performance Committee to provide assurance about the delivery of the financial and operational plans approved by the Board for the current year and for the longer term future, develop forward plans for subsequent financial years for consideration by the Board and examine in detail risks to the achievement of national and local performance and activity standards.

Purpose

To support the Trust Board in the analysis and review of Trust financial and performance plans, providing advice and assurance to the Board on financial and performance issues.

It will:

- review the annual business plans prior to Board approval and submission to the Regulator and review plans for the longer term
- Review financial performance against income, expenditure and capital budgets and consider the appropriateness of any proposed corrective action
- Review progress against efficiency programmes and consider the appropriateness of any proposed corrective action including looking in detail at the Safely Releasing Costs (SRCP) and Transformation Programmes and their delivery
- Consider the financial performance in the current year and look ahead to expected performance for the subsequent 2-5 years and review all significant financial risks
- Regularly review cash flow forecasts and the adequacy of funding sources and receive assurance on the robustness of the Trust's key income sources
- Receive the draft annual accounts before presentation to the Board for final approval
- Provide the Board with a forum for detailed discussions and assurance of progress against the Integrated Business Plan including the delivery of the Safely Releasing Costs (SRCP) and Transformation Programmes
- Assess the performance of the organisation against all national and local performance standards and consider plans for the longer term
- Carry out the annual review of corporate documents (e.g. Standing Financial Instructions, Scheme of Delegations, etc.) before ratification by the Audit Committee on behalf of the Board

Membership

3 Non-Executive Directors and Associate Non-Executive Directors (a Non-Executive Director will be the Chair of the Committee)

Chief Executive

Director of Finance

Medical Director

Director of Operations

Director of Human Resources and Organisational Development

Director of Service Development

The Chief Nurse will attend the Committee meeting by invitation for items within her remit.

In attendance

Company Secretary

Associate Director of Performance and Informatics

Frequency

The Committee will meet bi-monthly. Additional meetings may be called at the discretion of the Chair of the Committee as provided for in the Trust Standing Orders and the Standing Financial Instructions.

Quorum

Two Non-Executive Directors and two Executive Directors

Regular Reports

Integrated Performance Report

Finance Report

SRCP and Transformation Report

Carter Review

Authority

To summon reports (and individuals) to enable the committee to discharge its duties .

Reporting

The Committee will report to the Trust Board

Review

The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board governance cycle and presented to the Board. The Committee will provide regular reports on its activities to the Trust Board. The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit Committee through the internal and external auditors and external regulatory bodies.

Committee Services

Lead Director – Director of Finance

Secretary – Company Secretary

Committees reporting

Transformation Board

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 262

28 September 2016

Purpose Information

Title	Audit Committee Update Report (September 2016)
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Mrs E Sedgley, Non-Executive Director

Summary: The report sets out the matters discussed and decisions made at the Quality Committee meetings held on 1 June and 6 July 2016.

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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Audit Committee Update: September 2016

1. At the meeting of the Audit Committee held on Wednesday 7 September 2016 members considered the following matters:
2. The Committee received the management response in relation to Consultant Job Planning internal audit. The Internal Auditors agreed to undertake a further audit in March 2017 following the implementation and embedding of the allocate software system. The Committee members agreed to receive a more detailed update report at its next meeting in December with a further report to be submitted in July 2017.
3. The following internal audit reports were presented to the Committee:
   a) Discharge Planning (significant assurance received)
      i. The Committee members discussed the issue of Section 75 agreements and the impact on the Trust of them not being in place at this time. It was agreed that the rating of the action relating to Section 75 agreements would be increased from medium to high and should be highlighted to the Trust Board for action. The Committee also wishes to escalate the issues in relation to discharge and lack of section 75 agreements to be kept on the agenda of the Finance and Performance Committee as part of the performance review.
   b) Medicines Management Baseline Review (significant assurance received)
   c) Complaints Management (significant assurance received)
      i. The Audit Committee noted that no annual report relating to complaints had been received by the Quality Committee for the year 2015/16 and wishes to escalate the request for the annual report for the past year to be presented at the next meeting.
4. The Committee received the Counter Fraud Service progress report and noted the progress being made in relation to the referrals and investigations that were currently underway.
5. The Committee received the Fit and Proper Persons Policy for review and approval. Pending the inclusion of a section to address interim and acting up arrangements the policy was approved on behalf of the Trust Board.
6. The Committee received two proposed templates to review the effectiveness of internal auditors. It was agreed that the Committee members would undertake an annual survey to assess the effectiveness of the internal auditors and a survey shall be developed for external auditors as well.
7. The Committee received the proposed annual statement regarding the Modern Slavery and Human Trafficking Act. The Committee approved the statement for

signature by the Committee Chair and Acting Director of Finance. The signed statement will be uploaded to the Trust's public website and intranet site.

8. The Committee received and approved the proposed Anti-Fraud, Bribery and Corruption Policy.

9. The Committee received the proposed Standards of Conduct Policy for consideration which included arrangements for the declarations of interests, gifts, hospitality and sponsorship. Following discussions it was agreed to include further information regarding work undertaken on an honorarium basis and taxable gifts and hospitality. Pending this inclusion the Policy was approved by the Committee

10. The Committee also received the External Audit Progress Plan and Losses and Special Payments Report.

Kea Ingham, Company Secretarial Assistant, 13 September 2016

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 263

28 September 2016

Purpose Information

Title	Quality Committee Update Report
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Mr P Rowe, Non-Executive Director

Summary: The report sets out the summary of the Annual Report of the Infection Prevention and Control Committee and the Director of Infection Prevention and Control received by the Quality Committee at its meeting on 13 July 2016.

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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Quality Committee Update from July 2016 - Summary of the Annual Report of the Infection Prevention and Control Committee and the Director of Infection Prevention and Control

1. The Committee received the annual report of the Director of Infection Prevention and Control (DIPC) on behalf of the Trust Board.
2. The report summarises the work of the Infection Prevention and Control Team (IP&CT) during 2015/16, the progress made and the significant infection control and prevention challenges faced by the Trust.
3. The overall levels of healthcare associated infection have reduced over the year. The trajectory for MRSA bacteraemia for the year 2015/2016 was to have no more than 0 bacteraemias; the year end outturn attributable to the Trust was 1.
4. The post 3 days trajectory target set for Clostridium difficile infections for 2015/2016 was 28 cases and the outturn was 29. 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.
5. The national target of MRSA screening for all eligible elective and emergency admissions has continued satisfactorily.
6. Staff training through induction and mandatory updates has continued. 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 the Blackburn and Burnley hospital sites with stalls on main entrance; ward visits with Glo box and ‘5 moments’ leaflets given to staff on wards. The staff mandatory training DVD continued for all staff in place of the mandatory training day.
7. The Trust antimicrobial formulary continued to be reviewed in 2015/16 by the Antimicrobial Stewardship Committee.
8. The junior doctor’s antibiotic audit was developed further and quarterly audits continued in 2015/16 with audit presentations in Medical Audit meetings and Grand Rounds. This information is disseminated via the DIPC report to all divisions, via the Divisional Audit Lead and presented at the Infection Prevention Committee. The Antibiotic Stewardship Programme continued to be pursued with weekly Clostridium Difficile ward rounds, antibiotic audit ward rounds, Infection Prevention & Control Nurses (IP&CN) and ward pharmacist notifications.
9. There has been an active audit programme including environmental audits of clinical areas and compliance with the Hand Hygiene policy. During 2015/16, infection control policies have been developed and reviewed to ensure they incorporate current best practices.

10. 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.
11. The full annual report is available via the Company Secretariat.

Kea Ingham, Company Secretarial Assistant, 15 September 2016

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 264

28 September 2016

Purpose Information

Title	Trust Charitable Funds Committee Update Report (June and July 2016)
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Mr D Wharfe, Non-Executive Director

Summary: A summary of the discussions of the Committee is presented 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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: NA

Meeting of the Charitable Funds Committee, 1 June 2016

1. At the last meeting of the Trust's Charitable Funds Committee held on 1 June 2016 members considered the following matters:
2. The Committee received the annual report of the investment manager and the fund continues to perform well considering the recent fluctuations in the market and the investment manager suggested that there may be a move to a 50/50 spilt between UK and foreign based holdings in the future.
3. The Committee received the 'Guide to Our Risk Categories for Charities' document from Brewin Dolphin, following discussion it was agreed that that the Trust's rating is a 4, low investment risk. The Committee Chair and Acting Director of Finance were required to confirm the rating decision following the meeting by completion of relevant paperwork. A client services review is scheduled to take place in the autumn.
4. The Committee received an application to use funds in relation to onsite tobacco control and improvements to signage. Following discussion the request to utilise the Trust's Charitable Fund for improved anti-smoking signage was not approved by the Committee.
5. The Committee received and update about raising the awareness of the Trust's Charitable Fund. Members noted that, following a staff poll, the new name for the charity will be 'ELHT and Me'. The Committee were keen to see the remaining actions progress at pace and requested that a formalised action plan and timescales be developed with the majority of the actions being completed by the end of September 2016. Members noted that a formal re-launch of the charity would take place at the Annual general Meeting on 14 September 2016.
6. The Committee requested that a second Non-Executive Director join the Committee.
7. Members supported the use of the charitable fund for a £5 voucher for each member of staff for use in the staff canteens as a thank you following the positive CQC inspection with the overall cost for this exercise being £35,000.

Meeting of the Charitable Funds Committee, 27 July 2016

8. At the last meeting of the Trust's Charitable Funds Committee held on 27 July 2016 members considered the following matters:
9. The Committee welcomed Mr Barnes to the membership of the Committee.

10. The committee received the proposed plan for the re-launch of the Trust's charitable fund and MRI scanner campaign. The Committee discussed the options for raising funds from local and regional organisations. Non-Executive members requested that an overarching fund raising strategy be developed and include corporate fundraising.
11. The Committee requested that clarification to be sought in relation to permissibility of a request for £5,000 from the fund for the rebranding and re-launch of the charity. In addition it was agreed that the employment of a fundraising manager would be explored.
12. The Committee requested that a paper be produced for approval at a future Executive Team meeting in relation to the centralisation of dormant funds into the general fund.

Kea Ingham, Company Secretarial Assistant, 16 September 2016

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 265

28 September 2016

Purpose Information

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

Summary: The report details the agenda items discussed in Part 2 of the Board meetings held in July 2016.

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 Become a successful Foundation Trust
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk

rating.

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: n/a

Trust Board Part Two Information Report: 27 July 2016

1. At the meeting of the Trust Board on 27 July 2016, the following matters were discussed in private:

   a) Care Quality Commission Update
   b) Memorandum of Understanding for Pennine Lancashire
   c) Healthier Lancashire and Pennine Lancashire Updates
   d) Internal Communications Plan for Pennine and Healthier Lancashire
   e) Emergency Department Update
   f) Tender Update
   g) Finance Report
   h) Sustaining Safe, Personal and Effective Care 2016/17
   i) Sustaining Safe, Personal and Effective Care 2016/17 Themed Programme Discussion: Burnley Elective Centre
   j) Serious Untoward Incident Report
   k) Doctors with Restrictions

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